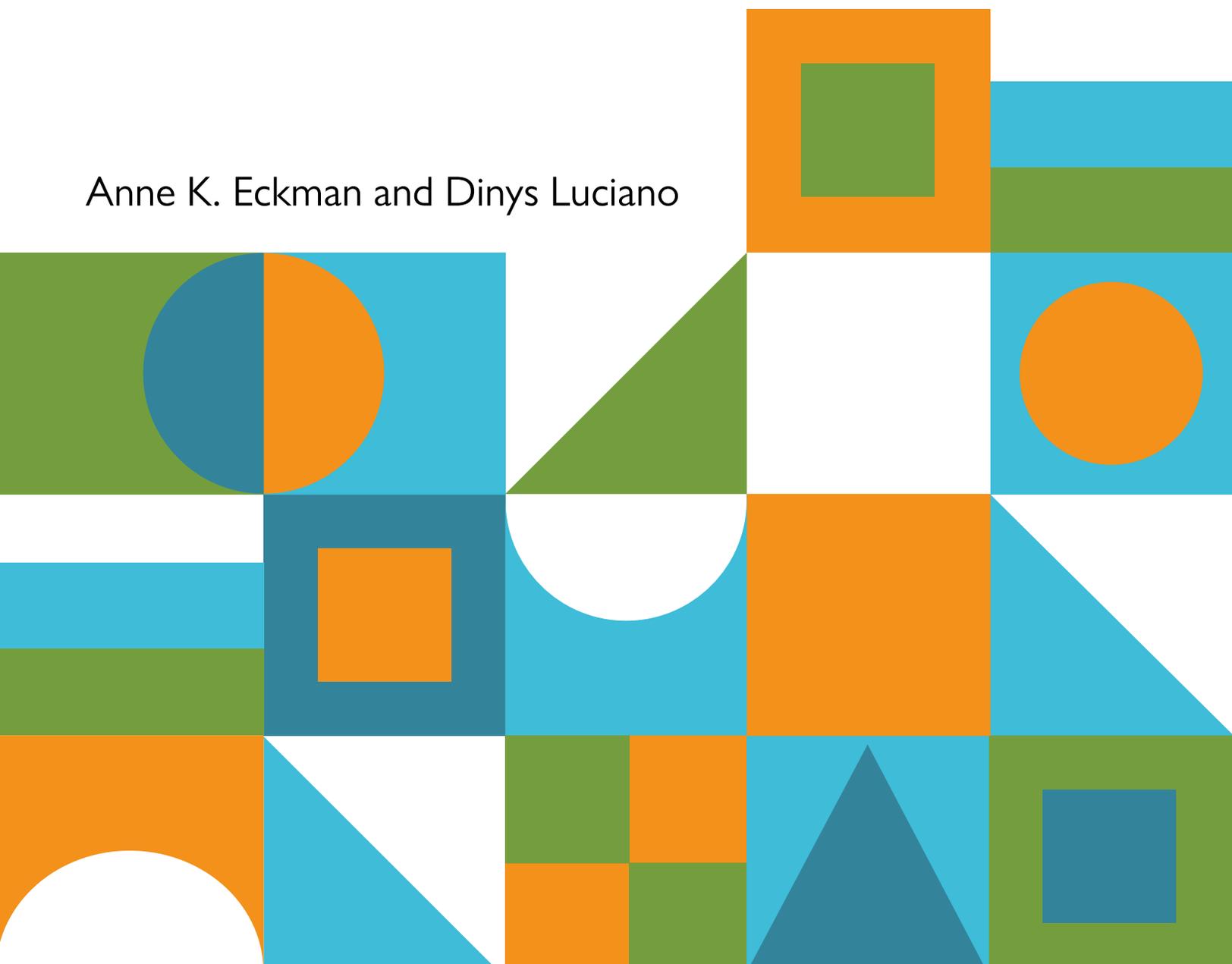# Practical considerations for intersectional, trauma-informed first-line support with survivors of gender-based violence

Anne K. Eckman and Dinys Luciano

DEVELOPMENT
CONNECTIONS

Practical considerations for intersectional, trauma-informed first-line support with survivors of gender-based violence

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INTRODUCTION

This document highlights how understanding survivors' experiences of traumatic responses, intersectional identities and connections between different types of violence can make first-line support more effective. It also offers practical tips to put this understanding into practice.

Given the pervasive nature of violence and its consequences, it is important that social, health, law enforcement, judicial and human services providers – as well as community and peer support workers – are equipped with tools to offer first-line support using trauma-informed and intersectional approaches.

