MAPPING A WHOLE NEW WORLD WITH THE EMMA CENTER: INTEGRATIVE HEALING TO GENERATE EMPOWERMENT

By

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ABSTRACT

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This project began as an investigation of best practices regarding treatment models in order to inform future development of The Emma Center (TEC). TEC is a nonprofit women's center for adult survivors of child abuse, domestic violence, and other traumas located in Humboldt County, CA. Their mission is three-fold: 1) to provide referrals, support, and advocacy to abuse and trauma survivors; 2) to raise awareness in the community about the effects of abuse and integrative, holistic approaches to healing; and 3) to open a women's residential healing center for women recovering from trauma-related conditions. It is with this latter point that my work with TEC has been concerned.

A main component of this project is the Best Practices Report which is the result of research looking at several case-studies of organizations appearing similar in vision to that of TEC's women's residential healing center. Each case was broken down in a specially designed database by important factors such as treatment philosophy and approach models as well as organizational structure and start-up procedures. Against these models I compare TEC's goal and mission.

Literature reviews present biomedical frame-works and the provision of services as well as the Empowerment movement and its origins. Since gender-related violence is primarily social, rather than medical in nature, placing this trauma and its subsequent

strategies for healing in the context of western disease models is itself problematic. Thus, an approach to healing for women should be rooted in the notion of empowerment, enabling women survivors of gender-related violence to pursue individual and collective strategies for social change in ways that are appropriate to the political and cultural nature of the trauma.

The project concludes after a report evaluating TEC. Perceptions of TEC's current needs, strategies, mission, and goals are looked at in depth. In light of strategic planning processes, I suggest possible adaptations and actions TEC might take in order to keep afloat and moving forward. The project ends with a reflexive statement to support the overall appeal that TEC make the most of the convergence of interests between the community and the individuals they seek to heal, expanding in the direction of social change work toward working toward their high goals.

DEDICATION

To me, myself, and I, for persevering and working so hard come hell or high water, even through the easy times. Thank you, professors, for working so hard with me. To my family for forever encouraging me, especially with their pride. To Mom, thanks for preening me with determination and a "go-get-it" attitude. To Aaron, 'my spirit's match;' for the challenge, the love, and home cooked meals. To Maebelline, the dog, for making sure I got off my butt, away from the computer, and into the fresh air so often. And yes, to America, the land of opportunity: may you one day ring true.

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CHAPTER 1

WOMEN'S HEALTH, AN INTRODUCTION

The Project

A nonprofit women's center for adult survivors of child abuse, domestic violence, and other traumas, The Emma Center (TEC) is grassroots in every sense of the word. Large networks within the community have been carefully constructed in order to fulfill their three-fold mission: 1) providing referrals, support, and advocacy to abuse and trauma survivors; 2) of raising awareness in the community about the effects of abuse and integrative, holistic approaches to healing; and 3) to open a women's residential healing center (WRHC).

In May of 2007, I signed a contract to support TEC's endeavor of manifesting the WRHC. The expected deliverable was a report citing 'best practices' of existing models and centers which was to be followed by a strategic planning outline. Motivated by the prospect of a one million dollar match, the but two-years-old non-profit set its sights high. Because of differences in goals between TEC and the funder, the possible money-match fell through; however, TEC's founder and former director decided to continue actively pursuing the WRHC goal.

Already successful and popular within the community since its recent inception, TEC currently operates out of an obscure office at the south end of Arcata, CA that doubles as a small haven for those who frequent it offering tea, soft couches and a lending library. An abundance of informational pamphlets and flyers for activities and

services for those interested in 'healing' the long-term effects of past traumas are available. TEC also hosts support groups with local university interns and connects clients to practitioners of the healing arts who have donated slots in areas such as chiropractic care, herbal treatments, massage, and biofeedback. Serving roughly 400 clients, TEC has a substantially positive impact in their lives. Finally, the central tenant of TEC's provision of services is that no one asks to be traumatized, therefore, it adds insult to injury when someone must pay for healing—plus, the results of being a traumatized woman frequently involve disempowerment and subsequent inability to afford treatment.

I dove into research for the Best Practices Report with the goal of uncovering existing examples of what TEC wishes to create. The ultimate goal of a women's residential healing center is envisioned as an idyllic, "private, quiet parcel of land…on or near the ocean and forest near Arcata in Northern California (The Emma Center, date unknown)" to provide respite from the women's everyday lives in order to focus on personal healing. There would be the healing benefit of nature, holistic treatments, outdoor activities and an organic garden. Women would stay for periods of a few months to a year and work with a clinical director on individually devised treatment plans. As an alternative to hospitalization for severely low-functioning survivors struggling with day-to-day life, the WRHC would clearly provide a more positive experience and outcome.

The sheer vastness of factors to be taken into consideration quickly overwhelmed me. From legal issues regarding land use and licensure to policy and treatment approach (e.g. whether or not to allow children, if so, what ages and under what conditions) to the

huge matter of funding and clients' practical barriers to access; the information to be waded through was thick. Additionally, TEC's goal is to offer their services to those who need it, whether or not they can pay. I found no such similar centers. Stateside clinical settings all charged in excess of $30,000 per month and other settings were structured as churches and training programs. Questions arose such as: will The Emma Center continue serving its current 400 clients once it is intensively serving a select dozen? Barriers aside, how much would these dozen women actually benefit given that they will have to re-enter 'the real world' and all its challenges? Is this approach to healing futile in its inherent location within a society that replicates social injury? How can TEC afford this when they currently struggle with funding their present operation? In what ways is TEC meeting its goal of educating the community about ameliorating its tendency to harbor and produce epidemic proportions of such social injuries that these women suffer? How could TEC more effectively serve its current clientele and facilitate the generation of momentum for empowerment? The founder was ready, however, to pursue the planning of the WRHC.

A short time later, TEC hired a new director and its founder stepped down for a sabbatical. The new director agreed that my questions needed answers. She took my preliminary Best Practices Report to the board of directors and my contract was revised to address these concerns. Not only would I complete the Best Practices Report with the new slant of possible alternative approaches to healing (empowerment), but I would also conduct a brief, intensive program evaluation of The Emma Center's current operation with concern for how they might become sustainable, and increase in clout and presence.

Practical Strategies

In context of healing the effects of violence against women, practical strategies must concomitantly address their particular vulnerabilities to such violence. The information on women's situations is clear: women are disadvantaged in terms of education, employment, and income; they are the most greatly affected by the negative effects of development on the environment, nutrition, and exposure to toxins. A woman's health is directly reflexive to her status in society (Bair and Cayleff 1993). Since socioeconomic and cultural factors are primary in affecting the health of women—'healing' women would necessarily address these factors *as well as* their individual person. With The Emma Center's 'grassroots' nature, I strongly appeal to them to take note of this convergence of interests between community and the individuals they seek to heal, expanding in the direction of social change work toward working toward their high goals.

This project is framed according to the above premise. I will first present the literature delineating the biomedical model and trends challenging its predominant position to incorporate more whole-istic notions of health and wellness. Chapter Three is an offer of The Best Practices Report which consists of case-studies describing other models similar to The Emma Center in goal and/or anticipated approach. It begins with centers such as the WRHC already in operation and gradually extends to centers that are more community action based with a focus on the woman to be healed as part of a larger collectivity. The next section, Chapter Four, imparts another literature review pertaining to the topic of empowerment. Both a process and a goal, empowerment is discussed in

terms of healing through working to heal ‘the society’ from whence womens’ injuries frequently arise. Finally, Chapter Five submits a qualitative program evaluation of The Emma Center demonstrating perceptions of where they currently stand with relation to their strategic planning goals. The chapter also maps effective strategic planning processes for their use. The final chapter concludes the project and ends with a brief reflexive statement.

CHAPTER 2

REVIEW OF THE LITERATURE:
A CRITIQUE OF THE U.S. HEALTH INSITITUTION

In "a man's world," the ways in which society is organized poses different consequences for women. In order to attend to these consequences, it is important to understand the gendered nature of health and health care. The following review of literature relies on Ratcliff's (2002) outline of this structuring within the US Health Institution.[1]

The Biomedical Model

Body As Machine

Since the seventeenth century the biomedical model has been the predominant paradigm in medical science and practice (Engel 1988). Because of its particular views and practices, only certain sets of particular questions can even be asked about disease, health, and health care. What is paid attention to, research grants, training curricula, medical reimbursements, what kinds of health care/ health care providers are available, and the typical neglect of prevention can all be understood in relation to the biomedical model.

[1] After accessing several of the sources cited in Ratcliff and Richies myself, I developed confidence in their appropriate summarization and use of the information. Because of this, and that the literature reviews for this project are but secondary research to situate the primary purpose (reports for TEC), I relied on their usage of other sources in several places.

Biomedical perspectives define health as the absence of disease. Therefore, eliminating disease is how the biomedical model promotes health. According to such an

approach, health care is focused on the screening, diagnosis of, and curing of disease while *prevention* is neglected. For example, great amounts of resources are spent on attempts to cure cancer rather than to prevent it, and huge investments are made in neonatal intensive care units rather than providing prenatal care for at-risk pregnant women.

A result of this focus on screening and diagnosing is the prominence of *pathology*. Western doctors are trained to be on guard and vigilant; the term "healthy and normal" is not typically used (Kapsalis 1997: 72, as cited in Ratcliff 2002). An excellent example is childbirth. Although a natural process—the unfolding of pregnancy—doctors anticipate problems and are ready to act with scalpel and drugs. A midwife, on the other hand, would sit, wait, and support the natural processes, try to sooth the woman's fear, make her more comfortable, or help to reposition her for more successful contractions. The doctor, however, has been trained to distrust natural processes and come to the rescue. The medicalization of natural processes takes control away from the individual and hands it over to 'the expert.' Women no longer birth children; doctors deliver them (Zschoche; 1980).

With a focus on the elimination of disease, "the biomedical model not only privileges cure over prevention and pathology over healthy processes, but it also privileges objective and technical approaches over subjective ones" (Ratcliff 2002: 3). This means that doctors are heavily trained in technical skills such as the performance of and reading of tests, and administration of treatments, yet how to interact with the actual patients is typically underemphasized. An illustration of this is the typical treatment of

women with long-term effects of abuse. The common mental instabilities of these people are frequently labeled as certain 'disorders' and medicated to maintain functioning and continuity. The technical focus (of screen, diagnose, and 'cure') largely ignores her subjective experience—in this case the *cause* of her problems. The technical emphasis of the biomedical model can perhaps be best summed in its implicit conjecture of the body as a machine.

> The Cartesian model of the body as a machine operates to make the physician a technician, or mechanic. The body breaks down and needs repair; it can be repaired in the hospital as a car is in the shop; once "fixed," a person can be returned to the community. The earliest models in medicine were largely mechanical; later models worked more with chemistry, and newer, more sophisticated medical writing describes computer-like programming, but the basic point remains the same. Problems in the body are technical problems requiring technical solutions, whether it is a mechanical repair, a chemical rebalancing, or a "debugging" of the system. (Rothman 1991: 34-35, as cited in Ratcliff 2002)

This metaphor of the body-as-machine narrows the doctor's focus to only the object of concern: the individual's body. The assumption that disease is located solely in the individual tends to ignore the role of family in successful treatment, as well as the context of the disease. A prime example of this would be domestic violence, stated by the United States Department of Justice to be the leading cause of injury in women for decades—yet the doctor fixes the injuries and returns the woman home. This is classic of the biomedical model's failings; injury is treated as sickness. Sickness implies etiology within the sufferer, it implies weakness, defect, hope for stabilization; sickness implies passivity and experts and denies personal and social accountability.

Critisisms of the Biomedical Model

Many sociologists, feminists, anthropologists and others have criticized the biomedical model for its limitations and propose alternatives that see health in a broader context. Variously called biocultural, sociocultural, sociomedical, or psychosocial models, these integrate social, psychological, cultural, economic, and political causes for disease. Moving beyond the doctor's failure to address the immediate instrument of injury in the preceding example, the abuser, would lead to tracing the cause of injury back to a patriarchal organization of society that privileges men and condones the control of women. "Stress, social support or its absence, poverty, discrimination, mass media influences (e.g., emaciated role models and diet advertisements), the neighborhood, community and ethnic context, and the power of corporations in producing unhealthy situations (e.g., the tobacco industry targeting women) are important candidates in these alternative explanatory models" (Ratcliff 2002: 3).

A biocultural model would contend that disease is socially constructed. Which diseases are "discovered," named, explained in terms of bodily processes, and accepted as such, are not strictly objective matters. Dominant beliefs once saw masturbation as a disease that caused physical, moral, and mental wreckage (Freund and McGuire 1995: 194, as cited in Ratcliff 2002). According to biomedicine, "disease is defined as statistical deviations from the norm on a measurable biological variable, be it anatomical, hormonal, neurophysiological, genetic, or biochemical" (Ratcliff 2002: 4). While these designations may seem objective, the question is: *who* decides what "harmful variation" is among these variables? Where are the boundary lines regarding to what degree that

variation constitutes natural diversity of human experience and what constitutes health consequences? Is having 'abnormally' small breasts a disease? Plastic surgeons say it is and label it 'micromastia,' justifying it as disease on grounds of deviation along the biological variable of breast size. But what makes micromastia a disease? The surgeons' power to declare it so does. What's more is the predominant cultures' standards of beauty that back such concerns. The confounding aspect to this topic is just that: the power of these conventions lie in the silent agreements to (often by default) form and maintain them by the very masses oppressed by them.

Technological Favoritism

A strong foundation for the use of technology is inherent to the biomedical model. Viewing the body as a machine coupled with its interventionist mentality, science encourages technical solutions. The education and socialization of health care professionals reflects this as do reward structures, litigation concerns, inadequacy in evaluative measures for technological systems, and the surge of for-profit based health care. All of these aspects push more and more technology.

The sheer influx of technology has greatly altered the health care experience. Doctors advance in the profession through surgical experience which promotes a proliferation of superfluous operations (Guillemin 1981 and Scully 1994, as cited in Ratcliff 2002). Fearing malpractice suits, doctors practice defensively which calls for extensive diagnostic tests. Patients often undergo barrages of tests with low information payoff because the doctor seeks documentation to back up treatment decisions.

Evaluations of new technology are often first conducted by parties with vested interests—which is in itself problematic—and are left to have follow-up testing conducted at the direct care level. Problems with evaluation frequently lie in the fact that doctors aren't trained to be critical consumers or evaluators, but apt consumers of the newest, high tech innovations. What is perhaps the most astounding is that for many new medical innovations, no evaluation is conducted at all and many medical innovations are used despite negative evaluations (Banta and Behney 1981and McKinlay 1981, as cited in Ratcliff 2002). Furthermore, technology often has a dehumanizing effect in that monitors are regularly relied upon for valuable information of a person's condition rather than the person themself (Cassell 1986, Munsick 1979, Banta and Gelijns 1987, and Crawshaw 1983, as cited in Ratcliff 2002). Finally, many issues are raised with the usage and dependency upon technology; most importantly, matters of accessibility, since technology is expensive (Bush 1983, as cited in Ratcliff 2002).

