CREATING
A
TRAUMA-INFORMED ENVIRONMENT OF CARE
FOR
WOMEN SURVIVORS OF VIOLENCE
FROM
ACID
AND
OTHER BURNS

A SOURCEBOOK

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Acid Survivors Foundation of India

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ACKNOWLEDGMENTS

Our salutations to the many indomitable women who have suffered acid and burns assaults and transformed into trauma champions. By going past their daunting physical and psycho-social challenges to adapt to a 'new idea of normal'. By picking up a new identity. By tapping into the dormant and invisible power within and finding the strength to rebuild their lives and selfhood. And, to those women who are on their way to regain a sense of safety and control over their lives.

Acid Survivors Foundation of India (ASFI) sees the approach of trauma-informed care as a crucial turning point. It holds within it the potential to revolutionise health services for women assaulted by acid or burnt. This is because it takes health care to a new level that goes beyond mere survival to their pyscho-social rehabilitation and community reintegration. It is a survivor-centered, strengths approach that empowers a women to steer her own recovery at her pace and through her own ways. We acknowledge this approach's role in the significant transformation in a woman survivor's experience.

ASFI has greatly benefited from several other toolkits (designed on related subjects) and innumerable research papers. Apart from our own work experience and understanding of core values, components and strategies that women survivors (of acid and burn violence), health personnel and service providers have found essential for safety and healing, these additional resources have provided us with an invaluable compass and overview to sensitively and purposively design the first ever sourcebook and toolkit to create trauma-informed care for women acid and burn survivors. Their contribution has been duly acknowledged in this sourcebook.

We are hugely indebted to Lush, UK, for their unstinting support in this project and their insightful guidance at every step. This endeavour would not have been without their collaborative partnership.

Our deepest gratitude also to the International Foundation for Crime Prevention and Victim Care (PCVC) for helping us steadfastly in making the trauma-informed care sourcebook a reality.

And, finally we would like to acknowledge the efforts of our editorial consultant Chitra Gopalakrishnan who has pulled this book together.

We truly hope that this sourcebook takes ahead a shared journey of discovery, understanding, dialogue, introspection, implementation and recovery among health and service providers, women acid and burn survivors and many others who are directly and indirectly affected by the women's trauma. By integrating systemic changes and instilling practices that are trauma-informed within service systems, the responsiveness to the needs of women acid and burn survivors can be hugely enhanced and outcomes of their recovery-healing process intensified and speeded up.

FOREWORD

CHAIRMAN'S MESSAGE

Acid violence is a vicious crime involving the throwing of acid mainly at the face / body of the victims. The consequences of these attacks are devastating and may include blindness, grotesque scarring which destroys functionality of the face / body besides having far reaching social, economic and psychological consequences.

A major psychological consequence faced by survivors of acid attacks is post-traumatic stress which affects their day to day activities. They are also faced with the risk of being re-traumatized inadvertently by health-care, investigative, judicial and social and other service providers. This is due to lack of knowledge about the impact of traumatic events on victims and a limited understanding of how to work keeping the sensitivities of survivors in mind. When such re-traumatization takes place the failure of the system leaves the survivors feeling misunderstood and unsupported; which perpetuates a damaging cycle that prevents healing and growth. This can be easily prevented by adopting trauma informed practices. This user friendly toolkit aims to provide this knowledge for service providers who work with acid survivors.

It must be remembered that becoming trauma informed is a process that involves striving towards a new way of understanding victims of trauma and providing support and services to them. This process involves a gradual integration of trauma concepts and trauma sensitive responses into daily practice by service providers.

I hope that all service providers dealing with acid survivors gradually adopt the trauma concepts and trauma sensitive responses while dealing with victims so as to not inadvertently impair them while trying to do good work.

Chairman
Acid Survivors Foundation India

PREFACE

Acid Survivors Foundation of India's (ASFI) history of work in acid violence has led up to this comprehensive trauma-informed care sourcebook. We see this sourcebook as a detailed introduction to a new approach (for those yet not familiar with it) -- one that is trauma-informed -- to address the issues of prevention, medical treatment, psycho-social care and rehabilitation for those women afflicted by acid and burns assaults.

This sourcebook has served as the reference point and base document for a practical toolkit -- Trauma-Informed Care Kit (TICK) -- that we have developed and published for a variety of service providers and service organisations.

As the sourcebook documents techniques, approaches and methodologies that have proven most successful -- through experience and research -- we are excited about its potential to favourably transform the lives of thousands of women, who have faced enormous, life-threatening violence and are living under severe trauma. We hope our TICK with its practical frame of reference complements the efforts of the sourcebook book and when used as an adaptation guide enables users to overcome barriers to obtaining trauma-informed care.

ASFI's beginnings stemmed from an initiative to explore the possibility of setting up countrywide network in India for prevention of acid violence, after care of survivors and advocacy for protection of the victims' rights. Backed by the UK based Acid Survivors Trust International (ASTI) and some leading Indian citizens in some metropolitan towns, the Acid Survivors Trust India (AST-IND) was established at Kolkata in December 2010. It was meant to be the central coordinating agency to organise the network and to set up facilities all over the country through chapters and local partners. Later the name was changed to 'Acid Survivors Foundation India'(ASFI).

Acid and burns assaults are gender specific offences and have lasting and devastating psycho-physical impacts on the women victims than other forms of violence. They traumatise the women at every moment of their lifespan. Pain, constant humiliation, permanent scars, and the loss of dignity and a sense of belonging become a permanent way of life.

Calls to act against acid and burns violence are gathering momentum in India due to their increasing incidence. Attention has been drawn to the gravity of these offences, due to various reasons, not the least because of judicial pronouncements and media intervention concerning specific cases. In a landmark judgment the Supreme Court has ordered the government to regulate the sale of acid, compensate the victims and impose stiffer sentences. The government for its part is treating acid violence as a specific offence with exemplary and deterrent punishment to the culprits and forcing them to provide some compensation to the victims. The Cabinet has passed the Criminal Law (Amendment) Bill, 2012, with special provisions for acid victims. For the first time, acid attacks have been included under a standalone provision in the Indian Penal Code (IPC). It has been proposed that two sections -- 326A (hurt by acid attack) and 326B (attempt to throw or administer acid) -- be added to the IPC. This is a non-bailable offence. The proposed law states that the attacker could get a jail term of 10 years to life for causing hurt by acid. He or she could be sent to jail for up to seven years for attempting to do so. *(1)*

With its firm belief in the United Nations Convention on Elimination of All Forms of Discrimination against Women (CEDAW), ASFI is keen to bring this issue, and that of burns victims who undergo similar travails, into sharp focus in public discourse and debate through several initiatives. Thus, for us, this sourcebook and the TICK are breakthrough initiatives to highlight the twin issues. We see this guide as relevant to India but not specific to it. It can be used across countries for trauma-informed care.

ASFI's road ahead is challenging in view of the size and population of the country, lack of reliable statistics about acid violence and appropriate backup legislation. The immediate objectives are to collect data, identify local partners, set up chapters and associates, generate awareness and raise resources to look after the acid victims. Steps are in process to set up chapters initially at Delhi and Calcutta and suitable linkages at Chennai and Mumbai.

Acid Survivors Foundation India

ASFI's mission

- to set up a network of chapters and collaborations throughout India to achieve the desired goal
- to enable acid violence victims to access suitable medical facilities and psycho-social care
- to help in establishing 'Healing and Recovery' centres that provide holistic attention to victims
- to coordinate and collaborate with disparate agencies engaged in similar work for advocacy of acid related causes including adequate compensation, free or subsidised medical treatment, rehabilitation and exemplary punishment to culprits
- to work for elimination of all forms of violence and discrimination against women and to bring about changes conducive to a humane society

ASFI's vision

- to eradicate acid violence from India through social, educational and regulatory measures
- to provide care and attention to acid survivors so that they can lead a life of worth, usefulness and dignity
- to promote an enlightened attitude towards human rights, gender equality, women's awakening and empowerment through various means

LIST OF ACRONYMS

ASFI: Acid Survivors Foundation of India

ASTI: Acid Survivors Trust International

CBT: Cognitive Behavioural Therapy

CEDAW: Convention on Elimination of All Forms of Discrimination against Women

DV: Domestic Violence

EMDR: Eye Movement De-sensitisation and Reprocessing Therapy

IPC: Indian Penal Code

NGO: Non-Government Organisation

PCVC: International Foundation for Crime Prevention and Victim Care (PCVC)

PTSD: Post traumatic stress disorder

SWOT: Strengths, Weaknesses, Opportunities and Threats

TICK: Trauma-Informed Care Kit

VAW: Violence against women

WHO: World Health Organization

THE TRAUMA-INFORMED SOURCEBOOK: A BACKGROUND

This **first-of-its-kind** comprehensive sourcebook by ASFI for women acid and burn survivors synthesises a range of practical, evidence-based methods, tools, strategies, resources and models to build capacity for trauma-informed approaches, care and trauma-specific services within existing health care facilities and recovery centres.

An attempt has been made to identify barriers to obtaining trauma-informed care and to begin to address it. The sourcebook ventures to provide a methodical, step-by-step, rigourously researched and a well-established frame of reference -- a set of explanatory and operational tools, in other words -- to develop trauma-informed practices and create effective trauma-informed health systems for women acid and burn survivors.

Trauma-informed care, when infused at every level of service -- from the stage of initial interactions of women acid and burn survivors with health staff in hospitals to ongoing supportive work at rehabilitation units and beyond to community reintegration -- can serve as the launch pad for a significant transformation in a survivor's experience. We have hence developed a practical toolkit --Trauma-Informed Care Kit (TICK) -- to enable this.

Premised on ASFIs own field experiences and from information gathered from detailed questionnaires for health facilities, service providers and women survivors and their families (*see appendix*) as well as international research papers and several other toolkits on related subjects, the overall intent of our sourcebook and TICK is to make possible a trauma-informed culture of rehabilitative care for such women -- physically, emotionally and psychologically devastated and caught in a seemingly irredeemable situation -- so that their recovery is swifter and more complete.

While attempting to provide trauma-informed care using the sourcebook and TICK as adaptation guides, the 'learning-to-action' process for health personnel and service providers (whether in NGOs or other organisations) will undoubtedly involve a critical realignment of current ideas and practices. It will mean a re-orientation of services and care, accomplishment of new skills, delineation of new roles and responsibilities, refining of learning and fostering innovative, untried experiments. As it involves working within a wholly new framework -- that helps better see, hear and work with the survivors -- the experience is bound to be radically different.

Yet such re-adjusted behaviours and practices (that involves a deeper commitment by service providers to people they heal) will result in a dramatic turnaround in the recovery process and firm up the resilience of the survivors. This has been proved by several global studies.

It is not hard to understand why. Positive interventions like these act as a tipping point to behavioural change among providers and hence this triggers an equally large change in survivor perceptions and practices. The fact that women blame themselves for acid and burns attack, detest their reactions of not resisting during or before the attack, and see their situation as utterly hopeless are important factors to contend with. These reactions play a huge role in the recovery and healing of the body and self of the survivor. By addressing and assuaging negative feelings around the survivor response to

the traumatic situation by focusing on their strengths and competencies, a vigorous recovery is possible.

This would especially be so, if the pivotal point of all these exercises is the clear understanding that these women hold rights that must be extended and respected at all costs. Prioritizing their choice and control over issues is, thus, of vital significance.

Sourcebook: Objectives

In particular, the five distinct chapters of our sourcebook aims to promote a fundamental understanding of the core issues behind trauma, trauma-informed health systems and trauma-specific services and show how they facilitate the recovery of women who have suffered acid violence and burns.

Issues addressed are:

- the trauma/s experienced by women acid and burn survivors
- factors that induce trauma and the kinds of trauma; reasons for their repeated triggering (occurrence) that causes the survivor to be re-victimised
- complex trauma and post stress disorder trauma (PSDT)
- the commonality and deviations in women's' experiences
- the short and long term impact of traumatic experiences
- the reasons behind such acid and burns attacks and the role of domestic violence (DV)
- the deeply entrenched and pervasive gender bias and violence that permeates many societies and normalise violence against women (VAW) in homes, streets and institutions
- the need to induct culturally competent trauma-informed approaches that allow a re-direction of cultural and social norms supportive of violence against women
- braiding principles and best practices of a trauma-informed approach into a facility (paying heed to awareness of trauma and its impact on women who have suffered acid violence and burns; and being attentive within the facility to promoting women's safety and autonomy; ensuring culturally competent practices; supporting women's control and autonomy; sharing power and

governance; integrating care; supporting relationship building and enabling their recovery)

- the relevance of trauma-specific services
- qualities needed by service providers to provide effective trauma-informed care
- handling vicarious trauma
- growth, resilience and healing: going beyond physical, social and psychological distress
- collaborations with family, non-traditional and expanded community supports

Empowering survivors

From the perspective of the women survivors of acid and burns violence (given the long-stay nature of the treatment and recovery period), the project focuses on trauma-informed care by facilitating her progress to:

- gradually discerning trauma in its entirety so as to curtail the negative impact of beliefs, emotions, feelings and behaviours
- making the links between trauma, domestic violence and mental health
- understanding herself as a whole individual self rather than letting herself being submerged or identified by her specific traumatic life experience
- being empowered to reduce her victimisation and re-victimisation
- recovering from physical, social and psychological distress
- facilitating self-growth, resilience and healing
- understanding and exercising her choices and control over her recovery
- tapping into her latent strengths
- focusing on trust and safety
- collaborating with non-traditional and expanded community supports (such as faith communities, friends and families, etc.) to recover

Why the exclusive focus on women?

Why do the sourcebook and the TICK focus exclusively on women acid and burn survivors? In many countries, social and cultural beliefs and practices that support VAW are entrenched at all levels -- home, family, community, society and the State. Home is the site of violence for many women and abuse by their intimate partners is a way of life. An increasing number of women are facing extreme forms of violence like acid and burns attacks.

The scale and severity of such violent inflictions is mounting globally, and especially in South Asia. The possibility of such cases not only being accidents but the result of resisting gender bias is large. In light of the fact that the majority of the victims of acid and burn violence are women, our efforts have been to place women at the very core of our sourcebook and TICK.

Our audience people who work with women trauma survivors

We intend the sourcebook and TICK to be guides that enrich and not just manuals. We see our audience as a wide one: health care facilities, health care providers, service providers from NGOs and social organisations, representatives of rehabilitation centres, families and communities affected by trauma, trauma-informed care programme designers and implementers, researchers, media reporting on health and gender advocates.

Our direct beneficiaries will always be survivors of acid and burns attacks, who can either directly use this manual or benefit from it indirectly through its use by health care and service providers. We hope it empowers them by helping them become their strongest advocates.

How to use this sourcebook

The five chapters of the sourcebook provides information on many aspects of trauma, including recovery and resources. It could be a regular guide or be consulted from time to time. It is divided into specific sections so that so that readers can swiftly locate and use what they need. It is best used as a practical and introductory guide to complement professional services not replace them. There are certain sections that may seem repetitious but the intent is to help users of specific chapters find quick and easy access to all information they need in a specific location.

Chapter one

attempts a perspective of trauma from the point of view of women acid violence and burns survivors. It presents the unvarnished realities of acid violence and burns -- the immense physical and mental agony that women survivors have to undergo and the lack of resources to deal with its aftermath. It moves on to then define trauma and a traumatic event and then proceeds to underscore its distinguishable elements; its many layers; its varying nature; its effects and trauma triggers. It unmasks the dangerous realities of the permanence of 'fight', flight' and 'freeze' or the hyperarousal mode and the complications of post traumatic stress disorder (PTSD), a clinical condition that many women survivors have to contend with.

Chapter two

looks at the backstory and contemporary realities of violence against women that is normalised in many societies. It throws the spotlight on domestic violence, the inadequate laws to tackle abuse within homes or the harsher forms of violence like acid throwing or burns. It moves the focus towards a culturally competent trauma-informed care that could radically change the dynamics of caring for women who have been assaulted. And, while critically evaluating its merits, it elaborates at length on how to braid culturally competent services within clinical and rehabilitative settings.

Chapter three

focuses on trauma-informed approaches, care and trauma-specific services for women who have suffered acid violence or have been burnt. Helping readers understand the crux of a trauma-informed approach, it elaborates on how to integrate a trauma-informed approach into a facility. It provides valuable tips to ensure smooth functioning of trauma-informed facilities and throws the spotlight on select readymade models that can be integrated swiftly into health facilities. The heart of the chapter comprises eight best practices of trauma-informed care, dealt with exhaustively. Attention is paid to trauma-specific services and care for women acid violence and burns survivors and how individualized modes of recovery can be shaped by counselors for women survivors. It also pinpoints the qualities service providers need to work with women acid violence and burns survivors and makes suggestions on how to handle vicarious trauma, a syndrome that service providers succumb to as they listen to one painful story after another.

Chapter four

undertakes solutions for physical, social and psychological stress that women undergo, looking in a very detailed fashion at the deep imbalances. It looks at the process of recovery in each area and community reintegration, as the final step that completes the circle of trauma-informed care.

Chapter five

is a compilation of exercises and activities that therapists can have women survivors undertake to set themselves on the path of recovery.

CHAPTER ONE

UNDERSTANDING TRAUMA: FROM THE POINT OF VIEW OF WOMEN SURVIVORS OF VIOLENCE FROM ACID AND BURNS

1. Vile and vitriolic: The truth about acid violence

Acid violence is the deliberate use of acid to attack another human being with the intention of injuring, disfiguring, maiming and blinding. Such acts of catastrophic and life-changing violence occur worldwide, although they are more common in Bangladesh, Pakistan, Afghanistan, Nepal, India, Cambodia and South Africa. Eighty percent of these attacks are directed at women and between 40 percent and 70 percent of them target women under 18 years of age. *(1)* The acids used to attack women are hydrochloric, sulfuric or nitric acid, which quickly burns through the flesh and bone. It takes five seconds of contact to cause superficial burns and 30 seconds to escalate into full-thickness burns.

Acid attacks: excruciatingly painful and hard to treat

Acid attacks are inherently gruesome and have few parallels in the excruciating physical ordeals that the survivors confront. Upon contact, the acid melts through flesh, muscle, and even bone, until thoroughly washed. Acid attacks are extremely difficult to treat: the acid seeps into the layers of the skin leading to long-term infection and corrosion. *(2)* Victims need multiple complicated and expensive surgeries. Sometimes victims even turn blind, deaf and disabled. And, disfigurement as a lived reality, as muscles and internal organs are destroyed, becomes immeasurably hard to cope.

Many hospitals have no facilities to handle acid violence

To make things worse, many hospitals have no facilities whatsoever to adequately handle such cases. Some doctors are not even aware of basic first aid measures such as flushing acid out of the body immediately after the attack. A few women even die as they're unable to access proper medical care after the attack. A 2008 report by ASTI aptly says "acid violence rarely kills … [it] always destroys lives." *(3)*

Acid thrown at women who question gender norms

This kind of violence has much to do with deep and disquieting gender inequalities at home, family, community and the society at large -- that are deeply entrenched in many societies. Acid attacks, like all other forms of violence against women (VAW), are a social phenomenon deeply embedded in a gender hierarchy that has historically privileged patriarchal control over women and justified the use of violence to "keep women in their places." In some cases acid attacks are perpetrated against women because they question gender norms that keep them in subordinate positions. Oftentimes, it happens

simply because a woman spurns unwelcome male advances. Or because of a domestic dispute. Or simply because the perpetrator is miffed with the outside world. Such attacks occur in homes, in residential localities, on the streets and within institutions. The culture of impunity that surrounds such violence allows the majority of offenders escape trial and conviction for these heinous crimes. *(4)*

Intense aftershocks

The aftershocks of acid attacks are as intense -- unbearable physical pain is coupled with debilitating emotional and psychological agitation as details of the incidents involuntarily reoccur in their minds. The reality of an altered face and body is tremendously hard to cope with. Common psychological symptoms include depression, loss of self-esteem, insomnia, fear, headaches, and suicidal tendencies. Fear is perhaps the most overbearing of these symptoms; fear of reprisal should they speak out or seek legal action, fear of a repeated attack, and fear of the outside world. Fear makes victims unwilling to pursue legal action or testify against offenders. *(5)*

Social ostracism

There is also social ostracism, isolation and loss of career to contend with. The assaulted woman can no longer move around freely, work or study. This is not so much due to her disabilities but because of the perceived dishonour she heaps on her family. A single woman who has been assaulted has no chance of marrying and is viewed as a lifelong burden to her family. If the victim is a married woman, her life becomes far more unendurable. She is caught in a double bind: not only does she have to continue living with the perpetrator, who is usually the husband or a male family member, but in many cases, her children, too, refuse to interact with her.

2. Fiery shame: Burning women

Another brutal crime that assaults the woman physically and psychologically and has similar fall-outs as acid violence is one in which women are burned alive by their partners. Bride-burning is the practice of dousing a bride with kerosene or other inflammable substances and setting her ablaze to die. It is commonest form of dowry deaths. The husband and/or in-laws have a role in this. Dissatisfaction with the amount of the dowry received is the main reason. But it needs mention that a woman could be burned years later after marriage as well, raising deep concerns about on-going domestic violence (DV) and the lack of safety for women within their own homes. Avnita Lakhani's book "*The Elephant in the Room Is Out of Control*" explains this syndrome at length. *(6)* A large number of women immolate themselves during a fight or when worn out by the on-going abuse within their homes. This syndrome is far more prevalent in South India.

Marital discord cause burn injuries

On a monthly basis, Kilpauk Medical College, Chennai, Tamil Nadu, India, receives 100 to 150 such cases of women seeking treatment for burn injuries or acid attacks, 70 per cent of them proving fatal, says Prasanna Gettu, CEO, International Foundation for Crime Prevention and Victim Care (PCVC). Ninety percent of cases are due to DV, she explains. They are either burned or set themselves on fire due to marital complications. In Tamil Nadu, there are more burn injuries unlike the North of India where there seemed to be more acid attacks. She also pointed out that most of the victims were married showing that post-marital life remained a challenge for most of the south Indian women.

Burns deaths are the maximum in low and middle-income countries

According to the World Health Organization (WHO), an estimated 1,95,000 deaths every year are caused by burns – the vast majority occur in low and middle-income countries. Non-fatal burn injuries are a leading cause of morbidity. Women in the Southeast Asia have the highest rate of burns, accounting for 27 percent of global burn deaths and nearly 70 percent of burn deaths in the region. In India, over 10,00,000 people are moderately or severely burnt every year. Nearly 1,73, 000 Bangladeshi children are moderately or severely burnt every year. In Bangladesh, Colombia, Egypt and Pakistan, 17 percent of children with burns have a temporary disability and 18 percent have a permanent disability. Burns are the second most common injury in rural Nepal, accounting for five percent of disabilities. *(7)*

- ***Deep burns, deeper damage***

In cases of deep, extensive burns, body structures under the skin can be damaged. Cartilage in the ears or nose could also be vastly affected causing changes in these structures. They may be blisters, swelling, skin loss, loss of fluids and electrolytes, shock and severe infections. Itching is sometimes constant and some survivors have to handle this on a minute to minute basis every day. Scarring becomes a huge problem not only because of its appearance but also due to the disablement due to stiffness and pain. Scar maturation can take up to two years.

After a burn injury, the skin undergoes many phases of healing. In the preliminary stage light-colored skin replaces open wounds. After the wound heals, the skin turns darker, stiffer and raised. Rehabilitation is undertaken at this point using pressure garments (to prevent the development of hypertrophic scars) or splints or through scar massages and stretching exercises. In the scar maturation phase, the scarred skin gradually returns to a more normal skin tone and becomes softer and flatter. At this stage, it is mostly necessary to continue wearing pressure garments or splints, performing scar massage and stretching exercises in addition to going through with cosmetic surgery.

Some burn survivors have to undergo multiple skin grafts and other reconstructive surgeries and sometimes burn injuries cause damage that requires amputation of fingers, toes, or limbs. Skin grafts can also result in hair loss because hair follicles do not regenerate. Others develop hypertrophic burn scars where the skin rises above the surface of the original burn injury. They can get hypersensitive and itchy.

In addition, a burns survivor needs vigourous nutritional support as the physiology of the body's response is characterised by an increase in adrenergic activity. The overall result is hypermetabolism, unmatched by any injury or disease. The energy needs of a burns patients, hence, increases two-fold or more. Fluid management and nutritional therapy become extraordinarily significant. The heightened need for calorie/protein intake gets jeopardised, as the survivor is not able to eat. A burns patient is expected to drink several litres of water a day but again taking down even a spoonful of water becomes a challenge. Tube feeding has to be resorted to on occasions.

