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The Invisibility of Violence Against Women Diagnosed With Schizophrenia

A Synthesis of Perspectives

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Women diagnosed with severe mental illness experience twice the rates of violence compared with women without mental illness. Despite awareness of violence, mental healthcare providers feel powerless to combat the problem. This article synthesizes 2 previous interpretive studies that examined violence perpetrated against women diagnosed with schizophrenia. This synthesis critically examines the perspectives of women who experience violence and schizophrenia and case managers who care for them. Stigma was an overarching theme in participants' stories but each group differed in its understanding of how stigma impacted women's lives. This disconnection perpetuates stigma and allows violence to remain invisible. **Key words:** *case management*, *mental health*, *schizophrenia*, *severe mental illness*, *violence*, *women*

THIS ARTICLE synthesizes the results of 2 previous studies that examined the high rates of violence perpetrated against women diagnosed with a mental health disability. This synthesis was undertaken to critically examine the perspectives of both women who experience violence with a diagnosis of schizophrenia and the mental health case managers who care for these women. Women and case managers shared their diverging perspectives on the theme of how stigma perpetuates violence. The aim of this article is to juxtapose these 2 voices to advance our understanding of how this population of women has become "invisible" and an acceptable victim of violence.

In the last 10 years there has been an increased focus on the pervasiveness of violence perpetrated against women with disabilities.[1-5] Although this is a heterogeneous group, violence is a major health problem that transcends the type of disability that challenges these women. General estimates of violence rates against women with disabilities range from 33% to 83% but vary depending on the type of violence and disability.[6] Women with physical disabilities were found to be more likely to experience abuse by a healthcare worker and to experience violence for longer periods of time.[7] Women with developmental disabilities were over 10 times more likely to be sexually assaulted compared with women without disabilities.[8]

Women with mental health disabilities are at particularly high risk of multiple forms of violence.[5,9,10] In studies that specifically asked women diagnosed with severe mental illness about lifetime incidence of abuse, 51% to 97% of women reported physical or sexual abuse.[5,11] Schizophrenia is a common type of severe mental illness and women with this chronic illness consistently report high rates of violence and victimization.[9]

These high rates of violence force us to question why most vulnerable women are

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so persistently violated. The devaluation of women in general, and women with disabilities in particular, is frequently cited as the main cause of this ongoing abuse. Our society perpetuates the stereotype that women who live with disabilities are asexual, dependent, and unable to successfully juggle valued life roles such as mother, spouse, and worker.[2] Persons who are devalued are more easily stigmatized and objectified.[2] Societal stigma against persons with mental illness has been a well-researched topic and studies have demonstrated that perpetrators of violence are aware of this stigma and target-vulnerable groups knowing that these populations are frequently isolated, dependent on outside care taking, or have an illness that limits their ability to communicate with family or the criminal justice system.[1,2] Our societal objectification allows predators this consistent access to vulnerable women because to confront the reality of women's struggles with violence would involve confronting our stigmatized beliefs about women with disabilities.

Violence, primarily physical and sexual abuse, frequently coexists for women with a history of severe mental health problems. Being a victim of violence is a common ramification of living with mental illness.[12] Eighty-two percent of women diagnosed with severe mental illness reported a lifetime incidence of physical abuse, whereas 69% reported a lifetime incidence of sexual abuse.[4] Violence causes a constellation of negative social, physical, and psychological outcomes for these women. These include increased rates of homelessness, hospitalization, HIV infection, substance abuse, posttraumatic stress disorder (PTSD), and suicide.[13–17] Women diagnosed with severe mental illnesses also encounter discrimination and stigma in their daily lives. Gender inequities, lack of insightful public policies, and the reluctance of our legal system to prosecute perpetrators have placed these women at even higher risk of violence and poor health.[12,17–19]

Many researchers have reported the high incidence of violence among women diagnosed with severe mental illness.[4,5,11,10] What is less understood is how these women live with this violence, what meanings have they derived from their lives, and what our mental healthcare system is doing to assist these women. This gap in the literature was the impetus for my 2 previous interpretive studies.