For-profit Health Care

As with the country itself, and many other industries, American medicine has largely been shaped by the profit and income orientations of key participants who developed and promoted various technologies, devices, procedures, and pharmaceuticals (Relman 1980). In recent years the for-profit aspect of the health care system has intensified with multi-state hospital chains, insurance-provider arrangements, and business strategies to recruit profitable patients. If balance sheets are dictating whether or

not a treatment is provided and to whom, who is looking out for our health? (Ratcliff 2002).

The Gender, Race, and Class-based Organization of Society

The way in which society is organized directly influences women's health, health research, and health care. This fourth theme, focusing on "gender as a ubiquitous system of oppression…" must also take into account and "examine other systems of oppression: racism, classism, ageism, and discrimination against lesbians and women with disabilities" (Bayne-Smith 1996 and Adams 1995, as cited in Ratcliff 2002: 7). Patriarchal views are replicated in the health care domain as a result of the health care system's growth from within a patriarchal society. Language in the health care system reflects this; treating men as the norm and women as the 'other.' Hysterectomies are justified because 'women outlive their ovaries' and are seen as vectors of AIDS rather than victims. This is not merely a scheme of the biomedical model, but a reflection of the culture that views women as less valuable than men, and as valuable mainly in their function as reproductive vessels (Ratcliff 2002).

The organization of society affects how healthy women are in the first place. A woman's health is directly reflexive to her status in society. Poverty, lack of power, racial discrimination, gendered division of labor, and the devaluing of women all affect a woman's health. Health research, largely designed and conducted by men, often excludes women because they are always in a potentially pregnant state which could interrupt procedures. Research findings to do with women are typically interpreted in

stereotypical ways. Women with less power have been used as guinea pigs or ignored, as have been women with disabilities. Health care is also stratified by gender and ethnicity. Doctors are predominantly male and nurses female while the less-paid direct care workers are mainly female and from minority ethnic groups. Female and minority patients within the health care system frequently have less power than male patients with doctors treating, diagnosing, communicating and reporting symptoms differently, and more likely to dismiss a woman's symptoms as 'psychological.' (Ratcliff 2002)

Postmodern Holistic Personhood

Like any institution or process, the biomedical model is comprised of individuals mutually constructing one another. Naturally, as new ideas are disseminated, things adjust accordingly. Emerging literature demonstrates that the biomedical model is proving insufficient, as expressed in patients' increasing pursuit of nontraditional or complementary therapies, doctors' growing attention to and research into psychosocial variables, and even some insurance companies' interest in outcomes that are focused on patient satisfaction. There is a new and growing concern "for the roles played in illness by minds, emotions and social processes" (Morris 2000: 8). Momentum is building toward the articulation of a biocultural model of health that recognizes that beliefs shape perception and alter bodily processes, and that cultures shape beliefs (Morris 2000). The biocultural perspective goes hand-in-hand with the view of the individual as holistic.

Many different disciplines and groups within recent Western thought are rejecting Cartesian mind-body dualism to call for the restoration of the person as mind, body, and

often spirit, as inextricably one (i.e., holistic). Social sciences' postmodern moment rejects dualism, in general, as symptoms of modern rationality. Changes are occurring in the way we think of things as if they were simply autonomous parts (Tyler 1987, as cited in Richies 2000). Seen as an outgrowth of industrial-capitalist structures to Western dominant male ideology, feminists also critique biomedicine for its devaluing of women's subjectivity—most notably cultural and emotional (Illich 1975, Komesaroff, Rothfield and Daly 1997, Martin 1987, and Mackie 1997, as cited in Richies 2000). A third group significantly challenging the model is the New Age movement. Begun in the early 1970s and overlapping the rise of complementary medicine, the person is understood as "indissolubly spiritual, mental, emotional, as well as physical… [and] the means to fulfillment in the family, in economic affairs, in political life, is a holistic balance relating to the self" (Hanegraaff 1997: 8, as cited in Richies 2000). The crucial notion is the assumption that "the human organism is a natural healing system with the capacity, supposing the individual's mental attitude and spiritual values are properly poised, for self-healing" (Richies 2000: 670). This self-determination to maintain equilibrium and balance of the person is explained by the field of anthropology that attributes the change in focus (to the person as 'holistic') to a deep and growing valuation of egalitarianism. The contradiction inherent in egalitarianism, however, is that it legitimates autonomy, which subverts egalitarianism. Richies (2000) argues that the holistic person is a cultural construction with the function of acting as mediator in this contradiction that allows both to be sustained simultaneously.

While the appropriationist tendency of the West may be at the heart of the New Age Movement and dually responsible for the vast popular interest in alternative concepts of health, it is perhaps the area where the dominant paradigm will give way. The new interest on healing practices as employed in cultures around the world "strips away the illusion that biomedical research is the only scientific approach to health care problems" (Morris 2000:13). People of color have long been demanding that healthcare practitioners take into account traditional belief systems in order to effectively offer quality health care to ethnic minority populations (Bair and Cayleff 1993). In their attempts to advocate for recognition that dominant Anglo-European cultural beliefs represent just *one* of many systems of thought, healing implies recovery of wisdom about the intrinsic interrelationships between self and other. In light of this, adherents to complementary and alternative medicines tend to hold a distinctive view of the healing relationship as more of a partnership where the healer assists and supports the patient. The relationship frequently "involves caring, touching, educating, and fostering personal responsibility and a positive outlook, along with providing more traditional treatment" (Goldstein 2002:48). Through the development of cultural competencies, health care practitioners can foster empathy and collaboration. Empathy, (seen as the emotional embrace of an*other)* has the potential to threaten and "escape the lines of bureaucratic control;" it is a risk-taking emotion that is often the natural outgrowth of contact. "Embeddedness within a shaping cultural context is what postmodern illness is all about" (Morris; 2000:11,14).

Given these trends, holistic modalities are increasingly being incorporated into the mainstream of patient care. In fact, the National Institutes of Health (NIH) has established the Office of Alternative Medicine (OAM) to investigate holistic modalities—or complementary and alternative therapies. The NIH has categorized holistic modalities and therapies into seven specific fields of practice (Dossey 1998):

(1) *mind/body or biobehavioral interventions* such as biofeedback, relaxation, imagery, meditation, hypnosis, psychotherapy, prayer, mental healing, art, dance, music therapy, and yoga;

(2) *bioelectromagnetics,* exploring how living organisms interact with electromagnetic fields for a variety of applications including bone repair, wound healing and immune system stimulation;

(3) *alternative systems of medical practice,* including traditional oriental medicine, ayurveda (a system of healing from India relying on diet, exercise, and meditation), homeopathy, naturopathic medicine, environmental medicine, and community-based health care practices (such as those practiced in shamanistic or Native American cultures);

(4) *manual healing methods* such as osteopathy, massage therapy, chiropractic, physical therapy, and therapeutic touch as diagnosis and therapeutic tools;

(5) *pharmacologic and biologic treatments,* including drugs and vaccines not yet accepted by mainstream medicine;

(6) *herbal medicine* encompassing herbal approaches for pharmacological use from Europe, China, Asia, India, and Native American traditions;

(7) *diet, nutrition, and lifestyle changes* promoting study of the effects of various food groups, vitamins, and minerals on acute and chronic disease, as well as on health maintenance and disease prevention.

In fact, anyone observing the American health care scene over the past few decades is likely to have noticed the remarkable growth of complementary and alternative medicine. Evidence about why these modalities are on the increase is not entirely

consistent. Dissatisfaction with the biomedical model and the desire for personal control over one's health care are not reasonable enough answers—as almost all patients express this desire. The core sets of beliefs inherent in holistic approaches seem to carry that 'transformational' appeal (Astin 2000, as cited in Goldstein 2002). Perhaps the most pertinent factors in its widespread growth are political and economic. Emerging relationships between holistic medicine and major economic actors such as pharmaceutical firms, managed care companies, insurance companies, media conglomerates, Internet providers, etc., as well as political forces like parties, bureaucrats, lobbying groups and ethnic and gender based movements/organizations also contribute to the success of holistic practices (Goldstein 2002). The convergence of interest between these economic and political forces in regard to holistic health care is an important factor in its success as well as an agent in furthering the institutionalization and official legitimacy of it.

Cooptation, Social Control

Ironically enough, the limitations of holistic health care (as incorporated into dominant practices) lie in its very mode of expansion, that of bureaucratization. Parsons (1951) argued that the state empowers the *institution* of medicine to regulate illness as a potential threat to the stability of the social system. He conceptualized illness as a form of deviance because it can interfere with the performance of normal role obligations therefore undually stressing other social institutions, namely the economic and familial. Through the physician, medicine regulates the extent of illness by limiting access to the

sick role to those who are ‘legitimately’ ill and by returning sick people to normal performance as quickly as possible. Since then, this argument has been expanded to include the “medicalization” of society that gives medical control over certain areas of deviant behavior, e.g., criminality, drug abuse, alcoholism and child abuse, areas traditionally in the hands of religion, law and education (Kotarba 1983). The incorporation of holistic modalities into mainstream medical frameworks means that it would have to function with the same constraints—opening it up to the same criticisms and accessibility issues. Furthermore, the holistic notion that disease is partly caused by disharmony within the individual reinforces the medical system’s already strong tendency to deal with disorders chiefly at the personal level and largely to the exclusion of attacking other levels, such as socio-economic or social organization factors. From within the medical profession, holistic modalities are unlikely to be any more effective than the biomedical model itself due to the settled interests and titled power of the profession. “What is to be feared is that we create a medical system uniting the new focus on individual responsibility for illness with the technological biases of biomedicine, ignoring or underemphasizing the social, the preventative, and the deeper roots of health and disease” (Guttmacher 1979: 20).

Consisting of the Best Practices Report conducted for The Emma Center (TEC), the next chapter presents information on existing healing centers. Keeping in mind the information presented here will help situate TEC’s aim to create a Women’s Residential Healing Center in context of their proclaimed ‘holistic’ values. Subsequent chapters include an additional literature review presenting the concept of empowerment as a

process and as an action, followed by a program evaluation of TEC to inform their future development.

CHAPTER 3

BEST PRACTICES REPORT

Introduction

The Vision

For a long time a huge sheet of paper hung outside the front door to The Emma Center's office covered with drawings depicting a rosy haven complete with a large house, cabins, gardens and grazing deer. My first task with The Emma Center (TEC) was an exploratory research project to identify and map healing centers and their practices. The purpose was to inform TEC of what successful centers did to start up, run effectively, and sustain themselves. A page from TEC's founder and former director Paige Alisen's 2003 book *Finding the Courage to Speak* describes her inspiration for the idyllic healing center:

> Maybe if people had somewhere safe and supportive to go, they could heal better, maybe even heal quicker. Someday I am going to open a center for people like me. It will be…a quiet, safe place for people to rest and heal… There will be regular house visits by doctors, therapists and social workers, a van with a driver for shopping, errands, and appointments. There will be regular support groups and healing circles. Maybe there could be a massage therapist, yoga instructor, and herbalists as well… Maybe some of the residents would even be able to take classes or go to lectures at the college. I imagine people would read, write or even paint, maybe learn small crafts. There could be a study room with books and a computer hooked up to the Internet. There could be an exercise room with a treadmill and weights and whatever else would help for body treatment… The house will be in the forest near the ocean. Damaged and hurt people need to be surrounded by nature. There could be a garden for those who want to tend it, with fresh vegetables and herbs… What would be really different about this house is that there will be house-helpers,

> caring individuals… who would volunteer their time… to help operate the house. They would help cook meals, clean, and just offer a loving, supportive presence to the house. Maybe as residents get better, they can return in later years as house-helpers themselves (Alisen 2003; 183).

This list, when broken down reads: an alternative to conventional institutionalized treatment. With its mix of traditional psychotherapy and incorporation of holistic or complementary alternative medicine, TEC's vision seemed to describe the ideal therapeutic community. By keeping the center small (twelve or so residents at a time) and by maximizing on the growing ties within the community, TEC hoped to keep government regulations to a minimum and humanistic aspects to a maximum.

The Need

Intended to facilitate the long-term healing of survivors of abuse and trauma, TEC's clients are typically underserved in the healthcare system. As low income, non or underinsured, many of these women cannot afford quality treatment. Due to posttraumatic conditions, few of the clients are able to work full-time. Those that do work full-time often make more income than allowed for state Medical, yet still cannot afford such health services. Sliding-scale fee therapy offered at many facilities is time limited (6-8 weeks) and weekly sessions are often too short and rarely are therapists trained specifically to treat trauma related conditions. Additionally, holistic health practices (e.g., massage and acupuncture) have been found very successful at treating symptoms of trauma, however, associated high costs and limitations from insurance companies to cover these treatments keeps clients from accessing these important health resources. TEC ameliorates this discrepancy with its current drop-in services. Founder

Paige Alisen asserts that more intensive treatment would benefit at least one-fourth of its current client base. Many women who have actually been institutionalized in under-funded government mental health facilities would certainly assert the need for an improved approach to intensive treatment.

Methods

Building off of this vision for a women's residential healing center (WRHC), including two focus groups conducted by a former intern, and a file folder under my arm containing web-page print outs of four seemingly similar centers; I embarked upon this journey aspiring to fill the information gaps in TEC's dream.

Focus Groups

I read through the notes of two focus groups conducted by Elizabeth Zenker, a former MA in Social Work intern to TEC in September of 2006. The first group was comprised of "Providers" who were women with experience in psychiatric residential settings and holistic practitioners. This group was attended by two Master's of Family Therapy each with private practices, one expressive arts therapist, one board certified advanced holistic nurse/family nurse practitioner/RN and professor of nursing, and one former assistant program director of an inpatient residential mental health facility for a total of five attendees. The second focus group was 'Consumers' consisting of four former residents in psychiatric settings and 'future/potential WRHC residents.' No other information on these women's situations is available. My research is a continuation of the topics covered in these focus groups in that I looked at actual, licensed residential

facilities' policies on similar topics. I will briefly summarize the information collected in these focus groups to help inform the reader of TEC's location with regard to their planning process and the complexity of the issues under consideration. (More information on TEC's planning process can be located in the Petite Evaluation Report).

Topics covered in the focus groups related mainly to the policies of the hypothetical center's day-to-day services and client screening. Specific areas included were: policies regarding the presence of children; visitations; policies regarding the screening of clients such as co-occuring disorders and alcohol or other drug treatment/use; management of emotional or behavioral problems; and accommodation of disabilities. Additional issues addressed by the Provider group were: supporting the providers: supervision and education of staff; ideologies of care; record-keeping; transitional programs for clients returning home from treatment; and the point of facility size. Overall, the topics covered were pertinent to defining what day-to-day life might look like at a full-functioning WRHC.

