Identifying and Responding to Domestic Violence Among Poor and Homeless Women

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TRAUMA AND RECOVERY

Understanding Trauma
People react to violence and abuse in complex ways, often resulting in serious emotional and medical consequences. Table 1 describes common symptoms of a psychiatric-medical syndrome among trauma survivors called Post Traumatic Stress Disorder (PTSD). PTSD involves the short and long-term effects of physical or sexual abuse as well as other traumas.

Table 1. Symptoms of PTSD

Intrusive Remembering	Avoidance	Hyper-arousal
Flashbacks	Avoiding places, people & conversations which are reminders of the trauma	Disrupted sleep
Nightmares	Difficulty remembering parts of the trauma	Poor concentration
Distress when remembering trauma	Emotional constriction	Startle response
Physiological reactivity when remembering	Feeling detached from others	Anger outbursts
Feeling the trauma is happening again	Feeling life is destined to be unlucky or shortened	Hyper-vigilance (feeling "on guard")

Understanding Recovery
Recovery is a long-term process that is often highly individualized. Some clinicians believe recovery occurs in three stages. In Stage 1, a survivor is often highly symptomatic. She may need to establish a sense of safety, including care and control over her body (basic health, food, sleep, exercise, avoiding drugs, etc.), create a safe environment (non violent relationships), develop coping skills to manage symptoms and high levels of distress, and attend to basic needs such as housing. Homeless and low-income women in the first stage of recovery face added instability and difficulty in establishing predictable and healthy practices because of economic constraints.

After establishing respectful relationships, an environment of stability, and an increased ability to cope with her feelings, a survivor is ready to move on to Stages 2 and 3. These stages involve reconstructing what happened, understanding its impact, and reconnecting with others around issues other than trauma. Table 2 summarizes the effects of trauma and goals for recovery (see page 2).

Table 2: Effects of Trauma and Goals for Recovery

EFFECTS OF TRAUMA	SHORT-TERM GOALS	LONG-TERM GOALS
Relationships	*Relationships*	*Relationships*
Mistrusts others	Asks for help	Forms safe, meaningful relationships
Isolation/Disconnection	Engages in safe sexual practices	Extends feelings of safety to others in relationships

Aggressive towards others	Sees possibility to trust some others	
Repeated victimization		
Emotions	*Emotions*	*Emotions*
Has intense emotions (e.g. rage, fear)	Identify and label feelings	Can comfortably experience a wide range of emotions
Feel emotions "too much" (feels "taken over")	Can "turn down" negative emotions	Autonomously uses affect tolerance techniques
Feels emotions "too little"(feels numb", uses drugs)	Regulates feelings with help of others	Free from harmful numbing strategies
Conditions of the Body	*Conditions of the Body*	*Conditions of the Body*
Panicked/anxious/"on guard"	Recognizes "symptoms" as reactions to trauma	Has repertoire of self-soothing techniques
Sleep disturbances	Is referred for/engages in treatment for PTSD	Develops mastery over symptoms
"Body memories"	Can use breathing or distraction to calm down	
Feelings about Self	*Feelings about Self*	*Feelings about Self*
Feels "bad," "unworthy," "unlovable"	Can ask for help with minimal shame	Regularly practices self-care
Neglects health	Does one nice thing for herself	Feels positive about herself and deserving of care
Self-harm	Decreases self-harm/risky behaviors	Stops self harm/risky behaviors
Risky behaviors		
Not Feeling Whole	*Toward Feeling Whole*	*Feeling Whole*
Dissociated/does not "know" or "remember" parts of her reality	Can become grounded in current reality with help of others	Practices grounding to prevent dissociation
Remembers feelings or memories, but not both		Feels "whole"
		Makes connection between past experiences and current feelings
		Integrates memory and affect
Memory	*Memory*	*Memory*
Memories intrude at times	Can recognize "flashbacks" as memories of traumatic experiences	Able to recall memories at will
No memory of parts of life	Interested in learning how to "turn memories off"	Free from memory intrusions

Spirituality/Worldview	*Spirituality/Worldview*	*Spirituality/Worldview*
Sees world as unsafe	Develops safe relationship with provider	Draws comfort/meaning from spirituality
May lose faith	Finds spiritual beliefs that encourage recovery	Realistic sense of hope for the future
Hopeless		Comes to terms with painful past

BUILDING A THERAPEUTIC RELATIONSHIP

Studies of poor and homeless women suggest that many believe health care providers are not safe, trustworthy, or understanding. Because people have failed to protect them, trauma survivors may feel alone and be slow to trust.