My first study asked women what it was like to live with the confluence of schizophrenia and past or present violence. I chose to focus upon women with schizophrenia because this illness often impedes a person's physical, social, and psychological well-being. Three themes developed from this first study: being stigmatized, foreclosing a future of possibilities, and finding meaning in symptoms.[12] Participants described the double stigma related to both the diagnosis of schizophrenia as well as feeling that society deemed them acceptable victims of violence. Women explained how the stigma of schizophrenia and abuse were interwoven, and they were not conceptualized as 1 preceding or leading to another. In short, violence and schizophrenia went "hand in hand." Living with this illness as well as violence influenced women's sense of hope for recovery and included ongoing grief related to lost possibilities. Living with schizophrenia for women involved coping with symptoms such as auditory hallucinations. These "voices" were often described as the voice of their abuser and were both frightening and meaningful, and women explained that their symptoms sometimes helped them make sense of their struggle to live in a world unsafe for women.

My second study focused on gaining a better understanding of what it was like for mental health care providers to work with women who are such frequent victims of violence. Previous research about mental health care providers found that mental health case managers value their work and develop caring relationships between themselves and their clients.[20–22] These relationships are generally described in positive terms and there is little discussion of violence or any possible noncaring interactions with consumers[20–23] other than ongoing struggles with lack of adequate funding, staffing, and lack of understanding by the community of mental health care needs.[20-22]

Themes from my second study with case managers include knowing and avoiding, accepting and forsaking, and being supportive and overwhelmed. These case managers readily acknowledged the vast amount of violence in the lives of women diagnosed with schizophrenia. They expressed no surprise that violence perpetrated against this population was so prevalent. In fact, they commented that most of the women with whom they worked had experienced violence. Moreover despite their close relationships with their clients, case managers felt unable to adequately address the issue of violence in women's lives. Case managers described being aware of the negative effects of violence on women but, for a variety of reasons, avoided addressing them. They saw themselves as advocates for women but were frustrated with declining budgets and expanded work roles, and thus felt alienated from women's problems with violence.[24]

Upon completion of these 2 previous qualitative studies I had a better understanding of how women's and case managers' viewpoints diverged, and how this divergence was unintentionally perpetuating stigma and subsequent violence that was a common aspect of living with schizophrenia for women. By positioning the voice of both women and case managers this article bridges this chasm of differing perspectives. Our stigmatized views of women with mental health disabilities need to be made visible; otherwise, this common violence will continue to go unchecked.

This article describes how each group developed conflicted meaning from its experiences with chronic mental illness and persistent violence. Within the context of stigma, both women and mental health care providers told stories of the label of schizophrenia, a perceived hierarchy of mental illness diagnoses, the lost value of listening, and the lack of hope for an improved future for this population of women. For both clarity and brevity, I have chosen to use the term *women* when describing the first group of participants, women who have been diagnosed with schizophrenia and live with violence, and case managers or providers for the second group of participants.

METHODS

Design

An interpretive phenomenological approach was used for both studies. I was interested in understanding the nature or meaning derived from a diagnosis of schizophrenia and violence, and this method allows participants serve as the experts of their own experiences. The phenomenological point of view attempts to uncover the nature of the phenomena in question and how they are understood as common human experiences.[25] Phenomenological research asks what particular experiences are like from a variety of perspectives. An improved awareness of how it feels to experience adversity, discrimination, or stigma challenges us to think about our nursing practice and how we may unintentionally cause harm through a lack of thoughtfulness. Reading phenomenological research has the potential to change practice by promoting increased thinking and understanding among providers about what it feels like to be our patients. Understanding these life processes may encourage providers to become better prepared to assist people who may be considered outside our circle of understanding.[25]

Sample

Both women and case managers were recruited from a community mental health center that provides case management services for persons diagnosed with severe mental illness. They were invited to participate through the use of recruitment posters as well as discussions with the principal investigator (PI) who provided an overview of the topic of interest. Eligibility criteria were described, and my sample consisted of 9 women in the first study and 11 case managers in the second study. For both studies, purposive sampling was used to choose participants who were willing to share their experiences with schizophrenia and violence. Eligibility criteria for women from the first study included the following: (*a*) adult women 18 years or older; (*b*) self-reported diagnosis of schizophrenia; and (*c*) self-reported history of violence. I chose not to define a particular type of violence to participants, to better understand how women define violence in their lives. Because of the vulnerability of this group of women, and threats to confidentiality, limited demographic material was obtained to ensure anonymity. The case managers included a variety of specific roles of psychiatric nurses, social workers, and rehabilitation specialists. Eligibility for this study included case managers who were either currently providing or in the past provided case management services to women with the diagnosis of schizophrenia and history of violence. In total 20 participants completed interviews, and each participant was interviewed 1 time. These interviews lasted from 1 to 2 hours and were conducted in various locations (office, coffee shop, and participant home) according to the participants' preference.