Each topic was written on a sheet of paper and pinned to the wall, attendees wrote checks on the page to indicate agreement for each topic. For example, on the paper regarding inclusion/exclusion criteria, four of the five Providers checked that clients must be detoxed and clean from drugs and alcohol for 3 months and involved in a strong recovery program before admission. Some of the groups' outcomes were as follows. Most of the Providers agreed to individualized assessment as a valid approach to issues such as pain management and medication, treatment of those with communicable illness, physical disabilities and food allergies/dietary needs. While the Consumer group was

split on the inclusion of children and visitation policies, the Provider group unanimously agreed to exclude children for concern of interference with their mothers' recovery and potential traumatization of the children themselves. All Providers agreed to a specified visitation day and most agreed that no visitors with current history of abuse or drugs should be permitted. The results on this issue are similar in the Consumer group. Providers checked off opinions regarding things such as an in-house dog or cat, smoking areas, different farm animals, a garden, quiet rooms, and ecologically responsible house norms. All Providers agreed on the importance of daily community meetings between staff and residents as well as daily psychotherapy groups and "self-co-created treatment goals." Three of the five Providers indicated a willingness to work with clients with pharmaceutical medications. All of the Providers agreed that they wanted good pay and benefits with enough staff to manage the center. Consumers were generally in agreement with Providers on most matters, but were asked more questions regarding matters of daily routine and types of therapies offered; access to nature, a hot tub, and fun time were the only specific therapies to which all agreed to.

While my research picks up where these focus groups left off, in that I mapped similar operating policies of existing centers, I found the information obtained through them indicative of TEC's emphasis on the idea of the center, rather than its feasibility, the need for, and funding of such a center. Additionally, it is interesting to compare and contrast these small, local groups' preferences on such matters to actual centers' policies and practices.

Case Studies

A total of eight organizations are included in the case studies beginning with the four centers already identified in TEC's file of therapeutic communities. I located two others of a similar nature to the vision of the WRHC including one center also with a short-term trauma-specific day program and two organizations with parallel missions but quite different structures of approach. Based upon ample information available provided on their websites, the residential centers were logged into a database I created with FileMaker Pro-8.0 where they were mapped out according to organizational nature, client profile, treatment approaches and modalities, policies of day-to-day practices, organizational structure, and start-up procedures. The centers most similar in design to TEC's vision were further examined via telephone interviews. The other two programs with similar missions yet different approaches were also included; one is a residential training and service program, and the other is a grassroots community organization melding social activism into the healing process.

As I began my research of case studies of centers similar in vision to that of TEC (such as a natural setting and use of complementary, alternative therapies), I began uncovering suggestions the WRHC may not be feasible. Resources needed for creating a WRHC would be huge and other concerns arose as well—regarding the actual need for such a center and TEC's ability to continue operating as-is due present existing funding challenges. Once I began reviewing the literature on the subject, the same types of things arose and further suggested the requisite of re-evaluating TEC's vision in order to meet the actual goal of healing as well as the need for organizational sustainability.

Other Research

In order to help inform this process I also conducted research on the history of current treatment paradigms (included in the Literature Reviews), processes of historical treatment approaches, as well as various treatment models in existence today. Additionally, I have included some helpful definitions. This information, based mainly from *Designing for Therapeutic Communities* (Canter and Canter, 1979) is presented below in brief, and precedes the actual case studies.

Probably the earliest perspective on the provision of therapeutic facilities is the custodial model, epitomized most clearly in the prison. Its approach is to provide facilities for those considered different and less effective than the rest of society; to protect individuals from themselves, society from them, or to protect them from society. Criticisms include the degenerate and often inhumane effects of 'warehousing' which refers to the bringing together of these people into groups usually for economic efficiency.

The Medical Model, built from the custodial model, arose in the 19th century alongside (medical) technological developments. Clients were seen as disease ridden, or 'unhealthy', and consequently in need of a quarantine setting where the appropriate treatment could be given so they would regain health. While dramatic successes did occur, poor hygiene plagued hospitals and cross-contamination was rampant. This led to improvements over time, such as drug-monitoring and hygiene programs. The result is our modern-day view of hospitals as a place of recovery rather than (just) death. A relatively recent attempt to move beyond the debilitating effects of dealing with those in

need of care within institutional therapeutic settings as ‘patients’ has preceded the emergence of the variety of holistic and other perspectives and models discussed above.

The Prosthetic Model uses the analogy of prostheses (compensatory devices for deficits such as walking sticks and spectacles) and also makes use of social prostheses. In the case of physical devices, dependency is usually unproblematic. Whereas with social prosthesis, dependency upon another person for a wide range of activities is undesirable, especially if the supporters will be unable to carry on long-term. In some cases, specific teaching methods are used gradually to enable the person to do without them. One great criticism of this model is the issue of long-term negative consequences due to the inability for normalization.

The Individual Growth Model is based on the belief that the therapeutic facility is established to enable people to grow to their full potential despite limited personal resources. This applies to more than physical surroundings and includes contact between staff and patients permitting the development of the staff/resident relationship over time. This implies a need for flexibility, allowing the environment (structurally and organizationally) to respond to developments and changes over time. It also implies the nurturance of each individual’s idiosyncratic tendencies through the opportunity for expression of ‘the personal touch’ in order to maximize individual growth potential. Through postulating the objective of individuals achieving their full potential, the risk of ‘fuzzy goals’ is greatly magnified. By its very nature, ‘potential’ is not presently available for objective scrutiny. By reason, then, there need be emphasis on the process, or procedures which should be available in the setting, what the possibilities available to

the client are, etc. The symbolic qualities of the setting come into play here: what the client sees as available opportunities and facilities to draw upon. Of course, these possibilities depend upon the organizational framework. Therapeutic communities are a common manifestation of this model in action today.

Finally, with the above framework in mind, consider the following definitions. The 'environment of therapy' can be understood dichotomously depending on which definition of 'environment' is employed. The continuum consists of a place/location where therapy takes place to a setting which is itself therapeutic. The first use of 'environment' is characterized as being an identifiable place: some*where* people go to receive therapy. Its very separateness enables it to provide the facilities deemed necessary (think in-patient). The second use can argue that settings which are separate, identifiable or distinct, will not be so readily therapeutic. In order to make people 'whole' or more like others in the community, it is essential to provide an environment which is part of the community and as similar to other normal environments as possible (think out-patient). Furthermore, the definition of the patient as either sick or injured carries with it a great weight. Sickness implies etiology within the sufferer; it implies weakness, defect, a hope for stabilization; sickness embodies passivity and requires experts; and it denies personal and social accountability. On the other hand, injury connects the sufferer and environment; it implies recovery, rehabilitation, even with possible handicap; injury requires active participation in recovery; and it requires personal and social accountability.

Findings: The Case Studies

The Life Healing Center of Santa Fe

The Life Healing Center of Santa Fe is a for-profit, corporately owned residential center designed specifically to treat trauma and addictive disorders. They provide "comprehensive, integrative residential treatment…[of] the whole person, body, mind and spirit." The Life Healing Center sees "fully experiencing ourselves as we are" as central to the task of healing. Extended care is offered to treat:

- Addictions—chemical dependency and abuse, sex addiction, eating disorders, and codependency
- Post-traumatic Stress—nightmares, flashbacks, hyper-startle, excessive fear, self-injury
- Affective Disregulation—depression, anxiety, mood swings
- Obsessions—despair, suicidal rumination, intrusive images
- Social Alienation—impaired family and social relationships, isolation, intense fear of abandonment
- Dissociation—numbness, confusion, impaired sense of self

The clients are men and women who are 18 years of age or older and have had previous inpatient or outpatient therapy. Clients are screened through a 14-page assessment for clinical appropriateness and medical records are required before admission and must interface with the outpatient referral. If on psychotropic medications, clients are required to be stable and compliant with their medication protocol. There is, of course, a cut-off for behavioral issues with which the center will

work. Clients must be detoxed of non-prescribed drugs and alcohol prior to admission. Regarding those with sexual addiction, no perpetrators are accepted. No domestic violence abusers are accepted, either. Children are not accepted and all visitations must be approved by the primary therapist and take place on the weekends. After 10-12 days and upon approval, clients can leave the facility in groups of 3 for between 4 and 6 hours. Problems are handled at a round-table with a psychiatrist as well as medication.

The Life Healing Center considers itself “eclectic” in its therapeutic program offerings which include:

Individual Therapy: Each resident is assigned a primary therapist and is provided with 2 hours of intensive therapy and one case management session each week. Collateral individual therapy is provided as needed.

Group Therapy: In addition to intensive individual therapy, The Life Healing Center offers over 35 hours of weekly group sessions. Among the groups offered are: Trauma Resolution Core Groups, Chemical Dependency, Eating Disorders, Sexual Dependency, Co- Dependency, Skills, Grief and Loss, Women's Group, Men's Group, Body Image Groups, Art Therapy, Spirituality Groups, Community Meetings, and other specialty groups.

Psychiatric Consultation: Each resident is provided with psychiatric evaluation soon after admission. The consultation includes a thorough review of any current medications and an initial plan for any needed adjustments. The psychiatrist continues to monitor progress and is available for additional consultations if needed. The initial

evaluation is included in the treatment package; additional consultations, if needed, are billed separately.

Individualized Program: The emphasis upon individualized treatment allows The Life Healing Center to tailor a treatment program to fit the needs of each resident. For example, people struggling with more acuity, or who need a sustained focus on stabilization and containment can go into the Serenity Program which provides increased structure for clients who need it.

12 Step Groups: The Life Healing Center embraces a two-phase recovery model. A solid recovery program needs to address both the addictive process and the underlying emotional pain. People who are in recovery from an addiction are expected to attend 12 Step Meeting regularly during their stay. Transportation is provided to these meetings. In addition, in- house 12 Step model support groups are provided several times per week.

Healthy Living: During weekends and evenings, activities are scheduled that teach residents healthy ways to relax, interact, and support their healing process. Transportation is provided to a state-of-the-art fitness center and regular outings are scheduled.

Spirituality Groups: These groups are designed to empower each resident to deepen one's own spirituality. No specific religious practice or doctrine is endorsed or promoted. Residents are invited to find practical ways to experience their spirituality with their healing process. The Life Healing Center recognizes the diversity and complexity of spiritual beliefs and respect the right of any resident to not participate in any aspect of the program that he/she feels infringes upon his/her personal beliefs.

Weekend Activities: The weekend program allows more time to focus on daily living tasks. The activities are designed to help the transition to living in a community.

Auxiliary Therapies - Provided for an Additional Charge: Equine Psychotherapy (only available to clinically appropriate residents), Massage Therapy with independent licensed massage therapists, Acupuncture sessions are facilitated with independent licensed Acupuncturists for residents requesting this treatment, and Career Counseling which includes career testing and consultation are offered by a professional career Counselor.

The center was started in 1995 by a group of local therapists. It was later sold to a family in Texas where it grew into its present form. In 2005 it was sold to the CRC corporation. Initial start-up budgeting and capital funding approach is unknown. From the beginning, The Life Healing Center of Santa Fe has operated solely upon client fees. No insurances, low-income options or sliding scales are available. Admission is only provided upon proof of client's ability to pay the $24,000 for a one-month minimum stay. Staff are present 24 hours a day, 7 days a week and the days provide a therapist to client ratio of 1:3, evenings 1:7 and nights 1:16.

Monte Nido Mountain Nest

Monte Nido is a for-profit residential eating disorder treatment center which aims to turn clients "on to life" again. Through a home-like environment and stimulating activities, goals include restoring biochemical functioning, nutritional balance, healthy

habits, changing destructive behaviors and gaining insight/coping skills to address underlying issues. The program uses activities to engage body, mind and spirit.

The clients include females with eating and exercise disorders including anorexia and bulimia. Ages served are 16 and 17 years old on a case-by-case basis, otherwise, 18 years and above. A one to two hour telephone interview is the initial screening tool used and is followed by a second assessment with a therapist. Accepted clients must be appropriate for residential treatment, if they need to be in a hospital (for example, with tube-feeding) or are unmotivated, suicidal, resistant or adhere to a vegan diet, they are not accepted. Current domestic violence situations are not addressed by the program. Family weekends for visitation are optional as well as group therapy with the family as long as it does not interfere with clients' treatment. Clients are permitted to leave the facility once trust has been gained, but must leave with another person and sign out for two hours at the most. Sharp items are carefully kept off the grounds. Suicidal cutting is not tolerated and clients will be hospitalized for it, although the center will work with clients who engage in superficial cutting. Therapists carefully monitor behavioral patterns through regular one-to-one sessions allowing clients privacy otherwise.

Monte Nido believes that everyone can fully recover from an eating disorder. Individual work as well as groups are utilized to facilitate this process. Goals are set according to small-steps at a time. Cooking meals and shopping with the chefs are a part of the program as well as dialectic behavioral therapy, art therapy, psychodrama, music, play, yoga, and spirituality workshops. Several outings are offered each week. The

clients' rooms are plush and private, each with their own deck and Jacuzzi. Although there is no garden, the grounds are beautifully landscaped and in a natural setting.

Monte Nido's current director, Carolyn Costa, an eating disorder survivor who worked in the field for over 30 years is also the founder of the Center. In 1996, she and her husband bought land and designed the program. They were initially licensed in the state of California for only six beds and have not had an empty bed since opening, in fact, there usually is a wait list. Over time, as equity built, the program expanded to more beds and sister facilities—two in CA, and one in Oregon. Carolyn also writes books and speaks at conferences regarding eating disorders. The fees to attend the program are $33,000 per month and are the sole source of funding for the center. There are no low-income or uninsured options for clients, although payment plans are available and insurance is accepted.

Wellsprings Ranch

The Wellsprings Ranch in British Colombia, Canada is a private, for-profit residential center for women's eating disorder recovery. WellSprings Ranch is the only residential treatment center for eating disorders in Canada that offers integrative treatment for the mind, body, emotions, and spirit. They are confident that their integrated, individualized, and compassionate approach combined with quality professional help can assist clients in achieving and sustaining a true recovery and wellness. A key to this goal is Wellspring's aim to heal the root of the problem—which is seen as being trauma based at its core—and not just the symptoms.

Wellsprings clients are women with eating disorders age 19 and older. Initially, a telephone assessment is used to screen clients. If they are good candidates and still desire to enter treatment, physician's letters are requested, blood work taken, weights recorded, x-rays and a host of interviews and paperwork must be waded through. Medical stability is required of all potential clients and actively suicidal clients are not accepted. Wellsprings admits clients based on a first-come first-serve basis after all outlined basic criteria is met and confirmed by medical doctors. Since a psychiatrist is involved with the program, dual-diagnosis and appropriate uses of medications are accepted to avoid destabilizing the client. Since the center hadn't yet opened its doors at the time of my interviews, they were unsure of a few things, including current domestic violence situations, however, they claim to have ideas and experience in challenging situations and wish to accept and help in such a situation. Visitors are permitted for a 3-day family program (once each month) where clients and family complete therapy together. A children's program is also offered during this time to help break the cycle of codependency in the family. Eventually, Wellsprings would like to host an adolescent group as well due to the uniqueness of that population. On a case-by-case basis clients are permitted to leave the premises, but only for special circumstances as the program is intended to give clients the opportunity to build their strength through specific program activities. There is a no-restraint policy for problem clients and therapy is used to work through any problems that might arise; however, if the problem is too great or poses a danger to other, the police are called. Safety is the bottom line.