Development Connections is cognizant of the relevance of first-line support for survivors, including those living where chronic violence is more prevalent, such as in places fragile and conflict-affected states, and in places with high levels of criminal violence. Developing this support in a manner that cultivates safety, trust and compassion for those affected by violence can facilitate their healing and growth. Equally important, it can help to sustain the wellbeing of those who are providing this support.

The lens offered by trauma-informed and intersectional approaches shifts the focus toward more holistic and intersectoral strategies to address gender-based violence, with the goal of enabling survivors and those who support them to thrive as individuals, social beings, and citizens.

Development Connections

1. FIRST-LINE SUPPORT: A BRIEF OVERVIEW

What is first-line support? Survivors of gender-based violence[1] often can benefit from validation of their experiences, rights, and effective linkage with a range of resources. Given limitations of survivors' time, distance to services, cost and other barriers, **first-line support** may be the most important support offered. According to the World Health Organization (WHO) (2014).

> *First-line support provides practical care and responds to a woman's emotional, physical, safety and support needs, without intruding on her privacy. … Even if this is all you can do, you will have greatly helped your client. (p.13)*

What are the goals of first-line support? The goals of first-line support include:

- identifying the survivor's needs and concerns
- listening and validating their concerns and experiences

- helping them to feel connected to others, calm and hopeful
- empowering them to feel able to help themselves and to ask for help
- exploring what their rights and options are
- respecting their wishes
- helping them to find social, physical and emotional support
- enhancing safety (WHO, 2014)

First-line support emphasizes the links between emotional and practical support. The initial support offered will have a long-lasting impact on the survivor's view of the support available for them, including whether their experiences will be believed and responded to with respect for their dignity, strengths, and right to self-determination. This assistance is also a critical factor determining access to key services, if desired, including legal aid, health care, financial support, shelter, referrals to community programs and peer support groups.

The specific scope, interventions, and guidelines included in first-line support may vary depending on the particular role and tasks of the person providing first-line support, the mission of each organization, the legal framework of the country,

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[1] Gender-based violence is defined as "any harmful act that is perpetrated against a person's will, and that is based on socially-ascribed (gender) differences between males and females" (IASC, 2015). This document focuses on considerations for providing first-line support with women and LGBTI (lesbian, gay, bisexual, transgender, and intersex) survivors, and uses "they/them/theirs" to indicate inclusion of persons with diverse gender identities. Specific considerations of providing first-line support for child survivors are beyond the scope of this brief.

the type of victims and/or types of violence.[2] Yet, these core goals apply across the provision of first-line support.

Who provides first-line support? Diverse formal and informal service providers are the first to identify or interact with survivors of gender-based violence. This includes law enforcement, advocates, health care personnel, teachers, humanitarian workers, counsellors, community leaders and peer workers.

Those who provide first-line support are in a unique position to assist survivors with immediate emotional support, safety-planning, and facilitating their access to services and support they need. They can help survivors to examine their alternatives, including alternatives for those with limited or no access to services or informal support. Critically, first-line responders are in a unique position to stand with survivors, even for the potentially brief period of interaction, by validating the injustices a survivor has experienced and affirming that survivors are the experts on their lives, their experiences, and their priorities.

2. HOW CAN AN INTERSECTIONAL, TRAUMA-INFORMED LENS STRENGTHEN FIRST-LINE SUPPORT?

Key communication steps: the LIVES model. Communication between a survivor and person offering front-line response is most often how first-line support gets put into practice. The **LIVES model** outlines five key communication steps of first-line response (WHO, 2014, p. 14).

Listen	Listen closely, with empathy, not judging.
Inquire about needs and concerns	Assess and respond to their needs and concerns – emotional, physical, social and practical.
Validate	Show that you believe and understand them.
Enhance safety	Discuss how to protect them from further harm.
Support	Help them connect to services and social support at institutional, community, and interpersonal levels.

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What else is important?

Recognizing trauma and survivors' multiple, intersecting identities and experiences of violence. Communication is central to providing first-line support. Yet, for first-line responders to communicate effectively and support survivors fully – it is also vital to consider the following key contexts:

- Survivors and providers may experience the impact of **traumatic distress** and overwhelm, which can be elevated in situations of first-line response. When this happens, it can be hard to listen, think, and communicate clearly (National Center on Domestic Violence, Trauma, and Mental Health [NCDVTMH], 2018). It is thus important to know how to recognize traumatic distress and to minimize triggers of distress – and to support a survivor's increased sense of safety, empowerment, and connection.

- Survivors' multiple, intersecting identities and multiple, overlapping experiences of violence profoundly shape experiences of gender-based violence, traumatic distress, and options for accessing support – and need centered throughout first-line support.