3. Hospitals are ill-equipped to handle burns emergencies

Not many hospitals in the developing world are equipped to deal with burns victims. Take the case of India. The number of trained burn and plastic surgeons is less than 1100 for more than 1100 million population in India. The patients are treated by a variety of service providers who aim at closing the raw wounds and this leads to invariable development wound contraction and scarring. *(8)* The situation is no different in South Asia.

4. Burns rehabilitation: a complex process

Burns rehabilitation is an extremely difficult and time consuming effort. Women have to cope with enormous physical pain and deal, at the same time, with low self-esteem and lack of motivation due to their altered looks and social rejection. Physiotherapy, correct positioning of the patient and various methods of splinting and grafting are undertaken to prevent contractures and deformities.

5. Psychological trauma of burns survivors

Their psychological trauma, includes, among other symptoms, grief, depression, anxiety, anger, delusion and recurrent and ongoing recollections of a trauma, leading to distress. Therapeutic interventions need to be sensitive and long-running. A very recent longitudinal study on rehabilitation of female burns patients in the Department of Community Medicine, Shri Sathya Sai Medical College and Research Institute, Kancheepuram, Tamil Nadu, India, shows just difficult this re-assimilation into family and society can be in the absence of sensitive care. *(9)*

6. Children who suffer burns

Children constitute a special population in burn care. In cases where women are burnt at home by their spouses, children rush to save their mothers and suffer burns as a result. Their physical pain may align with that of adults, yet they greatly differ in behavioral responses. Behavioral problems range from hyperactivity to anxiety to attitude and sensation-seeking behaviours, especially if they are teased or bullied in schools over their altered appearances. Psychological counseling, support groups and early interventions by adults in a child's life can help protect them from teasing. Teachers and adults can sensitise other children to some basic information about burns and how to treat a burn survivor with respect which can help create a supportive environment.

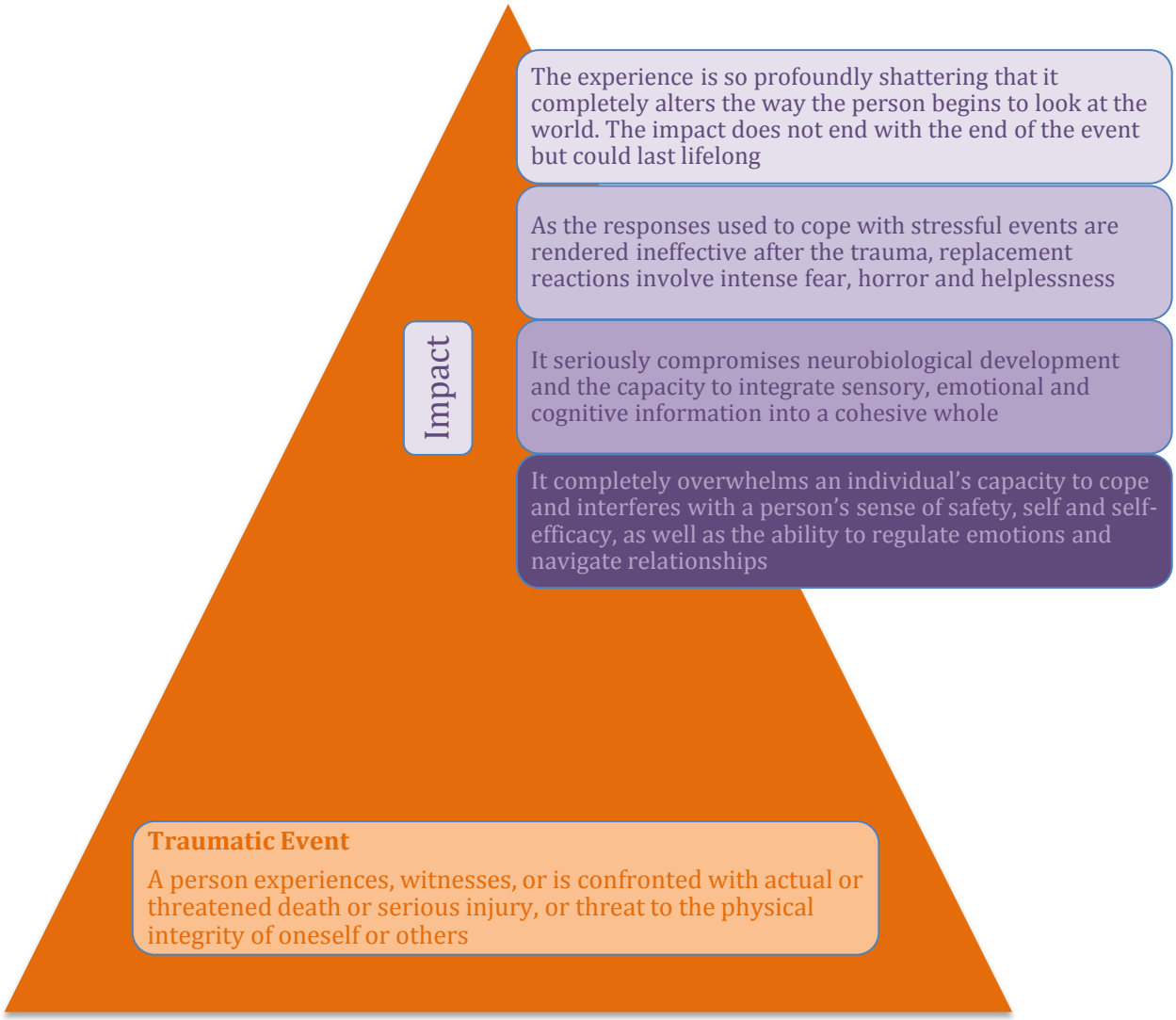
7. Viewing trauma through the lens of acid violence and burns survivors

Many dissections and reasoning of what constitutes trauma exist. We have chosen to go with those descriptions that are closer to our subject – the trauma suffered by women who have undergone acid violence and burns attacks.

Why is an understanding of trauma vital for health care facilities, and health and service providers attending to women acid violence and burns survivors?

A lack of understanding of trauma, its effects (that are deep and life shaping) and the specific needs of women who have suffered acid violence and burns attacks leads to grave misunderstandings of the survivor's responses/needs among health personnel and service providers. This could lead to acute frustration and actually cause harm rather than help survivors. Hence, understanding trauma is the first step to working differently and providing effective trauma-informed care for these women. This primarily means that health staff and service providers at all levels and all roles alter what they currently do based on this understanding. It must be remembered that the underlying here is that trauma impacts the 'core' of the women survivors' identity and touches many, if not all of her life domains. The workings of health facilities and treatment modes have to be similarly altered. *(10)*

What is a traumatic event?



The *American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV)* defines a traumatic event as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others.

The distinctive feature of the experience is that it completely overwhelms an individual's capacity to cope and thus inevitably interferes with a person's sense of safety, self and self-efficacy, as well as the ability to regulate emotions and navigate relationships. *(11)* This is predominantly because trauma seriously compromises neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole. It sets the stage for unfocused responses to subsequent stress. *(12)*

As the responses used to cope with stressful events are rendered ineffective in such situations, replacement reactions involve intense fear, horror and helplessness, as Judith Herman's seminal book Trauma and Recovery explains. *(13)* Dissociation (meaning a reduced awareness of one self) becomes part of a survivor's personality. *(14)* The experience is so profoundly shattering that it completely alters the way the person begins to look at the world. And, the impact does not end with the end of the event: people's thoughts, feelings and body responses could be impacted for a lifetime. Or if not, certainly for a very prolonged stretch of time.

- Other than a profound impact on the sense of self, trauma negatively impinges on memory. It can affect recall value, or a linear or chronological recall of events, or can repress memory continuity. As studies from the Sidran Traumatic Stress Foundation say, "There is evidence that trauma is stored in the part of the brain called the limbic system, but not language or speech. For this reason, people who have been traumatised may live with implicit memories of terror, anger, and sadness generated by the trauma, but with few or no explicit memories to explain the feelings."

- It is not the event that determines whether something is traumatic but the individual's experience of the event. People who have coping skills and a supportive environment to overcome their trauma recover faster than those who do not have these social and emotional scaffoldings. Negative coping mechanisms set in when the ability to cope is low and remain a part of a person's responses till s/he recovers and integrates the traumatic experience.

- In the case of an acid attack or burns assault, there is considerable trauma because of the unbearable physical pain, enormous mental disorder (as described above) and the inability at that moment to deal with the permanent changes in the physical demeanor. The survivors are also at a loss in their social interactions – as people stare, shun them or ask questions that are intrusive; questions that the survivors are not able to answer. This leads to even further emotional setbacks where emotions of anxiety, anger, sadness and depression chase one another. The trauma escalates when women have to deal with intimate partner violence, domestic violence and violence from those with unrequited love. The trauma worsens when they have to continue living with the perpetrators

Three distinguishable elements of an emotional trauma

Women who are assaulted by acid or are burnt undergo different traumatic experiences but three factors of emotional trauma are common to each of their experience:

- it was unexpected
- the woman was unprepared
- there was nothing the woman could do to stop it happening (even when women immolate themselves, the impulse seems unstoppable)

Who can be traumatised?

Individuals, families (when one or more individuals of their family suffers trauma), communities (when events affects its members), cultures (when an entire community is affected) and service providers (after hearing stories and seeing the suffering of those suffering from trauma; this syndrome is called vicarious trauma). *(15)*

- ***The trauma of DV, acid and burns violence***

Experiencing DV is traumatic for women and their children. Violence within homes are not discrete episodes but an on-going process of victimisation, a cycle of abuse with periods of abuse juxtaposed between periods of calm. The experience is devastating as the perpetrator is someone a woman loves and trusts. The use of controlling and coercive behaviour leaves a woman feeling fearful, powerless and hopeless. And, most importantly betrayed.

Very rarely is the domestic abuse of one kind. Generally where one form of abuse exists, it is within the context of other forms of abuse. The perpetrator of physical violence will also subject his victim to emotional and verbal abuse. Abuse rarely stays the same, but usually increases both in severity and frequency over a period of time. Advocates need to recognise both the severity of the symptoms and how they affect the women.

When the attack takes the shape of burning or acid throwing at homes, the women are traumatised in the extreme both because of the unbearable severity of the violence and because for many it seems like the end of the road with nowhere to go or there being no one to help. The sense of betrayal deepens when the woman's feelings are not validated by the community or institutions. What makes the situation worse is that many women have to continue to live with their acid violence or burns perpetrators as they are deterred by cultural, social and economic constraints. It is unsurprising that many commit suicide or attempt to. *(16)*

- ***The many layers of trauma***

It is extremely important to be conscious of the fact that there is no one way to understand trauma or women's (who have suffered life-shattering acid violence and burns) response to trauma. As we cannot fit their traumatic experiences into neat categories or equate one woman's trauma with another, it is important to accept that there are many layers and nuances to the concept and the experience of trauma. Peter A LeVine in his book *Healing Trauma* underscores some of these subtle gradations. *(17)*

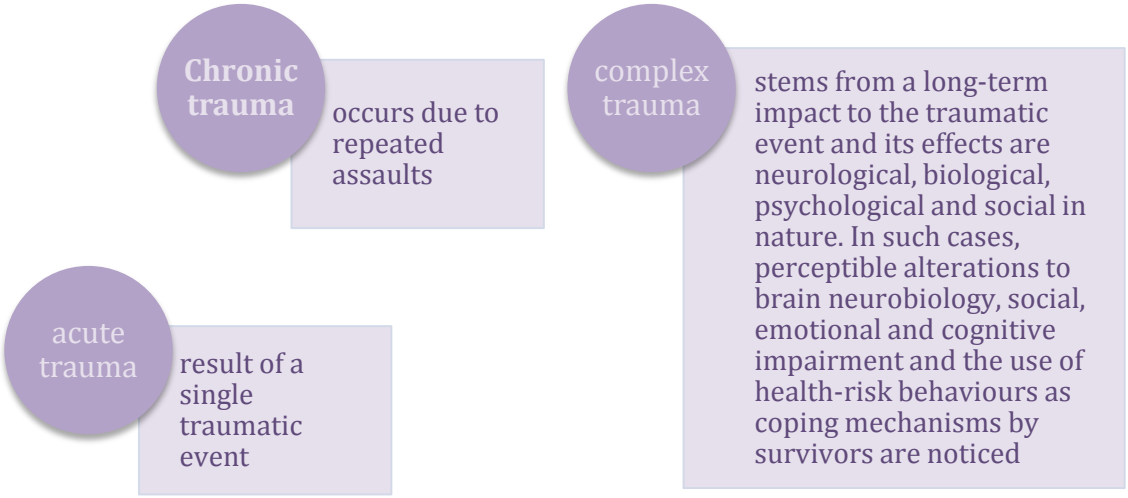
Trauma very often could be based on individual perception and need not necessarily come from a catastrophic event. Also, traumatic reactions could be normal reactions to abnormal situations. Thus, the varied reactions to trauma are not emotional and psychological imbalances but responses expressed by each of the women as a direct result of traumatic experiences and a means of coping with them.

- ***Trauma as a single event or multiple events***

More significantly, trauma could be a single event as a result of interpersonal violence, especially from a trusted person, or could even be multiple events over time. In the case of women who have suffered from acid violence or been burnt, the event trauma could be compounded by other traumas – such as rape, sexual abuse, stalking, incest or trafficking.

- ***Varying kinds of trauma***

Also, different levels of exposure lead to varying kinds of trauma. Though again difficult to categorise, they have been broadly grouped into three.



Trauma triggers

Any real experience or an episodic nightmare, or any smell, taste, feeling or sound that remotely or closely mimics the trauma experienced by women who have suffered acid violence and burns could remind her of the past trauma and cause her to respond as if she is back in the past. These remembrances are 'triggers' for fresh trauma.

Common triggers to trauma responses are: sounds, smells, colours, movements, particular dates and days and objects. *(18)*

- ***The permanence of 'fight', flight' and 'freeze' or the hyperarousal, hypervigilance mode***

When a person is confronted with danger, the instinctual reactions are either to -- fight, flight or freeze. When the danger has passed, the body, brain and instincts return to normal.

Yet the brain stores even the smallest details of the experience so that if faced with a similar situation in the future, the person is able to react with alacrity. But in cases where women are attacked with acid or are burnt, the trauma is so overpowering and distressing that these reactions remain alive and continuous. It is as if the incident is still happening, even though days, months and years have passed by. Hyperarousal becomes a constant factor. Babette Rothschild in *Eight Keys to Safe Trauma Recovery: Take-Charge Strategies to Empower Your Healing,* explains that hyperarousal in the bodies of survivors of trauma leads "to physical symptoms that can include anxiety, panic, muscle stiffness, irritability, weakness, exhaustion, concentration problems and sleep disturbance." *(19)* It also leads to hypervigilance (where the survivor is on a constant lookout for danger and is distrustful of new people, situations and places) and exaggerated startle

reflex (survivors may be easily startled or unable to get used to sudden sounds or movements) (20)

- ***Post traumatic stress disorder (PTSD)***

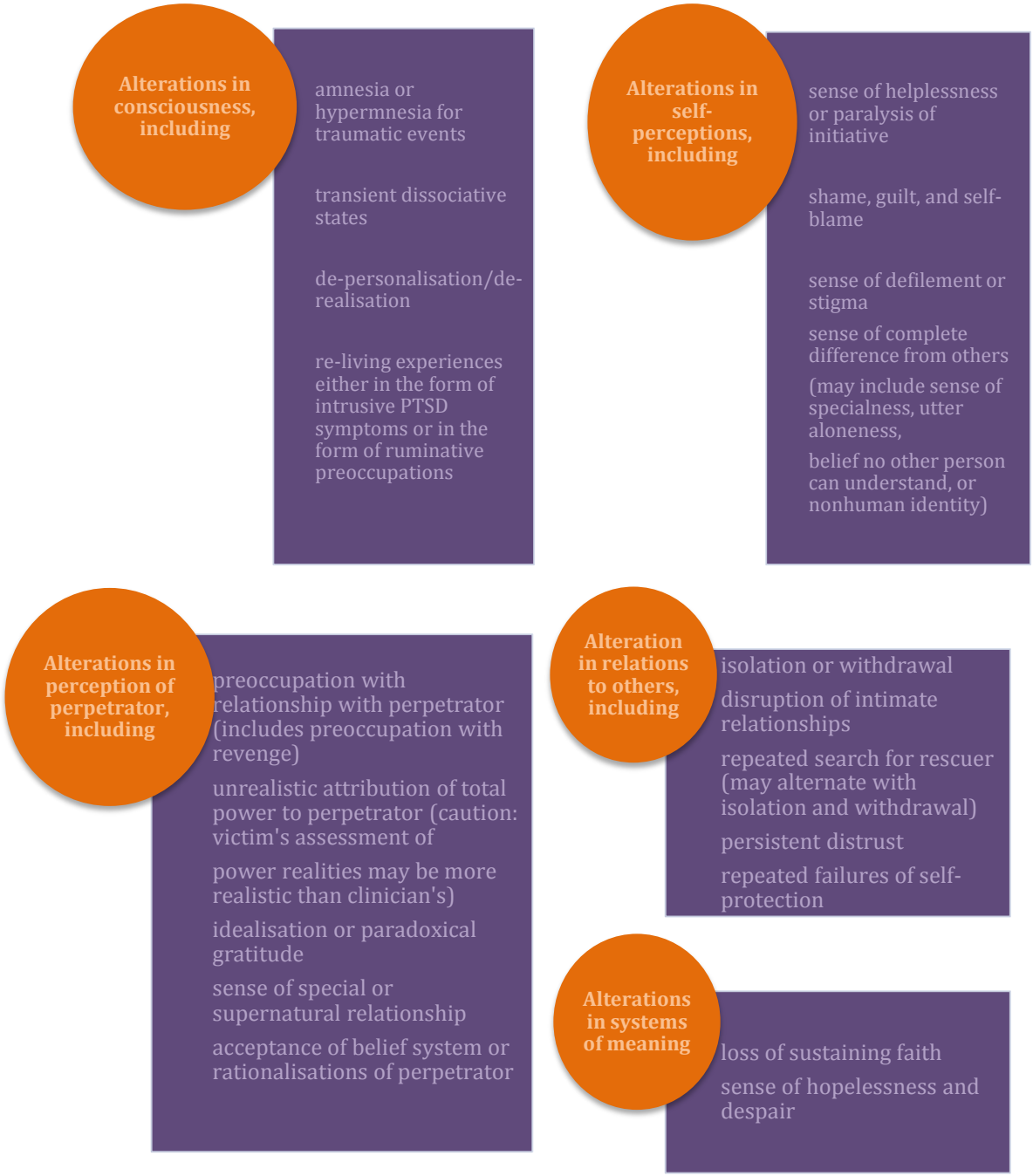
This is a distinctive psychiatric condition that develops among some survivors who are unable to deal with the trauma and block it out emotionally, both during and after the trauma. But ironically they repeatedly re-experience the traumatic event through flashbacks and nightmares. Called intrusion, it involves reactions that force the survivor to relive the traumatic events as though they are reoccurring in the present. When intrusive thoughts occur, the survivors spend a lot of time involuntarily thinking of the traumatic event and can't seem to stop it. It begins to dominate their lives. So trauma stays in their mind always and hypervigilance becomes a permanent condition. Worse, new fears may set in and there may be increased arousal such as nightmares, difficulty in falling asleep, hyperactivity, irritability, mood changes and increased aggression, among other symptoms. They might experience constriction or avoidance. This means a 'narrowing down of consciousness' or 'numbing' of feelings and thoughts associated with the traumatic situation. There are three 'D's' associated with constriction: detachment (withdrawal from people and activities); disorientation (feeling dazed) and denial (unwillingness to look at hard facts). *(21)*

Women with PTSD are, thus, unable to put the traumatic event behind them or minimise its impact. Yet this condition must thus be viewed as women survivor's coping strategies developed in the context of abusive experiences. They must be recognised and accepted as such if their healing process is to be effective. Also, it must be must looked at from her perspective from wherein these actions look logical.

The internationally recognised guidelines for the diagnosis of PTSD

- exposure to a traumatic event: the person experienced, saw, or learned of an event in which they felt a real or perceived threat of serious injury, death, or other violation of integrity to themselves or someone else
- re-living some part of the traumatic event (one or more). Intrusive thoughts, perceptions, images, etc.
- recurrent dreams of the event
- belief that the event is happening again, hallucinations, or flashbacks (children might re-enact the trauma)
- intense distress when exposed to reminders of the traumatic event
- physical reactions when exposed to the reminders *(22)*

Judith Lewis Herman in *Trauma and Recovery*, details the minute particulars of PTSD ***(23)***:



Traumatic incident reduction for those affected by PTSD is a long process. It is a "client-respectful, therapist-directed, memory-based intervention aimed at the reduction of trauma-related symptoms."

- ***Symptoms of trauma, its impact and the commonality and deviations in experience***

Each woman acid violence and burns survivor responds to trauma differently, as their situations are unique to them. Yet there is a commonality of experience. Their traumatic experience deeply disrupts their physical, psychological, social and moral outlook. Their emotional attachments too face upheavals and hence they suffer from dissociation and repression and take to addictive behaviours to restore a sense of control over their lives.

Secondary psychiatric symptoms get developed that are unconnected to symptoms of their previous trauma. The more severe their trauma, the deeper is the post-traumatic disturbance in pathology. Yet it must be clearly understood that all of these symptoms and syndromes are a direct result of traumatic experiences and survivors use them as core defenses to cope with them.

The challenge is to understand how trauma affects each woman -- differently -- and learn to empathise and see her through it. When rules are not followed or there is agitation or suspicion or there is disrespect of boundaries or there is over-caution with regard to it, it must be understood that this is 'normal' behaviour for the woman. It is their protective, coping mechanisms.

> Physically, acid violence and burns survivors undergo immense pain and have to withstand treatment, medication, physiotherapy and reconstructive surgeries. In particular, there is untold difficulty in falling asleep and staying asleep. The survivors have to cope with scars, tough exercise regimens and itchiness.

A majority of them feel enduring sadness; exhibit tendencies towards self-destruction; have numbing, suicidal thoughts or behaviours; suffer from low self-esteem; display hopelessness and despair; and feel helpless and alone.

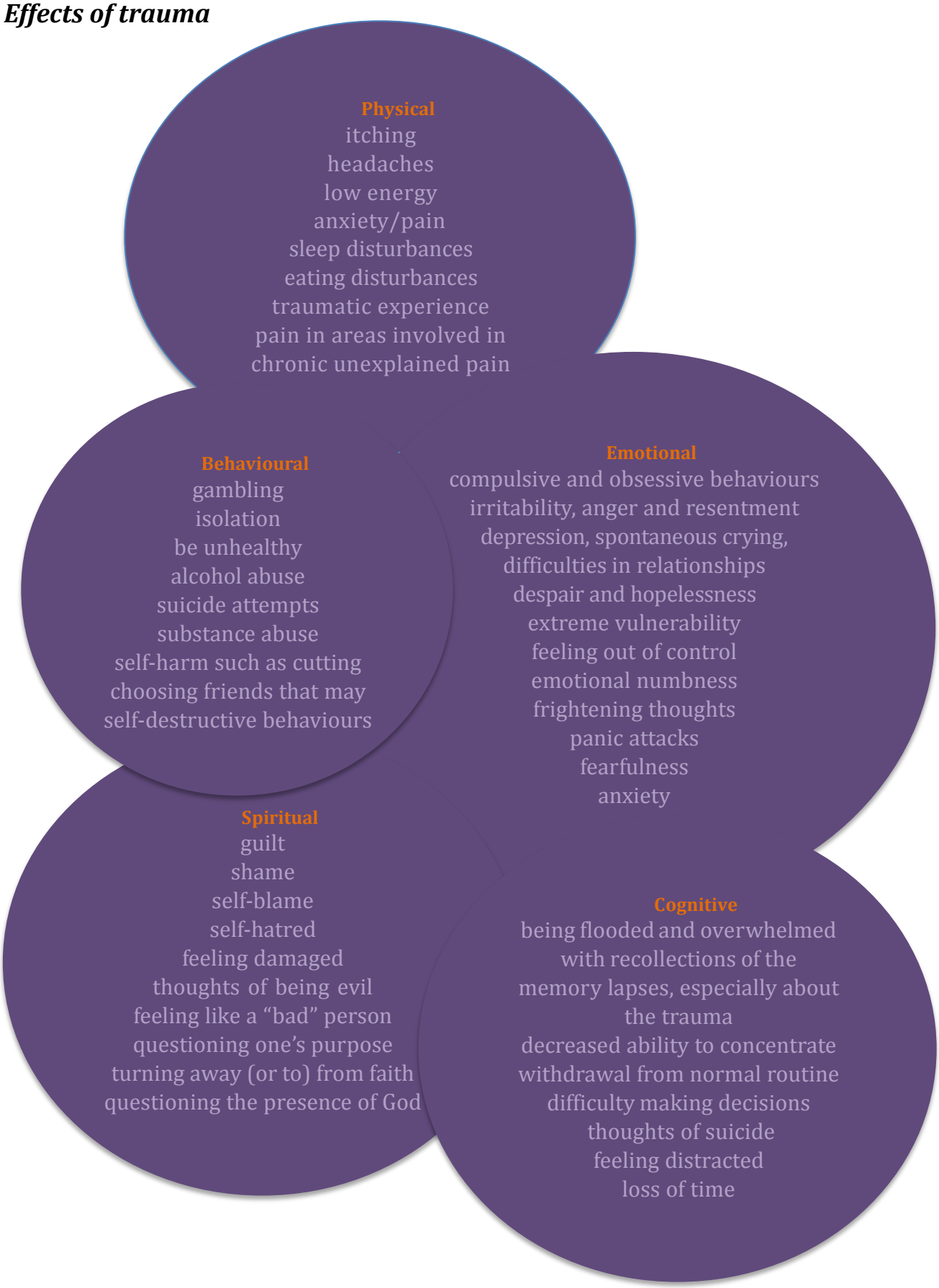
> In many cases, there are heightened emotional states -- uncontrollable anger is common as is hyper-sexuality. Some change their religion and others their sexual orientation. Drug use, preoccupation with revenge and hostility towards authority figures become the norm.