At Wellsprings, the whole person is treated according to a mind-body-emotions-spirit approach. With the stated goal of healing the root causes of problems and not just symptoms, activities are designed to integrate a variety of evidenced-based best clinical practices and complimentary modalities which are delivered through individual and group therapy. Wellsprings embraces abstinence-based 12-Step Fellowships and utilizes trauma resolution techniques as relapse prevention. The focus is on creating a healing environment including environmental considerations such as low coal usage, using organic food from local farms, eating mindfully, yoga, and deep process work. The central components of training clients for mindfulness and self-care are further supported through the sequestered nature of the program which takes place on an island. Many extracurricular outdoor activities are offered such as equine therapy and kayaking to help clients build themselves up physically and in terms of self-esteem. Of course, the environment itself is also a large part of the program, being located in a tranquil, natural setting with its own garden.

The center's director worked for many years in the USA based Betty Ford Center, The Meadows, and based the program at Wellsprings largely on that model. Start up procedures—still quite fresh with an opening date of Summer 2007—were described as "crazy" and bogged down with lots of bureaucratic red tape. Things other than the healing/program component consumed much of the founders' time and resources. Things such as licensing (through community health services), fire zoning, ambulance services, disaster plans, leases, and insurance were but a few of the these things. Wellsprings was privately financed through the existing Wellness Center Collective from whence came

the business plan. A bank backed the center based on the Collective's longstanding qualifications, and although no grants were obtained, a group of investors through the bank are committed to the program while it grows and expands. Currently using rented land and facilities, Wellsprings intends to grow from its current 8 beds to 28. Private medical care is looked down upon in Canada where medicine is socialized. With each citizen heavily taxed and free to utilize government issued care, a typical 2-year wait list for standardized and often low-quality treatment for certain pockets of people (such as those with eating disorders) is letting many patients down. While private care is out of reach for the poor, it does, at least provide options. Wellsprings charges approximately $23,000 per month for which only self-pay is available. Eventually, Wellsprings will implement fundraisers to raise money in order to offer coverage to women who cannot afford the program. One of their first clients, in fact, is the daughter of a well-known singer who has offered to sing for a fundraiser in the future.

Women's Institute for Incorporation Therapy (WIIT)

The WIIT is another private, for-profit residential center located in the United States. It is their goal to help clients reclaim themselves and build their lives through experiencing, recognizing, and learning to direct their strengths and talents in a positive atmosphere. The program treats women who are experiencing or have experienced depression, bipolar disorder, borderline personality, childhood abuse, sexual abuses, trauma, dissociative disorder, post-traumatic stress disorder, multiple personality, ritual

abuse and incest. WIIT operates as a separate unit of the licensed psychiatric hospital, Hollywood Pavillion, Florida.

Clients are women 18 years of age and up who voluntarily seek treatment for acute symptoms associated with psychological trauma such as dissociative disorders, dissociative identity disorders, PTSD, grief, loss, and depression. For liability reasons, no out-of-state patients are accepted. After an initial telephone screening and background check—medical as well as otherwise—if the client is still interested in participating, payment is be confirmed and admission procedures begin. WIIT does not use physical or chemical restraints (medications) and clients must be detoxed prior to admission of not only alcohol and other drugs such as marijuana, but also anti-psychotics, mood stabilizers, benzioaprines, etc. Other issues, such as self-harm and eating disorders are also contracted for treatment with their program therapist. Current domestic violence and abuse situations are also accepted as valid treatment situations. Family or other visitations are not allowed since the program is short-term and operates under the philosophy that an individual needs to learn to work with themselves, not anyone else. For example, if a victim of incest asks, “Should I confront my father?” WIIT program answers, “No, don’t talk to him, take care of yourself.” Since abuse victims tend to marry or otherwise surround themselves with abusers, family therapy is seen as a waste of time. It is the woman herself that needs to learn self-care and how to protect herself from unhealthy people and relationships. The program is voluntary and doors to the facility are unlocked during the day, however the program itself is structured to account for most of patients’ waking hours. If a patient is not participating in the program, they

are considered to be effectively discharging themselves. Due to the intense nature of the trauma-work, it is not infrequent that clients become overwhelmed, display dangerous behaviors and need hospitalization for their safety and health. At this point, clients work one-on-one with their therapist and may be moved, for a time, to the hospital.

WIIT is an intensive 2-3 week program that operates on the belief that while the women treated are suffering and in many ways have become dysfunctional, they are strong, intelligent and creative. The goal is to help patients recognize and experience their strengths and talents, which up until now have been invested in a survival effort which often relates back to childhood. WIIT then focus on teaching them how to redirect their strengths and talents towards reclaiming themselves and building their lives. Atmosphere is very important to the program. The unit is small and maintained separately from the rest of the hospital. The unit is not run in a traditional manner. Involvement in twelve-step recovery programs is supported for those with addiction or eating disorders, but primary treatment in those areas is not the focus. There is special artwork on the unit which acts as a catalyst for treatment. WIIT does not initiate abreactive work on the unit. They do not allow acting out or self destructive behavior. This is accomplished by making the standards known and having the patients contract with their therapist regarding their behavior. The peer experience on the unit is positive. The grouping with other motivated women with similar problems helps them to 'share the secret(s).' A typical day at WIIT consists of rising early, attending two groups before lunch and two afterwards, a recreation and peer support group, and evening time for individual written

and art assignments. Furthermore, patients are encouraged to participate in community governance and community meetings.

WIIT costs $1100 per day ($33,000/mo.) and accepts insurance, self-pay, and medicare. The entire hospital complex including the 10-bed WIIT unit are owned by one family. The center is grateful not to be under corporate ownership due to their unique approach which is contrary to the usual. Additionally, they say that insurance companies hate them because normally, such patients are drugged and released. The assumption that long-term treatment is necessary to resolve trauma is based upon the typical medical approach which is driven by insurance companies: patients are medicated, labeled, spiral further into more labeling and medication and eventually, the patient is blamed. WIIT claims that treatment in the wrong place or way will only further traumatize and create more triggers. They claim that clients are not mentally ill, just showing symptoms of a core wound that is demanding appropriate and significant attention. William B. Tollefson, PhD, NCP, CCH, RHt, CRT, CAC, is the Center Director of WIIT. He received his Doctorate in Clinical Psychology in 1984 and has developed a stabilization technique called Incorporation Therapy, which has proven to be very effective in helping women with trauma based Dissociative and Dissociative Identity Disorders (MPD). In addition to establishing and supervising the WIIT, he has traveled extensively since 1992, lecturing on Dissociative Disorders and training professionals in his treatment methods. He has been the featured speaker at a number of state and national conferences and has written a book. During my interview with WIIT, the generous offer was made to send a therapist to be trained for free and given copies of manuals and other pertinent papers.

Since TEC has the same goal of healing trauma survivors and is located so far away, they viewed such a collaboration as a benefit to humanity and not a threat to their business. Their advice was to continue The Emma Center as-is and simply start a small-scale, out-patient, intensive trauma recovery program based on their module.

The Acorn Programme

The Acorn Programme, located in the UK is a non-profit Quaker organization and residential center. They are a therapeutic community incorporating Dialectical Behavioral Therapy (DBT) recovery in 2 stages: managing feelings and relationships without resorting to dangerous behaviors and exploring the underlying reasons for the inclination to use such behaviors. Acorn aims to treat the 'whole person' including past experiences which frequently arise in treatment: trauma is usually associated with the self-defeating behaviors. Additionally, Acorn allows people with a history of trauma to use the diagnosis "Complex PTSD" vs. Borderline Personality Disorder, if preferred. Acorn also treats eating & mood disorders in addition to alcohol detoxification.

Clients of the Acorn Programme are women who engage in 'self-defeating behaviors' as an effort to cope with emotions or relationships. They are often those with a history of loss, separation, disruption of early relationships, trauma or abuse and borderline personalities. Treatment builds around a cooperative relationship with the client in a joint attempt to understand their behaviors and learn to control them. The program facilitates finding triggers and learning more self-affirming ways. The ultimate goal is to find life worth living. Group therapy, sharing daily life with others in a culture

of enquiry, Dialectical Behavior Theory (DBT), biosocial theory, learning new skills to replace old self-defeating behavior patterns and journaling of experiences are all methods Acorn utilizes to build skills and engage life, build positive experiences. All this takes place in Acorn's pleasant and spacious living setting in York, Great Britain, with individual en-suite rooms, ample therapy space, and a resident's phone and internet access on the ward. Locked doors and observation is not a part of the program. While the usage of medication is allowed, the goal is to minimize their use for the sake of not screening out clients' feelings. It is preferred that clients manage their own medications. Overnight leaves can be requested at community meetings if planned in advance. No violence is tolerated and disclosure of harm is required and treated with non-punitive help. Regular treatment reviews, and a planned and collaborated discharge are part of the process at Acorn. In addition to the 8-12 month inpatient program which is structured Monday through Friday, there is an outpatient relapse prevention program.

The Acorn Programme, who's parent organization started in 1792, is registered as an independent hospital. Private-pay, insurance, Primary Care Trust, employer sponsorship, and social services (available in the UK) are all accepted for payment. This necessarily includes clients of all income levels. Fees depend upon clients' level of care needs.

The Ashcroft Project

The Ashcroft Project is yet another UK based residential treatment center based upon the guiding principles that each service user has the right to dignity, respect, social

inclusion, independence and choice. Their aim is to support pathways to recovery and independence.

The Ashcroft Project serves women ages 16-65 who have demonstrated significant mental health care needs. The program provides a safe, healthy and positive environment to enable trusting relationships to develop. A unique component of the Project is to empower each woman to seek her own pathway to recovery. This is done through supporting each woman to achieve greater independence and social inclusion through activities such as art, music, dance, yoga and creative writing. Additionally, massage therapy and counseling are offered. Each woman has a key worker with whom she develops an individually tailored treatment plan. The women plan and cook their own meals with staff support. While they may access all available services, they are encouraged to develop links with the mainstream community, thus preparing themselves for the next step in their journey towards independent living.

To support the healing process, as much independence as possible is encouraged. There are 10 single-unit residential bungalows each with a washbasin and TV, and four 2-bedroom bungalows that all share a lounge, quiet room, study, dining room, and modern kitchen. A large studio for activities and a therapy suite with massage and counseling rooms also comprise the facility. Women in the residential program expect to stay between 3 and 12 months with up to one-week long breaks. After the initial residential program, women are moved to the supported housing program, if appropriate. Staying from 2-3 years, women in this setting have regular support groups and on-call help from therapists. The program is paid for by Social Services (in the UK) and

operated by the organization Break Charity. Clients are accepted based on need and availability of slots in the program.

The Self-Empowerment Institute

The Self-Empowerment Institute of the InterFaith Center (IFC) of Divine Love is a non-profit, spirituality based social services organization that operates a 4-stage Tantra Teacher Training Program. Tantra, not the typically thought-of westernized sexual version, but the ancient Indian Spiritual Tradition, seeks to contribute to the growth of humanity and alleviate its "ills." Tantra is, therefore, a holistic way of studying the universe at the point of the individual. A large component of the program is healing, and learning to facilitate healing in others.

Students are comprised of individuals who want to connect with their inner nature, or inner beauty and their ultimate destiny, the journey of the soul. Tantrikas, or those practicing, studying, or interested in tantra are typical applicants. There are only 12 students at a time, and parents are encouraged to bring their children to the program. A student can complete the 4-stages one at a time in three month intervals, or over the course of a whole year. Its “Love-Healing Program,” consists of many modalities: The Way of the Goddess (women's spirituality), Chakra Cleansing (cellular memory, restructuring), Kundalini & Hatha Yoga (physical centering, growing), Para-tan Healing (ancient method of sound/vibrational therapy), Tantric Massage (for self and others, to connect, sensuality), and Self-Health (body honoring, ayurvedic program, food preparation, music, and garden). Furthermore, literacy and the English language are

taught to local, (frequently abandoned) girls as a component of Karma Yoga, or service. The program takes place on a 10 acre farm in the South of India. Students live in clean and spacious (20x20 foot) three person rooms complete with beds, linens, and en suite toilet with shower. There are gardens, a kitchen, a 40x40 foot meditation hall, a temple and office available for use. The office is the only location of a telephone and there are no televisions.

Run by the guru Sri Param and many volunteers of the IFC Temple of Divine-Love around the world, the program is supported through many means. First, the Tantra Teacher program is funded through student fees of approximately $5500 per year—no matter where the student is from. Further means of funding are donations and fees from workshops hosted world-wide. Through incorporating social services with personal healing and learning practices, the Self Empowerment Institute seeks to maximize the healing inherent to actively acknowledging the deeply interconnected nature of life.

Las Dignas

Las Dignas is the Women's Association for Dignity and Life in El Salvador, Central America. A feminist political organization, *Las Dignas* began in July of 1990, in conjunction with the Peace Agreements that took place at the end of a brutal 12 year long civil war. Started as an NGO to support survivors of gender-related violence, *Las Dignas* emphasizes the emancipation of women as key to sustainable development. Using a gender-specific approach to heal traumatic impacts of gender-related violence suffered by

women members of oppositional groups during this war, *Las Dignas* formed as a collaboration between both psychological approaches as well as aid and development.

Since the early 1960s, many Latin American women actively participated in social change projects such as mothers' movements, feminist organizations, and peasant unions. These women were initially understood as apolitical social actors and therefore largely ignored by the military regimes. However, as their actions began impacting the power of the authoritarian State, these women, along with members of other various oppositional groups, were detained and severely tortured. In El Salvador's case, "After women established the street as their territory through participation in marches, sit-ins, hunger strikes and public meetings, the members of El Salvador's security forces began to view all women in public spaces with suspicion and treated them accordingly." (Stephens1995, 812)

In order to provide a backdrop from which to understand *Las Dignas*, this paragraph will offer a brief, yet somewhat graphic overview of what occurred during this period. Not only did state-sponsored gender-related violence occur on a grand scale, but misogynistic attitudes escalated, in general. Violence, assassinations, torture, disappearances, and particularly sexual violence, violated women's dignity and identities through terrorizing them into submission. Many of these acts were consciously designed to disempower women and instill within them the impossibility of even struggling for social change. Gang rape, body slashing (especially of nipples and breasts), rape by trained dogs, penetration and decimation of women's genitalia by electric rods, and even the introduction of live rodents were some of the horrors these women survived. Aside

from these physical and sexual forms of torture, psychological torture was also employed, designed to sever the female psychological connection with others. Some examples of this were the torture of her loved ones while she was made to watch, hearing the screams of others undergoing torture and rape, the delivery of false news of the death of loved ones, and the disappearance of those she cared about. While there are many more examples and forms of traumatization I could list, the point has been made. Because of the example set by the military of specifically targeting women for repression, a legitimation of violence against women grew within the domestic arena, as well. It is impossible to underestimate the long-term psychological effects, both individually and collectively, of the gender-related violences these women endured.