  - **Intersecting identities for survivors** include, but are not limited to: age (being young or older), race, ethnicity, legal status, sexual orientation and gender identity, ability, rural or urban geographic location, health status such as living with HIV, displacement from home as an internally displaced person or refugee.

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2   For example, the recent guidance from WHO (2019) specifies competencies, and related clinical skills training, for how health care providers can best provide first-line support to women survivors of violence.

When a survivor has children or cares for other loved ones, they may experience the additional urgency of providing for their needs too.

- **Survivors' experiences also include intersecting forms and types of violence,** such as: intimate partner violence, sexual violence, child maltreatment, bullying, human trafficking, elder abuse and neglect, institutional violence, etc. These types of violence are intertwined and often share the same root causes and compounding consequences across the lifespan. (Wilkins et al., 2014).

Taking an intersectional[3] lens means understanding and situating survivors' experiences within the complex sociohistorical, political and economic contexts in which they live. Acknowledging a survivor's full intersecting identities and multiple experiences of violence is foundational for understanding: the often intersecting and concurrent types of adversity a survivor has survived, their unique barriers and supports in seeking greater safety, and their assessment of what's worked and what other support (informal or formal) may help. It is also critical in seeking to avoid the further trauma of invalidating a survivor's experience.

TAKE A MOMENT TO REFLECT #1

Think of two different interactions you have had, or observed, with a survivor:

    1) One where you felt able to offer effective support, and

    2) One where you felt challenged in being able to offer support.

For each, what did you notice was happening for the survivor? and for you?

3. WHAT ARE TRAUMA AND TRAUMATIC DISTRESS, AND THEIR LINKS TO SURVIVORS OF GENDER-BASED VIOLENCE?

What makes an event traumatic? Many people experience stressful events in their lifetime. Traumatic events, by contrast, occur when a person experiences a sense of horror, helplessness, serious injury, or the threat of serious injury or death. It is important to note that what counts as a trauma is based on a person's (or group's) experience of an event. One person or group may experience an event as traumatic, while another may not.

Traumatic events and their impact can occur across all levels of the ecological model, throughout the lifespan, and across generations. Although not all survivors experience violence as traumatic, violence is often experienced as a trauma. Survivors often experience intersecting types of violence. And traumatic experiences – including gender-based violence and other traumatic events – may originate and operate across multiple dimensions, including the following:

- Intimate partner violence and sexual violence. Being the victim of emotional, physical, or sexual abuse, sexual assault, or rape, or witnessing abuse without the power to escape or intervene (e.g. child witnesses).

- Community violence. Ongoing threat of, and witnessing, harassment and crime in public spaces where one lives. This may include neighborhoods, schools, workplaces, faith-based organizations, markets (e.g., women living in territories controlled by organized crime).

- Structural violence. Denial of basic needs, rights, and resources related to systematic failure to provide resources, often rooted in discrimination based on survivor's identities, and perpetrated by institutions and their actors. This can include social norms that limit survivors' agency, and stigma and discrimination faced by survivors (and other human rights defenders) who claim or defend their needs and rights.

- Historical trauma. The historical legacy of "cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" such as colonization, slavery, forced displacement, and genocide (Yellowhorse Braveheart, 2003).

- Cumulative "daily stressors." Emerging research also highlights that the impact of

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[3]   The term and framework of intersectionality was originated by U.S.-based critical race legal scholar KImberlé Crenshaw (1994) and has since been highlighted as key to trauma-informed practices (Ashby, 2018).

"daily stressors" – such as not having basic needs met, forced separation from and fear for loved ones, routine stigma and discrimination for one's identities (e.g. race, gender, sexual orientation, ability, age, legal status, health condition such as living with HIV) – can be as traumatic as specific, larger traumatic events (Silove et al, 2017).

Okakulture. Her resilience: A Mural for women affected by violence in Oakland, California

Resilience and traumatic distress. It is important to note that most survivors of traumatic events and legacies do **not** end up with severe traumatic distress.

Being able to find **stable connection with supportive others**, **a sense of meaning**, and **access to resources and rights** provide important protection from traumatic distress. Connection to culturally-rooted ways and spaces of sustaining survival (e.g., women's tea gatherings, healing ceremonies, LGBTQ safe spaces, etc.) also nurture key reservoirs of **resilience.**

Yet, many survivors do experience patterns of **traumatic distress**. Those with less power are often exposed to more traumatic events. Given their position in society, **women and LGBTQ persons bear a heavier burden of traumatic distress** as a result of the intersecting traumas they experience; this includes the cumulative impact of ongoing daily stressors combined with different types and forms of violence related to their multiple identities.