Approval for this research was obtained from the community mental health agency review board as well as from the university internal review boards.

Procedure

Participants were interviewed individually and asked to tell their stories of chronic illness and violence. Women were asked to respond to the following question: "I am interested in learning about what it's like for women to live with a diagnosis of schizophrenia and a history of violence. Would you begin by telling me what it is like to live with both a history of violence and schizophrenia?" Case managers were asked to describe what it was like to work with this population of women. Each interview was conducted at an agreed-upon time and place. The principal investigator or a school of nursing staff member trained in transcription transcribed the audiotaped interviews verbatim. All identifying information, such as names, persons, places, or agencies, was deleted from the transcriptions. Following transcription, each interview was anonymously coded with a number. Each transcribed text was checked against the tape for accuracy and the PI then destroyed the tapes as well as any identifying materials.

Analysis

Five researchers skilled in the interpretive phenomenological research methodology analyzed each transcript. Members of this research team had varied healthcare backgrounds and included interests in women's health, community mental health, and substance abuse. The use of a research team with a variety of nursing and social work backgrounds was used to enhance the credibility of the results. Because the PI in these studies has a history of working as a case manager, it was particularly important to obtain rival explanations for provider themes, to avoid mere admonishment of case management practice and move the analysis forward into discovering how case managers feel about their work with this group of women.

Texts were analyzed to identify the common meanings and shared practices of a diagnosis of schizophrenia and being a victim of violence. The team members used a modified version of the multistage data analysis procedure described by Benner[26] and Diekelmann et al.[27] The analysis of the texts began with a process of having each text read by team members to obtain an overall understanding. "Bias" was not "controlled for" but made explicit and examined by research group members. Researchers prepared written summaries of the texts including the identification of common meanings or possible themes, exemplars from the text to support the themes, and the reader's interpretation of the themes. Research team members wrote across both individual and multiple texts. Team members reread and studied the interpretations generated previously to see whether similar or contradictory interpretations were found in the various interviews. At times there were differences of opinion generated within the group regarding specific interpretations and these differences encouraged a closer examination of the transcripts with ongoing written analysis and reviews of previous literature.

The interpretations represented a persistent involvement with the text to discover the obscure, or ambiguous nature of participants' experiences. Although there is an underlying assumption of this analysis that no single correct interpretation exists, the team's repeated examination of the whole and the parts of the texts with reference to the participants ensured that interpretations were focused and reflected in the texts.[27] Themes were developed that the research team concurred were particularly meaningful for each group of participants. Researchers brought and shared relevant literature to support, extend, or clarify identified themes.

Through the process of reading and going back and forth among the transcripts, the interpreters sought to identify the everyday reasoning and associations made by the participants. The goal of phenomenologists is not to present the reader with 1 set of finalized themes, but to orient the reader to a region of lived experience, to evoke a lived understanding of a phenomenon such that the reader will be challenged to reflect deeply and thoughtfully on the nature of being human.[25] Patricia Benner's question, "What do I now know or see that I did not expect or understand before I began reading this text?"[26(p101)] was used to question preconceptions regarding both living with schizophrenia and violence as well as being a case manager who works with this population.

FINDINGS

Stigma was an overarching theme in the stories of women and case managers. Both groups felt that stigma was an ongoing issue for persons diagnosed with mental illness, and they also spoke clearly of how being a victim of violence was also highly stigmatizing, particularly when paired with a history of schizophrenia.