The psychological, physical, and societal effects of these abuses, along with those which have occurred outside of conflict settings, are far-reaching. The results of psychological traumatization resulting in PTSD, dissociation, and physical psychosomation with its constant disturbances extend far beyond the individual. Families and society in general, also become traumatized in a form of psychosocial trauma. Realizing this, *Las Dignas* does not view the impacts of gender-related violence as a 'disease' or 'disorder,' for to do so would be to remove the political, social, and economic forces from which these traumas have arisen.

Las Dignas focuses on interventions that attempt to not only support the individual woman, but to reconstitute a sense of community and address the needs of civil society. To do this, *Las Dignas* incorporates the joint efforts of both the psychologist camp—trying to help women individually, as well as the international

development and aid camp—trying to create a sustainably functioning El Salvador (the literature reviews cover these two 'camps' in depth). Programs operated by *Las Dignas* cover not only violence against women through advocacy, support groups, and legal aid, but in matters of labor, education, economics, and political participation. They include:

- Program for a Life Free of Violence
- Program for Women's Economic Justice
- Education Program for Equality in General
- Political Participation Program
- Work Conditions Program, by County

In addition to these programs, *Las Dignas* offers services through their:

- Center of Attention on Women Who Encounter Partner or Sexual Violence
- Labor Assesment
- Feminist Debate School
- Center of Documentation

From organizing marches and lobbying for women's rights to facilitating access to information and legal services, *Las Dignas* utilizes gender-specific strategies to address gender-based traumas and their far-reaching effects. Through processes named Conscientisation and Reconstruction, the organization allows space to reflect, share, and legitimate feelings surrounding traumas as well as to valorize, heal, identify and reconstruct oppressive gender roles. The aim of this work is empowerment which is

characterized both in relation to self: self-esteem, courage, strength, happiness, solidarity, sense of control, confidence, ability to make plans/decisions, energy and hope for the future; as well as relating to the social and political: access to resources, ability to make decisions in family/community settings, sense of control in relation to others, fulfilling friendships, critical consciousness of subordination in family/society, participation in grassroots organizations, and involvement in political processes. Through such gender-specific approaches, women survivors are enabled to heal themselves *and* their communities in ways that fuel the break down of the patriarchal structures (militarism, authoritarianism, machismo) from where their disempowerment rises.

Summary

Research of the above centers demonstrates that functioning centers have started small and expanded incrementally (or have been started as subsidiaries of larger, successful organizations), and have economic stability. In most cases, economic stability is achieved through client fees or government sponsorship in the cases of the two UK based centers relying on socialized medicine. Organizational nature and structure aside, however, there is little information on these centers' actual success at meeting their mission of healing.

Each of the eight organizations presented in the above case studies share the general goal of healing women who suffer from gender-based traumas. Most of these centers have emerged from and operate within the biomedical model, yet incorporate popular holistic and complementary healing modalities. While these centers address the

whole person, they still do nothing to address the larger society in which the traumas occur and to which the women must return and interact. In addition to this shortcoming, half of the centers presented are for-profit and charge their clients between $20,000 and $30,000 per month with no programs for those unable to pay. This makes access impossible for a majority of women, notwithstanding the costs and difficulties inherent in sequestering themselves from their regular, day-to-day lives and obligations during that time. Furthermore, it is probable that stigmatization will occur from their associations with such programs. While these centers provide quality therapeutic programs, the neglect of addressing the source of injury (misogynism in society) largely situates the women as having "illness" and leaves them vulnerable to re-traumatization which, of course, defeats the purpose of healing.

For the purposes of demonstrating organizations that speak to the aforementioned shortcomings, I included case studies for The Self Empowerment Institute (SEI) and El Salvador's *Las Dignas*, two non-profit programs designed to heal in conjunction with the larger society. SEI, which operates as a training center also sequesters its students from their normal lives and therefore has all the same associated barriers of access. How will the woman store her belongings while she is gone? How will she re-start her life when she returns? What about her job and family? SEI's low cost ($5000 for a year), might just make up the difference in these difficulties. Additionally, families are welcome at the center. A flight cost must also be considered, however. This program, heavy on self-care education and healing, also provides experience in social change through its component of teaching orphan girls, not to mention the personal healing benefits in doing

so. Students emerge from SEI with an official, and marketable skill, as well as a network of associations from the world-wide Inter-faith Center of Divine Love. While this may be seen as a somewhat extreme example, SEI maintains the best of both worlds: a holistic program in a sequestered environment and active social change involvement during and after the program.

The second alternative model I have provided, *Las Dignas*, emerged out of a very specific traumatic experience, perhaps an example of the height of misogyny. As such, its main drive is to address underlying attitudes and practices at both personal and societal levels to prevent not only "usual" oppression, but to also prevent another grand-scale repeat of atrocities. *Las Dignas* provides no physical retreat from their clients' day-to-day lives. It does, however, provide solidarity and ongoing support *within* their day-to-day lives and communities. These women do not have to reintegrate into their communities; they heal within them, and in conjunction with them through the program's many and various activities. Available channels of power are tapped (active politics, education) and the program works to create more power (i.e., policy and economics). As such, *Las Dignas* and its participants embody a well-known and active face within El Salvador (and beyond). With such a prominent social position, a violent act against one woman is met by an entire population of women. This approach only furthers their mission of long-term healing and empowerment for women and their communities.

In conclusion of this report, I offer that healing involves two equally important factors, the individual and the society. Many of the centers (particularly of for-profit nature) address only the individual. Several barriers prevent women who need these

services from accessing them. Still, the barriers of a larger society, often intolerant and in denial, remain for the women to face alone. While there are means for participation in social change, it is essential to combine efforts to treat both the individual's needs (e.g. therapy), *and* empowerment processes to address larger concerns. Other centers, on the other hand, have proven successful in taking up the necessarily dual cause of healing women and their coexistent communities.

CHAPTER 4

REVIEW OF THE LITERATURE: EMPOWERMENT

> In the search for solutions, we should not overlook the fact that women everywhere are actively involved in working against social, cultural, racial, economic and political discrimination. It seems therefore just as important to ask the question of 'how do women stay healthy in difficult circumstances and how can we strengthen those processes' as the question 'what makes them sick?' (Rechters 1992: 749, as cited in Stein 1997)

The following literature review is drawn from rising theories of gender and development in post-conflict settings. A primary example of the empowerment model is *Las Dignas,* the El Salvadorean NGO discussed in the previous chapter which "conceptualizes and addresses the psychological effects of women of gender-related violence" through social development models rather than psychology alone (Leslie 2001: 50). With an emphasis on women's emancipation as the key to sustainable development, *Las Dignas* has formulated practical, gender-specific strategies to heal the traumatic impacts of gender-related violence suffered by women members of the opposition movement during the 12-year-long civil war. I will not only offer literature reviewing the rise of—and conceptualizations of empowerment, but will also trace its origins through social movements past and present that have informed its development into a viable and current movement within the international women's movement. This endeavor is largely informed by Jane Stein's (1997) work on the topic.

Conceptualization of Empowerment

If women are to heal and continue to live within the society in which they were injured, it makes sense to also heal the society of its tendency to inflict injury. This particular logic, especially when championed by survivors themselves, provides for the constructive channeling of angry emotions toward their situations. An emotion typically thought of as deviant for women, anger is of central importance in collective action, and particularly feminist collective action, providing much-needed emotional support and outlet (Hercus 1999). Since gender, race, class and nation—as distinctive social hierarchies—mutually construct one another (Collins 1998) and are known to be directly reflexive to women's health, addressing women's health intersectionally makes perfect sense. The goals of such action can be termed as 'empowerment'. Nina Wallerstein and Edward Bernstein (1988: 380) formulated the following definition:

> [Empowerment is] a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society. With this perspective, empowerment is not characterized as achieving power to dominate others, but rather power to act with others to effect change.

Consensus is developing amongst scholars, advocates, practitioners, activists, and women of the Third World that if the vision of restructuring society to reflect a feminist ideology of equity will become manifest, a movement of empowered women, households, and organizations is required (Stein 1997). This movement is gaining momentum as many communities' projects, organizations, networks, and conferences could be viewed as a women's movement centered around empowerment; for what good is healing—in fact,

how is it even possible—when one's day-to-day life is in itself injurious? It is necessary to "transform … women's survival tactics into viable political strategies" (Batt 1992: 13). How does this happen? There are five 'essential preconditions for an insurgent collective identity' as presented by Sara Evans (1979: 219-20) in her study of the US women's movement and include:

> (1) *social spaces* within which members of an oppressed group can develop an independent sense of worth in contrast to their received definitions as second-class or inferior citizens;
>
> (2) *role models* of people breaking out of patterns of passivity;
>
> (3) *an ideology* that can explain the sources of oppression, justify revolt, and provide a vision of a qualitatively different future;
>
> (4) *a threat* to the newfound sense of self that forces a confrontation with the inherited cultural definitions – in other words, it becomes impossible for the individual to 'make it on her own' and escape the boundaries of the oppressed group; and finally;
>
> (5) *a communication or friendship network* through which a new interpretation can spread, activating the insurgent consciousness into a social movement.

These conditions presently exist in most places, particularly in the West. Social spaces for women are omnipresent. They occur either as potential spaces, such as in the home or 'women's worlds,' and those consciously created by the women's efforts. Role models are ever arising and vast communication networks provide for knowledge about them. Ideological goals are expressed in feminism and myriad resistances to oppression. The 'threat' is a fact of life. And no woman, nor any human for that matter, can make it alone.

Of course, whenever power changes hands or is challenged, there is resistance, often *overt* opposition. But other threats to change movements exist and can bar empowerment: dependency, cooptation, political oppression, unmet expectations, divisions between generations, family disruptions, and intransigence. It is inevitable that every project will encounter difficulty in enduring, and perhaps will not even succeed. However, the failure of one project does not mean that members of that group will not attempt to meet their needs cooperatively at another opportunity. Possible negative outcomes must be anticipated, measured and evaluated regarding the health of the participants, as well as the positive aspects gained in working toward their goal. Empowerment activities, like any other movement 'by and for the people' is a layered and incremental process.

There is widespread desire among many women for self-determination today. Thanks to the current historical 'opening' there is space for change. Increased awareness of women's oppression and issues, as well as the possibility for change via democratization allow women the opportunity to envision and experience hopefulness. While the intellectualization of empowerment occurred in the West, its roots are firmly in opposition to oppression and tied closely to anti-colonialism and Marxist theory. As "social spaces" have opened throughout history, 'empowerment' has been an important aspect in revolutionary situations in Latin America, Asia, and Africa, the civil rights and women's movements in the US, and in the current international women's movement by and large.

The Roots of Empowerment

Anti-colonialism

Western Europe followed in the footsteps of Rome. As an empire and later a religious empire, hierarchical powers of Church and State extracted riches from the people. Condoned by 'god,' new cultural and personal systems of belief and deportment were forced upon people as the Empire expanded. Slaves were normally taken in skirmishes at the boundaries of said Empire without recourse to any specific racial justification. By the sixteenth century Western Europe had expanded its domain to Asia and Africa and Portugal was beginning to import black slaves to the Americas with regularity. Soon their political power focused on the 'new world' and with a growing demand for sugar; a world market in slavery and raw materials began (Winant 2001), in effect, creating the third world. In efforts for self-determination against those who dominated them lie the roots of empowerment.

Resistance to colonial rule in India, China, and Africa inspired and informed other similar movements around the world, including specifically the civil rights and women's movements of the USA. Important strategies emerged from the anti-colonialists: alternative forms of resistance, group processes in developing political consciousness, and the importance of pride in one's ethnicity. The *Satyagraha* movement of Gandhi in India welcomed the non-violent approach to revolution. Out of the many struggles of black people against the British, Spanish, Germans, French, Portuguese, and Afrikaners came a sense of collective identity, a pride in blackness. The strategies of non-violence,

group-processes to increase political consciousness, and ethnic pride directly affected the civil rights movement in the USA which was the precursor to the women's movement (Stein 1997).

Highlander and the US Civil Rights Movement

In 1932 activist Myles Horton, educator Don West, and Methodist minister James Dombrowski opened the Highlander Folk School in Tenessee (Horton, 1990). The school has been providing leadership training for people fighting for racial and economic justice as well as being home to intellectual leaders including Martin Luther King Jr. In the 1950s, Highlander played a critical role in the civil rights movement. One of the most important programs Highlander fostered was the Citizenship Schools. Originally designed to provide literacy training for southern blacks, one such school led by Bernice Robinson was molded into the core of a movement for social change. Uneducated herself, Robinson did not teach; she learned *with* the class; and the idea quickly spread. In the words of Horton (1990: 72): "It wasn't a literacy class. It was a community organization." The school trained Rosa Parks prior to her Montgomery Bus Boycott and the following backlash led to the schools closure in 1961. Later it reorganized and opened as the Highlander Research and Education Center.

The civil rights movement participants well understood the concept of empowerment. Many examples of successful self-help programs and community organizations grew from the civil rights movement. It experienced the common barriers to empowerment: groups grew dependent upon outside funding which could be

withdrawn when interests of funders changed or the movement became threatening; leadership cooptation was not uncommon; and power was often illusory. If connections were not made and sustained between the stakeholders and the larger world, no meaningful shifts in resources and power could result. The local nature of the Highlander program with its leaders' roles as participants, the process of group conscientization and community organization goals were bridges to the women's movement and later conceptualizations of empowerment (Stein 1997).

US Feminism and Consciousness-raising

Even though feminism's roots lie in earlier times (Rendall 1990), the feminism we know in the US today began with the civil rights movement. Many white women, although subject to less oppression—came to realize that the very gendered oppression they were facing paralleled racial oppression. The civil rights movement eventually began excluding white participation and white women who were previously involved moved north to expand community organizing there. With extraordinary women role models from the civil rights movement, these white women (usually southern, religious, and young) began organizing against the Vietnam War, in support of student's rights (Ferree and Hess 2000).

The importance of increased awareness of oppression formerly viewed as 'personal problems' became evident to these women. The need to recognize the structural and social roots of oppression came concomitantly with the need to do something about it. Attempts to sensitize male leaders to sexism or obtain existing

leadership positions proved unsuccessful. Processes such as "talking together, discovering common problems, and thereby understanding the need for collective action" (Evans 1979: 134) led to the women's self-organization—as women. These informal group processes of consciousness-raising were primary given the social spaces available exclusively to women. The project of transforming their individual, subjective realities was based in their own homes where they "could examine the nature of their own oppression and share the growing knowledge that they were not alone" (Evans 1979: 215). These processes of informal conscientization followed natural lines of networking and were therefore easy to form and support as the basis for a burgeoning movement.