4. HOW CAN TRAUMATIC DISTRESS SHOW UP FOR SURVIVORS OF GENDER-BASED VIOLENCE?

A person's experience of traumatic distress is unique to each individual. Yet, people who experience traumatic distress often experience certain common patterns. Understanding these patterns can help to inform how better to support survivors in first-line response.[4]

Traumatic experience, at its core, often includes feelings of profound

- Powerlessness
- Loss of one's sense of trust in oneself, others, and the world
- Disconnection from oneself, others, and a sense of meaning in the world (Herman, 1997/1992).

Courtesy of Deborah Koff-Chapin

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4   This document focuses considers these common patterns of responses to trauma, as first elaborated by Judith Herman(1997/1992), that many survivors of gender-based violence and trauma experience. Some survivors may also experience patterns of severe traumatic distress, such as acute or post-traumatic distress. Specific guidance on managing these patterns of distress is beyond the scope of this brief and its focus on first-line support. For further information, please see WHO (2013) Guidelines on conditions specifically related to stress, elaborated as part of the WHO Mental Health Gap Action Program (mhGAP).

In traumatic distress, the experience of trauma continues to be a primary lens through which a survivor experiences their world. This may be the case because traumatic experiences are ongoing, and/or because prior traumatic experiences may still be held in a survivor's being.

The impact of traumatic distress may show up in the following ways (Griese for Medica Mondiale, n.d.):

- At the individual level, survivors …
  - may more quickly come into tension states, and/or
  - may become overwhelmed, and shut-down.
  - This can happen in a very strong way in seemingly harmless occasions, so-called trigger situations, when a survivor feels under threat.
- In interpersonal and institutional interactions, survivors …
  - do not want to give up control,
  - may feel helpless, and may act passively, and/or
  - may find it hard to trust others or themselves.

Fight, Flight or Freeze: A survival response to stay safe

In a situation of severe threat, persons try to protect themselves through a survival "**fight, flight or freeze"** response. This response pattern can get lodged in person's nervous system, and quickly activated outside of a person's conscious control. So a survivor's system is often on high alert looking out for danger, and if something is registered as a potential threat, these "fight, flight, freeze" responses may be quickly retriggered.

If a survivor's survival response part of their brain is retriggered, the other part of the brain responsible for clear, logical thought is often (literally) off-line for the moment. It is important to provide support to help re-establish a sense of greater safety without relying on 'rational' talk or thought alone (see the "Techniques to help shift out of fight-flight-freeze" box below).

Remember: A survivors' patterns of traumatic distress **make sense** in light of what they have experienced and may be continuing to experience. These coping patterns **have supported the survivor to stay safe**, even if they may come at a high personal cost.

TAKE A MOMENT TO REFLECT #2

Thinking of the challenging interaction you had or observed. Looking through the lens of traumatic response, what might have been happening:

　　1) for the survivor?
　　2) for you?

What might have contributed to, or triggered, this response in that moment?

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5. HOW TO APPLY AN INTERSECTIONAL, TRAUMA-INFORMED LENS: THREE PILLARS OF SUPPORT

Intersectional, trauma-informed support. Intersectional, trauma-informed care means being aware of, and helping to reduce, traumatic experiences (NCDVMH, 2018; SAMHSA, 2014). From a do no harm perspective, **avoid re-triggering and re-traumatizing actions** that recreate feelings of being unsafe -- and instead **promote safety, empowerment and connection**. With an intersectional lens, welcome a survivor's intersecting identities that they want to share, including children and/or other loved ones if a priority for them. This support takes into account the complexity of survivors and their experiences.

Three pillars to guide actions. To put this into practice, it can help to use the following **three pillars** throughout providing first-line support (Griese for Medica Mondiale, n.d.).

| Consequences of violence and trauma	Three pillars of support
Threat • Fundamental insecurity • Shattered trust in oneself, others, the world • Increased vigilance	**Safety: Reduce stress and fear** • Create physically, materially, and psychologically safe spaces • Center survivor control and choice • Be transparent and trustworthy
Powerlessness • Helplessness • Feelings of vulnerability • Oppression and discrimination	**Empowerment: Build self-efficacy and self-worth** • Center survivor, their experiences, their priorities and their strengths • Focus on resources – what's worked, what else is a priority • Acknowledge intersecting identities, power differentials, and stigma and discrimination