Stigma as a label

Women felt that stigma caused people not to listen to or believe them and described feeling treated as a diagnosis rather than as a person. Women believed they were acceptable victims of violence. They spoke of being labeled by providers, their family members, and even themselves. These participants also discussed how the diagnosis of schizophrenia was so heavily laden with negative connotations that knowing their diagnosis caused them to feel more stigmatized. They felt treated as less intelligent and less valued. A participant explained:

> Everybody talks to me with the preconceived idea that I'm mentally ill, and they've got this, I feel sorry for you attitude, and this condescension. I'm not pathetic. Because you get labeled, and there's so much misunderstanding in society where mental illness is concerned. The label gets you. . . .People won't listen to you, this person is mentally ill, I'll listen to them for such and such an amount of time, and after that I don't want to hear what she's got to say, because she's just crazy anyway, and it's all off the wall. You see that stigma causes you to not want to talk because you know you're not going to be listened to.[12(p967)]

Women felt the label of "schizophrenia" was used to dismiss what they had to say. A woman stated that the stigma against people diagnosed with schizophrenia was used to perpetuate feelings of prejudice. By labeling women as "crazy" they do not need to be listened to, believed, or valued.

> It (stigma) keeps mankind separated, and keeps us from being happy, or being righteous with one and other, being real with one and other. Not having hatred on sight because of someone's pigmentation, or because someone's handicapped, or mentally retarded, or mentally ill, any of these various reasons why we, we give ourselves excuses to hate one and other.[12(pp967-968)]

Case managers also believed that stigma was problematic for women diagnosed with schizophrenia. They agreed that the combination of a diagnosis of schizophrenia as well as a history of violence was doubly stigmatizing for this population. But none of the case managers in this study discussed how their actions in caring for this population were perceived as stigmatizing. For providers, stigma was situated outside of their relationship with women. Although women clearly addressed the issue of how they felt disbelief was an aspect of stigma, case managers struggled with women's veracity with regard to stories of violence. Interestingly, case managers expressed only concern about believing women's stories when the violence was current; histories of past violence were presumed credible by case managers. "Almost every woman who I've worked with who has a diagnosis of schizophrenia has serious violence in their past, a HUGE amount of abuse." Case managers denied that women deliberately confabulated stories of being victims, but they worried that a woman's symptoms of schizophrenia skewed her perceptions.

> I think, as adults, they tend to get in iffier relationships. And we are really questioning whether it was symptomatic, part of the illness? Did that really happen . . . or are they, not necessarily making it up, but is it part of their symptoms?

Providers felt they must ascertain the truthfulness of their clients' assertions because they knew that the legal system would doubt women's accusations on the basis of their history of mental illness. Case managers agreed that the legal system worked against women with mental illness and they felt caught in the middle. This case manager was aware that women are rarely believed in our judicial system and thus, have little hope of a successful prosecution of offenders.

> Anything they say is going to be discounted. I hear ALL the time women will, particularly will talk about rapes, and they're just completely blown off as "unreliable" witnesses. DA's will not go to court, based on anything, if you've got that diagnosis. Anything you say has absolutely NO reliability or validity whatsoever. It it's almost like, if you hear voices, that means you're instantly a liar.

Women knew their personal safety was negatively impacted by ongoing stigma against persons diagnosed with schizophrenia. They discussed how they were not believed when they reported a sexual assault because of their mental health diagnosis. This participant described how her diagnosis was used to dismiss her accusation of abuse.

> The police just didn't think I was worth . . . a good enough woman to pursue any charges against a man. Kind of like a lower class citizen. Like, prejudice and hatred. Less of a citizen . . . less rights . . . less values . . . a degenerate person. Almost a form of racism against schizophrenia. Yeah, he asked (district attorney) aren't you known to be a severe schizophrenic? And so how do we know these facts are actually true?[12(p970)]

The question of belief was conflicted for most case managers. They struggled with the issue of "believing" clients' stories and understood that these women's ability to discriminate truth is frequently called into question. The complexity of this issue was highlighted by this provider's distress.