Several women become prone to dissociative episodes, compulsions, obsessions, paranoia, eating disorders and guilt. They remain unintegrated into their overall functioning. The Sidran Traumatic Stress Foundation, Maryland, defines dissociation as a complex mental process during which there is a change in a person's consciousness. There is disruption in the connections between the functions of identity, memory, thoughts, feelings and experiences. Time and memory gets distorted.

Other predominant behaviours include: distrust; re-victimisation and severing relationships. Or on the contrary, they fall prey to others by their failure to sense danger; collapsing under the weight of peer pressure and live with an uncertain future with no plans or long term goals. *(24)*

The effects of being traumatised are very specific to a woman and survivors are impacted physically, emotionally, behaviourally, cognitively and spiritually.

- ***Effects of trauma***



(25)

We demonstrate the extremity of suffering of women who face trauma because of acid violence and burns

Difficult Behaviours or Reactions in Hospital/Recovery Settings	**Common Trauma Reactions**
Hospital Setting:	
Does not answer questions about the incident or does not remember sequence of events, stares blankly	(Cognitive) Difficulty remembering things, confusion too many thoughts at once, dissociation
Is alert for signs of danger, appears to be tense and nervous	Hyper-alertness or hypervigilance, threatened assumptions (that the world is not safe or less safe than before)
Is gripped with fear, wants to know what has happened to her body	Replaying the event, confusion, feeling helpless, feeling not herself
Rehabilitation Setting:	
Has difficulty sleeping, keeps talking to others constantly all through the night, keeps roaming in the night, complaints the setting is not comfortable	Nightmares, insomnia, intrusive images, flashbacks, replaying the event
Refuses to do exercises, forgets schedules, does not cooperate with the counsellors or therapists	Avoidance of traumatic memories or reminders, depression, diminished interest in everyday activities, difficulty concentrating or remembering
Complains of aches and pains like headaches, stomachaches, backaches	Psychosomatic symptoms, impaired immune system
Does not talk much to others in the facility, keeps aloof, will not accept help from others	Feeling detached from others, increased need for control, difficulty in trusting, numbness/grief, feeling vulnerable
Has interpersonal conflicts with others in the facility	Irritability, restlessness, outbursts of anger or rage
Is alert for signs of danger, appears to be tense and nervous	Hyper-alertness or hypervigilance
Emotionally "out of control." Unpredictable emotional responses.	Affect dysregulation (emotional swings – like crying and then laughing)
Resorts to anti social behaviour, taking away others things, lying, blaming others, appears angry, does not want to abide by rules	Feeling unsafe, helpless, outbursts of anger

CHAPTER TWO

FOSTERING CULTURALLY COMPETENT PRACTICES WITHIN TRAUMA-INFORMED CARE

Cultural and social norms are rules or expectations of behaviour within a specific cultural or social group. Often unspoken, these norms offer social standards of appropriate and inappropriate behaviour, governing what is (and is not) acceptable and also co-ordinate inter-personal societal interactions. A variety of external and internal pressures are applied to maintain cultural and social norms. Thus, individuals are discouraged from violating norms through forms of social disapproval. *(1)*

It must be underscored that culture is not limited to one's ethnicity or birthplace, but also relates to age, disability, religion and spirituality, social class, sexual orientation, indigenous heritage, immigration or refugee status, and gender and sex as Laura S. Brown, author of *Cultural Competence in Trauma Therapy* explains*. (2)*

Moreover, cultural and social norms vary across societies -- behaviours acceptable to one group are not in another. Yet what is common to all societies is that the will of the dominant cultural group prevails.

In the context of our sourcebook and TICK, it must said that to a large extent the dominant culture of a society determines what type of threat is perceived as traumatic and how the meaning of the traumatic event is interpreted. It also shapes how individuals and communities express traumatic reactions. It forms a context through which the traumatised individuals or communities view and temper their own response.

Networks comprising families, communities and cultures are meant to protect, comfort and sustain people living within their confines. They also provide a sense of belonging and link families and individuals to a larger whole through a common language, history and beliefs.

When a crisis occurs, the family offers a comfort zone and is the first point of approach for an affected person. The familiarity of family relationships provides great reprieve and protection in the face of danger. In crises, cultural understanding helps people make sense of what's happening.

But if the dominant cultural group does not accept a person's trauma or see them as victims, or distances itself from the traumatised or attaches guilt and shame to their plight and condition, there is a tendency among the affected to feel disempowered and thus withdraw and be silent. This is a critical issue for men and women who undergo trauma. More so, for women whose marginalisation in society is further reinforced by such behaviour. Women who suffer trauma as a result of extreme violence are in a far more perilous state as they suffer not only from physical debilitation and disregard for their pain but also bear the burden of being blamed for the violence and social repudiation.

Cultures of assault and impunity: the backstory and contemporary realities

The backstory of many cultures and societies, particularly those in South Asia, is that they accept and endorse VAW to make it normative. Traditional beliefs allow a man to control his wife using physical intimidation in all manner of forms and men in general to control women's actions and beliefs. These acts may have serious health consequences or may even result in death. Yet VAW -- be it physical or in the form of controlling woman's freedom and choices -- is viewed as a 'private' matter not warranting public scrutiny or interference. Women are often held responsible for the abuse, creating social stigmas and cultural taboos around the subject, and deterring women from seeking assistance. This is today's reality as well as not much has changed.

The United Nations Declaration on Violence Against Women defines gender-based violence as an act "that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life."

DV on the other hand is a form of VAW perpetrated by intimate partners (including cohabitating partners as well as former partners) and other family members. It includes physical abuse (e.g., slapping, beating, and murder), sexual abuse (e.g., coerced sex through intimidation or threats), psychological abuse (e.g., verbal aggression, intimidation) or economic abuse (e.g., denial of funds or controlling access to employment). In violent relationships, victims may experience several forms of abuse.

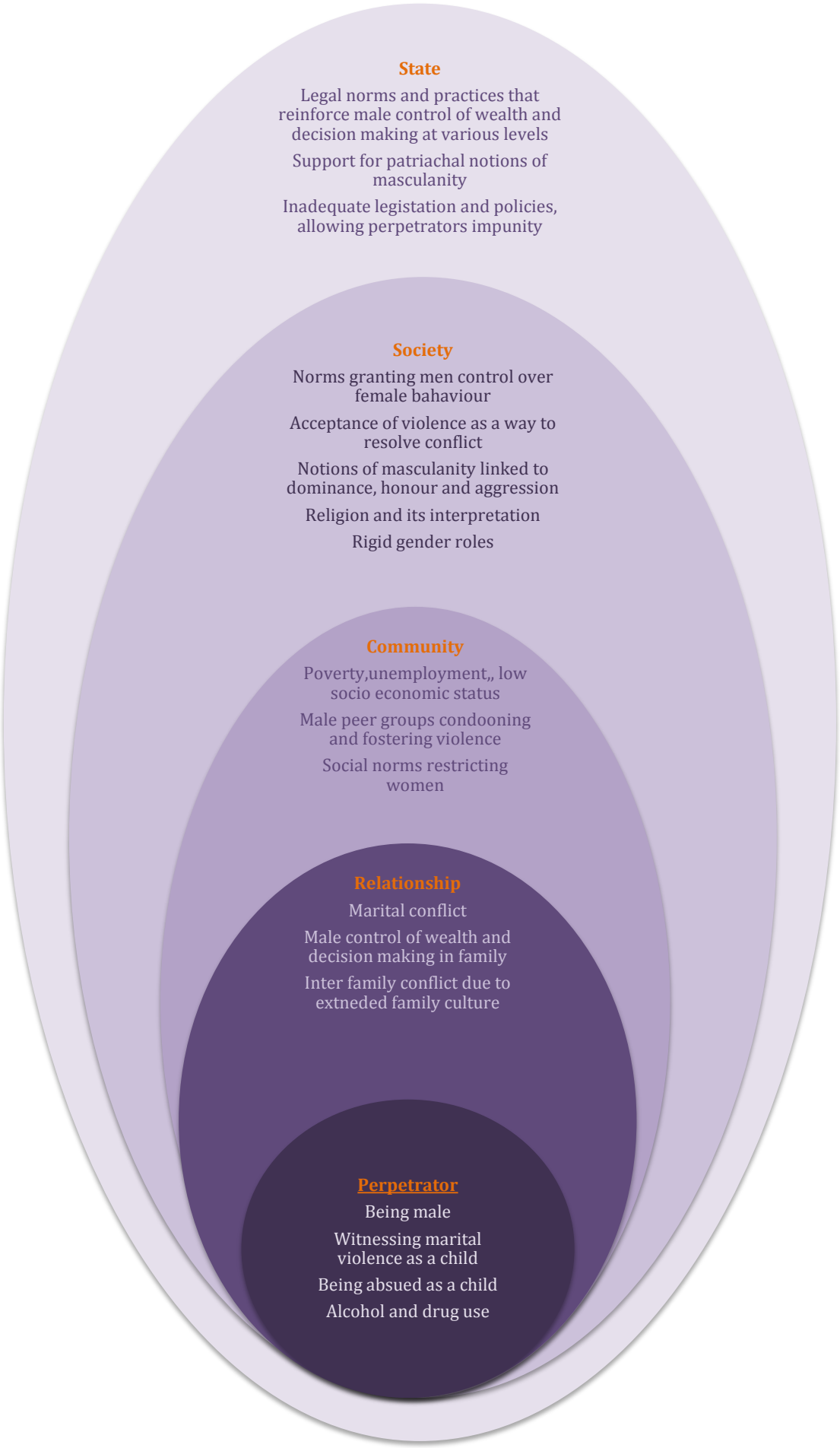
According to global estimates, "[A]t least one in three women is beaten, coerced into sex or otherwise abused by an intimate partner in the course of her lifetime." *(3)* One in every two women in South Asia faces violence in her home, according to an Oxfam GB Briefing Paper *Towards Ending Violence against Women in South Asia* (2004). Oxfam GB that initiated a six-year, six-South Asian country campaign to end all VAW in the region, in this paper elaborates: Social, cultural, political, economic, and legal factors in the region combine to leave women vulnerable to community-sanctioned violence. VAW is endemic to the region with culture-specific variations. It begins at the stage of conception; sex-selective abortions are frequent. One in six deaths of a female infant in India, Bangladesh, and Pakistan is due to neglect and discrimination. Culture-specific forms of violence include DV, rape, sexual harassment, incest, trafficking, honour killings, acid attacks, public mutilation, stove-burnings, and forced temple prostitution…. Enormous effort is required at the cultural and social levels, as most forms of violence against women are still viewed by a majority of the population as 'private matters' to be endured, and most certainly not a crime …. . Addressing violence against women requires challenging and changing unequal power relations between men and women, as much as it means dealing with issues of gender inequality in relation to resources, benefits, and political power." *(4)*

The paper goes on to say: although acts of VAW are perpetrated by individuals who should be held responsible for their crimes, gender-based violence is learned behaviour. Socialisation plays a major role and the individual is supported by the family, community and the State through normative rules or by impunity towards acts of violence. Sometimes, acts of violence are committed collectively. Violence is even fostered through

rituals, religious practices, symbolism and ideology. And, ironically it is the victim who shoulders the blame for the acts committed upon her.

What are the factors that encourage VAW? The paper identifies the following

individual level	family and relationship level	community level	society level	state level
factors include being abused as a child or witnessing marital violence in the home, having an absent or rejecting father, and the frequent use of alcohol and drugs.	cross-cultural studies have cited male control of wealth and decision-making within the family and marital conflict as strong predictors of abuse.	women's isolation and lack of social support, together with male peer groups which condone and legitimise men's violence, predict higher rates of violence.	studies around the world have found that violence against women is most common where gender roles are rigidly defined and enforced and where the concept of masculinity is linked to toughness, male honour, or dominance. Other cultural norms associated with abuse include the tolerance of the physical punishment of women and children, acceptance of violence as a means to settle interpersonal disputes, and the perception that men have 'ownership' of women.	studies have found that inadequate legislation and policies to prevent and punish acts of violence, as well as low levels of sensitivity and awareness among law enforcement agencies and social services, are linked to a higher incidence of violence.

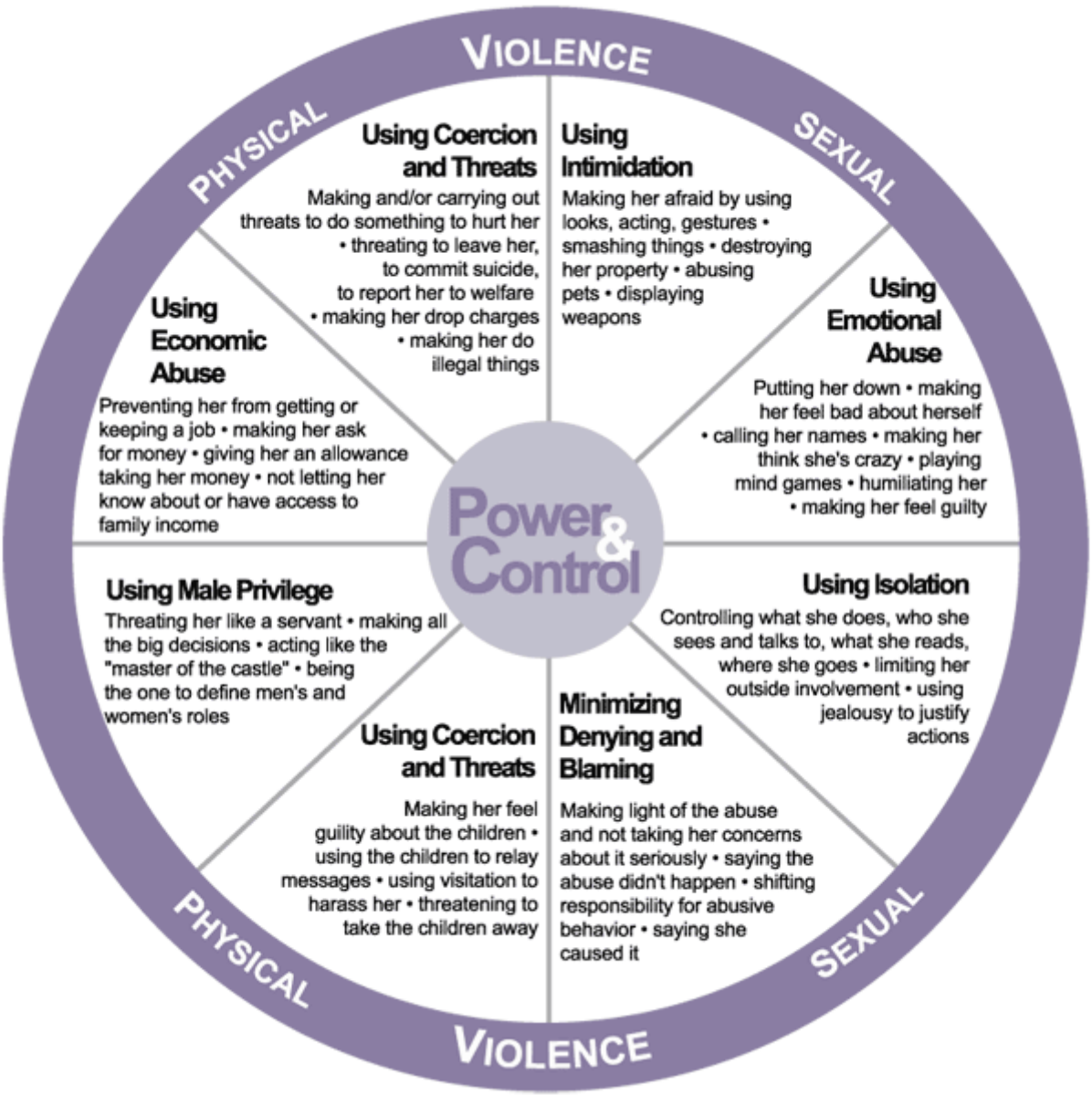


Source: Towards Ending Violence against Women in South Asia, Oxfam International Briefing Paper, 2004

Domestic violence: about power and control

At its core VAW and in particular DV is about power and control. Whether emotional, physical, or sexual, these abusive behaviours are used by men in a relationship to control or overpower the other. Leaving a relationship does not help in most times as the violence escalates as it represents a threat to the perpetrator's control.

The Arkansas Coalition Against Domestic Violence's diagram illustrates this best,



Source: Arkansas Coalition Against Domestic Violence

Extreme forms of violence: 'honour killing'

There is another peculiar justification for VAW in South Asia in its most extreme form -- killing. Such murders are carried out in the name of family 'honour'. It is evidence of just how culturally deep rooted the beliefs that perpetuate VAW are and also of how socially acceptable these modes of behaviour are, even though it involves killing a woman or women.

'Honour' killing is defined as murder, harm and or/threats committed by a family member against another member of the family, usually female, who is accused of behaviour that violates moral codes. They are carried out in retaliation to women's inappropriate behaviour or alleged inappropriate behaviour or disobedience. The murderers are usually male.

'Honour' crimes are based on the reasoning that men are superior to women; that a man has several inarguable rights over female members of his family, including controlling them severely; and that a family's honour is personified in a woman's sexuality; and that a woman's body represents the family's status and moral worth.

Cultural conditioning pushes women to shoulder an enormous amount of guilt and responsibility towards family honour. They are constantly uneasy that their actions may be construed as violating family codes and many women don't risk going out or speaking about violence as they wish to be seen as being in compliance with the social order.

Discounting the trauma of women assaulted by acid violence or burnt

Based on conservative estimates from the WHO, 100,000 people are burned every year in India. National statistics say 80 percent of victims are women and children. Survival rates remain low. Though unrecorded, a majority of women are burnt deliberately by spouses or family members or they set themselves on fire a desperate bid to put an end to their abuse. *(5)*

For those who make it, the fall-outs are physical complications like scar contracture, deformity and eventually loss of functions, as well as unaddressed emotional issues such as trauma, difficulty coping with disfigurement, and progressive exclusion from active participation in society. Physical and psycho-social rehabilitation services are often unavailable. In India, most doctors and nurses are not trained to treat VAW as a larger health threat. The situation is similar in other countries in the region.

Similarly, every year hundreds of women turn victims of acid attacks across Pakistan and Bangladesh. They are not only victims of abuse but of neglect and indifference as their trauma remains unrecognised and unaddressed. According to Acid Survivors Foundation Bangladesh, from 1999 to 2012, there were 3112 incidences of acid attacks. In India, over 56 acid attacks have been reported in 2012 and over 150 were reported in Pakistan.

In Bangladesh, a law was enacted to check acid sales, impose licensing requirements on manufacturers, importers and distributors. Since the passing of the bill, acid attacks in Bangladesh have declined. According to a report by the Avon Global Centre for Women and Justice, incidences of attacks have decreased by 15 to 20 percent every year following the enactment of the 2002 law.

Whereas according to the very same report, such incidences in India have risen. The Indian government (*as mentioned earlier in the preface*) also passed the Criminal Law Amendment Bill which recognises acid attacks as a separate offence. However, it is still yet to be assessed if these laws have discouraged acid violence. *(6)*

In Pakistan, it is estimated that up to 400 women fall victim to acid attacks perpetrated by their husbands or in-laws each year, but due to underreporting, only 1500 cases have been documented over the past 10 years. Attacks are often the fallout of DV and rooted in gender equality, manifested often through land disputes, suspicions of infidelity, family and 'honour' disputes and rivalry.

In 2010, Pakistan's parliament passed the Acid Control and Acid Crime Prevention Bill, which carries a punishment of life imprisonment. But the law is rarely enforced. The proposed Acid and Burns Crime Bill 2012 is a comprehensive legal mechanism that is intended to complement the criminalisation of acid throwing. *(7)*

In Nepal, there is no specific legislation in place to outlaw acid and burns violence. The introduction of a Domestic Violence Act in 2009 has guaranteed measures of legal redress for survivors of DV but is insufficient for the needs of acid and burns survivors wishing to secure justice.

Many South Asian countries have ratified the United Nations CEDAW and the General Recommendation 19 to the Convention (that characterise VAW as a form of discrimination, a human rights violation and an act that impairs the ability of women to realise other fundamental human rights).

But enforceability of the law, as discussed, remains a problem in all these countries. Even if it were not, this situation will not just be changed by state laws and international agreements that bind obligation of States to prevent all forms of VAW, to provide redress to victims and survivors of violence and to prosecute perpetrators.

Changing cultural dynamics: going past seeing gender violence as just a women's issue

For cultural change in perceptions and practices regarding VAW to happen, a beginning has to be made at the individual, household and community level. Men's and women's belief that VAW is a 'private' matter and culturally acceptable needs to be challenged and changed for the violence and discrimination to end. Until then, all women who face violence, and especially those who face harrowing acid and burns violence will continue to be traumatised, shamed, stigmatised and re-victimised on a daily and hourly basis. And, society will continue down the path of shifting blame to the victim. Instead of sympathy and support; there is only disdain and repulsion.

Moreover, restricting VAW to being a women's issue, one that is subaltern and peripheral, causes grave harm. While it equates a woman's identity with violence she encounters, it allows men to disentangle and free themselves from the discourse and allows their practices go unexamined. This, although VAW is centrally about them -- their need for control as a result of socialisation processes. This unmasks how dominant cultural systems strengthen themselves.

To eliminate this pervasive violence, we need to change these cultural norms; to place more emphasis on promoting healthy relationships between genders that are built on mutual respect and understanding. A paradigm shift can come with the leadership of men -- especially those who have the power to change power structures, and break the complicit silence that discount the role of women. They can act purposively to address such inequities. Members of the society should speak up when they witness violence and men should challenge men who subject women and girls to violence and violent situations.

Towards a culturally competent trauma-informed care

Interventions that challenge cultural and social norms supportive of VAW are often integrated with several approaches. The examples described here, however, are limited to those interventions, which exclusively or primarily aim to provide trauma-informed care for acid and burns violence survivors.

Social norms in the health care promotion ambit and in the arena of service delivery for women victims of violence sometimes carry forward the dominant culture's views on

VAW that re-victimise them all over again. As gender-based violence serves -- both by intention and effect -- to perpetuate male power and control, it is kept alive by a culture of silence and denial of the seriousness of the act of violence and its health consequences.

A trauma-informed approach that can allow for a re-direction of cultural and social norms supportive of VAW needs service providers to develop cultural competence.

What does cultural competence mean? It is defined as "a set of knowledge, attitude, behaviour and policies that interact to enable effective work in cross-cultural situations. Cultural competency requires a respect for differences both within and between groups of people." *(8)*

Laura S Brown's definition in her book *Cultural Competence in Trauma Therapy: Beyond the Flashbacks* captures the concept of cultural competence within a trauma-informed approach succinctly. She explains that trauma and its psychic aftereffects have a texture. The experience conveys meanings that derive from personal histories, cultural heritages, the social, political and spiritual contexts in which the painful events happen. A health service provider's ability to understand how a trauma survivors multiple identities and social contexts lend meaning to the experience of trauma and take forward the process of recovery within this context comprises the central factor of culturally competent training practice.