Isolation
• Shame and guilt
• Marginalization
• Denial
	Connection: Strengthen each other
	• Promote solidarity and networking
	  • In your first-line interaction and relationship (I see you, believe you, believe in you)
	  • In linking with other resources
	• Acknowledge injustice
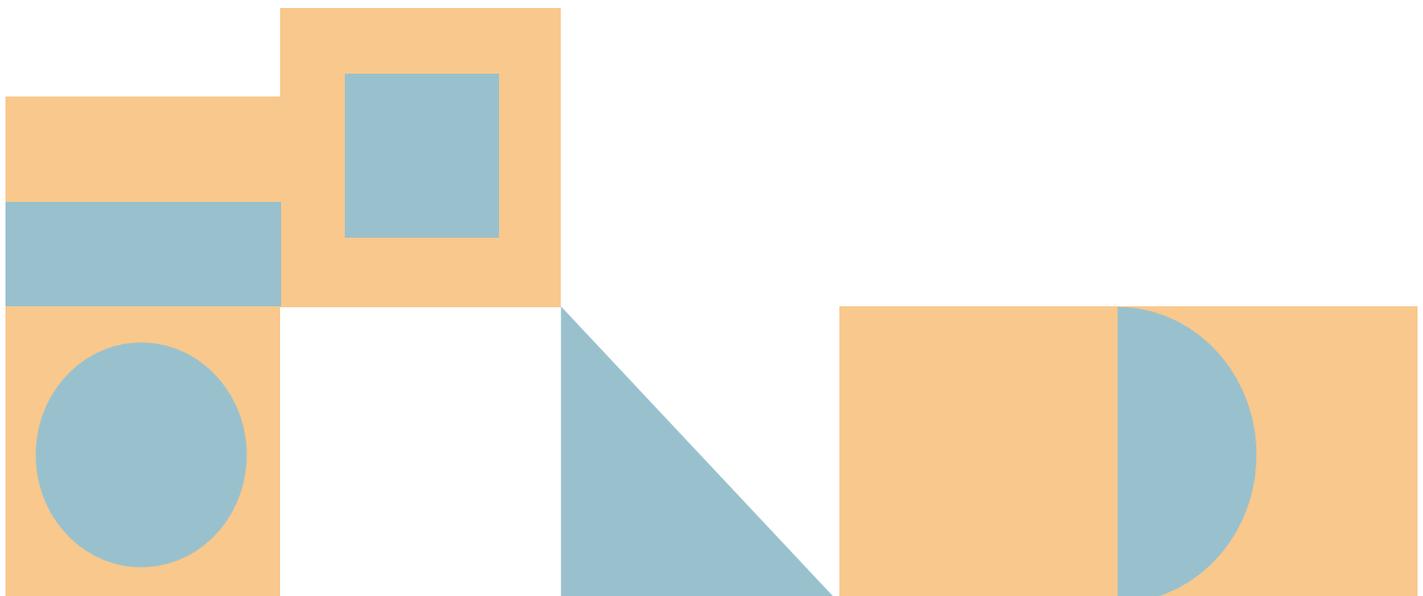
6. PRACTICAL TIPS FOR PUTTING THIS INTO PRACTICE

Here are some practical tips for how to put these pillars into practice in first-line support.

Pillar 1: To enhance safety . . .

a. **In the physical and material environment.** Consider what can increase a sense of comfort and control, such as: shifting location, offering choice about where survivor sits, reducing noise, offering water or food, having something visually soothing.

b. **Interpersonally.** Use your nonverbal presence (as well as what you say) to build safety and show that you respect the survivor's strengths and choices.

- Be aware of your body posture, closeness, tone, and pacing. Be clear that you are present with the person, and acknowledge limits (of time, of what you are able to do) if they exist without appearing rushed.

- Follow their lead. Ask them what brings them in, and what they are most hoping for support with today.

- Stay aware of signs of traumatic distress, and pause/shift if needed.

c. **If a person becomes over-whelmed, or retriggered,** pause and support a shift out of the 'flight-fight-freeze' response. Once a person is more grounded, be sure to normalize their reaction letting them know it makes a lot of sense.

Techniques to help shift out of fight-flight-freeze may include…

- Take a moment to pause – and slow down (or move gently)

- Invite the person to notice something that they see that is pleasant in the environment (and have something that is!)