> I've struggled with this for all the years that I have done this. One is women, who have reported sexual assaults, repeatedly. And, it's almost a boy crying wolf because what's happening is, if it's part of their delusional system, if it is a symptom of their illness and then they have had sex with people that they wished they hadn't, for them, it DOES feel like a rape. But when you go through the legal system, I have to go through that whole thing. And then what happens is they're doubted . . . all levels of it are doubted; it's NOT the reality they're in specifically. But now we're in another world. The cops don't believe it. You start to not believe it happened; it just gets very, very, very complex and it's not felt at any level. And I've struggled with that. And I think that the women who are once tagged, and it happens to mentally ill women very often, is "yeah, right, you know . . . a wink and a nod." And they are the most vulnerable women of all, and I think probably the most abused, because nobody's ever going to believe them.

Some providers spoke of needing to know "the truth" because they felt they would handle the situation differently if the woman's story could be verified or if the provider could definitively know whether it was a symptom of the illness.

> I think it's sometimes hard to know what really happened . . . IF it really happened. Was that person really assaulted or not? And I know we're supposed to never question, but you know when you find out that someone is telling you a delusional situation and you think it's real, then you start to wonder if it's real or not real? But I guess, ultimately, it doesn't really matter. Well, it DOES matter . . . if it's real. I work with a psychiatrist who says, "Well you always go from THEIR perspective, it doesn't matter if YOU think it's real. If THEY think it's real that's what you have to deal with." But I think it does make a difference in how you deal with it; you would handle it differently, if it's real or a delusion.

Case managers did not discuss how their professional skepticism about women's accusations of abuse has perpetuated the stigmatized notion that women diagnosed with schizophrenia are inherently untrustworthy or persistently delusional. Instead they focused on their own beliefs about the label of schizophrenia as well as the challenges with the legal system. Case managers remained conflicted about listening and believing women. It was a painful issue for providers, if they believed women's stories of violence, they must act on that and involve the criminal justice system, and the system is usually unsuccessful in prosecuting perpetrators when the victim has a diagnosis of schizophrenia. Beyond the legal system, case managers also felt ill-equipped to assist these women with obtaining violence-related services such as rape-crisis centers. But case managers situated the problem of how disbelief is stigmatizing beyond their own relationship with women.

Stigma and hierarchy

Both groups of participants shared stories that revealed how mental health diagnoses were not felt to be equally stigmatizing. Schizophrenia was understood by both groups of participants as being the most devastating and stigmatizing. This participant related how she felt when she was first diagnosed.

> When I was diagnosed with schizophrenia . . . . when I looked at my therapist and she told me, "you have an illness and it's called schizophrenia." And um, first thing that came to my mind was poverty. First word that popped into my mind: Schizophrenia, bottom of the totem pole, very lowest of the low, scum of the earth, you're mentally ill.[12(p969)]

Another woman spoke of how her family misrepresented her diagnosis to other family members.

> My family has a real hard time with it. I went to a family reunion, just this past summer, and one of my cousins said to me, "well, how is your eating problem?" And I looked at her and said, "Oh, it's okay" . . . I had no idea what she was talking about, but later I found that that was what my parents had said was wrong with me . . . that I had an eating disorder.[12(p968)]

Women understood that there were profound social ramifications associated with the diagnosis of schizophrenia, such as poverty and unemployment. This diagnosis involved more than a specific identification of illness. It was entwined with negative cultural beliefs about people—for the first participant, it meant living in poverty.

Women were not alone in their negative perception of the diagnosis of schizophrenia. Case managers also shared how they believed this chronic illness brought with it many negative effects. But providers believed this was due to the neglect of our political and governmental processes.

> And maybe that's part of why this happens with schizophrenic women, because, by becoming schizophrenic you also become poor. It's all associated. So the diagnosis is like a "life sentence" basically. Here is your life. From now on you'll be living under the poverty level; you'll be living in the worst part of town. So, it's hopeless, the poverty, the horrible poverty. The only way things will change is if somehow society or our government takes more pity on people and . . . right here it's getting worse . . . the poverty is a life sentence. I really believe it. That it's just hopeless . . . so I don't see it changing.

Many women described how, because of ignorance and shame from the diagnosis of schizophrenia, they became alienated from their relationships with family members. Families treated women as "schizophrenic" without truly having an understanding of this illness.