The foundation of all therapeutic interactions is the relationship between the provider and the client. The first step in helping trauma survivors is to establish a mutual relationship built on trust, understanding, and respect. Providers can play an essential role in a client's recovery by following the 4 C's: Connect, Counter, Collaborate, and Coordinate.

Connect
Build trust by engaging the client and making a positive connection. Listen to the client and validate her experiences at every opportunity. Provide concrete help whenever possible:

- Inform her about the process (who you are, your role, what you are doing, why you are doing it, the limits of confidentiality, when you will invite others to intervene, etc.).
- Be respectful, straightforward, interested, and acknowledge your limitations.
- Make eye contact. Use a compassionate and calm tone of voice.
- Always maintain appropriate boundaries.
- Provide immediate aid such as food or access to a telephone.
- Discuss safety issues and, if necessary, make a safety plan (see Part IV).
- Address housing, transportation, income support, and children's needs.

Counter Unrealistic Beliefs

- Counter the client's feelings of isolation and shame by showing that you are glad to see her and are concerned about her.
- Counter her view of herself by telling her she is worthy and capable of feeling better.
  •Counter her worries that she may be "going crazy" by helping her to recognize the effects of violence may be involved in her current distress.
- Educate her about the relationship between her symptoms and past traumatic experiences.
- Ask about "what happened," not what is "wrong" with her.
- Reinforce strengths you observe in the client.
- Show sensitivity to the social and cultural context of her life.
- Maintain boundaries.
- Discuss any touching of the client beforehand.
- NEVER use physical force or restraints. These may traumatize the client by re-enacting abuse.

Collaborate
Empower the client to be a partner in shared decision-making. Learn about her needs and wishes, and collaborate with her in choosing services and referrals.

- Provide options for treatment and referral. Talk with her about the information you will share with her, how you will share it, and at what pace-even where she will sit in the consultation room.
- Ask her about what she sees as her most important needs. Create a list of realistic short- and long-term priorities.

- Support her choices. If she has survived horrendous circumstances, she has developed coping mechanisms that work for her.
- Provide a sense of hope that together you can find helpful services.

Coordinate

Coordinate services to meet her basic needs as well as provide trauma-specific treatment. Help her feel there is a safety net of concerned people who will support her during recovery. Be a bridge until she engages in individual, group, or peer treatment.

- Coordinate care with different agencies.
- Show concern by keeping in contact with other providers (with the client's permission and involvement).
- Help her engage in case management services.
- Develop a peer-counseling network by connecting the client with others who have experienced trauma.

ASSESSING AND IDENTIFYING TRAUMA

A client's traumatic experiences may not be apparent. It is important to gently interview all women about trauma, and about their health and mental health conditions, even if they do not seem distressed. Otherwise, they may be misdiagnosed. Assessing and identifying trauma is not usually a linear process. The provider must take cues from the client's verbal and nonverbal responses, and conduct the interview accordingly. Understand the "whole" person. Learn about the client's strengths as well as her problems.

Focus on the Chief Complaint
Define the client's chief complaints, precipitating events, and major medical and/or psychiatric conditions. Understand what events or feelings immediately led up to the person's visit to the clinic. Once you diagnose the client's medical and psychological situation, prioritize treatment and service referrals in order of urgency. Acute crises, in the form of out-of-control behaviors or life-threatening medical conditions, are always the priority. Tables 3 and 4 describe common medical and emotional problems of trauma survivors.