She further elaborates that the therapist/health provider needs to have the capacity to be self-aware in regards to her or his own identities and cultural norms, to be sensitive to the realities of human difference, and to possess an epistemology of difference that allows for creative responses to the ways in which the strengths and resiliencies inherent in identities inform, transform, and are also distorted by distress and dysfunction.

In her analysis, she says, a therapist should:

- know self and identities
- be attuned to the diversity and complexity of humanity
- not pretend to not see or notice differences
- understand difference as a multi-dimensional phenomenon not limited by visible characteristics such as phenotype, body morphology, or apparent sex
- engage with clients from the position of these awareness's, and derive a treatment plan from those understandings of the therapist-client dyad

With reference to this sourcebook and TICK, cultural competence is the ability of a health practitioner and service provider to juxtapose their understanding of the cultural beliefs, values, attitudes and traditions and the central role violence plays in the lives of acid and burns violence survivors against their individual traumatic experiences as well as their own internal representations of those realities to produce positive health and recovery outcomes for them. A culturally competent service provider develops skills that allow women to benefit from services in ways that fit the context of their lives. The provider consciously strives to achieve the ability to effectively work within the cultural context of a client.

Thus, to be culturally competent, a provider should acknowledge culture's profound effect on health outcomes on the affected women and should be willing to learn more about this powerful interaction. Trauma occurs against the backdrop of social and cultural realities and identities and if these factors are not understood or stand dismissed, it discounts the trauma as well and silences the women.

The culturally competent provider for acid violence and burns survivors should thus be able to:

- take into consideration a woman's background and culture
- make an accurate health assessment based on a woman's background and culture
- communicate the assessment to the affected woman
- devise treatment plans which respect those beliefs
- identify and gently replace through dialogue gender-biased myths and barriers that curb the effective provision of trauma-informed care
- underscore cultural values that foster prevention of VAW and help women draw on cultural values and beliefs that support their safety and dignity

On bias and cultural privilege

Health and service providers come with their own understanding of cultures and VAW. There is a danger of non-conscious biases regarding race and gender. A service provider needs to be self-aware of her or his own identities and cultural norms and to be sensitive to the realities of human difference in order to effectively address distress and dysfunction.

It is only when this reality is recognised that they move to truly perceive their cultural 'privilege', the 'invisible back pack' they carry being the dominant group. It is characterised by ease (as their group is the norm and defines what is real) and safety (their group is not targeted because of its characteristics). Privilege unscrutinised can impair the service provider's role as they would dismiss the women's distress as an over-reaction. Also, they should be aware that initially this is how they would appear to a survivor whose life is shaped by an absence of privileges. For cultural competence to be infused into their work, they must be conscious of how both seen and unseen aspects of their identities carry meanings. Therapists may attempt to deny social realities by telling themselves (and sometimes their clients) that they are inattentive to a client's sex, size, or accent; such statements, reflecting experiences of privilege, are experienced as invalidating to clients from target groups, who are rarely perceived, and treated, outside of the framework of those variables. It is these multiple identities that define them. *(9)*

A system's ability to be culturally competent

A set of congruent behaviours, attitudes and policies that cohere as a system, agency or among professionals and enable that system, agency or those professionals to work effectively contributes to a system's/ institution's, or agency's ability to become more culturally competent. *(10)*

Experts have identified the five essential elements to promote cultural competency within an institution to be:

1. Valuing diversity
2. Having the capacity for cultural self-assessment
3. Being conscious of the dynamics inherent when cultures interact
4. Having institutionalised culture knowledge
5. Having developed adaptations to service delivery reflecting an understanding of cultural diversity

These five elements should be manifested at every level of an organisation including policy making, administrative, and practice. Further these elements should be reflected in the attitudes, structures, policies and services of the organization. *(11)*

Providing culturally competent services within clinical and rehabilitative settings: taking stock of challenges

The challenges for service organisations and providers to ensure 'health with care' -- that is at the heart of trauma-informed care -- to women who have suffered acid violence and burns, against a backdrop of cultural values that legitimise violence are to:

- Create a culturally-sensitive and welcoming environment for women survivors
- Premise the administering of trauma-informed care on the cultural framings of the society and its beliefs on VAW to better understand/address socio-cultural contexts and also validate the experiences of the woman's violence
- Pay heed to women's cultural beliefs/practices/sensitivities/dietary restrictions while questioning, dialoguing and interacting with them about their trauma history
- Be accommodative of women from various cultural groups and overcoming provider's own cultural biases and perceptions of VAW and women survivors of violence
- Ensure a respectful service ethos; making sure that customs, behaviours, gestures and terminology used by providers are mindful of the dignity of all cultures
- Ensure equality in the service environment to banish feelings of providers being the 'insiders' and the survivors being 'outsiders' and providers being the 'deciders' and the survivors being the 'followers'
- Turn the gender-hierarchy structure on its head by placing the woman survivor at the core of every intervention: her needs, safety, autonomy coming first
- Understand how women are affected by and cope with trauma and victimisation -– looking at it from their perspective, especially as trauma causes them to live behind multiple layers of defense mechanisms

- Provide a safe environment for the woman to discuss their painful experience. (It is important to remember that in their condition the women's safety concerns may vary daily. A small example is keeping a physical distance with her that she is comfortable with and a larger example is to keep her safe from her assaulter who may visit and threaten her or ensure she is not re-traumatised by act or gesture at the institution)
- Minimise power dynamics by restoring a sense of power to women
- Identify cultural values that foster prevention of VAW and help women draw on cultural values and beliefs that support their safety and dignity
- Provide women space and opportunity to be heard
- Foster their self-esteem
- Validate their experiences of violence and trauma and then engage with them in a sustained manner to help them reject cultural legitimacy of abuse
- Use the lens of gender and human rights to address these issues at every stage and be mindful of the dignity and autonomy of each woman
- Make women's choices and control over her recovery a non-negotiable part of trauma-informed care, as a clear departure from a system that discounts her voice
- Ensure that women are not re-victimised with violence, or attitudes and acts that deepen her anguish and stigmatization
- Understand her need to keep in touch with her abuser – this could be due to a number of reasons (access to children, financial dependence or her only contact with the outside world)
- Create a woman-conducive environment to administer trauma-informed care for women acid violence and burns victims, both at the hospitals and recovery centres
- Ensure an unbroken continuum of care for them from the stage of admission to hospitals to the stage of affirmative recovery and healing
- Harmonise medical (physical) and non-medical aspects of trauma-informed care
- Maintain women's mental care and ensuring 'transition planning' before they are re-integrated into society structures
- Develop capacity for gender-sensitive, trauma-informed care (of health staff/service providers and every person who interact with the survivor at length -- be it the family members or the community or faith-based organisations) through sensitisation, supervision and training
- Identify and replace gender-biased myths and barriers that curb the effective provision of trauma-informed care through advocacy
- Understand and correct own prejudices through behaviour change communications efforts
- Suggest alternative methods of care provision so as to overcome gender-bias hurdles

- Choose the appropriate models of care depending on the facility or the organisation's capacity and potential
- Pay emphatic attention to women survivor's confidentiality issues: with service providers clearly detailing the extent and limits of their confidentiality (the survivor should be confident of discussing matters with the provider without concerns of charges being filed, if she is not willing to do it)
- Understand and address issues related to DV that casts a deep and long shadow in women's lives
- Be sensitive to issues relating to their children: separation, custody. It is very painful for women in hospitals and recovery centres to be away from their children from long stretches of time
- Enlist community participation and support to allow for a re-integration of the survivors into the mainstream
- Foster connections with culture-specific groups to aid in the rehabilitation process
- Empower women by enhancing the individual strengths of survivors and fostering their capacities to make their own choices
- Empower without overwhelming – it is important for providers to recognise that these women have had decisions taken for them most of their lives. It would be difficult for them to go from a restrictive environment to one where a number of choices need to be made. So the process of empowerment must be gradual *(12)*

We present below a sample of cultural competence self-test that service providers and organisations could use to check whether they are culturally sensitive to diverse populations. We have taken a leaf from an exercise developed by Tawara D. Goode, Georgetown University Child Development Center-UAP (*available online: http://nccc.georgetown.edu/documents/checklistsids.html*) to help you hone your skills. (This could be fine-tuned/adapted with acknowledgement to address issues in your own setup.)

Cultural competence self-test

The following self-assessment can assist physicians in identifying areas in which they might improve the quality of their services to culturally diverse populations.

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices that foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programme.

Promoting cultural and linguistic competency

Self-assessment checklist for personnel providing primary health care services

Directions: Please enter A, B or C for each item listed below.

A = Things I do frequently

B = Things I do occasionally

C = Things I do rarely or never

1. ___ I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my programme or agency.
2. ___ I ensure that magazines, brochures and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my programme or agency.
3. ___ When using videos, films or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my programme or agency.
4. ___ I ensure that printed information disseminated by my agency or programme takes into account the average literacy levels of individuals and families receiving services.

1. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:

   ____ Limitations in English proficiency are in no way a reflection of their level of intellectual functioning.

   ____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

   ____ They may or may not be literate in their language of origin or English.

2. ____ I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

3. ____ For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

4. ____ I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

5. ____ When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.

6. ____ I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

Values and attitudes

1. ___ I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

2. ___ I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with individuals and families served by my programme or agency.

3. ___ I intervene in an appropriate manner when I observe other staff or clients within my programme or agency engaging in behaviours that show cultural insensitivity, racial biases and prejudice.

4. ___ I recognise and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

5. ___ I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

6. ___ I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (e.g., who makes major decisions for the family).

7. ___ I understand that age and life-cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

8. ___ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

9. ___ I recognise that the meaning or value of medical treatment and health education may vary greatly among cultures.

10. ___ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.

11. ___ I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

12. ___ I recognise and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder or special health care needs.

13. ___ I understand that grief and bereavement are influenced by culture.

14. ___ I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my programme or agency.

15. ___ Before visiting or providing services in the home setting, I seek information on acceptable behaviours, courtesies, customs and expectations that are unique to the culturally and ethnically diverse groups served by my programme or agency.

16. ___ I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my programme or agency.

17. ___ I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my programme or agency.

18. ___ I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or programme.

19. ___ I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

20. ___ I advocate for the review of my programme or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

CHAPTER THREE

ARRIVING AT A TRAUMA-INFORMED APPROACH, CARE AND TRAUMA-SPECIFIC SERVICES FOR WOMEN AFFECTED BY ACID VIOLENCE AND BURNS

The core of a trauma-informed approach

When individual personality characteristics account for little in the face of an overwhelming trauma, a trauma-informed approach to care becomes essential. This approach is based on the recognition that many behaviours and responses expressed by survivors are directly related to traumatic experiences, in the words of the Center for Mental Health Services, National Centre for Trauma-Informed Care, Maryland, United States.

> Quite simply put, it is an approach that engages with people who have histories of trauma and acknowledges the centrality of trauma in their lives.

According to Harris, M, and Fallot, R in their book *Using Trauma Theory to Design Service Systems, New Directions for Mental Health Services*, the service systems in facilities that function within a trauma-informed approach framework, thus, reconsider and reconfigure care and services based on the basic understanding of the role violence plays in the lives of women acid violence and burns survivors; accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will avoid inadvertent re-traumatisation; and will facilitate consumer participation in treatment. It also requires closely knit collaborative relationships with other public service systems and the local network of private practitioners with particular clinical expertise in trauma and trauma-recovery. *(1)*

Another key issue is that the trauma-informed approach emphasises understanding the whole individual and appreciates the context in which that person is living their life.

There is a conscious shift towards the individual and away from some particular and limited aspect of their functioning. It also underlines the fact that their life is understandable and that behaviours make sense when they are understood as part of a whole picture. *(2)*

> Rather than asking, "How do I understand this problem or this symptom?" the service provider instead asks, "How do I understand this person?"

"Traditional" vs. "Trauma-Informed Approach" (Harris and Fallot, 2001)

	"Traditional"	"Trauma-Informed"
Understanding trauma	Trauma is a single event the response to which is defined/diagnosed as PTSD. Impact is predictable.	Trauma makes the survivor question even the most fundamental assumptions about the world – in the wake of trauma he or she constructs a new theory of how the world works and how people behave. Trauma is viewed not as a single discrete event but rather as a defining and organising experience that forms the core of an individual's identity. Practitioners assume that trauma changes the rules of the game.
Understanding the consumer survivor	The consumer and her or his problems are synonymous. The problem has a life of its own, independent of context. There is a blurring of the distinction between a problem and a symptom. Allocation of responsibility on the consumer is either too great or too little.	Emphasis is on understanding the whole individual and appreciating the context in which she lives her life. ("How do I understand this person?" rather than "How do I understand this problem?"). Trauma-related symptoms arise as attempts to cope with intolerable circumstances and those symptoms emerge in a context of abuse. Consumer-survivor evaluates her responsibility for change – not a passive victim.
Understanding services	In many cases, the only viable goal is stabilisation (in most efficient manner possible) – once symptoms have been managed, treatment ends. Services are crisis-driven. System strives to minimise risk *to itself.* Services are content specific, time limited, and outcome focused.	The goal is to return a sense of control and autonomy to the consumer-survivor. Emphasis is on skill-building and only secondarily on symptom management. Service time limits are set in collaboration with the consumer-survivor. Services are strengths-based. There is a focus on prevention of further trauma within the client's system. Weighs risks to consumers along with risks to the organisation.
Understanding the service relationship	Consumer is passive recipient of services. The provider is accorded more status and power within the relationship. Consumers often find themselves frightened and cautious. Trust is assumed.	Core of the service relationship is a genuine collaboration. Trust must be earned. Provider and consumer both bring strengths to the relationship.

In the context of our sourcebook and TICK, service providers within a trauma-informed approach framework for women acid violence and burns survivors, should thus:

- use their understanding of trauma as an integral and inseparable part of their programme
- reshape policies and procedures that may re-victimise or re-traumatise the women acid violence and burns survivors
- involve the women acid violence and burns survivors in designing and evaluating the services
- place priority on women acid violence and burns survivors safety, choice and control and make her a powerful force for her own recovery

Integrating a trauma-informed approach into a facility

Creating a culture of trauma-informed care within a facility depends on its ability to develop a skilled workforce that has both the drive and the desire necessary to create this environment. Based on the principles of recovery and the non-negotiable attributes of a trauma-informed system of care, workforce development should be adequately resourced, fully supported by leadership, and understood to be an on-going and multi-dimensional effort.

Cultural shifts are arduous processes that take time, focus, and perseverance. The leadership should be prepared to deal with slow progress and with periods of downswings and delays.

Implementation must be thought through very carefully. Planning about building and maintaining momentum must be meticulous. The procedure involved must be fleshed out. Who will be in charge of what must be factored in with timelines. What if someone doesn't deliver within the time frames? Will supervisors be held accountable? Many such questions will arise and need to be answered before implementation.

One crucial element needed is supervision. Good supervision means reporting, reflection, consideration of multiple perspectives and creating models to handle several scenarios and future encounters.

Six elements that fuse a trauma-informed approach into a health care facility

For a trauma-informed approach to become integral to a health care facility, **six elements have been considered vital** by the State of Texas Alternatives to Restraint and Seclusion (STARS) toolkit called *Creating a Culture of Care (2011)* *(3)* This is hugely adaptable to facilities for women acid violence and burns survivors.

The six elements are:

1. **SWOT analysis:** An opportunity statement based on an analysis of the organisations' strengths, weaknesses, opportunities, and threats (SWOT) should be the starting point of this culture change of instilling a trauma-informed approach within facilities.

1. **Vision, values, and mission**: The facility's goals should run parallel with trauma-informed care. This would mean an altered working environment for employees and the survivors, calm surroundings to reduce conflict, restraint and seclusion, involvement of the women survivors and all levels of staff and leadership at every level, and the inclusion of resources to achieve change (peer support specialists, comfort rooms, physical and psychological therapists). One could also identify "champions" to be involved in keeping the culture change momentum. These are people who exhibit attitudes, qualities, and skills that will be introduced and reinforced in training materials. They are also leaders among their peers who have influence over workplace culture. Trainers should be selected from the population of "champions".

2. **Policies and procedures**: They should be re-oriented to: address trauma-informed care; lay emphasis on training and advocacy (all the units should be sensitised to the trauma-informed care philosophy, approach, and mechanisms, including restraint-related policies and the existence of a review committee); ensure data collection (that enables monitoring of key variables a plan for person-centered activities and programming to ensure opportunities exist for person-centered); and enable effective treatment activities within the unit and the community. Training cannot be a one-time event. Refresher trainings as well as non-classroom exposure to information and supports are vital. And, there is need to train everyone at once. Failing to train everyone within a short time period risks return to "business as usual" as the lure of the old ways is almost always stronger than initiative to change.

3. **Incident review:** There is need to implement a 24-hour on-site response to observe, analyze, and debrief all restraint incidents (where the survivors have to be physically restrained when violent or aggressive).

4. **Workforce development**: The development of an organisational training plan and curriculum in advance as the basis of a new vision is a must. Trauma-informed assessment tools to critically evaluate progress and monitor pitfalls needs to be in place.

5. **Communications:** Communicating about the altered way of functioning is a must. The vision, values, and mission could be made visible through a medley of means – posters, buntings, stickers, caps, signs on gates, letterhead, name badges, etc. A monthly newsletter that includes recognition and reference to principles of trauma-informed practices could be a part of this initiative.

Valuable tips to ensure smooth functioning of trauma-informed facilities

- all staff and volunteers must be trained simultaneously on what it means to be trauma-informed
- trainings should be refined through supervision
- mentoring and working together as a team to reinforce learning is a must
- incorporating feedbacks of staff and women survivors into programmes is necessary
- weaving in trauma-informed care and practices for women acid violence and burns survivors at all levels must be consistent and continuous
- resource materials on trauma-informed care must be readily available to staff and volunteers
- documenting practices and innovative models can be built on

A spotlight on select models of systemic trauma-informed approaches

The Sanctuary Model: This is a cultural re-haul intervention at the level of an organisation that focuses on converting the setup to be trauma-informed. Both staff and women survivors are enabled, through this model, to become decision makers and work together to create a democratic and non-violent culture where everyone is safe. Initiated in the mental health sector, the model is today universally regarded as "a template for changing social service delivery programmes". This model is not about intervention techniques. Rather, it incorporates the underlined concepts into organisational functioning. They are the cultures of: non-violence (helping to build safety skills), emotional intelligence (helping to teach/affect management skills), inquiry and social learning (helping to build cognitive skills), shared governance (helping to create civic skills of self-control, self-discipline and administration of health authority), open communication (helping to overcome barriers to healthy communication), social responsibility (helping to rebuild social connection skills) and growth and change (helping to restore hope, meaning and purpose).

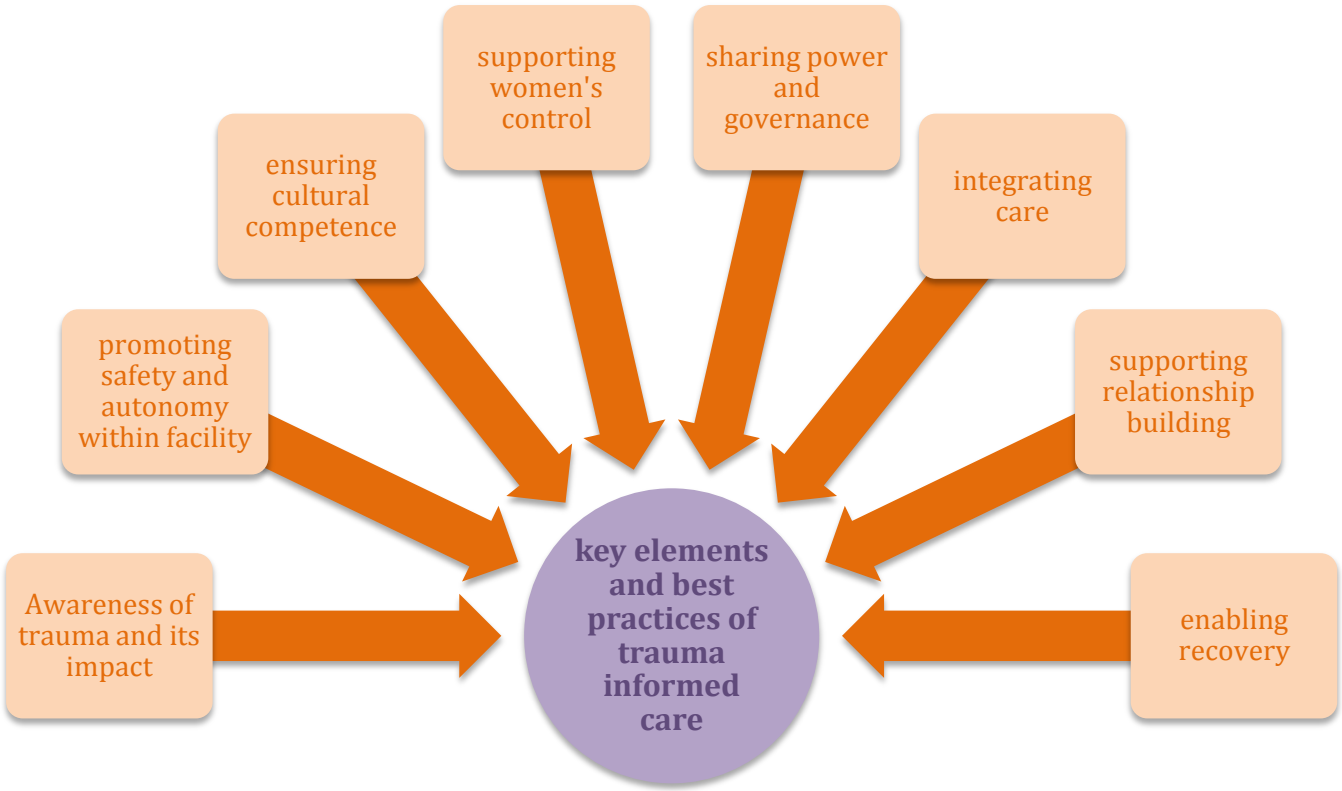
Client Involvement in Service Delivery: This model necessitates the provision of comprehensive information to women survivors about their service options and allow them to direct their own treatment. It also attempts leadership training so that women can inform programme development.