> It makes you sick to your stomach sometimes the way you feel around people if they know you're schizophrenic and they're not, and they . . . like I've had problems with my family, how they deal with schizophrenia, and how they associate with me . . . they mostly avoid me. And you feel this rejection a lot, you feel a lot of rejection. And it, I guess it just goes along with the illness.[12(p968)]

Case managers also spoke of how women diagnosed with schizophrenia were intrinsically different, and their response to violence was more difficult for case managers to grasp, particularly when compared with women with other psychiatric diagnoses. Providers' stories reflected their belief that women diagnosed with schizophrenia were less willing to discuss violence, and subsequently less able to participate in their own recovery.

> I feel like it (violence) is much more hidden. I feel much more support, and acknowledgement and programming around people with PTSD. That's when I think of violence, that's who I think of. Those are the people who are able to be the squeaky wheels for themselves, or for each other. But schizophrenia, there's no, there's nobody really talking about that. But it's just not on their radar.

Despite case managers' knowledge that violence was often a part of women's lives, it was described as hidden, concealed, and thus, not actively addressed. Another provider highlighted how schizophrenic women were set apart.

> Because a lot of our consumers with PTSD are very bright, very verbal, very . . . good advocates for themselves, very outspoken people. And that is pretty much the exact opposite of the women with schizophrenia. They don't want to talk about it, maybe it's not safe for them to talk about it, or like I said, they have too much other stuff going on. I would imagine them feeling very intimidated in a group of those kind of women with PTSD, and with . . . very different needs despite similar histories, or different styles anyway.

Another case manager described how both denial and psychosis caused women diagnosed with schizophrenia to be both at higher risk of violence and less likely to discuss it.

> A lot of these women (with schizophrenia) are much more capable of denial compared with others, they need it. I think that a lot of these things tend to happen to women with schizophrenia more often than other people with mental illness, and the violence is more extreme because they are so vulnerable to it. This illness just puts them at such risk and when the illness is really bad, they're psychotic, they just don't remember it because they are too sick, or it's all wrapped up with being psychotic.

Women diagnosed with schizophrenia clearly described how they believed their diagnosis of schizophrenia was used to discriminate against them in a myriad of ways. This mental illness was understood to be the "bottom of the totem pole" of chronic mental illness. They also felt that case managers perpetuated this hierarchy through their beliefs that these women were somehow "different" and less able to advocate for themselves.

Stigma and listening

Women discussed numerous negative experiences trying to communicate with people about their illness and struggles with violence. Many shared how they, over time, chose to be silent. Discussing violence was fraught with negative repercussions for women. They were labeled as symptomatic, disbelieved, and ashamed. This participant described why she chose not to discuss the violence she experienced.

> I feel like if I told them, that I was sexually abused, they may not, not be able to handle it. And that's the way I feel about society today, is that if you are sexually abused, and you want to talk about it, people can't handle it. They can't. Just like you know, saying . . . I'm Jeffrey Dauhmer. I mean it's really bad. You can't talk about it with people.[12]

Providers avoided discussions of violence among women. Women with this diagnosis were believed to be unwilling to talk about violence, or their memory of violence was faulty because of psychiatric symptoms. This case manager discussed a client whom he had worked with for many years, but had never actively addressed the issue of violence in her life.

> She didn't want to talk about it too much. I think a lot of that was because the trauma happened when she was really decompensated, really psychotic. She would kind of elope or run off when she was psychotic and just had to be on the streets and be very vulnerable and she would allow herself to hook up with any guy that showed any interest, and she would easily get victimized . . . and I saw that happening, you know to some degree . . . .she was raped and battered and all that kind of stuff. It happened a number of times. But I don't know that she knew much about it, you know. I mean, I think she had a sense that bad things happened to her when she was really ill. But she never wanted to talk about it, and I really doubt that she really remembered much about it. I kind of got the sense that she didn't remember the violence stuff but that's just my sense, we didn't really talk about it.

This provider unknowingly perpetuated stigma through his belief that women diagnosed with schizophrenia were unable to talk about, remember, or understand the impact violence had on their lives. Women felt that no one would listen, and after a time they stopped trying. They shared how they would sometimes be encouraged to be less "isolative" but this isolation was attributed to their illness, not a lack of safety or a conscious decision not to make themselves more vulnerable to rejection. A young participant described how she felt forced to maintain secrecy surrounding her sexual abuse. "Because there was nobody I could tell it to, because if you told somebody, even today, they think there's something wrong with you, especially if you're schizophrenic. And that you have a disease, and that. . . . You're garbage or you're trash."[12(p971)] Case managers were aware that they avoided conversations with women about violence. One provider acknowledged that asking about violence and listening to these stories were too emotionally difficult.