Table 3: Common Medical Conditions Found Among Trauma Survivors

ACUTE CONDITIONS	CHRONIC CONDITIONS
Acute injuries (contusions, sprains, minor lacerations, fractures, abdominal injuries, concussions, and gun shot wounds; also joint damage, scars.) Common sites are head, face, neck, ears, vaginal area, anus, and areas covered by clothing.	Chronic injuries
Blunt head trauma (associated with unconsciousness, blurred vision, seizures, and "rage reactions").	Chronic pain (in pelvis, abdomen, back, breast, and muscles)
Medical concerns related to rape (gynecological trauma, risk of pregnancy, risk of HIV and other STDs, rectal bleeding, and musculoskeletal or other injuries).	Gastrointestinal problems (e.g., irritable bowel syndrome, and stomach aches)
Pregnancy problems (miscarriages, placental separation, ante-partum hemorrhage, fetal fractures, pre-term labor, and uterine rupture).	Sexual dysfunction (functional dyspareunia, sexual difficulties)
Delayed prenatal care-seeking	Frequent vaginal and urinary tract infections
Self-harm (overdose, cutting).	Sexually transmitted diseases
Physical symptoms of panic (heart palpitations, dizziness, and nausea).	

Table 4: Emotional Disorders and Problems Common Among Trauma Survivors		
Posttraumatic Stress Disorder (PTSD)	Self-Harm (overdose, cutting)	Dissociative Fugue
Anxiety Disorders	Psychotic Conditions	"Parts" of the Person Controlled by Behavior
Substance Abuse/ Dependence	Suicidal Ideation or Self-Harm	Loss of Consciousness
Major Depression	Drug/Alcohol Overdose	"Rage Reactions"
Dissociative Disorders	Panic Attacks	Somatization Disorder

Look for Indicators of Trauma
Observe the client and listen carefully for indicators of possible trauma, both current and in the past. Table 5 describes some of these indicators.

Table 5. Indicators of Possible Trauma: Behavioral Styles You May Observe Among Survivors
Consider the likelihood that a client has survived violence if she exhibits any of the following behaviors:
Dissociation A client has a blank or "faraway" look. She may exhibit a lack of apparent distress when she is experiencing physical pain or describing an intensely emotional situation (e.g., talks in monotone voice as though she is disinterested, bored, or reading a script; she may not cry). *Cause:* Repeated intense feelings may have caused her habitually to "check out" or "go away in her mind" in order to not be overwhelmed.
Fear/Anxiety/Mistrust A client is wary or mistrustful of the provider. She may hesitate to answer questions or may show signs of arousal/anxiety, jumpiness, nervousness, or hyper-vigilance. *Cause:* She may have been "on guard" all the time to protect herself from someone who was hurting her.
Feelings of Badness A client treats herself as if she were "no good" or "undeserving". She may neglect caring for her body, ask too little of providers, believe she's never good enough, or feel deserving of mistreatment by others. *Cause:* She was told or she concluded from others' behavior that she was "at fault" for past traumas.
Refusing Help A client appears "tough" or "hostile", or refuses help. *Cause:* She may have been so abused that it is painful to feel vulnerable or to need help from anyone.
Self-Harming A client has scars on her arms or other body parts from hurting herself. *Cause:* Hurting herself is a way of relieving the intense pain of her feelings, or a way to feel alive instead of feeling "numb."
Demanding/Helpless A client requires a lot of care or portrays herself as unable to take control of her life. *Cause:* This style may stem from not being taken care of unless she was very demanding, or from repeatedly being powerless to change frightening circumstances.

Ask about Current and Past Violence

When you talk with the client, be sure she is alone. Never ask questions about abuse in front of a boyfriend, chaperone, etc. If it is not possible to arrange for privacy, postpone questioning for another visit. Work with clinic security officers to develop protocols for situations when the person accompanying the client is unwilling to provide privacy. When necessary, use a professional interpreter or another provider fluent in the client's language. Do not ask a client's family, friends, or children to interpret when asking about domestic violence or incest.

Give the client as much choice as possible about how to present her story. Pay attention to her reactions and respond accordingly. Provide her with feedback.

- If a client indicates a posttraumatic response, ask more questions to find out if she is experiencing mistreatment either now or in the past.
- Many survivors are likely to "relive" a traumatic experience as they talk about it. Your client may become upset, or may dissociate and look blank. Check in with her by asking if she is feeling overwhelmed.
- If a client has "checked out," use grounding techniques to help her orient herself. See Table 6 for a description of grounding techniques. Check in with the client at the end of your time together. Make sure she is aware of her surroundings, able to keep herself safe, and can tell you what she is going to do in the next few hours. Explain that it is normal for her to react to your discussion for a period of time after your visit.