Principles and best practices of trauma-informed care

Trauma-informed care is a **strengths-based framework** grounded on an understanding and responsiveness to the impact of trauma. It emphasises physical, psychological and emotional safety of both providers and survivors to rebuild a sense of control and empowerment. *(4)*

It makes sense to repeat the oft repeated refrain here that trauma-informed services approach people from the standpoint of the question: "*What has happened to you*?" rather than "*What is wrong with you?".*

The **eight key elements and best practices of trauma-informed care** for women acid violence and burns survivors that service providers should understand and work on are:



- **Awareness of trauma and its impact on women who have suffered acid violence and burns**

  - the woman survivor's perspective comes first. Her trauma and reactions to the violence, should inform all the actions of service providers and their services should be 'survivor-centered'. This is because trauma affects a woman's core: her emotions, identity, relationships, expectations of herself, and others and her worldview
  - the underlying motif is: each woman survivor has a unique and valuable perspective which must be respected and built on to enable her to recover

- it must be understood that trauma has its de-humanising effects and can set in motion a range of physical and emotional symptoms, these symptoms must be viewed as adaptations to it
- the pain that women suffer after an acid or burns attack is immense; anxiety and terror sets in immediately after and will not subside soon
- emotional distress occurs as a result of the dramatic alterations in the way a woman looks and her inability to deal with public reactions and perceptions of these alterations – people stare, avoid them or ask uncomfortable questions
- it is, hence, critical to sidestep acts that could re-traumatise women and cause them to disengage from a programme
- providers need to respond with compassion and encouragement when women are attempting to deal with feelings that are overwhelming
- information of what they are undergoing; what to expect in the future must be provided so that the women are aware that what they are facing is normal and there are no surprises in the future
- they need to support women in understanding the connections between their experience of trauma and their present strategies for coping
- early warning signs of re-occurrence of trauma could be – restlessness, agitation, pacing, and shortness of breath, sensation of tightness or sweating. It might develop into clenching of teeth, wringing hands, bouncing legs, shaking, crying, giggling, or breathing hard before it develops into re-occurrence of trauma
- providers can help them contain it and enable the learning of coping strategies, emotional management, healing and empowerment
- it is essential to treat the whole 'individual' rather than merely reacting to behaviours
- an understanding of trauma and its impacts can be enabled by trauma-informed policies and training that acknowledge the women's experience of trauma, foster an understanding trauma and its impacts, and detail trauma-informed care practices
- on-going trauma-related training and support is critical. Appropriate support activities include regular supervision and team meetings

- **Promoting safety and autonomy within the facility**
  - women who have been through trauma have many apprehensions while seeking help or entering a health facility
  - women and families who have experienced trauma require spaces in which they feel physically and emotionally safe

- the woman survivor is the best expert of her experience – she knows what makes her safe. It is important to involve her in her safety planning
- her idea of safety may vary from time to time- -- it is important to accommodate this
- safety should always be defined from the women survivors' point of view. This becomes complicated as women seeking safety belong to different ages, cultures and have different views of safety, yet each one's autonomy must be respected
- as self-determination is based on the capacity to choose what action to take rather than complying to action chosen for us, women must be allowed to determine modes and methods of their safety
- women must, hence, be extended personal control to choose and give informed consent: so women set the agenda for what they want to accomplish and how
- women's identified measures need to be consistently and respectfully provided
- providers need to remember that way they say and do matters in this context as it directly connects with a woman's sense of safety
- a warm, welcoming, soothing environment is a must with private and public spaces for women to interact and withdraw
- registration must be an unhurried process and the women must be allowed to slow down or stop if she is uncomfortable with divulging personal details
- many women forget personal details; it is common symptom of trauma or she may not remember events in sequential details so it is important to be patient
- rules and information of what to expect from the facility and staff must be explained gently but clearly to the women to avoid surprises
- it is important to adapt screening and intake procedure in a manner that women are not required to disclose trauma before they are ready and willing to discuss it
- many women will not remember the rules discussed or break them to cope with their stay –- providers should be aware of this
- many women who suffer trauma will not sit with their back to the doorway – provisions must be made for a clear exit
- a provider's calm personality helps the women feel less traumatised and sets a tone of mutual respect
- it is important to understand boundaries -- physical and emotional -- and only make connections at the level the women are comfortable with. If a woman is not comfortable about being touched or speaking about certain issues, it is important to show restraint as it contributes to her sense of safety

- physical safety can be ensured by adhering by the following precautions – avoid forcing too much eye contact with her; being aware of proximity to her; avoid asking her too many questions; offer frequent breaks; draw upon her resiliency; and asking before attempting to touch or console her
- emotional safety can be ensured by the correct choice of language, tone and behaviour
- when planning for emotional safety it is vital to pay attention to triggers like -- women seated or staying too close to each other; their space invaded; not being listened to; loneliness; fear of darkness; being teased or taunted; too much yelling at the facility; being touched and feeling isolated, among other symptoms
- strategies to provide emotional calm include encouraging them to converse, sing, read a book, take a shower, lie down, listen to music, exercise, walk or speak to a therapist
- there might also be extreme anxiety among women in being separated from their children for which it is important to allow women to devise their own emotional safety plan

- **Ensuring cultural competence**
  - culture plays an important role in how victims/survivors of trauma perceive, manage and express their traumatic life experience/s and identify the supports and interventions that are most effective
  - culturally competent services are respectful of, and specific to, cultural backgrounds
  - culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the women, families and communities they support. They are alert to the
  - legitimacy of inter-cultural difference and able to interact effectively with different
  - cultural groups
  - a beginning can be made by exploring the women's meaning of violence and harm within her family and culture
  - it is important to respect a woman's cultural norms about domestic violence and help her reframe her experience within that framework
  - it must be kept in mind that recalling the trauma is very painful and impacts the women critically
  - alerting her to norms that are supportive of women and the ones she can draw on to build her resilience can follow
  - a woman's privacy and confidentiality with respect to the details she divulges on domestic violence must be protected

- a provider must be cautious of his/her own cultural biases and not let it cloud her healing and recovery process

- **Supporting women's control**
  - women survivors of trauma should be aided to regain a sense of control over their daily lives and build competencies to strengthen their sense of autonomy and eventually recovery
  - they should be helped to regulate stress responses and emotions – at their pace – as well as build skills for self-regulation and emotion modification
  - they should be allowed to tell their stories when they feel it's the right time
  - it is important to respect her voice, choice and comfort level
  - it would be good to suggest she keep a diary to chart her emotions, responses and progress
  - a non-judgmental attitude creates an opportunity for dialogue with the woman survivor
  - it is unrealistic to expect instant trust; yet the provider must do everything in his/her power to be trustworthy
  - providers need respect women's defenses; it is important not to take them away before they have the strength to protect themselves in healthier ways
  - women need to be asked what will help them feel comfortable/better and how best they can be helped
  - tools to help her practice her new self-regulation must be extended for her to practice on them
  - service systems should be set up to keep women (and their caregivers) well informed about all aspects of their treatment, with the woman having ample opportunities to make daily decisions and actively participate in the healing process

- **Sharing power and governance**
  - power and decision making should be equalised across all levels of the organisation, be it in everyday decisions or the creation of policies and procedures
  - this decreases hierarchy and builds openness, transparency, trust and inclusiveness
  - in trauma-informed care, hospitality is defined as equalising power, especially in the context of someone who is not known to the one inviting
  - empathic relationships must be cultivated to draw out the women's voices
  - collaborative ways of determining needs and plans and handling distress must be ensured

- such inclusiveness carries the idea of being welcoming and thoughtful to those not usually served
- accessibility is an important ingredient and the provider must be available at all times
- practical means of sharing power and governance include recruiting clients to the board and involving them in the design and evaluation of programme and practices
- service procedures, practices and settings must be constantly reviewed to ensure a trauma-informed culture of empowerment
- the final measure of sharing power and governance – a sign that it has been accomplished – is when a woman steers her own way to recovery

- **Integrating care**
  - integrating care involves bringing together all the services and supports needed to assist individuals, families and communities to enhance their physical, emotional, social, spiritual and cultural wellbeing

- **Supporting relationship building**
  - safe, authentic and positive relationships assist healing and recovery
  - it is important for providers to communicate care and concern to the women survivors
  - the providers need to listen to a survivor's story actively so that her distinct experience is understood
  - it is important to understand what a woman is saying to the provider and not saying and how she is saying it
  - the questions asked must be in the language that the women understands; and not be too intrusive or abrupt. Dialoguing is a sounder approach
  - validating a woman's experience offers her a support system, that have been denied so far by other structures and caused her trauma
  - the focus should be on informational exchange interspersed with social talk; and on interactional rapport building
  - by recounting the horrors of DV and the incident of trauma, women are able to come to the situation where they are at. They are able to overcome numbing or the other negative combat mechanisms. This new frame begins to make her feel more in control and empowered
  - each women will heal in her own way so services must be personalised and flexible
  - it is vital to ask a women how she is feeling at different points of stay

- trauma-informed services facilitate such relationships; and takes it a step further to enable peer-to-peer support
- many survivors may wish to keep in touch with their partners though they have inflicted such serious violence on them. It is important for the providers to realise that their feelings are real. Sometimes, there is also confusion. Providers need help her deal with confusion and grieving by accepting her wide range of emotions
- relationships need also be built with the families of women and their communities if healing and reintegration is to be complete
- it is important to sensitise them to trauma-informed approaches as well so that once she is out of the facility her recovery continuum is maintained
- negative community attitudes can derail and imperil a woman's recovery

- **Enabling recovery**
  - recovery is the main goal of trauma-informed services
  - the central message is: recovery is possible and the main effort is to instill hope amongst women survivors by fostering a positive vision of her future
  - recovery does not necessarily mean complete freedom from post-traumatic issues. However, it does mean regaining the understanding, support, and practical assistance so that trauma survivors can find within themselves a source of hope and renewal
  - trauma-informed services empower individuals, families and communities to take
  - control of their own healing and recovery
  - while women are helped by the providers their own efforts to heal themselves are far more potent
  - peer support for women in healing is crucial. Shared experiences and mutual exchange of stories among women survivors can help them understand they are not alone and climb over some of their pain
  - service providers need to adopt a strengths-based approach, which focuses on the capabilities that these women bring to a problem or issue
  - strengths-based approaches rely on women's resilience (courage, values and beliefs); other strengths (inherited, learned and chosen); skills (natural talents, learned and practiced skills); outside resources (people, information, organisations)
  - the stages of their recovery follows a pattern (Judith Herman, Trauma and Recovery) –- establishing safety (securing safety, stabilising symptoms, fostering self-care); remembrance and mourning (reconstructing the trauma, transforming the traumatic memory), reconnection (reconciliation with self) and resolving the trauma

- it is vital that women survivors be assisted through these stages
- post-facility resources and referrals must be provided
- families and communities need to then be briefed on how to support and help women survivors re-adjust to real world and pick up threads to reintegrate *(5)*

Trauma-specific services and care for women acid violence and burns survivors

Trauma-specific services consists of specific actions taken to deal with the consequences of trauma among women to facilitate their healing. These actions need to focus on developing an understanding and appropriate responses to the complex psychobiological and social reactions to trauma and less on recounting and categorising the trauma events. *(6)*

There is no single way to provide trauma-specific care. It is normally done through consultation with trauma experts and feedback from survivors. Strategies used are those which suits the needs of the survivors and they are offered in trauma-informed settings. The techniques are largely ones that ground and help women cope with dissociative symptoms and other behavioural problems. Attempts are made to desensitise in some cases so that the painful images becomes more tolerable and skills of modulation are imparted to control powerful emotions. Culture-specific models that involve the survivors and their families and communities have been developed by many to help heal.

Trauma-specific services include: individual or group counselling; therapeutic approaches; using spirituality and methods like story, art, sand play, theatre, yarning and dance to heal.

- ***Kinds of support groups***

There are many types of support groups that can be organised to help women. A **process-oriented group** flows with the topic and the energy of the group. A **psycho-educational group** is one that has a determined topic and focusses on educating survivors and providing them with information. Participants can pitch in or it can be conducted solely by a facilitator.

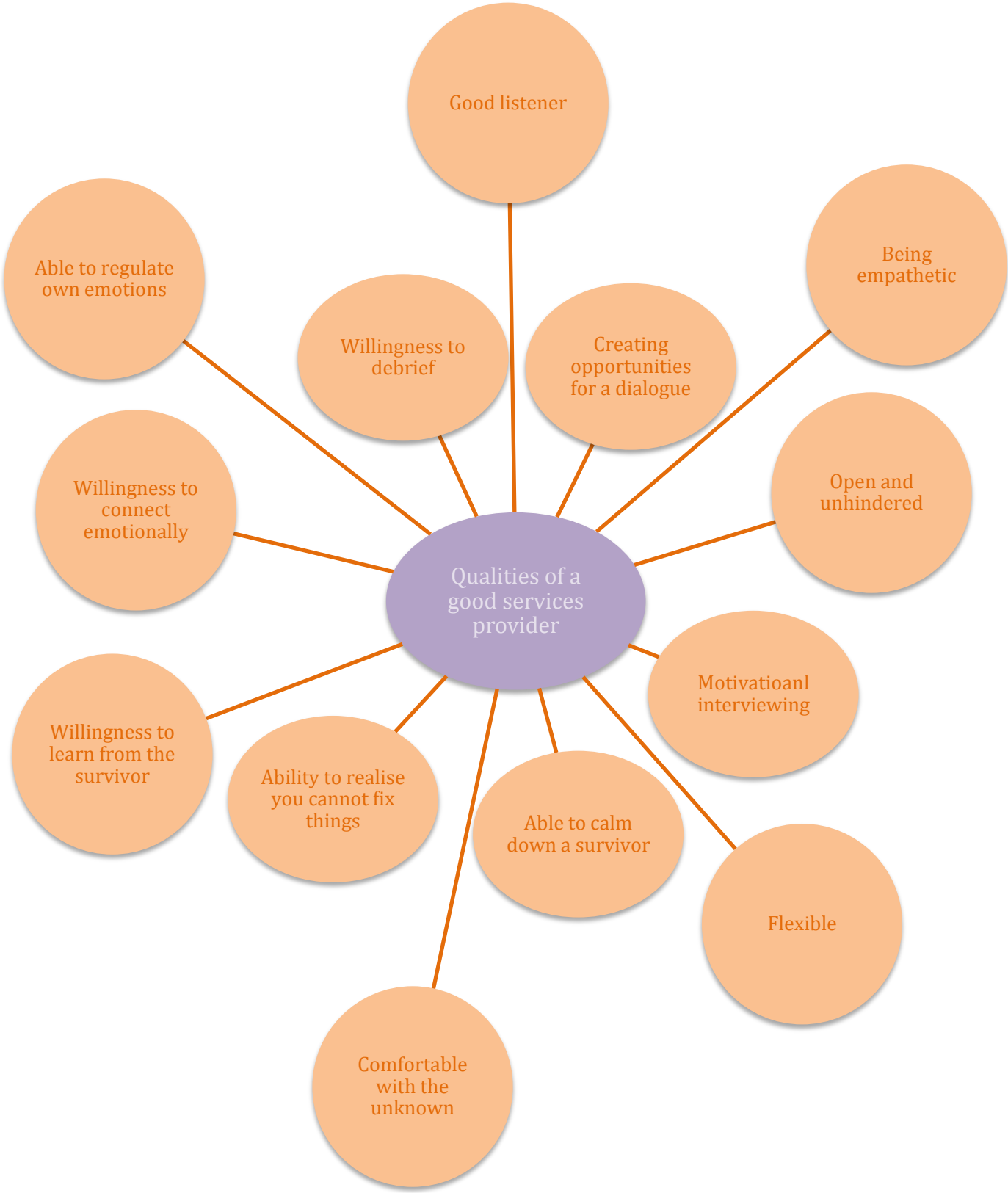
The groups can be taken forward by setting the stage wherein the purpose is acknowledged; the participants are greeted; their feeling inquired into to denote their presence and importance for the group. Feelings must be incorporated to enhance involvement. Establishing guidelines and receiving inputs from survivors allows the group to become vibrant. Guidelines are common values that everyone agrees upon. The discussions should be orderly but it is possible that it may be interrupted by some who are restless or overwhelmed. This should be addressed with kindness and sensitivity. The strengths of the group must be focused on with a keen awareness of safety, if circumstances go out of control. Handouts and pictorial posters can be used for effective communication. A calming environment is possible with aromatherapy.

- ***Support groups: themes***

Such support groups and evidence-based models for the purpose of women who have suffered acid violence and burns could focus on: **coping with DV; parenting; mental health; and overcoming physical challenges** (as a sense of physical and mental well-being and control over it is very important for women who have suffered abuse). An **Eye Movement De-sensitisation** and **Reprocessing Therapy (EMDR)** can be taken forward which involves recalling traumatic memories while focusing on personal strengths and engaging in distracting behaviours such as lateral eye movements. **Cognitive behavioral therapy (CBT)** is an effective therapeutic approach in behavioral health. It shows people how to understand and improve the connections between their thoughts, emotions, and behaviours. It is effective in treating severe depression and anxiety and has successfully helped people with body image distress. A burn injury can put stress on the entire family and change the family dynamics. Sometimes burn survivors and their families benefit from **family therapy** (counseling). A session on **coping skills** would be helpful. Some people react to seeing or meeting someone with burn or acid scars for the first time by opening staring, moving away or asking personal questions. Acid and burns survivors can learn coping skills to feel more confident and social skills to defuse these uncomfortable situations and make them less awkward.

- ***Running models starting with one theme, moving to another***

There could be **running modules** based on **containment** (where the goal is to help women describe levels of consciousness and understand the different parts of memory to increase self-awareness); **grounding** (where the idea is to identify grounding techniques); **tolerating distress** (where women distinguish negative aspects of being unable to tolerate distress and verbalise benefits to learning how to tolerate distress); **self-soothing** (women will identify methods of self-soothing and begin to look at healthy ways of coping with harmful ways); **boundaries and safety** (women begin to develop a sense of how much or how little control they have over what happens to their bodies and begin to understand how to set interpersonal limits); **trust and intimacy** (women will be able to identify at least one barrier that inhibits their ability to trust other people and work on ways to remedy this); **life story** (women share their stories and understand how trauma has affected them) and **closing ritual** (women experience healthy closure and learn to detach from the facility and its members to begin a new life; yet taking away important lessons from the facility and members). *(7)*


Qualities of a good services provider
Good listener
Able to regulate own emotions
Willingness to debrief
Creating opportunities for a dialogue
Being empathetic
Willingness to connect emotionally
Open and unhindered
Motivatioanl interviewing
Willingness to learn from the survivor
Ability to realise you cannot fix things
Able to calm down a survivor
Flexible
Comfortable with the unknown

Qualities service providers need to work with women acid violence and burns survivors

Working with trauma survivors is extremely difficult, strenuous and can drain a service provider emotionally. The skills and characteristics outlined below are essential for them to cultivate strong relationships with trauma survivors. We have adapted this section with the help of a medley of toolkits. *(8)*

- ***Good listener***

Providers must be willing to actively listen to trauma survivors by focusing intently on what they are saying and showing utmost interest. This will encourage the survivor to open up and share information and feelings that will help in healing and recovery. Leaning forward a bit, nodding, making eye contact and body proximity helps, provided the women are comfortable with these. The providers must be willing to listen to the very disturbing details the women may want to share.

- ***Creating opportunities for a dialogue***

Engaging the women survivors with a non-judgmental attitude will create an opportunity for dialogue and enable the women to come to grips with their situation. To promote conversation, a service provider can use paraphrasing as a way to validate the women's experience and encouraging her to carry the conversation further. Reflection is another technique. This repeats what the women are saying. "In other words you feel ……..", "It seems you feel …" Questioning can lead to more conversations and so could mild and gentle challenges.

- ***Being empathetic***

Survivors need support and understanding. Providers need to open up channels of communication and emanate compassion and empathy. For example, "I get the sense that you are feeling sad and hurt by what happened". This statement does not come through as a judgment, but rather as the service provider trying to figure out where these thoughts are emerging from. Also, it is important to help the women handle overwhelming feelings. In these situations, it is important to remember that the intention is treat the whole person and not just react to behaviours or their feelings.

- ***Open and unhindered communication***

Providers need to be able to talk openly about issues, feelings and experiences related to the trauma with the affected women. They need to at the same time give the woman time and space to disclose these things. Sometimes it is easy. Most times it is not. If they are not comfortable discussing certain things or not willing to go into details then the service provider needs to know how and when to back away. It is also important that the service provider not communicate his/her bias. Doing so might intrude upon her sense of guilt, shame or hurt. She will then withdraw into silence that would be extremely harmful.

- ***Motivational interviewing***

This is a technical term that describes a particular type of interviewing that is empathetic; avoids hard confrontations; accommodates resistance and supports autonomy and self-efficacy of survivors.

- ***Flexible***

Providers must be flexible when working with trauma survivors in order to demonstrate care and concern. This can include a willingness to change normal routines or procedures to accommodate some trauma survivor's difficulties and behaviour.

- ***Able to calm down a survivor***

The provider must be able to able to calm an agitated women through verbal assurances and sensory interventions (comfort rooms, bringing her belongings, art therapy, journal writing and social support). A provider needs to assuage a women's fears, guilt and self-blame, anxiety, anger and resentment, sadness and compulsive repetition.

- ***Comfortable with the unknown***

An acid violence victim or burns survivor's experience of trauma may not be something with which the provider can directly relate. This may induce discomfort and uncertainty. Staying open to different possibilities and trusting the survivor's needs will allow the service provider to open up horizons.

- ***Ability to realise you cannot fix things***

The provider cannot fix the women's survivors problems. S/he can at best be empathetic and validate a woman's experience. This by itself can go a long way to helping her.

- ***Willingness to learn from the survivor***

Providers are experts. However, when providers position themselves thus, it makes the women feel like outsiders. It is important to democratise the relationship, see them as equal and then move one step ahead and be willing to learn from the women – as it is their survival and recovery that are the provider's priority.

- ***Willingness to connect emotionally with women trauma survivors***

In order to make a strong connection with trauma survivors, providers must make a connection to the women's emotion and step into her world.

- ***Able to regulate own emotions***

Given the intense emotions that can emerge from discussions with women survivors, providers need to be able to regulate these emotions and stay grounded during and after work with survivors. Some tips include: calming breathing techniques; drinking water periodically and being aware of one's own memory triggers.

- ***Willingness to debrief***

If the provider is to be successful in processing the experience, it is important that they be able to debrief with co-workers about their experiences with trauma survivors. It is normal to be left with difficult feelings after conversations about trauma, or its impact. Service providers would be more helpful when they can share with others their feelings and thoughts.

Handling vicarious trauma

Listening to the severity of the women's experiences and their graphic accounts is highly stressful. It can impact the service provider by leaving him/her exposed to direct and vicarious sources of traumatic stress.

Vicarious trauma is defined as a metamorphosis in the helper's inner sense of identity and existence that stems from utilising controlled empathy when listening to clients' trauma-content narratives. In other words, vicarious trauma is what happens to a service provider's neurological (or cognitive), physical, psychological, emotional and spiritual health when they listen about traumatic situations while having to control their emotions.

Terms like 'compassion fatigue' and 'burn out' are used to explain the exhaustion and de-sensitisation that service provides undergo

Service providers can also succumb to physical illness, emotional exhaustion, low morale and lower productivity at work that may lead to errors with survivors. It could even create long term impacts – subtle or marked changes in personal, political, spiritual and professional outlook.

Some warning signs of vicarious trauma

- minimising survivor reactions
- intrusive images
- nightmares
- dissociative experiences
- feeling helpless and hopeless
- diminished creativity in addressing problems
- fear
- anger and cynicism

Below is a checklist that a service provider can use to understand symptoms that may precede vicarious trauma:

VT Symptoms	*0*	*1*	*2*	*3*	*4*
Increased fatigue					
Increased illness					
Feelings of alienation from those around you					
Inability to play or take down time					
Dreading going to work or volunteer setting					
Problems with respecting your own boundaries					
Increased cynicism					
More fear for safety of loved ones					
More fear for own safety					
No “me” time					
Talking about trauma work all the time					
Feeling disconnected from friends and family					
Feeling invisible outside of work					
Less enjoyment of sex					
Loss of respect for victim/survivors					
Negative world-view					
Existential/spiritual emptiness					
Feelings of hopelessness					
Feelings of despair					
Intrusive thoughts					
Nightmares					
Social withdrawal					
Emotional numbing -“hardened heart”					

Source: http://www.aafp.org/fpm/2000/1000/p58.html

Addressing vicarious trauma

Purposeful and well directed self-care can effectively diminish the consequences of vicarious trauma. If the provider is conscious to anticipate vicarious trauma; and develop self-awareness to recognise how personal behaviours and frameworks are shifting, it is possible to deflect some of the ill effects.

Caring for physical health (through regular exercise, proper diet, adequate sleep); psychological health (recognising limitations, setting boundaries, identifying triggers that impact, and using music, humour and art as outlets); keeping active socially; being attentive to goals and moral framework; and incorporating the knowledge of trauma into professional life can also minimise the risks of succumbing to vicarious trauma.

Given below are very comprehensive service provider and organisational checklists derived from other toolkits wherein a yes or no answer to the questions are used to help decide whether your practices and those of your agency's are trauma informed.

The first one presented below is a trauma-informed checklist developed by the National Center on Domestic Violence, Trauma and Mental Health that has been also reproduced in Trauma-informed Care, Best Practices for Ohio's Domestic Violence Programme, Ohio Domestic Violence Network, available on: http://www.ncdsv.org/images/ODVN_Trauma-InformedCareBestPracticesAndProtocols.pdf

You may wish to use these as prototypes and adapt it to see whether your services are trauma-informed.