> But one of the things we realize is that most of us don't ask, and we search a lot for why . . . why don't we ask? And we came up with a number of (reasons) . . . the stories are probably too horrible to hear-number one, (number) two is . . . once you ask then you have to do something, and there was nothing to do.

Once the topic of violence was raised by women, providers felt there were few treatment options available to this population of women. Violence was understood as something that was inevitable.

> For this person, like so many others, the violence goes with the illness, you can't get away from it. The violence seems to just follow them, you know, so many of our clients, men and women, are victims and no matter what you do, or their family tries to do . . . they seem to be such vulnerable targets.

Listening to and allowing women the opportunity to discuss the violence they had experienced were not understood as important interventions case managers could provide. Their conversations were filled with a sense of hopelessness and frustration with the lack of safety for women, yet this safety was not understood as something they might have an impact upon preventing or treating.

Stigma and loss of hope

Stories from both women and case managers were filled with loss and hopelessness for change. Women told how they lowered their own personal expectations for their life, and how they felt hindered because of their ongoing efforts to manage their illness.

> I grew up getting straight A's and being class president . . . excelling in college, even when I was ill, I kept coming back for the next semester, ready to go. But my illness has gotten worse over the years, which it does, these illnesses just get worse over the years. Now my doctors are just scrambling to find a medication that will work for me.[12(p973)]

The sense of hopeless and loss for women included both the ramifications of their illness as well as having been a victim of violence. Women believed that the violence they experienced forever altered the opportunities that were available to them.

> I found that, after being with my perpetrator this weekend, things kept going through my mind. I

> lost my husband, I lost my children, I pretty much basically lost my life because of what he did to me. And it's a hard thing to get over, the feeling of loss, because I started having problems with schizophrenia and depression, I lost everything. I lost my family, I lost the ability to watch my kids grow up, I wasn't able to work. I pretty much lost everything that was important to me.[12(p973)]

Case managers expressed little hope that situations could improve for this group of women. They could not see a future that did not involve violence and none of the case managers described any belief in the power of activism to change this situation.

> . . . it kind of alternates with me, between being . . . sad and thinking about how much pain, and how much, horrible stuff people have gone through. And they don't, maybe talk about it to anybody, you know? Maybe they've never . . . and then other times it just feels like, um . . . . you know sort of burn-out mode, like "I give up." There's nothing I can do about this. There's sort of an almost "forgetting" that it's there. Uh, and I think I'm in that mode more often than I would like to be.

Providers admitted to compassion fatigue or difficulty maintaining a caring attitude. Case managers experienced this as a disconnection from women, a volitional "forgetting" that violence was problematic in their lives. Case managers felt little hope for improvement in the lives of women. This lack of hope is highly problematic because extending a sense of hope is a primary aspect of caring.

DISCUSSION

Violence is common in our society and for a variety of reasons women with disabilities are deemed acceptable victims of this violence. We cannot ever completely understand what it means to be an acceptable victim of violence, or to live with a label that allows others to perpetuate discrimination. Rather the goal of this research was to show how stigma perpetuates the invisibility of violence. By juxtaposing 2-participant viewpoints, I aimed to vividly portray their varying perspective on violence. The intent of this study was to bring stigma to the forefront, to encourage further contemplation regarding the violence experienced by this population of women, and the hopelessness that infuses our current mental health system.

Each group of participants viewed violence and a diagnosis of schizophrenia through its own lens, either that of a woman who was challenged by this chronic illness and violence or a case manager whose vocation involved working with this population of women. The 2 studies were conducted separately and were not intended to arrive at a single, unified point of view. At the same time, further discussion of the similarities and differences in the way each group understood violence and a diagnosis of schizophrenia is needed to prompt providers and systems to make visible the violence that is such a common part of women's lives.