Few interview instruments are designed for homeless and low-income women. One instrument specifically modified to be sensitive to these women--and used by many Health Care for the Homeless clinicians--is the "Posttraumatic Diagnostic Scale Modified for Use with Extremely Low Income Women." To obtain the questionnaire, contact The Better Homes Fund : 181 Wells Ave, Newton Centre, MA 02459;Tel: 617-964-3834; Fax: 617-244-1758; dawn.moses@tbhf.org.

Table 6. Grounding Techniques
Grounding Techniques are strategies to help a person who is dissociating "come back" into current reality and feelings. Grounding techniques help the person become aware of the here and now. A useful metaphor may be "walking out of a movie theatre." When the person is dissociating or having a flashback, it is like watching a mental movie (more like an extended nightmare). Grounding techniques help the person step "outside the movie theatre" into the "light of day" and "present environment." Their task is to hold onto the shattered moments from the past, but also to realize that what they were experiencing was "only a movie."
1. State what you observe: "You look like you are feeling very scared/angry right now. You are probably feeling things related to what happened in the past. Now you are in a situation where no one is hurting you. Lets try to stay in the present~ take a slow deep breath, relax your shoulders, put your feet on the floor, let's talk about what day and time it is, let's notice what's on the wall around us, etc. What else can you do to try to feel okay in your body right now?"
2. Techniques to help the client decrease the intensity of her affect: • "Emotion dial:" a client imagines turning down the volume on her emotion • Clenching fists to move energy of emotion into fists and then release • Guided imagery to visualize a "safe place" • Distraction (see below)

3. Techniques to use external stimulation to distract from unbearable emotional states:
- Focus on external environment.
- Focus on recent and future events (e.g., "to do" list for the day).
- Self talk to remind oneself of current safety.
- Use distraction, such as counting, to return to focus on current reality.
- Somatosensory techniques (wiggle toes, touch a chair) to remind of current reality.
- Holding ice, wet facecloth, running hands under cold water.

4. Deep Breathing
- Inhale through nose, exhale through mouth.
- Place hands on stomach, watch hands go up and down as belly expands/contracts.

Respond Compassionately

Believe the client and validate her experiences. Many survivors who have confided in family members or other trusted figures have been disbelieved, blamed, shamed, told to "get on with life," or told they are "crazy." When you say to a client that emotional and physical violations are/were undeserved and wrong, you may help a survivor feel more worthy of self-protection and respect.

Try to understand the effects of the client's disclosure from within her social context. Social norms about what is considered violent or violating differ across cultures. Important social figures within the extended family or community may have critical influence over the individuals involved in the violence. Encourage the client to define her own culture and community, and try to understand the beliefs of this culture.

MAKING A SAFE PLAN

"Safety" has different meanings for different people. Women who have experienced extreme or sadistic traumas, or who have lived under conditions of poverty, psychiatric labeling, or violence experience their world as fundamentally and pervasively "unsafe." It is important for caregivers to provide direct, practical, and concrete help on the basis of what the woman says she needs, rather than on the caregiver's notion of "safety."

Immediate Safety
Ask the client about current dangers she faces. Imminent dangers may include battering, abuse, rape, threats of violence to herself or her children, or return to a psychiatric institution where she was restrained or put in seclusion. A pregnant woman may be at especially high risk for partner violence. If the client is in danger of being hurt, then make a Safety Plan (see Table 7).

Table 7. Making a Safety Plan

In situations where abuse is ongoing, a Safety Plan should be developed to keep the client and her children safe from harm. The most dangerous time for a woman in a violent relationship is the period immediately after she leaves. Thus, it is extremely important for a woman to think through her plans carefully and to consider the consequences of her plans. For women to successfully leave, she must have various supports and resources in place.

A Safety Plan includes, but is not limited to, problem-solving with the client about the following topics:

- Where will you go? Do you have friends/family or is there a shelter that could provide safety?
- If you go back to your partner/unsafe situation how will you escape if violence happens or you feel threatened again? How will you maintain your emotional safety and self-care in the context of ongoing danger?
- How will you prepare your personal belongings and important papers you'll need if you had to leave your shelter/home immediately?
- How will you arrange to keep copies of important papers and an extra set of clothes at a trusted place or with someone you trust?
- Do you know how to contact the police to obtain a protective restraining order? Do you need legal assistance or immigration counsel?
- How will you make arrangements for your safety at work or in public places?