Group techniques of the US women's movement proved very effective in gaining political ground. A major and rightful criticism of the movement, however, lies in its failure to include issues of class and race which would have necessarily expanded the movement beyond the white middle class (Davis 1983, Smith 2005, Zinn, Dill, and Summer 1996, as cited in Stein 1997). Identity based politics as a source of strength, community, and intellectual development come hand-in-hand with the caveat of its tendency to ignore intra-group differences such as race and class. Violence against women of color is likely the 'weakest link' in society and efforts to remedy the situation would necessarily deconstruct and reconstruct the present lynchpins of domination. In order to understand identity politics in light of recognition of the multiple dimensions of identity, violence must be addressed intersectionally as a basis to "ground differences among us and negotiate the means by which these differences will find expression in constructing group politics" (Crenshaw 1991: 1299). Feminists rooted in the USA or

European women's movements came to their empowerment through gaining "a sense of self-knowledge and of discovering the historical, social, political, and economic roots of the systemic gender-based problems through group processes" (Stein 1997: 57). Despite this glaring discrepancy, the mode of personal experience can be seen as preparation to acknowledge and value the international women's movement. As so succinctly put by Peggy Antrobus (1989: 190; as cited in Stein 1997), an important figure in the women's empowerment movement:

> I… speak from the perspective of a Third World feminist with the privilege and role power associated with the middle class, a university education, and an important position, namely one of the 'elite.' But more important, I speak as someone whose 'real' authority emerged mainly from the personal power of a developing and deepening feminist consciousness, which naturally led me to challenge those institutions—personal, professional, and political – in which my role power is embedded.

Although the situations of women in the Third World differ considerably from that of US women, their ability to empathize and work together is established (Stall 1998). Their crucial ideological grounds and tactical needs are the same: the development of creative survival strategies, the importance of process as well as outcome, and a perception of the ways in which power works (Thomas 1999). Thus, despite the relatively specific parameters of these movements, anti-colonialism, the civil rights movement, and feminism share the goals of emancipation, of overcoming domination and oppression. Their historical linkages show an inspiring progression of ideas moving between people and time (Stein 1997).

US Community Mental Health, Social Work, and Community Organizing

The civil rights movement in the US profoundly affected the 'helping' professions of mental health and social work. Powerlessness and 'negative valuation' of blackness among blacks contributed to recognition of the structural and racist conditions responsible (Solomon 1976: 12, as cited in Stein 1997). From this an understanding of the importance of replacing 'doing for' by 'doing with' emerged through reappraisal of the professional's role as an instrument of the powerful and supporter of the status quo, as well as the questioning of the 'scientific basis' of practice. Julian Rappaport (1981) worked to develop a theory of empowerment promoting 'doing with' as opposed to the conventional 'doing for' among community psychologists. He felt that 'doing for' represented the absence of empowerment: "powerlessness, real or imagined; learned helplessness; alienation; loss of a sense of control over one's own life" (Rappaport 1981: 3). The result was professional tumult and attempts to intellectualize concepts of empowerment.

Community activities, particularly urban community organizing and social action, also contributed to growing notions of empowerment (Kindervatter 1979). Actual issues of power and resources at the heart of such endeavors led community activists away from the pitfalls inherent to the 'helping professions' such as fostering comfort zones in people that cause them to be more comfortable with individuals than in groups, individually oriented techniques, and a lack of role models that take and make power (Stein 1997).

US Self-Help Tradition

The past three decades of the modern self-help movement in the USA are also cited as contributing to the empowerment movement. Less dominated by professionals than mental health or social work fields:

> This legacy of commitment to a model of exchange among equals of assistance, caring, resources, and information, when grafted to the precept of self-determination articulated by anti-poverty activists, black power advocates, student power leaders, and other grass roots political actors of the 1960s, became the conceptual basis for the contemporary empowerment movement (Simon 1990: 29; as cited in Stein 1997).

US feminism has strongly interacted with the US tradition of self-help where women have struggled to restore their self-reliance and lessen their dependency on life-defining institutions. Women formed groups to counter problematic treatment by the medical establishment and found therein enhanced senses of solidarity and personal identity. Typically noncompetitive, cooperative, non-hierarchical, with local definition of problems, evolving process, shared or circulating leadership, emphasis on control over one's own life, small beginnings, and a critical stance toward professionalism (Katz and Bender 1990), the attitudes and behaviors of these feminist self-help groups parallel empowerment groups. A difference, however, is the basic commitment to social change and justice, although the potential is there (Rappaport 1986).

Several connected movements throughout history have exposed large numbers of people, namely US women, to the concepts and processes of empowerment. It is perhaps most important that their visibility has worked to increase the visibility of women in the

Global South whose own strategies for empowerment have also been developing (Stein 1997).

Non-formal Education in Latin America

Belief in the importance of education and literacy in the face of little to no opportunity for it were the first and primary purposes behind non-formal education in third (and first) world development. Paulo Freire, a well known Brazilian educator, demonstrated (1970, 1974, 1990 as cited in Stein 1997) the inextricable link between "non-formal education with empowerment, and with efforts aimed at social and political change" (Stein 1997; 59). Freire traveled extensively to consult and transport his theories of the impact non-formal education can have for adults.

A process termed *praxis,* Friere's methods work to sensitize leaders to the plights of oppressed people to work toward raising their consciousness of their social and political situation. The end goal is the transformation of society. *Praxis* involves critical thought, dialogue, listening, discussion, self-reflection and action. Small group processes and action are key to ending the silence and subsequent internalization of abuses. A long and arduous process, sometimes the greatest improvements occur for only the individuals involved as opposed to 'the society.'

In the context of poor women, illiteracy or inability to navigate the systems of paper trails, Freire's pedagogical techniques can make all the difference. Learning to read and write in the dominant language can lead to power. Power in new hands leads to change.

Influenced by Marxist theories and friends with Myles Horton, Freire's influence on the field of development has been pivotal. Both men were raised in impoverished and oppressed locations worlds apart. Both became well educated. Both clung to family and ideological and religious philosophies. Two fundamental ideas run through their work: (1) freedom for all; (2) the ability and right of all to "achieve that freedom through self-emancipation" and through participation in popular education practice that "simultaneously creates a new society and involves the people themselves in the creation of their own knowledge" (Horton 1990). These are the roots of empowerment: intertwined and spread out from near and far, confronting imposed domination, lack of power and deprivation (Stein 1997).

Empowerment as a Process and an Outcome

"The *idea* is more important than the thing itself. We do not know what empowerment is, but like obscenity, we know it when we see it" (Rappaport 1984: 2). With so many components tied into the idea of empowerment, it is difficult to formulate a clear definition. From psychology to politics, empowerment is both a process and an outcome of achieving power in order to effect change. Empowerment processes address matters of both practical needs and strategy. Stein (1997) sites Barbara Israel's three different levels of empowerment: individual, organizational, and community. Of course, the interactions between these levels are fluid. As individuals grow in their conscientization and skills, the groups (organization) grows in functional efficacy. Membership broadens, resources, allies, and opportunities increase; new goals are set and

personal and political transformations take place. In context of this project and The Emma Center's goals to heal women survivors of trauma and abuse, isn't it time for healing to come full circle?

CHAPTER 5

PETITE EVALUATION: THE EMMA CENTER

Evaluating The Emma Center

Many changes have occurred since The Emma Center's inception in April of 2005, particularly over the past year and a half. Growing from an idea into its present state within a comfortable office that serves 121 currently active clients, The Emma Center (TEC) has developed a familiar face in women's circles countywide. Last year (2007) alone, TEC took 650 client telephone calls and processed 90 new client intakes. Approximately 40 clients are actively served each month in one of TEC's various programs. TEC uses both a pre- and post- treatment health survey in addition to the Post-traumatic Stress Index Survey, (PCL-C) to monitor client progress and effectiveness of treatments; nearly all client surveys show marked improvement of symptoms. With only one full-time staff member, one part-time position, three social work interns (each spending 15 hours a week in direct services), and three regular volunteers, TEC serves approximately one client per official woman-hour on the clock. With wait lists and funding crisis looming, TEC Director requested a program evaluation of this very important community organization.

The local community has demonstrated its support and valuation of TEC. It has twice been a recipient of The Vagina Monologues annual fundraising events in the area, in both 2006 and 2007. Additionally, TEC has begun holding an annual Mother's Day Brunch which has brought in net profits of $2700 in 2006, and $7300 in 2007—

demonstrating phenomenal increase in community support. Besides grants, it is the generous donations from community members (for this brunch and other similar activities), as well as donations of treatment slots by local health practitioners that make TEC possible. However, with extremely few grants geared toward on-going operating expenses and limited support to undertake fundraising, TEC is presently facing an 8 month life-span based on current funding. With its unique philosophy and grassroots approach to holistic healing over the long-term and the recent closure/cut-backs in other local mental health centers, TEC maintains an important position in the community and must find a way to carry on.

With such substantial growth in such a relatively short period of time and a wonderfully unique and effective service, TEC's confidence was buoyed. In July of 2007 the new non-profit Created Equal proposed a possible liaison between themselves and TEC. Formed to distribute a portion of the founder's newly amassed computer-business fortune, Created Equal expressed an interest in TEC's long-term goal of opening a women's residential healing center (WRHC). Offering a $1 million match in funding, TEC put their long-term goal to the forefront of focus. They formed a Manifest and Design Committee and contracted myself to conduct a Best Practices Report to help inform them of successful centers' practices and procedures. Before too long, however, it became evident that the plan to make the WRHC happen was years away. Created Equal's interest diverged away from TEC's goal of long-term healing toward helping women with immediate crisis and decided to pursue a domestic violence shelter. Additionally, my research was turning up all sorts of road blocks, such as TEC's status as

a new organization not yet financially sustainable. It would be a betrayal to the community to allow TEC to fold in lieu of creating a WRHC that would only serve 10-20 clients per year. There are theoretical reasons to suggest that for long-term healing, a residential center may not be the most effective direction to move toward, anyways. At this point in time—WRHC hopes waning—Paige Allisen, TEC Founder, stepped down for an indefinite break and hired a new director. In August of 2007, she resigned completely. With little support, new Director Marybeth Bian took over operations of TEC, mainly focused on obtaining funds to keep the organization functioning. In September of 2007, the Board of Directors agreed to suspend actions and budgeting for the Manifest and Design Committee.

In the face of such upheaval, the loss of the Founder's involvement, looming financial crisis, a new director, and an air of frustration regarding divided interests on focus—TEC or WHRC—a clear map of the situation was deemed necessary. This report is based upon TEC's program evaluation conducted in February 2008. For reference sake, the following quotation of TEC's Mission Statement is taken directly from their website in its entirety:

> The Emma Center is a nonprofit women's center for adult survivors of child abuse, domestic violence, and other trauma. Our focus is on the long-term effects of trauma and an integrative, holistic approach to healing. Our mission is three-fold: 1) to provide referrals, support, and advocacy to abuse and trauma survivors; 2) to raise awareness in our community about the effects of abuse and integrative holistic approaches to healing; and 3) to open a women's residential healing center for women recovering from trauma-related conditions.
>
> Most abuse survivors live with a myriad of trauma-related health conditions, including posttraumatic stress disorder, depression, chronic

> headaches and fatigue, and gynecological and digestive problems. Lack of immediate and affordable treatment means many women are unable to heal from past abuses, have a difficult time functioning in their daily lives, and are at-risk of ending up in unhealthy or even violent intimate relationships. Through grassroots efforts and community collaboration, The Emma Center seeks to help fill this gap in treatment to aid women in their healing process.
>
> The Emma Center is a not-for-profit, tax-exempt 501(c)(3) organization.

Methods

In order to gauge the opinions and understandings of board members, staff and volunteers of The Emma Center (TEC) of its present state, I conducted a brief, evaluation. With the input of professors and a group of fellow Sociology graduate students, I designed a short instrument of ten open-ended questions mainly concerning current practices and needs of TEC as well as one question regarding their long-term goal of opening a women's residential healing center (see Appendix A). A header on the questionnaire included TEC mission statement and brief instructions. I made ample copies of the instrument and left them in at TEC office in the care of Marybeth Bian, Director. The questionnaires were located in a manila envelope to which I attached an introductory letter explaining the evaluation's importance, confidentiality, and my contact information for any questions. In the two weeks available to fill out the questionnaires, seven were completed. Four of the seven questionnaires were completed by members of TEC's Board of Directors in the February 2008 monthly meeting and the remaining three were completed by regular staff: the Director, the part-time employee, and one intern. While the amount of responses were less than I had hoped for, the range

of positions demonstrated in the them appears significant enough to be representative of the 12 possible responses.

Analysis of the data was conducted systematically in two main steps. Initially conducted on an 'open slate,' I read through each questionnaire looking for themes and coded accordingly. This step was done to debunk any assumptions I may have held and to determine common threads among the set. The second step involved analysis informed by fundamental non-profit strategic planning process guidelines. Of the many sources of information on strategic planning models, I opted to use the five steps outlined by CompassPoint of San Francisco (Idealist.org 2008) because of its comprehensive simplicity. Based on analysis of the completed instrument as well as readily available information on the organization, I present a snapshot of TEC as it currently stands and offer a few suggestions.

Methodological suggestions could include the following, although the general goals of the evaluation were sufficiently met by the current approach. One, an instrument including sets of questions with Likert scale answer categories would have helped to standardize comparisons between responses. Two, a client questionnaire group would also have provided richer data. The addition of a client group would imply random sampling strategies and involve a longer time frame to get results. Third, were time constraints a non-issue, I would have liked to form focus groups against which to validate these findings. Finally, the wording of question #3 allows for a close-ended answer, contrary to my intention. Overall, with the goal of mapping TEC operations and present

situation as well as perspectives of those facilitating its current operations, the methods used sufficed; resultant information should prove useful.

Blank-Slate Findings

Based on TEC's basic information (mission statement and goals) I was surprised at the disparity between responses. While most of them indicated an ample understanding of TEC's services, two of the seven seemed to have little knowledge of what, specifically, TEC carries out on a day-to-day basis. Three major concerns have arisen out of the data and are as follows: 1) Current and growing unmet needs within TEC's client base and target population; 2) TEC's existing funding and sustainability challenges; and 3) an incongruity of focus between TEC's needs at present and its long-term goal of creating a women's residential healing center (WRHC). I will next present themes that emerged from the data, question by question.

1. **Please describe the services provided by The Emma Center**.

For reference, the following is existing data from TEC records:

- **Trauma Support Groups** (10 separate support groups were offered in 2007 attended by approximately 99 different clients. Support groups ranged from group talk therapy to yoga).
- **Healing Arts Program- HAP** (There are currently 10 local practitioners donating 2-3 treatment slots per month which served 144 different clients in 2007. Massage and biofeedback are among the treatments offered).
- **Individualized Support** (In 2007, 145 clients took part in Individualized Support services such as case management, advocacy, and goal setting).