- Invite the person to notice: 3 things they see, 2 things they hear, 1 thing they can touch, and then repeat this

- Consider inviting the person to notice their breathing, and count the length of their inhale and exhale for a few rounds

- Offer a drink of a beverage; swallowing also helps to reset elevated breathing associated with a fight-flight-freeze response

Pillar 2: To promote empowerment, and center the survivor's *strengths* and *priorities*

a. Ask about a **survivor's priorities** now, for example "What do you need – what are you looking for?"

b. Work with a survivor to identify their current coping skills: **what has been working, and what else they most need now?** Be sure to help consider informal (friends, neighbors, other survivor actions that can reduce harm or risk) as well as formal resources.

c. **Promote their own self-care** as this can help them to cope with the short- and long-term effects of a trauma. Good physical health can support them through this process and emotional self-care can help to recover their sense of feeling balanced and grounded (Rape, Abuse & Incest National Network (RAINN), n.d.). Self-care may be especially challenging for victims and survivors of violence, who are often made to feel like they are not worthy of love or care (National Domestic Violence Hotline, 2014).

d. Know local referrals, be prepared to tailor them, and be equipped to recommend **the priority resource(s)** that may best address a survivor's identified priorities. Recognize that for many survivors **the safety and needs of their children and other loved ones (parents, siblings) may be their priority.** Be sure to help survivors learn what resources and choices are available for them: food, shelter, social support, peer support groups, legal assistance, protection, clothing, etc.

e. **Remember that** survivors have good reasons to be quick to see danger and not to trust. This has been a key element of their survival and is important to validate. Explore survivors' experience and concerns about different potential resources, and offer a realistic assessment of how different resources might (or might not) be respectful of survivors. This **realistic assessment, grounded in survivors' lived, intersectional identities and expertise** about their experience of different settings, can support a survivor to feel empowered to better consider what might help.

Self-Care After Trauma
Tips from RAINN

Self-care is about taking steps to feel healthy and comfortable. Whether it happened recently or years ago, self-care can help you cope with the short- and long-term effects of a trauma like sexual assault.

Physical self-care
After a trauma, it's important to keep your body healthy and strong. You may be healing from injuries or feeling emotionally drained. Good physical health can support you through this time. Think about a time when you felt physically healthy, and consider asking yourself the following questions:

- **How were you sleeping?**
  Did you have a sleep ritual or nap pattern that made you feel more rested?
- **What types of food were you eating?**
  What meals made you feel healthy and strong?
- **What types of exercise/physical activity did you enjoy?**
  Were there any particular activities that made you feel more energized?
- **Did you perform certain routines?**
  Were there activities you did to start the day off right or wind down at the end of the day?

Emotional self-care
Emotional self-care means different things to different people. The key to emotional self-care is being in tune with yourself. Think about a time when you felt balanced and grounded, and consider asking yourself the following questions:

- **What fun or leisure activities did you enjoy?**
  Were there events or outings that you looked forward to?
- **Did you write down your thoughts** in a journal or personal notebook?
- **Were meditation or relaxation activities** a part of your regular schedule?
- **What inspirational words were you reading?**
  Did you have a particular author or favorite website, to go to for inspiration?
- **Who did you spend time with?**
  Was there someone, or a group of people, that you felt safe and supported around?
- **Where did you spend your time?**
  Was there a special place, maybe outdoors or at a friend's house, where you felt comfortable and grounded?

Pillar 3: To strengthen connection, keep in mind the value of your relationship, the survivor's relationship with themself and their strengths, as well as the potential to facilitate greater access to additional external resources.

a. Be sure to value what you and **your relationship** can offer in an interaction:

Does the survivor …

- feel more seen, heard, and valued for their strengths/skills and full identities
- experience support to identify immediate priorities
- feel acknowledged in the injustice of their experience and of (potential) barriers/limits of response

b. If appropriate, identify **a next step they can take** to move closer to their priorities, supporting a survivor's connection to their internal values, strengths, and resources including a survivor's self-care and resilience.

c. **Provide direct support to link with and navigate** various systems: legal/judiciary, health, social protection/support, financial assistance, including community organizations, faith-based organizations, child protection, humanitarian services. This may mean when making a call on their behalf, being clear about who/where/when to go, arranging transportation from one organization to another, institutional measures to ensure her safety, etc.