Self-Injurious, Suicidal and Homicidal Thoughts
Trauma survivors are at higher risk for self-harming behavior as a way to manage overwhelming feelings, discharge tension, communicate important messages to others, attempt self-purification, or for a variety of other reasons.

When survivors begin to acknowledge the full extent of their betrayals, they frequently express a wish to die and may attempt suicide. The most important risk factors for suicide include having made past attempts, feelings of hopelessness, and having a detailed plan with intention to act and the means to carry out the plan. A client is most at risk for self-harm when her depression is improving because she has more energy and an improved capacity to think through her actions. The provider should ask all survivors about suicidal or homicidal feelings.

Crisis Planning

If the client is in danger of hurting herself, talk with her about crisis planning to prevent harm to herself or others.

- Validate her experiences and work together to discover other ways she can cope with and express her feelings. Find out if there is anyone with whom she discusses her feelings.
- Help the client develop strategies to prevent or distract her from acting on self-destructive thoughts. Examples include: spending time with a friend instead of being alone, calling a Help Line, seeking the company of people she trusts, or going to a place where she doesn't fear being hurt.
- Discuss alternatives for containing and expressing intense emotional states such as vigorous exercise, baths, long walks, screaming, artwork, writing in a journal, listening to music, watching TV, or stretching.
- Ask her if she has reasons for living. Help her acknowledge reasons to stay alive.
- Make a specific time to "check in" with her about how she is feeling.
- If a client says that she is unable to care for herself or keep herself safe, help her find a place where she can be safe. Consider options for how she might stay in her own home with some assistance.
- Refer the client to trauma-specific clinical services when appropriate. Continue to monitor her closely until she has made the transition to appropriate clinical care.

TREATING A TRAUMATIZED CLIENT

Managing Acute Crises
Symptoms exhibited by a person suffering from a trauma-related psychological condition or substance abuse can intensify to the point of crisis:

- Some survivors with trauma-related psychological difficulties may also have a major mental illness, while others who appear to be psychotic are inaccurately diagnosed. They may be experiencing severe dissociative states in which what they say sounds bizarre or grotesque but reflects memories or reenactments of real experiences they have endured or witnessed.
- Trauma-related intense emotional states are scary for a survivor. She may feel "taken over" and appear out of control
- A client in a dissociative fugue state loses memory for significant amounts of time leading up to the medical visit and may not be aware of who or where she is.
- Medical problems may be secondary to drug/alcohol intoxication, suicide attempts, or other self-harming behaviors.

Assisting Clients in an Emotional Crisis
A combination of supportive and directive interviewing is most effective when dealing with a client in an emotional crisis. The goal of crisis intervention is to: (1) ensure the safety of client and staff, (2) address the client's immediate distress and identify what has triggered it, and (3) restore the person to her maximal level of functioning.

Supportive Interviewing

- Act professionally (identify your role, maintain appropriate boundaries). Treat the client respectfully.
- Ask about, label, and validate her feelings.
- Appeal to the client to use techniques for self-calming that have worked for her in the past.
- Use grounding techniques to help reorient the client, if necessary (see Table 6).
- Never use coercive restraints, force, or threats.
- Use sedative medications as a last resort and only if the client agrees.

Directive Interviewing

- Help the client to understand the nature and purpose of your interaction. Ask concrete, simple, closed-ended questions.
- Help her "reality test" by gently correcting her misperceptions.
- Set limits in a firm, straightforward manner, but do not act challenging.
- Provide choices for how to bring behavior and feelings under control.
- Set positive expectations to show that you believe the client can regain control.

Use of Medication
Some medications are useful for treating and relieving trauma-related conditions. Psychotropic medications should only be prescribed by a psychiatrist who is familiar with the gender-specific psychopharmacology of trauma. A careful evaluation of past history and current health with special attention to a history of substance abuse should be conducted before medications are prescribed. Many psychotropic medications are addicting and women are generally more sensitive to medication levels. The following medications can sometimes be helpful for clients with severe trauma reactions:

- Antidepressant medications, especially the newer SSRIs, have been shown to decrease some numbing and hyper-arousal symptoms, and help clients manage intense emotions.
- Desyrel ® (Trazadone) is an antidepressant that sometimes reduces sleep disruptions. It may be given alone or together with antidepressants that may cause insomnia.
- Benzodiazepines are sometimes prescribed for panic and anxiety-related insomnia.
- Neuroleptics should be used extremely cautiously for clients with trauma-related disorders because there is no evidence to support their utility and they may have serious side effects. If the client is having psychotic symptoms, it is important to rule out the possibility that the "hallucinations" are flashbacks or dissociative states that express feelings/memories of "alter" personalities.