Women and case managers understood that stigma was highly problematic. Women described how they felt rejected, isolated, and disbelieved because of the coexistence of violence and schizophrenia. Perpetrators of violence had knowingly targeted these women because they were aware that this stigmatized group would be less likely to report, or be believed if they did report violence.[12] Providers also knew that stigma existed for women, but they perceived that stigma was found elsewhere, not within their own relationships with women. Women knew that the coexistence of violence and schizophrenia contributed to their stories of violence being doubted or disbelieved. Providers substantiated women's understanding that no one would listen to their stories by avoiding hearing them. Discussions of violence were thus silenced for both groups. Women also believed that schizophrenia was the "lowest" on a hierarchy of mental illnesses and providers' substantiated this belief by negatively comparing this illness to other types of severe mental illnesses.

Providers and consumers accepted violence among women as "the way things are." Neither group expressed hope for possibilities of change that violence could be overcome. It appears that the dominant discourse that negated providers' sense of responsibility to assist women extended to consumers. They, too, believed that violence and a diagnosis of schizophrenia went "hand in hand." Women did not speak of "recovering" from a history of violence and severe mental illness. Providers were equally unsure of women's ability to recover or their own role in assisting this dubious recovery. In short, consumers and providers accepted violence as inherent and pervasive and, as a result, suffered a host of negative ramifications.

Both consumers and providers experienced violence in different ways. Women experienced violence directly, an intentional kind of violence that was meant to harm and cause pain. Providers may have experienced a more covert, insidious, nonintentional violence, "a kind of constraining and violencing of the spirit"[28(p168)] that exists in systems when workers experience expectations beyond their ability to produce, when caring, listening, and being-with are no longer valued in comparison with completing tasks.

Violence may be understood as both a visible as well as invisible entity for both groups of participants. Smythe[28] described this kind of violence as "the violence of the everyday," and it is not understood as overt violence but when violence is simply taken for granted, described as "the way things are," and there is no compulsion or push for change. Practitioners of mental health care who experience this type of everyday violence feel overwhelmed with a job that they feel has value, yet are unable to care for people in the way they had expected. Smythe further explained:

> Violence is enacted in the momentum of "how things get done." I argue however that it is often not that the person does not want to care, but that the systems of practice have stripped the word care of its meaning. In a climate of economic rationalism, doing will always take precedence over caring, for doing things brings measurable outputs. Perhaps it is the responsibility of researchers to bring to the light the consequences of caring that is not caring.[28(p197)]

As the largest group of providers, nurses need to provide the leadership to engage in conversations about how recovery from violence can be enacted. Nurses are involved in a variety of venues such as practice, education, and policy settings that could promote and extend a vision of recovery from violence as possible and within the scope of practice for nurses. To ignore the current dissonance that exists among case managers regarding violence will perpetuate their discomfort, lack of clarity, and lack of initiative to make changes. Providing recovery-focused care needs to include opportunities for providers to engage with consumers of mental health care so these varying perspectives can be made visible and discussed. Too often, as this research has shown, communication between providers and consumers of care is undervalued in our ongoing quest to "get more done."

Findings from this research demonstrate the need for public policies that provide protection, safety, and justice for women with severe mental illnesses and histories of violence. Programs designed for women without a history of mental illness are not currently meeting the needs of this population. Both women and providers have indicated that women are stigmatized because of their illness when they attempt to use services for violence prevention and treatment. Women attempt to obtain assistance for the violence they have experienced but give up hope when their providers as well as the criminal justice system refuse to listen. Mental health care practitioners need to work with the legal system to change policies that assume this population of women are "liars" and do not deserve justice. By not prosecuting perpetrators of violence, we are demonstrating our willingness to allow these women to continue to be victims.

It is clear that we need to challenge ourselves to overcome the hopelessness that is currently pervasive in the provision of mental health care. Too often providers feel isolated from other healthcare systems. Perhaps bridging systems of care that are concerned with persons with disabilities may be a method of increasing our support systems and decreasing the stigma surrounding mental health problems. Collaboration between consumers and providers is needed to jointly refute the belief that violence is accepted. We need to move beyond extremes of "idealizing or villainizing" women and case managers to stimulate the change that is necessary to transform mental health services. Future research on the topic of violence among women diagnosed with schizophrenia should prioritize the expertise of both women as well as providers, to devise community interventions that incorporate their values, beliefs, and advocacy.

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