d. Make the appropriate **follow up considering their needs and institutional guidelines.** This may include offering them a follow up visit, encouraging them to contact you if you can be of further assistance, follow-up with organizations to which they are referred, and coordinating with other programs or services within your organization.
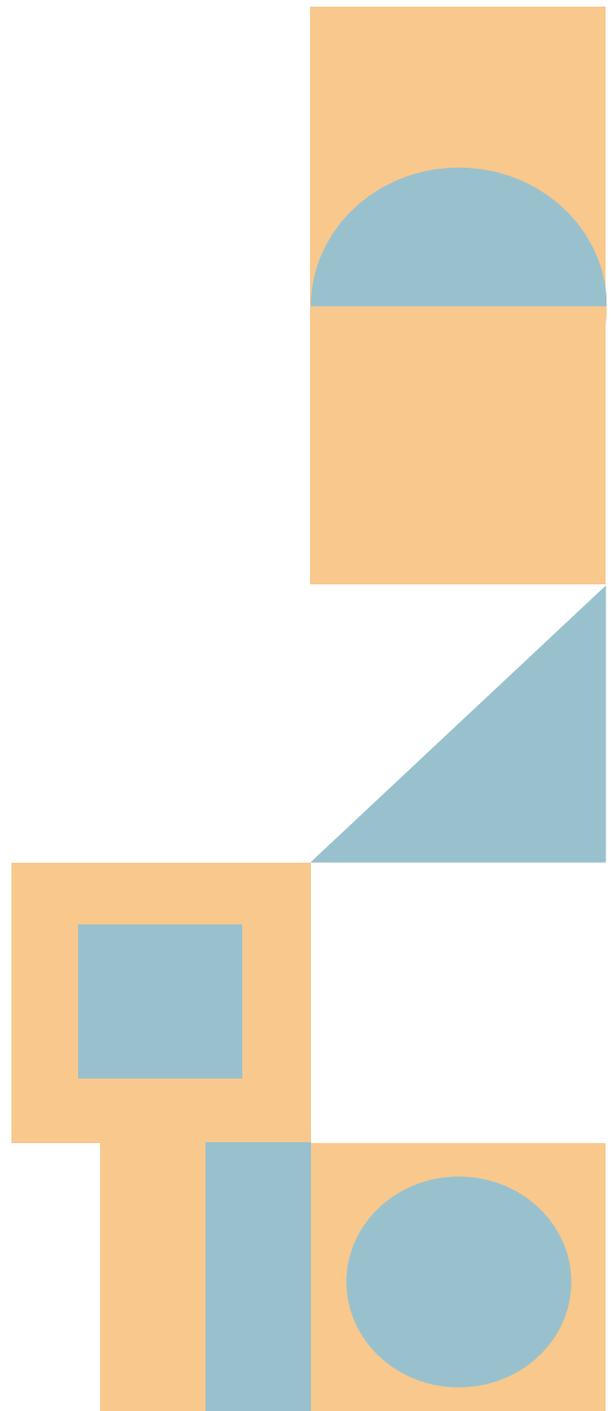
7. PRIORITIZING YOUR OWN SUSTAINABILITY: SELF AND COLLECTIVE CARE?

Workers who provide front-line support for women survivors of violence will also experience the following burdens (Luciano, 2019; WHO, 2014; WHO, 2011):

- Stress related to directly witnessing violence, and its impacts
- Stress from hearing stories of violence and trauma (vicarious traumatization)
- One's own direct unresolved experiences of conflict, trauma, helplessness

Work-related stress affects service providers and community/peer workers from all backgrounds and types of work (Choi, 2011; Coles et al, 2013; van Leyveld, 2008). Work stress and burnout have a significant impact on service providers, community and peer workers and organizations as a whole. This is especially true for those who provide first-line support to survivors of gender-based violence and who themselves may have personal experiences of violence.

Front cover image of Raising Voices, 2019.
Self and collective care

Given that this is part of the work, it is critical to stay aware of one's own indications of traumatic stress and what helps to sustain one's wellbeing and ability to restore oneself physically and emotionally. It may be helpful to continue to connect to why one does this work, as well as to redefine success in ways that can help one to tolerate the limits (as well as rewards) of what you as one responder can do in one interaction.

Responsibility for wellbeing should not only rely on an individual worker. It also needs to be assumed by collective structures including the policies and practices of organizations. Organizational factors contributing to stress and burnout of those providing support to victims of violence include the nature of the work, work demands, and the organization of the workflow and environment (Kulkarni et al, 2013).

Ciudad Mujer Honduras with the support of the Inter-American Development Bank has elaborated a strategy for self-care and security of its personal that is available for application at the local level and can be adapted to different types of organizations (Luciano, 2017). At the global level there is also growing advocacy by organizations such as Raising Voices and others for greater attention to self and collective care as an essential component of sustaining this work (Raising Voices, 2019).

REFERENCES

Ashley, W. 2018 (September). *Power and privilege in trauma work*. Workshop presentation for A Window Between Worlds, Santa Monica, California.
Accessed via password at www.awbw.org.

Choi, G. (2011). Secondary traumatic stress of service providers who participate with survivors of family or sexual violence: A national survey of social workers. *Smith College Studies in Social Work 81*(1), 101-119.