1. We discussed ways that shelter living can be difficult for everyone and talked about the particular things that would make being here work for her……

2. We discussed the ways we view this shelter as a community and what that means for both residents and staff (i.e. supportive peer environment, shared responsibility, accountability to each other, notions of physical and emotional safety, any rules we have and why we need them, processes for addressing difficulties that arise, concepts of inclusive design and mutual respect) ……

3. We discussed what kinds of accommodations might be needed for her to feel safe and comfortable in the shelter and developed strategies for making this happen (e.g.) a quiet room, ways to reduce sensory stimulation, relief from certain chores, identification of potential trauma triggers, respite from childcare, addressing issues of stigma, concerns about sleep patterns, lights, locked doors, medication, additional time or repetition to process information, particular kinds of things she might find upsetting, what things are most helpful when she is feeling that way (being alone, having a quiet place to go, listening to music, contact with others, physical contact, no physical contact, ways to check to see if she is really "there" and what might help her reconnect, etc.,). ……

4. We discussed some of the common emotional or mental health effects of domestic violence and what one can do about them. ……

5. We discussed the things abusers do to drive or make their partners feel "crazy"……

6. We discussed the ways abusers use mental health issues to control their partners. ……

7. We discussed how she feels the abuse by her partner has affected her emotional well-being and/or mental health. ……

8. We discussed ways she has changed as a result of the abuse. ……

9. I asked if she is having any kinds of feelings that concern her. ……

10. We talked about how many of the things she's experiencing are common responses to abuse. ……

11. We talked about the links between lifetime trauma, DV, and mental health issues and whether she'd had other traumatic experiences that might be affecting her now. ……

12. We talked about how a survivor's own emotional responses to abuse can affect how she responds to her children and offered strategies for noticing and addressing those concerns. ……

13. I assured her that if her responses to any of the abuse or trauma she's experienced caused her suffering or get in the way of things she wants to do then we can help her access additional resources and services. ……

14. We talked about whether there were any mental health needs or concerns she might want to discuss (re: past interactions with mental health providers/mental health system, treatment medications hospitalisations). ……

15. I asked if her abusive partner interfered or has attempted to interfere with current or past mental health treatment or medication. ……

16. We discussed our medication policy and asked her to let us know if she has any particular medication related needs that we could be helpful with (e.g. has run out and needs new supply, is having problems with side effects, is not sure they're helping, she can't afford them/insurance or Medicaid won't cover them, etc.). ……

17. I provided links to information or resources to help her advocate for herself around medication issues. ……

18. We discussed her interest in mental health consultation and/or referral and her wishes and concerns about that. ……

19. While conducting support groups or house meetings at which she was present, I discussed mental health symptoms as being normal responses/adaptations to trauma and abuse. ……

20. I provided information, support and reassurance if/when she was uncomfortable with the mental health needs of other women in the programme. ……

21. At her request (and with her written consent), I participated in conversations with her and her mental health provider/s about the issues she is facing and informed her mental health providers about domestic violence-specific issues they needed to be aware of, including appropriate documentation; safety and legal issues; abuser accountability and not involving her partner in treatment; the role of advocacy and any additional needed resources and supports. ……

22. I advocated with mental health providers/systems on her behalf if/when she requested this (and with her written consent). ……

23. I reflected on my own responses to and feelings about this particular person, where they come from and how they may be affecting me (i.e. vicarious trauma, transference/counter transference, evoking my own experiences of trauma) either privately or with trusted others (including supervisors, peers, family, friends, etc.) ……

24. I reflected on how my responses might be affecting her. ……

25. I noticed how difficulties among women in the shelter/agency community affect staff and how difficulties among staff or within the agency, affect women in the shelter/agency community (in general) as well as this particular woman. ……

26. I noticed instances when tensions among women in the shelter/agency community and staff related to this individual and found supportive ways to discuss this with her. ……

27. I discussed the process of healing from abuse and other trauma using empowerment-based approaches (e.g. offering a sense of hope; providing……

information; viewing symptoms as adaptations; thinking about what happened to you, not what's wrong with you; offering connection but understanding the effects of experiencing betrayals of trust; discussing "feeling skills" providing information and access to peer support resources). ……

28. We worked together on strengthening or developing new "feeling skills" (i.e. relaxation training, grounding, affect regulation exercises). ……

29. We worked on incorporating safety planning into other mental health recovery planning /peer support activities and/or helped her connect with peer support groups. ……

30. I feel that I have the supervision and support I need to reflect on and respond effectively and empathically to the issues that arise in my work. …..yes ….no

31. I feel that my agency has created a culture that is welcoming to all survivors; supports openness and communication among both staff and shelter residents; promotes an atmosphere of mutual respect and shared responsibility; is attuned to policies and practices that may be re-traumatizing to survivors (and staff) and has thoughtful and respectful mechanisms in place to address issues as they arise. …..yes ….no

The service provider and organisational checklist provided below could be adapted as well. It has been sourced from: Trauma-informed – The Trauma Toolkit: A Resource for Service Organizations and Providers to Deliver Services That are Trauma-informed, The Klinic Community Health Centre, Canada, 2008.

Service provider checklist

Knowledge:

■Y ■N Can you explain to a client what trauma is, including effects?

■Y ■N Do you recognise the signs and symptoms of trauma, even if a person does not verbally tell you?

■Y ■N Do you know what PTSD is? Can you explain it?

Assessment:

■Y ■N Do you routinely ask about previous trauma and how it is impacting trauma survivors?

■Y ■N Do you ask them if they have used or currently use drugs or alcohol?

■Y ■N Do you routinely ask about mental health issues related to the trauma?

Comfort level:

■Y ■N Are you comfortable asking about traumatic experiences and hearing the responses?

■Y ■N Are you willing to actively listen to difficult feelings and emotions that may arise?

■Y ■N Are you comfortable talking about traumatic experiences?

Relationship building:

■Y ■N Is establishing trust and safety a priority in your work with people?

■Y ■N Do you make sure clients are comfortable with the questions you ask on assessments?

■Y ■N Do you try to establish a genuine, caring connection with clients?

Responding to disclosure:

■Y ■N Do you acknowledge to the client the difficulty and courage involved in talking about trauma?

■Y ■N Do you respond to disclosure with belief and validation?

■Y ■N Do you encourage the client to disclose only what they are comfortable with sharing?

Coping:

■Y ■N Do you ask clients how they cope with the difficult feelings surrounding the trauma?

■Y ■N Do you ask how they cope with difficult behaviours that may result from the trauma experience, i.e., substance abuse?

■Y ■N Do you acknowledge the link between trauma, mental health, and addiction?

Personal attitudes and beliefs:

■Y ■N Do you believe that trauma survivors are resilient and able to recover?

■Y ■N Do you believe that you can affect positive change for clients?

■Y ■N Do you dispel the many myths surrounding trauma in your work with people?

Resources:

■Y ■N Are you familiar with community resources for trauma survivors?

■Y ■N Do you refer clients to trauma-recovery services?

■Y ■N Do you advocate on behalf of clients who need assistance in accessing resources?

Strengths-based:

■Y ■N Do you focus on clients' strengths and resources?

■Y ■N Do you try to instill a sense of hope and change for clients?

■Y ■N Do you work as a team with the client, letting them make decisions about their care?

Cultural awareness:

■Y ■N Do you consider clients' cultural backgrounds when making referrals and discussing community resources?

■Y ■N Do you get an understanding of their issues from their cultural perspective?

■Y ■N Do you make efforts to provide culturally appropriate services when requested?

Organisational checklist

Philosophy:

■Y■N Does your organisation include trauma recovery as part of its mandate and/or programming?

■Y■N Does your organisation subscribe to the evidence-based, best-practice, trauma-informed treatment model?

■Y ■N Does your organisation support efforts to minimize the possibility of re-traumatisation?

Staff training:

■Y ■N Do you train staff on the dynamics and impact of trauma?

■Y ■N Do you encourage your staff to attend information sessions and workshops on trauma?

■Y ■N Do you train staff in communication and relationship-building skills?

Administration:

■Y ■N Do you have trauma survivors on your board of directors?

■Y ■N Does your mission statement address trauma survivor input and participation?

■Y ■N Are there trauma survivors on your administrative team?

Suicide prevention:

■Y ■N Are all of your staff members trained in suicide intervention/prevention?

■Y ■N Are suicide assessments included in the assessment and intake process?

■Y ■N Does your organisation acknowledge the impact of suicide on clients and staff, and include supports around suicide grief?

Cultural awareness:

■Y ■N Do you provide training for staff in cultural competency?

■Y ■N Does your organisation strive to include ethnic and minority groups in staffing and client programmes?

Hiring practices:

■Y ■N Does your organisation include experience in working with trauma survivors in job descriptions?

■Y ■N Does your organisation hire trauma survivors?

■Y ■N Does your organisation hire Elders or those involved in traditional/spiritual healing practices?

Policies and protocols:

■Y ■N Does your organisation include universal screening for trauma for all clients?

■Y ■N Has your organisation ensured that current policies and protocols are not hurtful or harmful to trauma survivors?

■Y ■N Does your organisation involve trauma survivors in the creation of policy and protocols?

Survivor involvement:

■Y ■N Does your organisation include trauma survivors in programme development and evaluation?

■Y ■N Does your organisation include trauma survivors in service provision in paid or voluntary roles?

■Y ■N Does your organisation get assistance from trauma survivors when developing procedures that are potentially invasive?

Link between trauma, mental health and addiction:

■Y ■N Does your organisation acknowledge the links between trauma, mental health issues, and addiction in its policies and procedures?

■Y ■N Does your organisation provide training and knowledge to staff on co-occurring disorders?

■Y ■N Does your organisation's screening procedure include mandatory trauma assessment where addiction issues are present?

Support and supervision for providers:

■Y ■N Does your organisation have mandatory supervision for staff working with trauma survivors?

■Y ■N Does your organisation foster a climate of sharing feelings and experiences related to clients in a safe and confidential setting?

■Y ■N

Total Y: _____ Total N: _____ Date: _____ How did your workplace score? Revisit this survey after putting the Trauma-informed Toolkit into practice and re-evaluate.

Total Y: _____ Total N: _____ Date:

CHAPTER FOUR

DEVELOPING SURVIVOR SKILLS FOR WOMEN: GOING PAST THE ACID VIOLENCE AND BURNS ATTACKS

How do women go past assaults on them with acid? Or being burnt? How do they deal with their changed appearances faces and circumstances? How do women manage past their treatments in health care facilities? How do they deal with ongoing pain, itching and scars? How do women cope with the loss of social moorings, post the tragedy? How can social anxiety and isolation be minimised? How can families help the women better? Is complete reintegration into families and society possible? How can women deal with the intense and unavoidable psychological fallouts of their trauma?

In this section, which is intended for all women survivors of acid violence and burns, we hope to broach these issues. The women can directly benefit by reading it or could benefit indirectly when service providers -- be they doctors, psychotherapists or service providers at recovery centres -- use some of these components to see them through their crisis.

Solutions need to be in the guise of multi-pronged and integrated efforts by several agencies -- health care facilities, doctors, health care providers, psychotherapists and other service providers at recovery centres like counsellors -- where women need to be treated in a holistic manner and not just for symptoms, healed and re-assimilated into society to pick up the threads of a lost way of life. Women need to be made resilient enough able to gather will and courage to empower themselves and take on a new identity.

We have compiled this section using information from various sources. We are deeply indebted to the efforts and insights of all these experts. (1)

- ***Pain and discomfort***

Pain and discomfort are an inescapable part of acid and burn injury and recovery. From the repeated dressing of the wound to the reconstructive surgery (sometimes several) and physiotherapy – the pain continuum seems endless. Many women survivors even face ongoing pain that continues to be a problem long after discharge from the hospital. They have to combat:

- **acute pain**: sharp short-term pain that typically erupts during a procedure like dressing changes or physical therapy
- **breakthrough pain**: pain that re-occurs through the day, often due to wound healing, contractures (tightened muscles) or repositioning
- **resting pain**: "background" pain that is almost always present
- **chronic pain**: ongoing pain that lasts for six months or longer after the wound has healed
- **neuropathic pain**: pain that is caused by damage to and/or regeneration (re-growing) of nerve endings in your skin

It can disrupt every aspect of their life, including:

- **sleep**: pain can make it difficult for them to fall or stay asleep
- **inability to lead a normal life**: normal, day-to-day activities may pose to be a challenge, making women feel hopelessly dependent
- **ability to work**: pain can impede their ability to function or concentrate on the job

- **mood**: pain spills over as depression and anxiety, especially when the pain is severe and lasts a long time
- **quality of life**: pain can deprive them of a stable lives and sharing time with loved ones
- **healing**: pain can affect healing if it precludes women from being able to sleep, eat or exercise enough

Pain management for acid and burns survivors is complex and requires careful assessment by health care providers. They assess its intensity, duration, timing, quality (how the pain feels, for example, stinging, throbbing, itching, aching, shooting) and its impact (how the pain affects your emotions and your ability to do things) in order to find the best treatment. It often requires a multidisciplinary approach that may include both medication and non-medication treatments and the involvement of a team of health providers, such as psychologists or physical therapists who work along with the physician.

Pain is treated using:

- **opiates** that help but they may be less effective for chronic pain; their side effects are constipation and depression
- **over-the-counter** pain medications such as non-steroidal anti-inflammatory drugs
- **anticonvulsant medications** that work by changing the way the body experiences pain; their helpfulness varies perceptibly from person to person
- **sleep medications** help especially when pain interferes with sleep
- **antidepressants**: some antidepressants provide pain relief for some people (even if they are not depressed) and help with sleep

- ***Sleep problems***

Sleep problems occur in more than half of people who have had severe burn injuries. Insomnia is the most common sleep problem. Many factors can disturb sleep after burn injury and some continue to affect women long after they have left the hospital and healing centres. The reasons are: anxiety and PTSD, depression, constantly thinking about the burn event, pain, itching, certain medications, the altered hormone levels and contractures caused by scar tissue that limit the ability to move and get comfortable.

Women survivors need to urgently seek treatment for poor sleep because not doing it can interfere with their recovery process. This is because it can worsen the ailment and pain, slow down wound healing, cause restlessness, irritability and changes in behaviour.

There are many different approaches to solving sleep problems. The choice of treatment depends on the cause, type and severity of the problem as well as the stage of recovery from acid/burn injury. There are effective medications that can help sleep better. These include sleep aids, antidepressants and/or anxiety medications. They can be used alone

or in addition to one of the above approaches to improve sleep. As with any medications, it is extremely important to take medications for sleep only as your doctor has prescribed and discussed with you. This includes over-the-counter sleep medications.

Non-medical efforts could include adhering to **sleep hygiene** -- the practice of following sensible guidelines for promoting regular, restful, good-quality sleep. This includes avoiding daytime naps, maintaining a regular time for going to bed and getting up, avoiding stimulant-containing drinks, foods and drugs in the late evening, staying away from stimulating activities late in the evening, and exercising regularly.

Stimulus control can be attempted. It can help 're-programme' the mind to associate the bedroom and bedtime with only sleep-promoting (calm and pleasant) activities rather than failure to fall asleep. Some guidelines for stimulus control:

- go to bed only when sleepy
- set a regular wake-up time, no matter what time you actually fall asleep the night before
- get out of bed whenever you are awake for longer than 15-20 minutes
- avoid reading, watching TV, eating or worrying in bed and the bedroom
- do not nap during the day

Touch therapy where a continuous rhythmic schooling of a non-injured parts are undertaken

Music therapy involves the playing of soothing music

Relaxation techniques reduce anxiety and tension at bedtime. Women can try:

- progressive muscle relaxation
- meditation training
- imagery training
- biofeedback
- hypnosis
- yoga

A practitioner will be able to guide the women to practice them at the facility and at home.

CBT teaches sleep hygiene, employs stimulus control techniques, and trains in relaxation methods/practices. In addition, sometimes people with sleep problems develop thoughts and beliefs about sleep that keep them from falling asleep. A CBT therapist can work with women to address and eliminate the thoughts that may be keeping them from being able to fall asleep

- ***Dealing with scars, contractures and itching***

Burns and acid violence survivors often become frustrated that they have persistent issues with scarring and wounds long after their initial burn injury has healed.

Once the primary burns have healed, the healed skin turns vulnerable to **skin breakdowns and wounds.** Life gets curtailed for acid violence survivors and burns victims as their exposure to the sun needs to be minimised.

Contractures constitute a major impediment. They are the chronic loss of joint motion due to structural changes in non-bony tissue. These non-bony tissues include muscles, ligaments, and tendons. They affect the ability to move and take care of oneself. Casts and splints are used to help with movements and stretching exercises become a must.

Rubbing can create **blisters**. They can also develop from clothes that fit too tightly, rubbing while putting on pressure garments (garments specially designed for burns victims), or rubbing a burn that itches. Blisters need to be pierced and drained as soon as they are noticed.

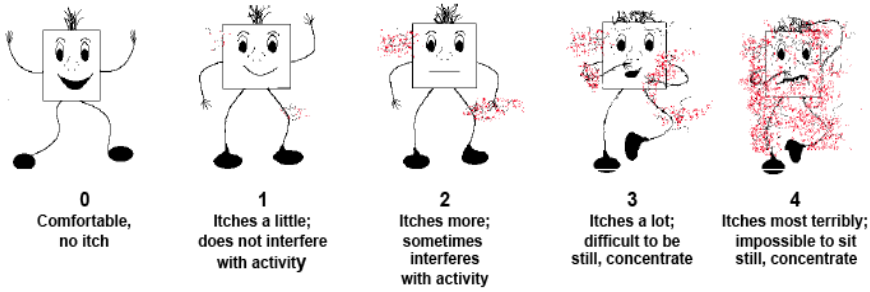
Bumping the skin can create **skin tears or ulcerations**. Sometimes scar tissues get damaged. Allergic skin reactions may develop. To deal with ulcerations, the wound needs to be covered with a thin film of antibiotic ointment, especially when exercising and stretching. If the wound continues to crack open, enlarge or deepen, health care providers need to recommend a splint or cast so the wounded area is kept still for a day or two. To halt skin tears there is need to put firm pressure over the wound for about five minutes until the bleeding stops. Then the area needs to be washed gently and thoroughly with mild soap and water. A small amount of antibiotic ointment and a non-stick dressing such as Xeroform or Adaptic needs to be applied. To deal with allergic reactions, it is vital to discontinue all soaps, lotions and ointments till the reaction has gone away.

Hypertrophic burn scars (scars in the area of the original burn that are raised) are the most common complication of a burn injury and limits a survivor's ability to function as well as affects their body image. This can lead to isolation, depression and lower quality of life. No single treatment is ideal for treating scars. For many years, custom pressure garments were thought to be the best treatment. Even if they don't improve the scars, they help in decreasing itching and protect the skin from injury. Silicone gel sheets are pieces of thin, flexible medical grade silicone that are placed over the scars and may decrease itching and dryness. They are generally durable and comfortable to wear. They can be worn alone or underneath pressure garments, splints or casts. Massage can help soften and desensitise the scar. When combined with stretching, massage can make the scar looser, softer and more comfortable. Surgical treatment is also an option if scarring prevents the women from performing certain activities.

Burns can also damage or destroy the oil glands that normally keep skin from getting too dry. The lack of oil glands leads to dry **itchy scars**; the larger the burn, the more likely that itching will be a problem. Itching could be relieved somewhat with the use of pressure garments and topical, moisturisers or oral antihistamines**.** Silicone gel

sheets may decrease itching and dryness. They are generally durable and comfortable to wear. They can be worn alone or underneath pressure garments, splints or casts.

Health care teams normally assess the intensity and impact of the itch by making the survivors describe the intensity, or how strong the itch is. They are asked to rate the itching on a scale of 0 to 10, where 0 is "no itch" and 10 is "worst itch imaginable." Children are often asked to use the Burn Man Itch Scale to describe their itch (see below).



To describe how itching may be affecting the survivor's life, the health care team may use the 5-D Itch Scale. This is a set of questions that asks you about the

1. Duration (number of hours per day)
2. Degree (intensity)
3. Direction (whether it is getting better or worse)
4. Disability (impact on activities)
5. Distribution (location on your body)

- ***Dealing with the exercise regimen***

Exercise begins on the day of the woman's traumatic injury and continues until all wounds close and the scars die or are no longer metabolically active. Fibroblasts, responsible for wound contracture, set into a burn wound in the first 24 hours and remain active for up to two years after the injury. Exercising several times throughout the day helps to reduce the decreased strength and joint range of motion that may occur from scar contracture.

But it poses an enormous train for the women. Especially because before she returns to her community, she should be ready for an aggressive outpatient rehabilitation programme designed to increase:

- strength
- endurance
- range of motion in the involved regions
- functional independence
- ability to return to work

Women survivors are expected to do the following:

Stretching exercises: as they are most effective when performed slowly and until the scar blanches.

Active and resistive range of motion: women are expected in some cases to use pulleys, free weights and weight bearing exercises; these are started early in the rehabilitation process, even when burn wounds are still open.

Many burn survivors have decreased muscle bulk and low endurance on account of a prolonged hospital stay, high dependency on ventilators, and bed rest after skin grafting. **Training on the bike or repetitions of ascending and descending stairs are used to help to build endurance.**

Many others feel tired all day long and remain inactive. It may take months for a survivor to revive. **Performing endurance training** and helping the burn survivor return to a normal sleep cycle (decreasing naps in the day to prolong periods of sleep at night) will assist her return to a "normal" level of activity.

Decreased torso rotation and the ability to perform reciprocal activities as a result of immobilisation is remedied through the use of therapeutic balls.

Survivors who suffer from decreased agility in hand use (as grafting to the upper arms require immobilization) are expected to undergo pinch, grip and fine motor activities to facilitate good fine motor control.

Post release from hospital and rehabilitation centres, home exercise routine are considered a must. Scars contract every minute of every day. Exercising one hour three to five times a week is necessary to prevent contractures and deformities. Women survivors are instructed in home exercise programmes prior to discharge from the hospital. Follow ups are necessary when women survivors come back for outpatient appointments.

Alternate modes of treating stress

Medications and treatments cannot take away all of the pain. A woman survivor's 'coping' style largely determines how much she lets the pain affect her. Given enough social support and strength, and using her own will a woman can manage the pain effectively. Alternately, in the absence of all this, she can give up and withdraw into depression. Psychologists are needed to work with women to remedy the feeling of hopelessness.

By focusing on situations they can control -- such as their own rehabilitation, physical therapy, doing daily routine activities, and following the pain management strategies suggested by their doctor -- women can be enabled to cope. Also, to overcome these all these individual reactions, women survivors can actively be part of their recovery plan and make inputs into it.

By valuing their inputs and addressing their concerns one by one, health care providers can make remarkable progress with women. Other approaches that psychologists could work with women are:

- **Grounding:** this technique promotes the present, here-and-now awareness. It connects the women to the present moment so that a survivor can connect with her resources and options

- **Relaxation**: relaxation techniques are essential during and post hospitalisation as they are useful to lessen the stress placed on the woman's body. As acid and burns injuries puts immense stress on the body that continues for many months during the recovery phase it causes muscle tension resulting in increased pain

- **Reality check:** the process of assisting a woman survivor to figure out what is happening in the moment rather than what she feels is happening

- **Feelings check:** following the cycle of feelings and emotions to try and control them

- **Imagery:** using the imagination to manage difficult experiences

- **Journal writing and artwork:** to facilitate self-awareness and acceptance

- **Cognitive (thinking) relaxation techniques** use the power of thoughts to relieve stress. These techniques include meditation and a process called "cognitive restructuring," which helps change the way the women think about their pain and reassure themselves that the pain is temporary and manageable

- **Somatic relaxation techniques** use deep breathing, yoga, and progressive muscle relaxation, to relieve tension in muscles

- **Hypnosis** has been shown to be a powerful tool in relieving both acute and chronic pain. A psychologist can teach women self-hypnosis that could be included in their daily routine

- **Pacing of activities**: daily activity and regular exercise are crucial to rebuilding strength and stamina. Caution should be exercised so as not to overdo it. It may increase the pain

- **Talking:** using words to describe thoughts and feelings to oneself and others

Social challenges

- ***Loss of identity***

Acid and burn survivors experience social challenges during the transition from the safe zone of the hospital back into the community. The first being the difficulty in accepting the reaction of others and themselves to their condition and disfigurement. A survivor's sense of self-identity, family identity, gender identity and racial identity stands seriously threatened.

- ***Being stared at***

It becomes difficult to cope with people staring; avoiding them; asking intrusive questions; discussing the woman's injury in public and within her earshot and bullying and teasing.

This table, developed by *Changing Faces*, a UK-based charity giving support and information to people with disfigurements to the face, hands or body, and their families, uses the acronym "SCARED" to illustrate how reactions on both sides can be misunderstood or cause discomfort.

Feelings/Reactions on Both Sides that can be Misunderstood or Cause Discomfort		
Burn Survivor	**Other**	
Self-conscious	Sorry, shocked	S
Conspicuous (Noticed)	Curious, confused	C
Angry, Anxious	Anxious	A
Rejected	Repelled	R
Embarrassed	Embarrassed	E
Different	Distressed	D

Source: https://www.changingfaces.org.uk/Home

- ***Social anxiety***

A woman acid violence or burns survivor may be suffering from social interaction anxiety if she exhibits any of the following symptoms in social situations:

- feeling nervous or on edge when meeting new people or among strangers
- avoiding social situations
- feeling isolated and alone
- feeling emotional distress, including depression

Some strategies that women survivors could use when meeting strangers or going into public places

- use a welcoming tone of voice
- confident body language
- be warm and friendly
- make eye contact
- smile often

Social interaction skills training can help a woman deal with stares and questions. If people stare, women could look back or frown or ask what is bothering them. Questions could be answered positively or with humour or the subject could be changed if the women are not too keen to discuss.