- **Counseling Assistance Program- CAP** (34 people began free or low-cost counseling through TEC's network of 6 local counselors in 2007).
- **Lending Library** (123 clients checked books out of the approximately 500 book-strong lending library in 2007 on topics pertaining to women's health).
- **Referrals to Services** (Uncountable, ongoing referral services to supports such as to Humboldt County Domestic Violence, drug and alcohol treatments, low income housing, and medical care regularly occur via phone calls and drop-ins where talking over hot tea is customary).
- **Educational Workshops on Traumatic Stress** (21 separate workshops on traumatic stress were offered at TEC office as well as at Take Back the Night, Soroptomists, Healthy Mom's, etc. in 2007).

Perhaps the most popular offering of TEC is the Healing Arts Program (HAP) serving approximately 35% of clients and was listed in the answers of six out of the seven respondents; five mentioned the educational component; four the lending library and referrals services; three mentioned case management (individualized services), support groups, and the counseling assistance program; and two respondents listed (generally referencing TEC office space) in the words of one respondent, "…a place, and a library, for women where they can feel safe and become more informed." Two of the seven respondents listed the "yet to be realized: residential center" as among the services provided. While most respondents furnished lists of TEC offerings, two listed the services in a tremendously simple fashion: "Providing alternatives for healing."

2. Which of these services do you think are most effective and why?

The most frequently listed service for this question was the HAP program with four of the seven considering it of the most effective. As one respondent put it, this is "because of demand and staff hours spent on these services and potential for long term healing." Drop-in services, including the library and education; were listed as most effective by three respondents because they are a "good resource for more knowledge concerning abuse, trauma, and PTSD" and because they "address the focus population…[where] there are a variety of options for women to choose from." One respondent listed therapy groups (and HAP) as effective in that they are "alternatives to just talk therapy [since] so many people are disconnected." Other responses included "What is most effective is that we can offer alternatives," "I don't know, I'm very new," and finally, one response asserted among the most effective service provided, is "working toward healing center."

3. Do you think that the provision of these services matches with the mission of The Emma Center? If not, where are the gaps?

This question offered the most accord among responses with four simply answering "yes." The new respondent from above hadn't yet formed an opinion at the time of the survey, and two noticed some gaps. The gaps listed by the respondents were that current service offerings "take most of the [staff's] time…and is on the back burner" with the second respondent listing a comparable concern in terms of needs:

> The center is unable to respond to the number of women who need the services—more personnel, more hours needed. Outreach and education could be a ½ to ¾ time job to reach the full community.

4. In your opinion, what does 'healing' mean?

Due to the highly subjective nature of this question, I will list each response in its own illustrative voice. I have ordered the responses according to their general location on a continuum moving from a sickness etiology (which implies coping) and toward an injury etiology (which implies recovery). Notice how the last respondent connects the individual who needs healing to the larger context of the "*causes* of the symptoms" and states that healing means ameliorating these, as well as the individual's own behaviors.

1. Becoming well. Improving aspects to become well.
2. Mental and physical wound care.
3. Providing supportive measures to allow natural health to occur.
4. A healthy journey toward health/goals without stumbling blocks on the road (ha, ha).
5. Healing is the process of recovering in healthy and meaningful ways from a difficult situation or experience.
6. Feeling one and comfortable in one's own body. Able to deal with life symptom free or tools to use when there are flare-ups.
7. Amelioration of causes of the symptoms which reduce or interfere with a person being able to function with satisfaction (self). Not just the behaviors.

5. **How does The Emma Center sustain itself financially and how might the situation improve?**

To sum the answers up, one respondent said: "It doesn't." This question revealed unanimous expression of concern for TEC's financing. Answers included grants, fundraisers, and donations. While some respondents listed these actions as answers to how TEC supports itself, others listed increasing these same actions in terms of improving the situation. One staff member suggested board participation in fundraising and grant writing, another stated, "more participation overall in fundraising." A board member recommended that TEC simply "get someone who can devote time to raising funds." Finally, demonstrating a minimal understanding of the funding world and TEC's independent positioning which allows for freedom of how and what services to offer, one respondent said, "this situation needs to improve by the government giving us money."

6. **What actions is The Emma Center taking to 'raise awareness in the community'?**

Answers to this question ranged from detailed lists to a single statement saying, "talking to service organizations." Three of the seven responses listed fundraisers as one mode of disseminating awareness in the community. Other answers included tabling at local school functions (i.e., Humboldt State University and College of the Redwoods), participation in community events such as Take Back the Night and Sex Expo, the distribution of TEC newsletter and flyers, workshops offered to the community and as in-service components to the coordinators and counselors of domestic violence services, as well as educational publications and presentations in the media such as on local radio

shows. I purposely left this question vague as to what, exactly TEC is raising awareness about: whether about the organization itself, or the issues and concerns it addresses. Answers to this question reflected this ambiguity. I will put forth, however, that awareness about TEC as an organization generally entails dissemination of information on the relevant issues it addresses. Four answers seemed to be focused on activities to raise awareness specifically about TEC as an organization.

7. **Are these actions successful? What are the indicators? What is the main or most powerful message that the community is hearing from these actions?**

This multifaceted question resulted in answers reflecting respondents' focus in question six, above. Three yeses, two somewhat yeses, one no, and one "I'm not sure," comprised the answers to this question. The 'yeses' were indicated by purchases of TEC's PTSD booklet, increased referrals, and that "clients are streaming in. The message: we have services for you." This last indicator is also the basis of the somewhat yeses which can be further explained by the no: "money talks—we don't have enough." On the whole, with the exception of the "I'm not sure" response, TEC is successful in having a presence in the community as a service organization, however, that presence is not enough to guarantee their sustenance financially which enables the provision of services.

8. What are your opinions regarding the goal 'to open a women's residential healing center'?

This question was asked mainly to gauge the degree of focus presently directed toward this 'long-term goal' of TEC despite its need to face immediate concerns. It is in the answers to this question that the largest divide between board members and staff exist. The consensus among the three staff/intern respondents is that the WHRC is a great future goal. One respondent offered the opinion that "women do better healing in the community, but…" that there *is* a need for an alternative to county mental health hospitalization for extreme cases. Another staff respondent expressed some frustration around this subject saying: "Don't get me started. I think it is a good goal. There is a lot that needs to be done before we reach this goal. We need to continue focusing on the clients." Board members, on the other hand (with the exception of one), speak of the goal in the present tense. From a simple: "It's needed," to the acknowledgement of "there are many steps, we have only started," and: "It will be the most effective element of the center but requires massive effort, energy and money," the consensus of board members is solidly focused on the WRHC. The fourth board member agreed that the WRHC is a "good goal, but 1st [we] need to survive." The observation of this pattern is further affirmed by answers to the remaining questions.

9. Please identify possible unmet needs in The Emma Center's target population.

With two respondents not answering this question, one each from the board and staff group, and one board member stating that "there are always unmet needs, but I

believe Emma Center is doing great work—everything they can," the remaining four each offered suggestions. Two answers agreed that in general, more services need to become available. A board member said, "Every woman who calls or walks in needs some treatment (healing opportunities), many need long term treatment. It's not available for most," while the staff member put it this way: "[There are] not enough services. More, more, more. Always need to be expanding services—to do that [we] need more staff!" The second responding staff member specified that there is not enough low-cost or sliding scale therapeutic counseling available. Finally, a board member stated the unmet need as follows—and it speaks for itself: "Build the residential center and they will come." It is already apparent, however, that "they" are coming for the services presently offered and being turned away or made to wait indefinitely.

10. How can The Emma Center serve its clients better?

Echoing trends in earlier questions, answers to this one follow suit. One board member doesn't know, and one says, "Build the residential center!" Another board member reiterates the need to "stay alive [with] fundraising," and yet another spells it out thus:

> The question is, where to focus the energy? –On The Emma Center as we know it; expanding it significantly? Or move forward toward a residential healing center? –With a huge expansion both could be done, if we had the skills, talent, and will.

Staff, again, offered more directly specific proposals such as "more programs, more individual case management and groups;" "Have staff that devotes their time to them

[clients]! Not having to juggle fundraising and client services;" and "More money for the center, [so we] can expand our services. Also, a bigger office!" Based on these responses, it seems that those involved in the running of TEC generally concur that in order for TEC—as we know it—to survive and be effective in its goals, it must expand. As for how to direct that expansion, and in what time frame, as yet remains at variance between actual staff and relatively uninvolved board members.

Findings in Context of Strategic Planning Steps

Introduction

Because of The Emma Center's present focus on the women's residential healing center (WRHC) goal, the relevancy of evaluating the organization not only in terms of a snap-shot of their current situation but also in terms of their readiness to embark upon such an endeavor and how they might effectively go about it warrants a closer look. For this reason I will also address evaluation responses against typical strategic planning processes. There is vast availability of literature on strategic planning both in print and online. After reviewing several of these sources I selected an outline of strategic planning steps put together by The CompassPoint Nonprofit Services of San Francisco which is a nonprofit training, consulting and research organization. Located on a hub for non profits including a directory of thousands of nonprofit web sites, an online library, and a database of volunteer opportunities nationwide, this outline appeared the most fundamental, comprehensive, and user-friendly (Idealist.org 2008). It includes the basic

work needed to be done and what can be expected as an outcome. I will offer sugestions to TEC at each of the five outlined steps.

Step One – Getting Ready

"To get ready for strategic planning, an organization must first assess if it is ready." Aside from numerous issues to address regarding readiness, the essential components are whether or not the leaders of an organization are committed to the effort and are "able to devote the necessary attention to the big picture."

> For example, if a funding crisis looms, the founer is about to depart, or the environment is turbulent, then it does not make sense to take time out for strategic planning effort at that time.

If an organization deems itself ready, it is then suggested that the following five tasks be performed to "pave the way," these five steps comprise the workplan.

- identify specific issues or choices that the planning process should address
- clarify roles (who does what in the process)
- create a Planning Committee
- develop an organizational profile
- identify the information that must be collected to help make sound decisions.

Having alrady decided itself to be ready in the summer of 2006, TEC performed, or at least began many of these steps. The specific issues or choices to address were developed through a collective brainstorming process where clients and intersted parties drew the WRHC on a large paper on the wall. This was followed with focus groups on

how the WRHC would actually be: ideal setting, therapies offered, children present or not, to have a garden and chef, visitation policies, etc. This first step also melded into the second with the contracting of myself to research and report on similar centers' best practices (The Best Practices Report). TEC Founder, Paige Allisen spearheaded the effort by working with me and networking with many other volunteers and potential funders regarding the process. Due to the hurried nature of this process in light of the potential funding match (mentioned earlier in this report), roles were not clearly demarcated. TEC Board of Directors hired a new executive director in order to free up Paige Allisen to work on manifesting the WRHC. A Manifest and Design Committee was formed by TEC board members, headed by Ms. Allisen, to plan and execute the goal. Efforts were made to develop an organizational profile, called TEC Portfolio—geared toward potential funders and designated to be another task of mine. During my research for The Best Practices Report and portfolio, I came to realize the magnitude of this undertaking as well as suggestions from the relevant literature that for the goal of creating an *alternative* to conventional treatments—simply eliminating locked doors and hospital ward while adding holistic treatments to minimized biomedical approaches in an idyllic setting—was perhaps not the most effective trajectory anyways. Around this time (July 2007), Ms. Allisen informed me that the Created Equal potential funding match had been withdrawn due to differences in goals, but to continue pressing on. Additionally, it became appearent TEC was on shaky grounds as is—and such a large undertaking was presently unfeasible. During our weekly meetings I began to disseminate my findings to

Ms. Allisen, starting with an interim, stepping-stone idea I had come up with which many of TEC staff liked quite well. She said:

> I don't even want to hear it. We've been working on this project for a long time now. I'm sure someone has come up with every possible angle already—and it's been rejected. Don't even try to explain it to me.

In response I began explaining the research that demonstrated the barriers to the idea: TEC's present struggles to survive; that were we to continue engaging the WRHC, TEC as we know it may not be able to continue serving its existing client base. In addition to these things, I raised the possibility that the WRHC may not best fit the needs of the target clients. I tried to tell her that these discrepencies were making it difficult for me to complete my tasks: to sell the WRHC when so much seemed to point that energy was needed elsewhere. Before I could finish she said:

> I expect that the current Center will be cut-back in lieu of creating the WRHC. There are other organizations that can pick up the slack we leave. I know this project is a huge leap but I know that if we just jump we can do it.

Ms. Allisen then informed me that she would be taking an indefinite period of time away from TEC for personal care, that she did not have the energy or will to think about or participate any longer, that I would continue my work under Marybeth Bian, Director. In August, Ms. Allisen resigned completely from TEC. Working with Ms. Bian and my professors, my contract was revised to finish the Best Practice Report, cease work on the portfolio, and to conduct a brief program evaluation.

I have documented this story here to demonstrate that although some of the features of Step 1 have been started, the initial "readiness" precondition is not met. TEC

faces a "looming funding crisis," the founder has departed, and the environment can be characterized as somewhat "turbulent." Based on the findings revealed in answers to the evaluation instrument, I would suggest that TEC hold off on attempts to develop the WRHC and consider ways to address:

1) Current and growing unmet needs within TEC's client base and target population;

2) TEC's existing funding and sustainability challenges.

Step Two – Articulating Mission and Vision

The purpose of a mission statement is to inform readers of where the organization is going and mainly that the organization itself knows where it is going. The goal is to communicate the essence of the organization, its focus and purposefulness. Mission statements typically describe an organization in terms of its:

- **Purpose** – why the organization exists, and what it seeks to accomplish
- **Business** – the main method or activity through which the organization tries to fulfill this purpose
- **Values** – the principles or beliefs that guide an organziation's members as they pursue the organization's purpose

To sum this up, the mission statement is a summary of the "what, how, and why of an organization." A vision statement, on the other hand, presents the organization's "image of what success will look like." With clear articulations of both mission and vision statements, an organization is prepared to create "a shared, coherent idea of what it is

strategically planning for." For the reader's convience, I will once again quote TEC's mission statement:

> The Emma Center is a nonprofit women's center for adult survivors of child abuse, domestic violence, and other trauma. Our focus is on the long-term effects of trauma and an integrative, holistic approach to healing. Our mission is three-fold: 1) to provide referrals, support, and advocacy to abuse and trauma survivors; 2) to raise awareness in our community about the effects of abuse and integrative holistic approaches to healing; and 3) to open a women's residential healing center for women recovering from trauma-related conditions.
>
> Most abuse survivors live with a myriad of trauma-related health conditions, including posttraumatic stress disorder, depression, chronic headaches and fatigue, and gynecological and digestive problems. Lack of immediate and affordable treatment means many women are unable to heal from past abuses, have a difficult time functioning in their daily lives, and are at-risk of ending up in unhealthy or even violent intimate relationships. Through grassroots efforts and community collaboration, The Emma Center seeks to help fill this gap in treatment to aid women in their healing process.
>
> The Emma Center is a not-for-profit, tax-exempt 501(c)(3) organization.