SPECIALIZED TREATMENT

Work with the client to develop a mutually agreeable treatment plan. Discuss options in a simple, straightforward manner. Support her decisions and choices. Try to match your client's needs with available services.

- Determine the support your client needs and refer her for appropriate services (e.g., outpatient treatment, residentially based programs, 12-step meetings, detox, counseling, etc.).
- Encourage use of peer support groups, peer networks, and self-help groups.
- Arrange for a case manager to make linkages with services.
- Consider a consultation for medication. Be extremely cautious in recommending medications, especially if you do not know the client well. Be especially conservative in cases of current violence, because medication may dull a woman's preparedness or may be confiscated and sold by her perpetrator.
- For clients with co-occurring conditions, the best treatments are those that simultaneously address the effects of all conditions.
- Learn about traditional and non-traditional treatment options and services in your community. It may be useful to collect referral sources in your area, computerize the list, and collate them into a brochure.
- Consider the woman's ethnic identity and cultural context when making a referral. For clients who are wary of service systems, or for clients who are immigrants or whose native language is not English, it may be necessary to be more proactive about making referrals.

DOCUMENTING AND REPORTING VIOLENCE

Documenting the Effects of Violence
Thorough documentation of a victim's injuries/complaints, etc. may provide important evidence if the survivor needs legal support. Writing a clear note in the medical chart about the effects of violence will alert future providers to the importance of the client's history of trauma. Notes in the medical chart should include:

- Domestic violence history, including present complaints or injuries. Include date, time, and location of domestic violence incidents.
- Past experiences of physical and sexual abuse, and frequency. When appropriate, use the patient's own words in quotation marks.
- Client's injuries, including type, location, size, color, and age. Document injuries on a body map.
- Alleged perpetrator's name, address, and relationship to patient (and children, if any).
- Legal steps taken by the survivor to obtain restraining orders or to file suit against a perpetrator.
- Other physical or mental health problems that may be related to abuse.
- Details of your intervention and all actions taken.

Whenever possible, and with client's consent, take Polaroid photographs of injuries. Discuss the client's feelings about photographs and the usefulness of this form of documentation. If your site is not equipped to perform forensic exams, please call a local Rape Crisis Center.

Reporting Abuse
Mandatory reporting obligations differ by state. Health care providers should discuss reporting policies at their respective clinics. A good source for reviewing state statutes can be found in the Family Violence Prevention Fund's web site: http://www.fvpf.org and in the publication entitled, Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers.[1]

Produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition against Domestic Violence. Written by Carole Warshaw, M.D. and Anne Ganley, Ph.D. with contributions by Patricia Salber, M.D. Information is based on statutory law as of 1994.

CARING FOR THE PROVIDER

Discussions with clients about painful experience may trigger powerful emotions on the part of health care providers. As with any experience that reminds a provider of prior losses, dissatisfactions, or traumas, dealing with these reactions may prevent interference with work and emotional well-being.

Providers who work with clients who have been traumatized often experience an identifiable syndrome that parallels the posttraumatic syndrome of the client. This is known as "vicarious trauma" or "secondary PTSD." It includes helplessness about not being able to "fix" or "help" the client, hopelessness about being able to "make a difference," anger over the brutality and injustice of the victimization, and guilt over not being as distressed as the client. If not addressed, these common reactions may result in decreased quality of job performance, demoralization, withdrawal from colleagues, and exhaustion. Providers should develop a Self-Care Plan, including:

- Establishing a self-care routine by eating nutritiously, sleeping regularly, and exercising.
- Finding a balance between work and downtime by managing time effectively, and making time for relaxation and enjoyable activities.
- Finding a sense of meaning and mission in work by connecting with it spiritually and participating in professional organizations.
- Establishing supports for replenishment by having one's own therapy, staff support systems, and continued training.
- Engaging in social activism to bring about broader change by joining a professional organization.
- Creating a sense of "community" among colleagues.

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