The **3-2-1-GO! Strategy** developed by James Partridge (www.changingfaces.org.uk) would help greatly. This strategy includes a person (in this case women) to be ready in their (her) mind with:

- 3 things to do if someone stares at you (her)
- 2 things to say if someone asks what happened
- 1 thing to think if someone turns away

Such readiness helps face up to unexpected or hostile reactions.

- ***Social isolation***

The survivor's social world can hugely determine the eventual outcome of trauma, as Judith Lewis Herman says in *Trauma and Recovery*.

Women survivors of acid violence and burns attacks are often abandoned by their families. The women are caught in a double bind: being subjected to extreme violence and the lack of social support and acceptance after the traumatic event, despite it not being their fault. Married women face the double trauma of sometimes having to return

to a spouse who has been responsible for the assault or to in-laws or parents who are not happy having them back in their fold. Sometimes even their children abandon them

These harsh circumstances force the women into a peculiar kind of isolation with a lack of contact with other people in normal daily living. It further results in an emotional low and continued feeling of stress that retards recovery. Also, the apertures of economic and personal opportunities begin to close up.

Other times, families, though supportive, don't know how to deal with the women's situation. They are confused and scared themselves – seeing what she has been through and not knowing how to handle it. They are as traumatised about the situation, the hospitalisation, the unexplained symptoms, the pain and the financial burden it places on them.

Also, staying within health care facilities and rehabilitation centres is socially difficult. There are bound to be women from different age groups and strata of society with very different mental symptoms.

How can families help women survivors?

Families need to:

Be patient and understanding: As healing from emotional or psychological trauma takes time, it is essential to be patient with the pace of recovery and remember that everyone's response to trauma is different. It is important not to judge your loved one's reaction against your own response or anyone else's.

Offer practical support: to help women get back into a normal routine. That may mean help with collecting groceries or housework, for example, or simply being available to talk or listen.

Not pressure women into talking but be available when they want to talk: Some trauma survivors find it difficult to talk about what happened. Don't force women to open up but let them know you are there to listen whenever they feel ready.

Help women socialise and relax: Encourage them to participate in physical exercise, seek out friends, and pursue hobbies and other activities that bring them pleasure.

Not take the trauma symptoms personally: Women survivors may become angry, irritable, withdrawn, or emotionally distant. Remember that this is a result of the trauma and may not have anything to do with you or your relationship

- ***Going back to work***

If the medical team determines that the women survivor is ready to return to work but lacks the stamina, there is need for her to participate in a return to work programme that will gradually build her stamina for work, both mentally and physically (through fitness training).

There are some important things that women survivors need to do before they go back to work:

- converse with health care providers about the readiness to return to work. He or she can help assess current limitations and a reasonable time frame for returning to work
- spend time during recovery period to focus on what needs to be done emotionally and physically to return to work
- seek counseling to help cope with psychological and emotional issues about returning to work
- learn how to handle questions raised by co-workers or employer about the injury
- provide the employer with a time frame for when she may be able to return to work so the employer can plan accordingly
- if the woman survivor is not able to return to your job for a while, there is need to talk to the employer about jobs that she may be able to do during recovery
- the employer must be alerted to all/any restrictions faced: not being able to work in very cold or hot environments; not being able to lift heavy things etc
- it is essential to seek help with a vocational rehabilitation counselor if regular employment does not suit women

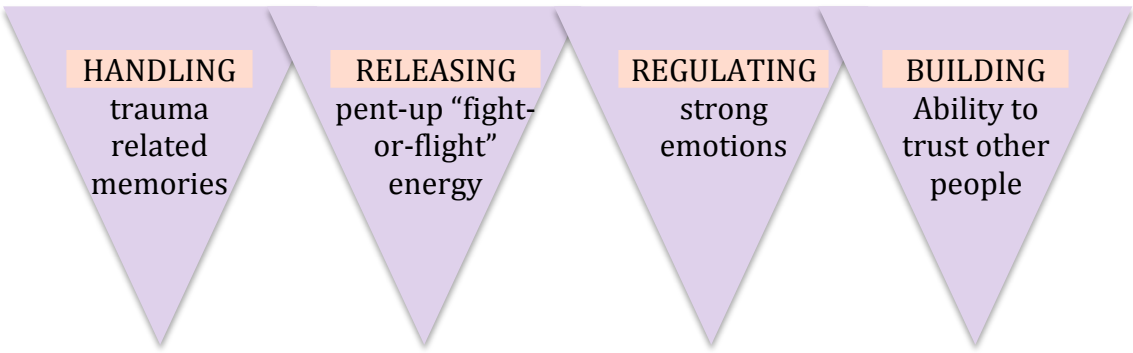
Solutions for family and community reintegration, during recovery and post recovery could come in the guise of:

- counselling and demystifying the elements of trauma -- should be the first step -- so that the women and their families can better understand the woman's condition
- discussing the range of emotions that women display with her and her family
- the family needs to briefed on the fact that a woman survivor will take a long time to heal; this can preempt family disgruntlement with time consuming care that continues long after discharge from the health care and rehabilitation facility
- discussing the links between trauma, domestic violence and mental health is important
- it is important to explain to the women survivor and her family how the trauma has impacted on her ability to trust people and her ability to manage her feelings
- sensitising families to change their cultural practices that accept VAW as normal should follow
- women survivors, too, need be to sensitised to draw on the strengths of cultural values that are mindful of her personhood
- to pre-empt a woman from socially secluding herself for fear of stigmatising the family, family members should form her core support group and encourage her to go out
- such social reintegration will open up her professional and personal future

- befriending is a technique that can be used to help her re-enter the social space. Befriending has been defined as 'an intervention that introduces the client to one or more individuals, whose main aim is to provide the client with additional social support through the development of an affirming, emotion-focused relationship over time'. *(2)*
- mentoring is another method that could be tested out. Mentoring is defined as a relationship between the volunteer and the individual, based on meeting agreed objectives set at the outset and where a social relationship, if achieved, is incidental. Mentors work with the client (often) on a short-term basis, and thus one key goal is to provide clients with the necessary skills and abilities to ensure that they are able to continue and sustain any achieved change following withdrawal of the service. *(3)*
- volunteers -- who provide vulnerable women with emotional, practical and social support, acting as an interface between the community and public services and helping individuals to find appropriate interventions – could be used.
- groups focused on social activities can help include these women within society and build their self-efficacy. Such groups can be highly structured to achieve specific aims or more 'organic', developing activities dependent on the interests of the group members. Facilitation of groups can either be peer-led or carried out by specialist staff within health and social care.
- dealing with a situation where the spouse has attacked her is always difficult for a woman; the pressure to decide whether she should stay in the marriage or leave is enormous
- women find it difficult to leave for a variety of reasons: children, love for spouse despite the event; financial dependence; lack of any other home. It is important to be compassionate and gentle to the women in such situation.

Psychological distress

Trauma treatment and healing involves



While each acid violence and burns survivor experiences psychological distress differently and comes to terms with it in her own way, the common trauma-related memories and feelings are:

Feel

- sad, anxious or irritable
- helpless
- hopeless
- upset about depending on other people for assistance
- unconnected, distant from your family, friends or the general public
- alone
- disturbed
- unrelaxed because of lack of sleep
- suffering from PTSD
- inability to trust anyone
- worries about the future

Causes for distress

- thinking about the event itself
- fearing the appearance of the injury
- perturbed by the changes in appearance because of scars (suffering from issues of body image – their perception and confidence of how they look)
- bothered and hurt by public reaction to injury (staring, curiosity)
- extreme pain while the wound is still healing and after it has healed
- pain that continues for years afterwards
- immense itching
- dependence on others
- disruption of their normal lives
- separation from family and friends
- being shunned socially
- the lack of intimate relationships
- extensive financial burdens due to the incident

Fallouts of distress

- slows down recovery considerably
- makes pain and itching worse
- deepens depression
- lowers participation in rehabilitation therapies and wound care
- makes communication with burn team members difficult
- reduces interest and pleasure in daily activities
- disrupts sleep

The woman survivor's psychological issues during and post the treatment can be addressed by:

- consciously extending professional help at the facility to restore her physical, social and psychological safety
- alerting her on what to expect in terms of pain and the emotional handling of the situation when she enters the facility
- allowing her to develop a rapport with the therapist so that the woman associates that person with comfort and reassurance
- facilitating her to work with the therapist in coordination with the health providers and service providers at health care and recovery centres
- instilling trust within her person (it must be understood that the women have lost all their trust in people and their sense of order and justice has been shaken to the core)
- coaching her in techniques of relaxation, especially those with focused imagery, that can be very helpful in quickly assisting the woman survivor feel more comfortable
- explaining and demystifying her mood swings, anger, sadness, anxiety as normal; extending this information to the family as well
- teaching her to talk about her feelings, asking for the help she needs, controlling self-hate directed towards herself and PTSD
- helping her anticipate the emergence of psychosocial issues
- helping her move back and forth in time, from the protected moorings of the present to the horrors in the past, so that she can simultaneously re-visit the feelings in all their fullness while holding on to the sense of safe connection extended by the facility
- ensuring that she is not coerced into speaking or revealing what she does not want to
- holding conversations in common areas or if the woman survivor so requests it could be done in private
- involving the women's families in their care; psychotherapists must lend assurance to families, calm their concerns and enable them to help the women survivor as this will empower her to help herself
- encouraging her to attend professionally-led support groups and choose the one that addresses her concerns the best
- allowing her to form new social bonds if the old ones have collapsed
- channelising energies towards activities -- women heal faster when they do things they enjoy
- helping women find comfort in getting back to doing the things that they did before the incident
- maintaining a continuity of care through all her phases of treatment is key

Phases of Recovery with Expected Psychosocial Symptoms and Suggested Treatments

Phase	Expected Symptoms	Recommended Treatments
Admission	Anxiety, terror pain sadness, grief	Antianxiety medication Analgesic medication Psychological support, reassurance Normalisation relaxation techniques
Critical Care Phase	as at admission acute stress disorder	Antianxiety medication Analgesics Medication targeting acute stress disorder symptoms
In-hospital Recuperation	increased pain with exercise anger, rage grief depressive episodes, rapid emotional shifting	analgesics psychotherapy (cognitive-behavioural and family therapy) pharmacological treatment of anxiety and depression
Rehabilitation and reintegration may be several years)	adjustment difficulties post-traumatic stress disorder anxiety (including phobic response) depression	re-entry programme medication targeting post-traumatic stress disorder psychotherapy (cognitive-behavioural and family therapy, social skills) anxiolytics taperes off over time anti-depressant medication

Source: Patricia E. Blakeney PhD, et al; Psychosocial Care of Persons with Burn Injuries, The International Society for Burn Injuries, Texas, available online: Source: http://www.worldburn.org/documents/PsychosocialCare.pdf

Handling PTSD

The therapies to handle PTSD are many. Some of the therapies have already been discussed in the section *Physical challenges: post assault, post treatment***.** We repeat some again in this section. This information has been derived from the National Center for PTSD. *(4)*

To begin with the women should understand why the therapist has chosen a specific treatment for her, how long it will last, and how to tell if it is working. It is essential for her to feel comfortable with her therapist and that she is working as a team to tackle her problems. One can believe that a rapport has been established with the psychotherapist if the women are comfortable discussing their problems with the therapist; the therapist understands what she is talking about; if her concerns are taken seriously; her experiences validated; she is treated with compassion; and she is provided with mental safety and trust.

- ***Cognitive therapy***

Cognitive therapy helps in handling PTSD. The therapist helps women understand and form a different perspective about how they think about their trauma and its aftermath. The goal is to make women see how certain thoughts about their trauma cause stress and make symptoms worse. The therapist helps women identify these thoughts and replace them with less threatening thoughts. Women are also able to cope with feelings such as anger, guilt, and fear. After a traumatic event, many women blame themselves. Cognitive therapy helps them realise that the traumatic event was not their fault.

- ***Exposure therapy***

Exposure therapy teaches women to lower fears about their memories. It is based on the idea that people learn to fear thoughts, feelings, and situations that remind them of a past traumatic event. By making them talk about their trauma repeatedly, therapists help women control their thoughts and feelings about the trauma. The idea is to make them unafraid about their memories. This may be extraordinarily difficult to begin. But with practice, women begin reacting differently to their trauma. They are on the one hand 'desensitised' to its effects (women deal with bad memories a little bit at a time) and on the other 'flooded' with memories (when they learn to cope with this avalanche of memories they are able to overcome their sense of being overwhelmed).

- ***Eye movement desensitisation and reprocessing***

EMDR is another type of therapy for PTSD. Like other kinds of counselling, it can help change how women react to memories of their trauma. While thinking of or talking about their memories, women are trained to focus on other stimuli like eye movements, hand taps, and sounds.

- ***Group therapy***

Group therapy allows women to talk about their trauma with others who have had similar experiences, and they are able to recall it with a certain level of comfortableness. It helps women build self-confidence and trust, cope with their symptoms and memories, be in the present rather than being overwhelmed by the past, build relationships with others who understand what they have been through and deal with emotions such as shame, guilt, anger, rage, and fear.

- ***Brief psychodynamic psychotherapy***

Brief psychodynamic psychotherapy allows a woman to learn ways of dealing with emotional conflicts caused by her trauma. This therapy helps women understand how their past affects the way they feel now. Her therapist can help her: identify what triggers her stressful memories and other symptoms; find ways to cope with intense feelings about the past; become more aware of her thoughts and feelings, so she can change her reactions to them and raise her self-esteem.

- ***Family therapy***

Family therapy is important as PTSD can affect the whole family. Children, husbands and other family members may not understand the women's emotions and unexplained outbursts. They themselves feel deluged by stress, guilt and anger. Family therapy, thus, involves the whole family. A therapist helps the woman and her family to communicate, maintain good relationships, and cope with tough emotions. The family is taught how to treat PTSD. In this kind of therapy, all family members can express their fears and concerns. The woman survivor is encouraged to talk freely and listen to others.

Recovery

The question often asked is whether women survivors who have experienced trauma ever go back to normal. The answer is that women do go back to leading productive and fulfilling lives. Most survivors are definite in their response that they would never have liked to undergo an experience like this. But having come through it, they feel they have learnt a new way of life and found just how strong and resilient they are. While normal lives that they lived before is now not possible, survivors say that they have found a new sense of normal.

The process of recovery involves getting a roadmap of the healing process with the health care providers; entering a phase of 'remembrance and mourning' where the women survivor revisits the trauma, works through the grief, confronts her horrors and establishes a foundation of understanding, safety, stability and self-regulation with the therapist as an ally; and arriving at the stage where the women survivor is able to re-connect with people and activities. The final aim of recovery is to restore power and

control to the survivor. And, the only way that a survivor can steer her own recovery is to be in control of her healing, have a say in it and take responsibility for it.

It is important to view survivors as having been through an extraordinarily difficult time and finding the strength to survive that experience and find ways to protect herself and her children. Many women survivors who suffer burns and acid violence at the hands of their husbands find the courage to leave the relationship and fend for themselves. Others find a way to stay and reconcile their feelings of anger and distrust with acceptance and forgiveness. Whatever the solution, a woman survivor arrives at – it is her own. We need to celebrate this power of hers.

- ***Qualifying recovery***

The road to recovery for women survivors is a hard and arduous one. While trauma may affect a woman for the rest of her life, one can say with a degree of certainty that a woman survivor has recovered when

- she is able to control her physical symptoms of PTSD
- she is able to bear feelings associated with her traumatic feelings
- memories don't limit what she chooses to do
- memories of the trauma are linked to feelings – a huge re-connect with something that has been numbed
- damaged self-esteem is restored
- important relationships have been re-established
- she has reconstructed a system of meaning and beliefs that encompass the story of the trauma
- she has begun to take decisions and acts on them
- taking control of her life entails facing dangers as well -- a remarkable breakthrough
- she emerges as a new person: having integrated the learnings from before, during and after the experiences of her trauma *(5)*

- ***Exit interviews***

When the women exit from health care facilities and rehabilitation centres after treatment, she is expected to face the world, with or without family and social support. Exit interviews at these facilities are very important in this regard as it can prepare women on what to expect and smoothen the transition.

Exit interview are not easy. It is about termination of a relationship that has been supportive, nurturing and longstanding. Providers must thus be sensitive to the emotions that women go through, and the fact that many women feel they are leaving a safe space. They must validate her mixed feelings and help her articulate them. They must help her learn to separate her feelings of severing bonds from her importance to the group and expectations of a new life

It is important that the providers help women survivors experience a healthy closure. They can help immensely by enabling women survivors internalise message from their experiences at the facility.

Providers need to ask her where she will go henceforth, outline potential behaviours and feelings that she may experience after leaving the facility, suggest coping behaviours, remind her of the positive ones she has developed at the facility and ask questions about what plans she has made for her safety and economic independence.

The women's families, too, needs extensive psych-social education that provides them a trauma-based cognitive framework within which they can reframe the family values. The counsellors must be able to give the family confidence that they can support the women through their challenges. They could be encouraged to re-return to the facilities for reassurance and help.

The women when leaving the facilities must go with the message that:

- they are normal and are expected to fully recover
- there are going to be difficulties during the adaptation process -- where women struggle to develop new lives, new body images, new ways of happiness
- self-efficacy is important – it is needed that they develop new social skills to deal with predictable hurtful reactions
- there will be some degree of risk as they take more control over their lives and participate more actively in their communities; their new positive coping skills can come in handy while dealing with them
- there will be days or moments when women's emotions will again spiral out of control
- families (in whatsoever way the women describe it) should be part of her recovery process
- it is entirely possible to be strong and competent, optimistic and autonomous *(6)*

- ***Community reintegration: the final step***

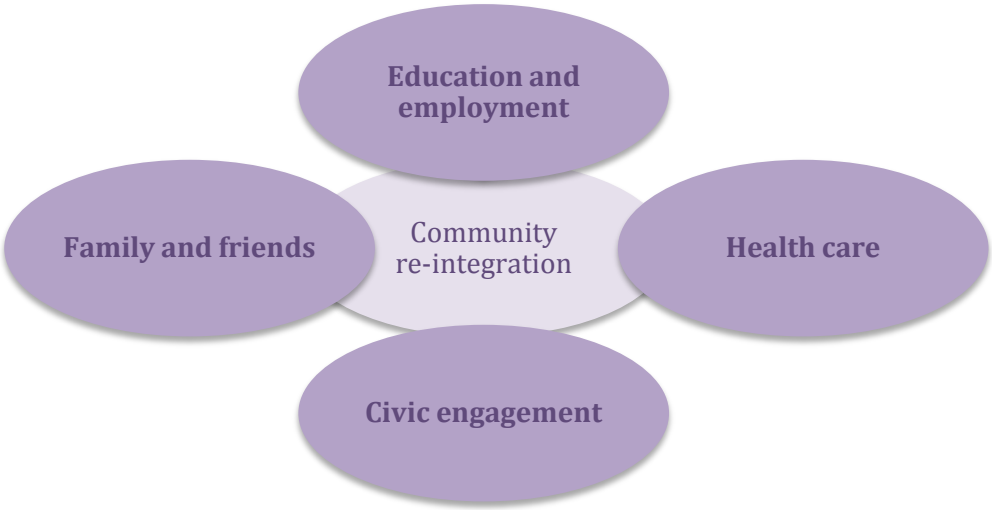
Community reintegration may be defined as a sense of social inclusion -- to belong to, to be valued by and influence the society that one belongs to.

The primary objective of a trauma-informed approach for women who have suffered from acid violence and burns is to ensure their full reintegration into the community.

There are bound to be challenges in societies, which marginalise women and normalise violence against them. One significant challenge, that of negative public attitudes and resistance to community integration. Many communities are unwilling to change attitudes or invest in easing the re-entry of these women into society.

Yet there is enough evidence to show that community integration that drives participation of these women in community activities facilitates recovery. *(7)*

Community re-integration needs to at its core be inclusive of:



- **Education and employment**: Many women survivors who want to return to studies or work, have been unable to when their illnesses have been most acute or because of social and institutional rejection (on the basis that they are not equipped to deal with them)
- **Health care**: Most hospitals do not have special wards or rehabilitation centres
- Recreational and vocational facilities: There is little or no provision for such facilities
- **Civic engagement**: Most women survivors are eager to be part of something beyond the confines of their traumatic world but find no avenues
- **Family and friends**: Many women have to contend with severed ties from family and friends. Helping them finding ways to regain their social roles is a duty that rests on the community

Community reintegration must not be mistaken as charity. On the contrary, it actually means taking women's self-determination and choice more seriously systemically. It means communities promote the use of mainstream resources by women survivors whenever they want, and address the barriers that limit opportunities of such women.

Communities can begin by recognising women survivor's skills, strengths, and extend resources/supports that will help them use them to better their lives

CHAPTER FIVE

RECOVERY IN ACTION

There are very many invaluable techniques that are used to allow survivors of trauma to get centered, calm and ready to face the world. We have taken the liberty of pulling some activities and exercises out of a very informative workbook by Linda A Curran who has worked on all aspects of psychological trauma. We have used her very latest book called *Trauma-Informed: Activities, Exercises and Assignments to Move Client and Therapy Forward, 2013. (1)*

The situations described here may vary from the ones the survivors at your facility have to cope with. Yet the difference is situational rather than in spirit. If the activity is set out for a child coping with harsh parental control, it could apply to a woman's control over her spouse. These exercises could be used as a broad framework and fine-tuned to move the women survivor and her therapy ahead.

I. Developing a nurturing voice

Attachment work

Developing a nurturing inner voice is one way to counterbalance the critical parental messages that so many of us have introjected—the voice that keeps telling you that you're not good enough, that something is wrong with you, and what a disappointment you've always been and will always be. Presently, that voice and its messages serve only to limit you and keep you stuck in the past, whereas creating a new one -- a responsive, empathic one to calm, soothe and encourage you- would be much more helpful in the present.

Exercise 1

Ask yourself these questions:

1. Do I know anybody who has this nurturing quality? (S)He may be real or fictional, it really doesn't matter. Who is it?
2. When you've settled on one person, bring him/her to mind and allow him/her to truly come to life. Picture the person in his/her nurturing aspect. What does this person look like? What is (s)he doing? Perhaps singing to a child, stroking his /her hair? Using a calming voice, when a child is scared? Cooking a favourite meal? Reading a storybook? Whatever feels right.
3. Allow that scene of nurture to become as vivid as possible. Truly listen to the words being said and the tone of voice(s) he is using.
4. Now, imagine being one of the people in the scene, either the child or the nurturing figure, whichever feels right for you. What would it feel like to be that child/nurturing figure? Try taking on the role. Truly embody it for a few minutes.
5. Now imagine a time when you were criticising yourself. Hear the words you said and the feelings that those words brought up for you.

6. Now consciously switch out of the critical voice and into this more nurturing one -- words and tone.
7. Notice what it feels like to be responded to with kindness and compassion instead of criticism.
8. Practice this imaginally a few more times.
9. The next time you find yourself using the critical voice, once again consciously switch out of the critical voice and into this more nurturing one, both words and tone.
10. Practice switching voices as often as you are able.

Exercise 2

Remember a time when someone said, "thank you." And you knew that (s)he truly meant it.

1. How did it feel to be acknowledged, appreciated, or loved?
2. Embody that feeling for a few moments.

Now remember a time when a loved one acknowledged something good that you did or said.

1. How did it feel to be acknowledged, appreciated, or loved?
2. Embody that feeling for a few moments.

Now remember a time when you felt appreciated or loved.

1. How did it feel to be acknowledge, appreciated, or loved?
2. Embody that feeling for a few moments.

What do you value most about yourself?

Of the people to whom you matter (and who matter to you), if asked, what would they say they value most in you? What qualities do they admire?

Now, think of your closest friend. If asked, what would (s)he claim to value most in you? Are those things the same (i.e., do you value the same things in you that your friend does)?

What other things about you do you value, but others may not recognise? What are they?

II. Containment imagery script

"The Container" is an imagined resource that addresses the need to compartmentalise the distressing material, in order to be present in the here and now, attending to what one needs to. Be clear: This script is not a repression or suppression of memories, thoughts, affect, or emotion. It is a technique employed to allow one to attend to what (s)he needs to attend to until (s) he has the necessary resources to attend to those distressing/disturbing memories, thoughts, affects, or emotions. (**Remember: Time is a resource**.)