Coles, J., Dartnall, E., & Astbury, J. (2013). "Preventing the Pain" when working with family and sexual violence in primary care. *International Journal of Family Medicine*, *2013*, 198578. Accessed at http://doi.org/10.1155/2013/198578
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3600345/

Crenshaw, K. 1994. Mapping the margins: Intersectionality, identity politics, and violence against women of color, 93-118 in *The public nature of private violence*, ed. by M. Fineman and R. Myktiuk. New York: Routledge.

Herman, J. 1997 (1992). *Trauma and recovery: the aftermath of violence - from domestic abuse to political terror*. New York: BasicBooks.

Inter-Agency Steering Committee (IASC). 2005. *Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention and response to sexual violence in emergencies.* (Field test version). Geneva, Switzerland: IASC.

Inter-Agency Standing Committee (IASC). 2015. *Guidelines for integrating gender-based violence interventions in humanitarian actions: Reducing risk, promoting resilience, and aiding recovery*. Geneva, Switzerland: IASC.

Griese, K. for Medica Mondiale. n.d. *Stress and trauma-sensitive approach (STA).* Accessed at http://global-peacebuilders.org/wp-content/uploads/2019/02/Stress-and-traumasensitive-approach-STA.pdf

Kulkarni, S., Bell, H., Hartman, J., & Herman-Smith, R. (2013). Exploring individual and organizational factors contributing to compassion satisfaction, secondary traumatic stress, and burnout in domestic violence service providers. *Journal of the Society for Social Work and Research,* 4(2), 114-130. doi:10.5243/jsswr.2013.8

Luciano, D. 2017. *Estrategia de cuidado, autocuidado y seguridad del personal.* Tegucigalpa, Honduras: Ciudad Mujer Honduras y Banco Interamericano de Desarrollo.

Luciano, D. 2019. *Manual de referencia y contrarreferencia para casos de violencia contra las mujeres en Francisco Morazán.* Tegucigalpa, Honduras: Ciudad Mujer Honduras.

National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). 2011. *TipSheet: Impact of trauma on interaction and engagement.* Chicago, IL: NCDVTMH. Accessed at http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/06/Infosheet_Impact-of-Trauma-on-Communication_NCDVTMH_Dec2011.pdf

National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). 2018. *Tools for Transformation: Becoming Accessible, Culturally Responsive, and Trauma-Informed Organizations An Organizational Reflection Toolkit.* Chicago, IL: NCDVTMH. Accessed at https://static1.squarespace.com/static/58e7e4676a496342ee566554/t/5b4d10165 75d1fb6653178cb/1531777088937/Becoming+Accessible_Culturally+Responsive_ Trauma+Informed_National+Center+on+DV+Trauma+%26+MH_2018.pdf

National Domestic Violence Hotline. (2014, August)*The importance of self-care.* Accessed at https://www.thehotline.org/2014/08/08/the-importance-of-self-care/

Raising Voices. 2019. *Self and collective care.* Accessed at http://preventgbvafrica.org/wp-content/uploads/2019/01/Self-and-Collective-Care.pdf

Rape, Abuse & Incest National Network (RAINN), n.d. *Self-care after trauma [fact sheet].* Accessed at https://www.rainn.org/articles/self-care-after-trauma

Silove, D., Ventevogl, P., and S. Rees. 2017. The contemporary refugee crisis: An overview of mental health challenges. *Journal of World Psychiatry, 16,* 130-139. Accessed at https://onlinelibrary.wiley.com/doi/epdf/10.1002/wps.20438

Substance Abuse and Mental Health Services Association (SAMSHA). 2014. *SAMSHA's concept of trauma and a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: SAMSHA. Accessed at https://store.samhsa.gov/system/files/sma14-4884.pdf

Van Lelyveld, C.R. (2008). The experience of vicarious trauma by the police officers within the South African police service in the Limpopo Province. Mankweng, Limpopo: University of Limpopo.

WHO (2019). *Caring for women subjected to violence: a WHO curriculum for training health-care providers*. Geneva, Switzerland: World Health Organization.

WHO (2013). *Guidelines on conditions specifically related to stress.* Geneva, Switzerland: World Health Organization.

WHO (2014). *Health care for women subjected to intimate partner violence or sexual violence*. *A clinical handbook*. Geneva, Switzerland. WHO. Accessed at https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

WHO. (2011). *Psychological First Aid: Guide for field workers.* Geneva, Switzerland: WHO. Accessed at https://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf?sequence=1

Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute. Accessed at https://www.cdc.gov/violenceprevention/pdf/connecting_the_dots-a.pdf

Yellow Horse Brave Heart, M. 2003. The historical trauma response among natives and its relationship with substance abuse: A Lakota Illustration, *Journal of Psychoactive Drugs*, 35:1, 7-13, DOI: 10.1080/02791072.2003.10399988