I would propose that while TEC presently has both a fine mission and vision, the articulation of them is been melded together which creates the liklihood for confusion. The first step in evaluating the mission statement would necessarily include the breaking down of the current "statement" into the categories presented in Step Two which might look as follows:

- **Purpose** – why the organization exists:

> Most abuse survivors live with a myriad of trauma-related health conditions, including posttraumatic stress disorder, depression, chronic headaches and fatigue, and gynecological and digestive problems. Lack of immediate and affordable treatment means many women are unable to

> heal from past abuses, have a difficult time functioning in their daily lives, and are at-risk of ending up in unhealthy or even violent intimate relationships.
>
> …and what it seeks to accomplish: "Our focus is on the long-term effects of trauma."

- **Business** – the main method or activity through which the organization tries to fulfill its purpose:

> 1) to provide referrals, support, and advocacy to abuse and trauma survivors; 2) to raise awareness in our community about the effects of abuse and integrative holistic approaches to healing… Through grassroots efforts and community collaboration, The Emma Center seeks to help fill this gap in treatment to aid women in their healing process. The Emma Center is a not-for-profit, tax-exempt 501(c)(3) organization.

- **Values** – the principles or beliefs that guede an organization's members as they pursue the organization's purpose: "…an integrative, holistic approach to healing."

It may be useful to expand these categories, particularly the "values" section. What may be informative here ties into my understanding of TEC's premise that it adds insult to injury for women to pay for healing and that TEC is committed to helping women who cannot afford it, to receive healing services. I suggest as well, to take a deeper look into what item #2 of the present mission statement means by "raising awareness in the community…" as it may be grossly under-estimated in current practices. Board members, staff, and clients are, of course, the best candidates for re-evaluating the mission statement and probably have greater insight as to how and what needs changed or expounded upon. Furthermore, notice that item #3 in the present formulation of TEC's mission statement does not fit into mission statement categories of 'what, how and why'

as it comprises “the vision.” Based on this I propose a separate formulation of TEC’s vision, possibly to include plans/ways of sustainability and any interim steps.

Step Three – Assessing the Situation

Once a clear definition is agreed upon as to why an organization exists and what it does, it must evaluate its present situation with “an eye to the future environment.” Strategic planning and management involve scrutiny of the organization’s ability to respond to changes such as what the primary concerns are, funding matters, new program opportunities, policy and regulation changes, and client needs, just to list a few possibilities. “Situation assessment, therefore, means obtaining current information about the organization strengths, weaknesses, and performances… highlighting critical issues that the organization faces.” I would assert that TEC is largely ready to address this step— this report being a key step in the process. Again, based upon information emergent from the evaluation instrument, the three primary concerns lie in energy diverted toward the long-term vision of the WRHC, client needs and present funding challenges. The tangible products of Step Three should include a quality dataset of information to inform decisions, and “a list of critical issues which demand a response from the organization – the most important issues the organization needs to deal with.”

Step Four – Developing Strategies, Goals, and Objectives

After affirming the mission and critical issues, an organization must then “figure out what to do about them: the broad approaches to be taken (strategies), and the general and specific results to be sought (the goals and objectives).” Many possibilities and

combinations of methods exist to achieve this step: examples from other organizations, focus group or brainstorming sessions; individual inspiration and ideas; and conventional decision-making methods. The ultimate end is for leadership agreement on how critical issues will be addressed.

This step is perhaps the most time consuming and requires the most flexibility. This stage often requires obtaining yet more information, reevaluations of conclusions reached during the situation assessment stage, and the consideration of new insights that may arise in the process which might even change the very trajectory of the mission statement. "It is important that planners are not afraid to go back to an earlier step in the process and take advantage of available information to create the best possible plan." Step Four should result in a clear "outline of the organization's directions – the general strategies, long-range goals, and specific objectives of its response to critical issues."

Step Five – Completing the Written Plan

In effect, this step involves putting down onto paper each of the completed products from the previous four steps: the mission statement, critical issues, goals, and strategies to accomplish them. Typically, one specified member of the process who will execute this task. Once drafted, a copy is distributed to key participants for review (in most cases, the board and senior staff). It is at this point that consultation between planners and senior staff occurs to determine if the written plan can be transmuted into actual operating plans. The operating plans would include detailed steps or actions to be taken to accomplish the strategic plan's goals. An additional aspect of this step would be

to confirm the plans' ability to answer "key questions about priorities and directions in sufficient detail to serve as a guide." Any incongruities should be attended to by timely revisions, not dragged out or buried and ignored. Unresolved conflicts "inevitably undermine the potency" of the whole process. The final product of Step Five is a solid strategic plan.

Conclusion

The Emma Center has come a long way since its inception just a few short years ago. Meeting a need with far reaching effects, it is important that they keep up the good work. In light of the present funding concerns and growing unmet needs, TEC is facing some changes. First, the September Board of Directors decision to shelve efforts to build the WRHC should be taken seriously. While, of course, it must be considered in the planning process as it is the "long-term goal" of TEC, more attention demands to be paid the present situation. Second, a thorough orientation process is needed for anyone considering working with or for TEC. Our current board member who simply "doesn't know" is unlikely to provide much effective board support without such knowledge. It seems that a few respondents have already touched upon what is perhaps my most valuable insight as an evaluator of the organization: that there are creative options to meet the challenges facing TEC. Perhaps it is not only fundraising, grants and donations that will spell financial sustainability for TEC. Perhaps expanding the existing services to meet unmet needs can be done in a way "to kill two birds with one stone" (please excuse the morbid cliché). I highly suggest TEC put substantial effort into a strategic planning

process as outlined. Aside from creative brainstorming and thinking "outside of the box," some more specific implications from this evaluation follow.

A needs assessment of TEC's target population would greatly strengthen and inform any work—present and future. In conjunction with this, I would propose a re-visitation of item #2 in TEC's mission statement, "to raise awareness in our community about the effects of abuse and integrative holistic approaches to healing." I would encourage a deeper investigation of "the effects of abuse" and, specifically, what and where abuse is located within "our community." From gender roles to generational mores and norms, abuse, at its fundamental level occurs in the psychology of a people, not just between a husband and wife, father and child, as many of TEC's lending library books spell out. A woman's health is affected by so much more than her experiences: her status, class, and race within the larger society are shown to link drastically with her health. (The tip of the iceberg of this topic has been touched upon in my research related to these—Best Practices Report and Evaluation—projects conducted for TEC and can be read in the Literature Review sections of TEC's copy of my work in its entirety). On this note, it is perhaps *all* women who might be considered targets of TEC, and that "integrative holistic approaches" means, necessarily an approach that considers not just the individuals but the community and society in which the individuals are located. From the Best Practices Report, the *Las Dignas* organization is exemplary in this approach. Some other similar organizations include Sista II Sista (www.sistaiisista.org) and Incite (www.incite-national.org). Led by women of color who make an obvious correlation to the status/health dynamic of women, these organizations are on the forefront of ending

violence against women. The example set by the women of these organizations speak directly to the necessity of empowerment of women should *anyone* wish to live violence-free. Perhaps expanding the interpretation of TEC's mission statement to address this society which inflicts so much violence and injury on the whole –as opposed to just those few injured women fortunate enough to have connected with TEC—would not only serve those women's healing, but the growth and expansion of TEC into an organization—a hub—that is healing society's compulsion to inflict so much injury. That said, The Emma Center is off to a great start and the future is truly wide-open.

CHAPTER 6

CONCLUSION AND FINAL THOUGHTS

Recap

With this conclusion my long appointment with The Emma Center is coming to a close. Of the 240 hours spent with the organization over the past two years, I have completed three closely interconnected and equally important tasks, andI have learned a lot. Task One was conducting a Best Practices Report to inform The Emma Center's (TEC) project of building a women's residential healing center (WRHC). Between losing their potential funding match and my research findings which demonstrated the project infeasible, the push for creating a WRHC at this time was suspended. The Best Practices Report, still, however, speaks to The Emma Center as they look to the future deciding what to do in the face of funding crisis and the need to expand services. Task Two consisted of a Petite Evaluation to provide a "snap-shot" of TEC and to gauge whether or not present understanding of those running the organization are aligned with their specified trajectory. While mostly yes, this is the case, and findings confirmed the funding and unmet needs concerns, analysis of strategic planning steps, some interesting implications revealed the need to reevaluate TEC's mission statement and scope. Lastly, the Third Task consisted of compiling loads and loads of research on the topics of women's health, treatment, and organizational structures to inform Tasks One and Two. The most pertinent section of this research comprised the subject of Empowerment. The

Emma Center has seen renowned success in its short three years of operation. Their potential for exponential and profound impacts in their field is extraordinary.

It is my hope that the ideas outlined in this project are found by the reader to be sensible and self-evident as a valid framework with which to draw together the many aspects of women's lives and health. Common understandings and terminology are among the first steps to be taken in recognizing where we are. The important questions, now must be addressed: how, why, and what?

Reflexive Statement

It all began with a visit to The Emma Center. A kind woman greeted me and sat me down on a plush couch "to talk." I felt rather uncomfortable until the tea she had offered me began to warm me from the inside out. The woman told me about the center, how it started, what services were available and asked me what I thought I might be interested in. Being "poor," The Emma Center helped me obtain my first professional massage, and oh what a day that was! After filling out a form or two I browsed the lending library and settled on a selection the woman recommended, *A Language Older Than Words* by Derrick Jensen, local author and activist. It took me nearly a year to read the book which, in a nutshell, explicates the interconnected nature of all life and how modern society acts as a trauma machine for purposes of control. The book changed my life. Day after day I read and fumed, realizing how hugely helpless is humankind—but somehow, seeing how this happens all mapped out planted a seed of hope. I had been out

of school for nearly three years at this point. I couldn't imagine 'just working' for the rest of my life, I knew there had to be more, something to work *for*.

I fantasized about all kinds of ideas to "change the world." From traveling the country and performing vaudeville shows wrought with subversive messages from atop my car to teaching kindergarten, nothing seemed quite *enough.* I was heavily involved in yoga and personal enrichment activities, but I realized I needed to learn *more*, to gain a greater understanding of how the plethora of interconnected elements work together. I figured, when you can't figure out what to do, do *something.* So I applied for the Sociology Master's program at HSU. It best fit my fuzzy goal to 'change the world' and my interest area of how people co-create reality. In Fall of 2006 I was accepted and began the rigorous task of gaining the skills I would need to succeed in both school and in any future work I may endeavor.

When looking for an organization with which to complete my placement requirements for the program, I had one criterion in mind: proactive approaches toward "changing the world." At the time, what that meant to me was *holistic* and focusing on positive actions as opposed to ameliorating some ill. I searched and searched. My yoga classes were costly, and largely a privileged white women's phenomenon, The HSU Women's Center was engaged in all sorts of amelioration causes from "Take Back the Night" to "The Campus Coalition to End Sexualized Violence," and the general "New Age Movement" was way too broad in scope not to mention the appropriation and cooptation involved with it. Truthfully, I did not want to associate with an "abused women's" organization, I wanted to find something demonstrating empowerment and

action with undeniable results. Down to the deadline and no closer to my ideal, I returned to The Emma Center to sign a contract and "give back" to the organization that provided the means to my initial spark.

Now, at the end of this chapter of my educational journey, I know that although I have learned so much, there is an incredibly huge and growing body of information I do not and may never know. I possess vital skills and tools that will allow me to function in a meaningful way wherever the future takes me. I am no longer slumped with depression and sadness over the state of the world. I no longer feel helpless. While I have a clearer glimpse now more than ever of the magnitude of "ills" we, the people are up against, I have a valuable understanding that, in the words of Professor Jennifer Eichstedt, "Yes, it's all interconnected—and it's huge! Don't get bogged down with that! You each have to pick your wedge, drive it in, and keep hammering!"

Based on my emic perspective, then, I envision a future Emma Center that continues its tradition of grassroots community networking with an expanded trajectory. It would provide healing for the individual and community, concomitantly. With the espousal of their "community education" goals coupled with current services such as advocacy and workshops, it is possible that necessary funding sustainability could be met. Based on the literature and my position as a member of the local community where TEC is based, I imagine that if a large building were obtained (through fundraising, grants, and donation) and used to generate regular income (possibly from renting space to participating therapeutic practitioners). Used as a hub, said building could provide TEC with a more prominent face in the community, a location to conduct workshops, organize

social and political change activities thus expanding their exposure and client base while generating empowerment for participants—healing both them and the larger society where such injuries occur. Additionally, 2-3 week residential retreats could be regularly conducted at idyllic local health retreats by therapists who might receive free, intensive training offered by a trauma specific residential center listed in the case studies. Overall, it is clear TEC occupies an important place in the community and there is much work yet to be done! As they have already proved, where there is a will, there is a way.

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APPENDIX A

ORGANIZATIONAL TEMPLATE FOR BEST PRACTICES REPORT

Name of Organization:
Contact Person:
Phone: **Fax:** **Email:**
Address:
Parent Organization:
Nature of Parent Organization:
Treatment Philosophy:
Brief Description of Therapeutic Community Activities:
Client Profile: **Children:**
Age Limit:
Number of Staff:

Number of In-patient Clients: **Outpatient:**
Client Funding/Fees Requirements and Modes of Payment: **Organization Funding Sources:**
Medical Care and Special Features:
Any Other Relevant Information:
What makes it a therapeutic community: **Facilities:**
Setting (eg, , Licensure, etc.:
Ongoing research, audit programs, and/or effectiveness or quality procedures in place:

APPENDIX B

SURVEY INSTRUMENT USED FOR PETITE EVALUATION

Program Evaluation Instrument
For: The Emma Center 2008

Directions: *Review the mission statement below and answer the following questions according to your personal understanding and opinion.*

Mission Statement: The Emma Center is a nonprofit women's center for adult survivors of child abuse, domestic violence, and other trauma. Our focus is on the long-term effects of trauma and an integrative, holistic approach to healing. Our mission is three-fold: 1) to provide referrals, support, and advocacy to abuse and trauma survivors; 2) to raise awareness in our community about the effects of abuse and integrative holistic approaches to healing; and 3) to open a women's residential healing center for women recovering from trauma-related conditions.

1. Please describe the services provided by The Emma Center.

2. Which of these services do you think are most effective and why?

3. Do you think that the provision of these services matches with the mission of The Emma Center? If not, where are the gaps?

4. In your opinion, what does ‘healing’ mean?

5. How does The Emma Center sustain itself financially and how might the situation improve?

6. What actions is The Emma Center taking to ‘raise awareness in the community’?

7. Are these actions successful? What are the indicators? What is the main or most powerful message that the community is hearing from these actions?

8. What are your opinions regarding the goal ‘to open a women’s residential healing center’?

9. Please identify possible unmet needs in The Emma Center’s target population.

10. How can The Emma Center serve its clients better?