Clinician reads:

Allow yourself to be comfortable …either lying down or sitting up with your back, neck, and spine fully supported. Knowing that you will not be interrupted for the next little while, begin by gently closing your eyes.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Now begin to bring your attention to your breath -- the direct experience of your breath --however it is -- and however it changes. Allow yourself to softly focus your awareness on to the breath that is arising right now -- the in-breath and the out-breath, the rising and the falling. If you can, try to follow one full cycle of the breath from the beginning of the in- breath through its entirety and then to the beginning of the out-breath through its entirety. Allow yourself the time and the space to be in direct contact with the breath throughout one entire cycle.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

As you continue to pay attention to the breath, you may notice distractions that arise. Just allow yourself to notice those distractions… any bodily sensations or any thoughts that may arise. If possible, allow yourself to become aware of the separateness of those bodily sensations -- notice how those sensations are separate and distinct from your thoughts, your ideas, and your words.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Now, as you continue with this focused awareness, you will notice how often you lose contact with the breath…maybe you become caught in a thought or an idea or plan, or maybe some other bodily sensation pulls your attention. When a distraction happens, simply notice that you have lost connection with the breath, and gently bring your awareness back.

(Clinician should breathe with the exhalation longer than the inhalation.)

We'll begin now with a deep breath in through your nose…inhaling slowly and deeply. Exhale through pursed lips until all the air has been released.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Now we are going to be creating a container. It doesn't matter what kind of container it is, as long as it can "hold" any all disturbing material. If you were going to develop such a container, what would it look like? Some people have used boxes, safe, trunks, or chests; others have use book bags, or other pieces of luggage. It can anything really, a tank, a submarine, an underground well -- anything that suits you.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Can you bring to mind an image of something like that --something that would be able to contain any and all disturbing material? When you have one in mind, take a good look at it. What material is it made out of? How is it held together? How big is it? What colour is it? Are there any marking on it? If there are markings, notice them; if not, that's fine. But I'd like you to add something to this container. I'd like you to add in some way -- whether it be a note or a sign or an inscription of sort -- a notation to indicate that this container will remain tightly sealed. It will remain tightly sealed until you wish to open it and retrieve something from it. Otherwise it will remain sealed. It can be opened -- but only by you -- and it should be opened only in the service of your healing.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

So once again, look at your container. Does it already have that message on it? If not, place it on there now.

(Pause.)

Now, how does this container open? Are you able to open it by yourself, or do you need help? Is there a lock on it? If not, feel free to put one or several on it now.

(Pause.)

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Once the locks are in place, we'll experiment with opening and closing them, locking and unlocking them. As you do that, notice how much, or how little, effort it takes to open and close the container.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

When you feel comfortable handling it, I'd like you to think of something that you might put into the container—just for practice. Do whatever is necessary to open it up, and then place something in there. When I say "something," I mean anything, really, that may be distressing or disturbing to you right now. It could be thoughts of worries, bad feelings or bad memories …it could be something that you have to do but not right this minute. Or it could be something that keeps you from being present with this exercise. It could be self-judgment, doubt, or pain. Whatever it is, you're going to put it into the container… whatever you need to do to get it in there, do that now.

(Pause.)

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Once the disturbing material is in, close it up and lock the container. (Pause.) Now, breathe deeply as you look at the locked container, securely holding anything that you need or want it to hold.

(Breathe audibly with the exhalation longer than the inhalation.)

Notice how you feel in your body having set aside whatever distressing thing you put in your container. Can you sense that it is fully contained? Is there something that keeps it from feeling fully contained? If so, can we try opening your container and putting that in there as well? Remember that this container is yours and will hold anything and everything you need it to hold for as long as you need it to.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Now imagine walking away from your container so that it is no longer in your sight. Notice the feeling in your body now that you are no longer burdened by what you put in the container. Notice your breath -- your in-breath and your out-breath- and any sensations of relief you feel in your body. Maybe shoulders have dropped a bit, or some of the tension in your neck has subsided. Whatever feelings of relief you notice, breathe deeply and just notice.

Whatever you put in the container is now securely locked inside. It is for you to open whenever you wish to put things in or take them out.

So now, just for practice, let's go back to your container. Once you have it in sight, look closely see if you read what is written on the outside. (Pause.) Continue focusing on your breath as you continue to approach the container. When you are within reach, unlock it and open it up. As you open it notice that what you put in there is still there, separate from you. You might want to put something else in, or maybe even a few things. Or you may just wish to lock it back up. Whatever feels right and safe to you, do that now.

(Pause.)

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

Any once you're finished practicing putting things in your container and securely locking it back up, you can walk away from the container. As you walk away, begin to bring yourself and your awareness back to this room. Know that this resource -- this secure container -- is available to you at any time. Know that you can use it to hold any and all disturbing things. Know that all the things that you have chosen -- or anything that you choose to contain in the future -- will be secure and will remain secure. You can access the material whenever you feel ready to do so. But for now, you may leave it, knowing it is safely and securely contained.

(Clinician should breathe audibly with the exhalation longer than the inhalation.)

And now, whenever you are ready, gently bring yourself back to the room by counting up from one to five. When you reach the number five, your eyes will gently open. You will be awake and alert, and feeling only peace. One…two …three…Take a deep breath… four… and five.

III. Transference exercise

Individual or group

"We don't see things as they are; we see things as we are."

At the conclusion of this exercise, distribute the Attachment Patterns Worksheet. After completing the worksheet, facilitate a discussion regarding adult attachment patterns.

Instructions: Begin by conjuring up an image of your boyfriend, or husband/ wife, or a close friend. Now bring to mind some aspect of their personality to which you have a strong reaction -- positive or negative.

Write down your reaction on a piece of paper.

Now describe in some details that aspect (or those aspects) of his /her personality and your reaction to them. Write down the thoughts you have while experiencing that part of him/her write down your feelings toward that part of him/her. Write down how you behave in reaction to that part.

Now, draw a box around what you just wrote.

Write at the top of the box, "Is this transference?"

Next, conjure up an image of your parents.

Is the personality characteristic of the person that you wrote about, along with your reaction to it reminiscent of -- or in some way similar to -- your relationship with one (or both) of your parents? For example, does either parent share a particular personality trait that you react to so strongly?

Transference may be more tricky than simply reacting to others the way you reacted to your parents(s).Here are several possibilities:

- You see the other in the same way as you believed your parent to have been (simple transference)
- You see the other as being like what you WISH your parent COULD have been like.
- You see the OTHER AS YOU were as a child and you act as your parent did.
- You see the other as you were as a child and you act like you WISHED your parent could have acted.

IV. Representing feelings

Group

Instructions:

The facilitator asks participants to "choose something in the room that represents how you are feeling now."

Give some time for each participant to identify something.

During the first go-round, invite each participant to tell the group what (s) he has chosen. (If a participant is unable to identify something, ask them how they feel and allow the group to suggest some ideas.)

After each participant has identified what (s)he has chosen, go around again, allowing each to elaborate on what (s) he chose, why (s) he chose it, and what feeling it represents.

During this go- round, the facilitator should draw out group members, helping them to identify possible issues to which this feeling (s) may be related.

Identify and discuss any commonalities or themes within the group.

V. The best gift ever given/received

Group

This two-part exercise deals with giving and receiving

Instructions

Part one

The facilitator brings in a gift-wrapped box, places it prominently on display, and begins by drawing attention to the box. The facilitator then asks participants to recall in their imagination the best gift they have ever received. Allow time for the memory to become vivid in all its dimensions. Instruct the group to pay attention not only to the gift, but to their sensory experience while experiencing the memory of the gift.

On the first go-round, the facilitator asks each participant to identify just how they feel presently, without sharing any information about the gift.

On the next go-round, each participant is asked to identify the following:

- What and why (s) he felt as (s) he did
- What the gift meant to him /her

- Who gave the gift
- What it was like to receive the gift

Part two

The facilitator asks participants to once again close their eyes and recall in their imagination the best gift they have ever given. Again, allow ample time for the memory to become vivid in all its dimensions. Instruct the group to pay attention to just the gift -- what it feels like knowing (s) he will be giving it -- and then to the act of giving the gift. Pay specific attention to the receiver's reaction, along with the participant's sensory and emotional experience during the memory.

On the first go-round, the facilitator asks each participant identify the following

- Who the gift was for
- Why it was so special
- How (s) he felt at the time (s) he was giving the gift
- How (s) he feels presently

Finally, ask each participant to contrast to two experiences.

VI. Checking in with the body

Individual or group

The focusing process is based on research of Eugene Gendlin, who recognised that we all experience nascent, yet meaningful, bodily sensations for which he coined the term, felt sense. Gendlin posited that when these sensations were brought into conscious awareness, and attended to in a certain way, personal meaning would emerge. He subsequently developed a loose protocol to facilitate this process for which he coined the term focusing.

We are all familiar with emotions, but a felt sense is not an emotion. It is a new human capacity. The felt sense of a situation or problem, when it first forms, is typically vague and unclear. You can sense that something is there, but it is hard to get it into words exactly. The felt sense is holistic in nature and contains within it much more than we can easily think or emotionally know about our situation. As the therapist and client spend time with the felt sense, new and clearer meanings emerge.

The felt sense, of its own accord, brings the exact word, image, memory, understanding new idea, or action step that is needed to solve the problem. The physical body, in response, will experience some easing or release of tension as it registers the "rightness" of what comes from the felt sense. This easing of tension is what tells us that we have made contact with this deeper level of awareness and that we are on the right path. It is a body-oriented process of self-awareness and emotional healing, in which people learn to become aware of the subtle level of knowing that speaks through the body. (Cornell, 2012)

Although felt senses may occur in any area of the body, they are most often experienced in the core (abdomen, stomach, chest) or up higher in the throat. Distinct from emotions, the felt sense is better described as the feeling of the combination of sensations and emotions (e.g., if the emotion is "fear," the felt sense would contain some combination of sensations "jumpy, tense, excited, throat closing, can't speak….or "deer in the headlights feeling…..can't move"). The felt sense has an immediate here-and-now quality, transient, often vague, and not readily describable.

According to Ann Weiser Cornell Ph.D. of the Focusing Institute, the following are the *key stages of focussing*:

- "I'm sensing into my body."
- "What wants my awareness now?" or "How am I feeling about that issue?"
- "I'm saying hello to what's here."
- "I'm finding the best way to describe it."
- "I'm checking back with my body."
- "Is it Ok to just be with this right now?"
- "I'm sitting with it, with interested curiosity."
- "I'm sensing how it feels from its point of view."
- "I'm asking……"
- "I'm letting it know I hear it."
- "I'm saying I'll be back."
- "I'm thanking my body and the parts that have been with me."

Focussing instructions: short form by Eugene Gendlin, Ph.d

1. Clear a space

How are you?

What's between you and feeling fine?

(Don't answer; let what comes in your body do the answering. Don't go into anything. Greet each concern that comes. Put each aside for a while, next to you.) Except for that, are you fine?

2. Felt sense

Pick one problem to focus on. Don't go into the problem. What do you sense in your body when you sense the whole of that problem?

Sense all of that, get a sense of the whole thing, the murky discomfort or the unclear body-sense of it.

3. Get a handle

What is the quality of the felt sense? What one word, phrase, or image comes out of this felt sense? What quality-word would fit it best?

4. Resonate

Go back and forth between word (or image) and the felt sense. Is that right? If they match, have the sensation of matching several times. If the felt sense changes, follow it with your attention. When you get a perfect match, the words (images) being just right for this feelings, let yourself feel that for a minute.

5. Ask

What is it, about the whole problem, that makes me so ---------? When stuck, ask questions:

What is the worst of this feeling? What's really so bad about this? What does it need? What should happen? Don't answer; wait for the feeling to stir and give you an answer. What would it feel like if it was all OK?

Let the body answer.

What is in the way of that?

6. Receive

Welcome what came. Be glad it spoke. It is only one step on this problem, not the last. Now that you know where it is, you can leave it and come back to it later. Protect it from critical voices that interrupt. Does your body want another round of focusing, or is this a good stopping place?

Source: Eugene Gendlin Ph.D.,The Focusing Institute. In Carrying Life Forward Through Thought Retrieved, (2012), 11/20/12, from http:/www.focusing.org.

VII. Body scan: awareness of the felt sense

Individual or group

Exercises

Use the diagram on the following page. First, you will scan your body, noting your sensations on the lines next to the image.

Begin in a comfortable position -- sitting or lying down. Now, breathe deeply as you focus inward. Begin with the first segment -- focusing your attention and awareness on just that part of your body. (Although, most people begin at the top of the head, you should feel free to begin wherever you like. If you choose to skip any section, just note that.) After a few breaths into just that part, note what is/was present -- however it is… and however it may have changed. Then, using the following outline, take a moment to write your awareness on the lines next to the outline.

SENSATIONS

*The moment doing any exercise feels wrong in your body, stop following the instruction, and back up slightly. Stay there with your attention until you can sense exactly what is going wrong.

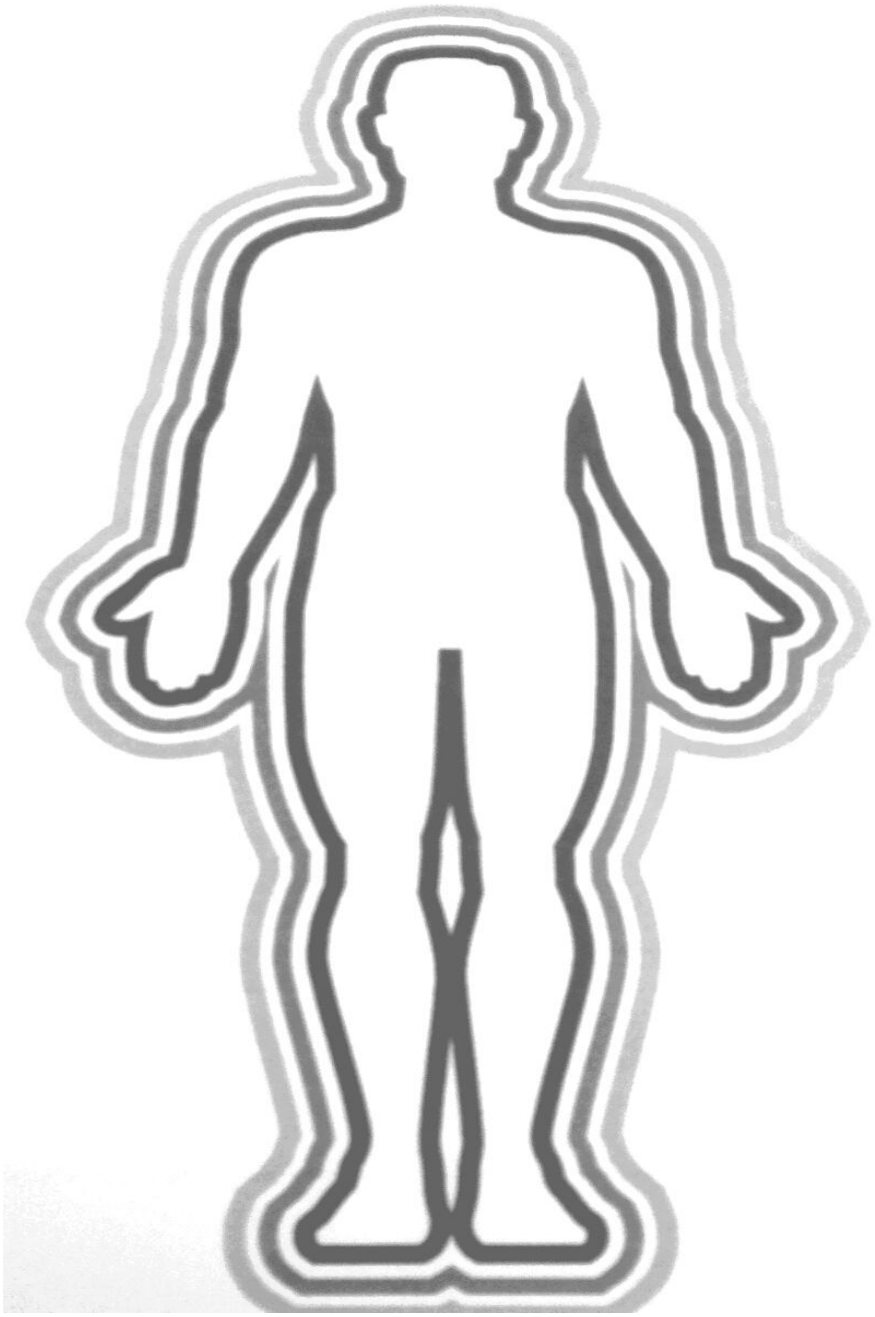
VIII. Drawing out emotion -- awareness of the felt sense

The following pages present a series of emotions. Each page contains an emotion along with space for a label and a drawing. The instructions are the same for each emotion:

1. Reflect on the emotion. Try to bring up a specific incident when you experienced this emotion strongly. Allow the space for it to expand. Pay attention to way in which you physically experience the emotion (i.e., what body sensations do you notice? Where in the body are the sensations the strongest?).
2. Using your nondominant hand, label the emotion. You may use the word or any other word or phrase that conveys its meaning for you (e.g., fear). You may write the word FEAR or you may want to write afraid, scared to death, etc.
3. Again, using your nondominant hand, draw a picture of the emotion. Use the colours, textures, and strokes that you feel appropriate to each emotion.
4. Reflect on the finished drawing.

On the lines provided, use your dominant hand to write out any of your observations and reactions to the drawing.

LABEL: ----------ANGER



Reflection

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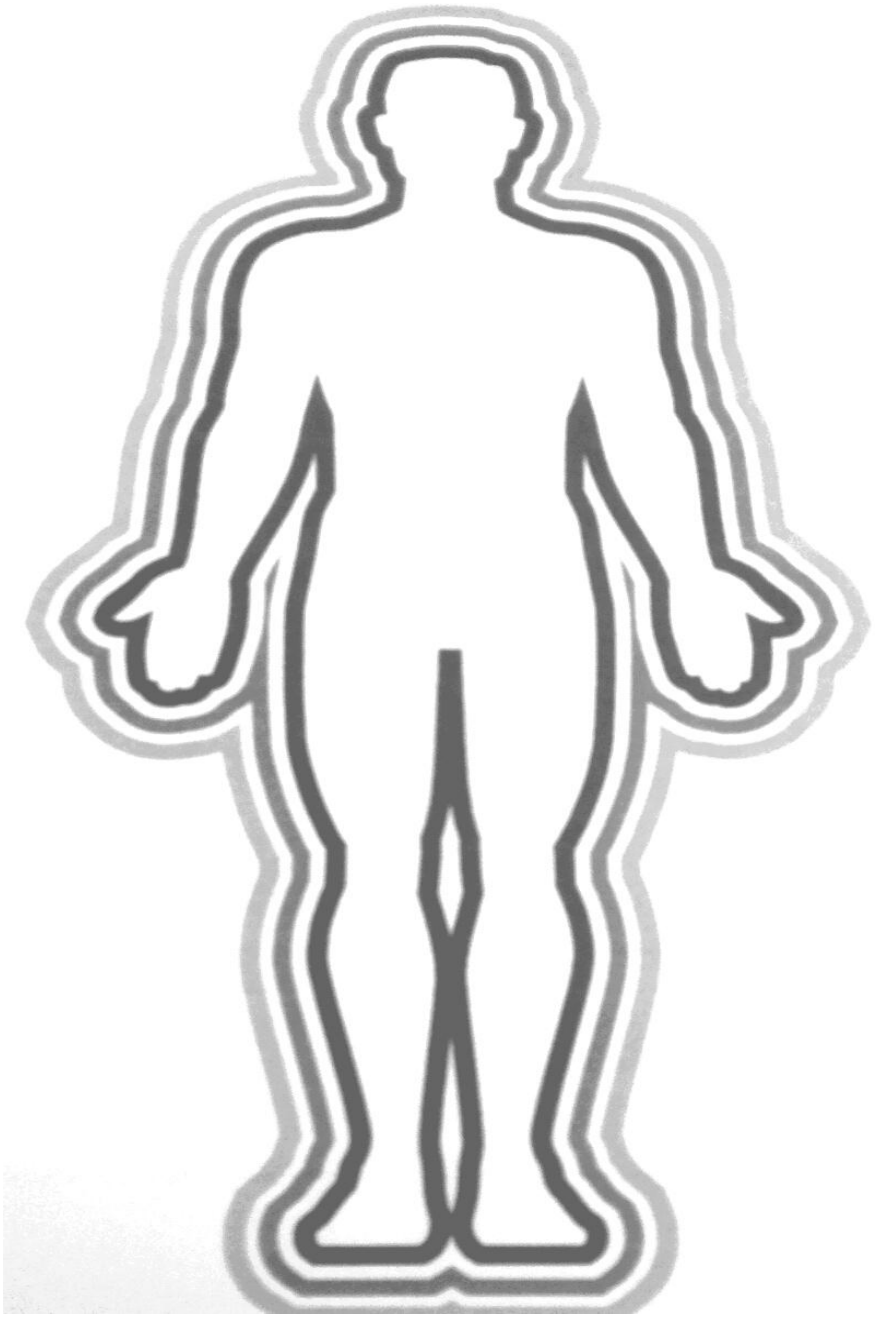
LABEL: ----------SADNESS



Reflection

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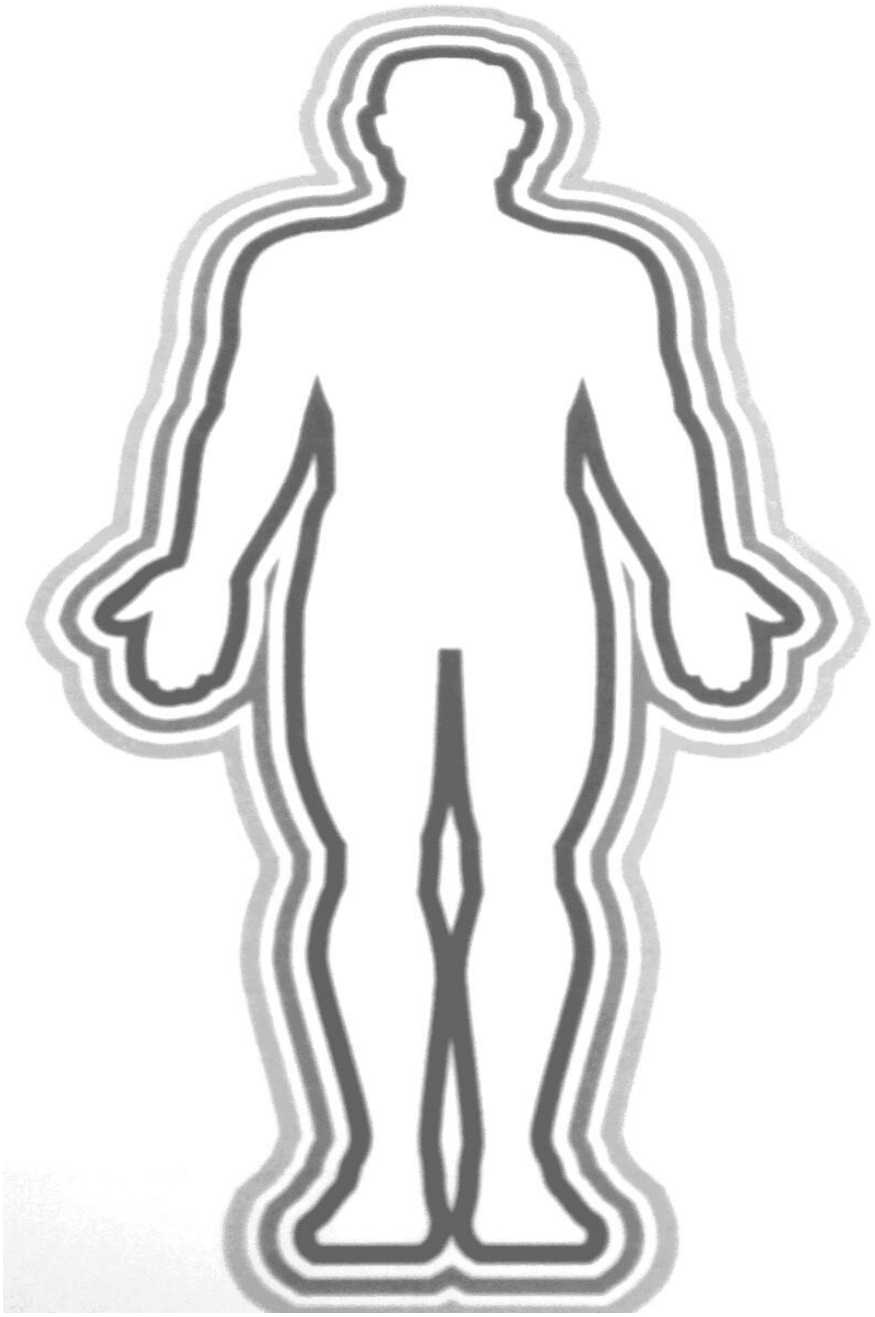
LABEL: ----------FEAR



Reflection

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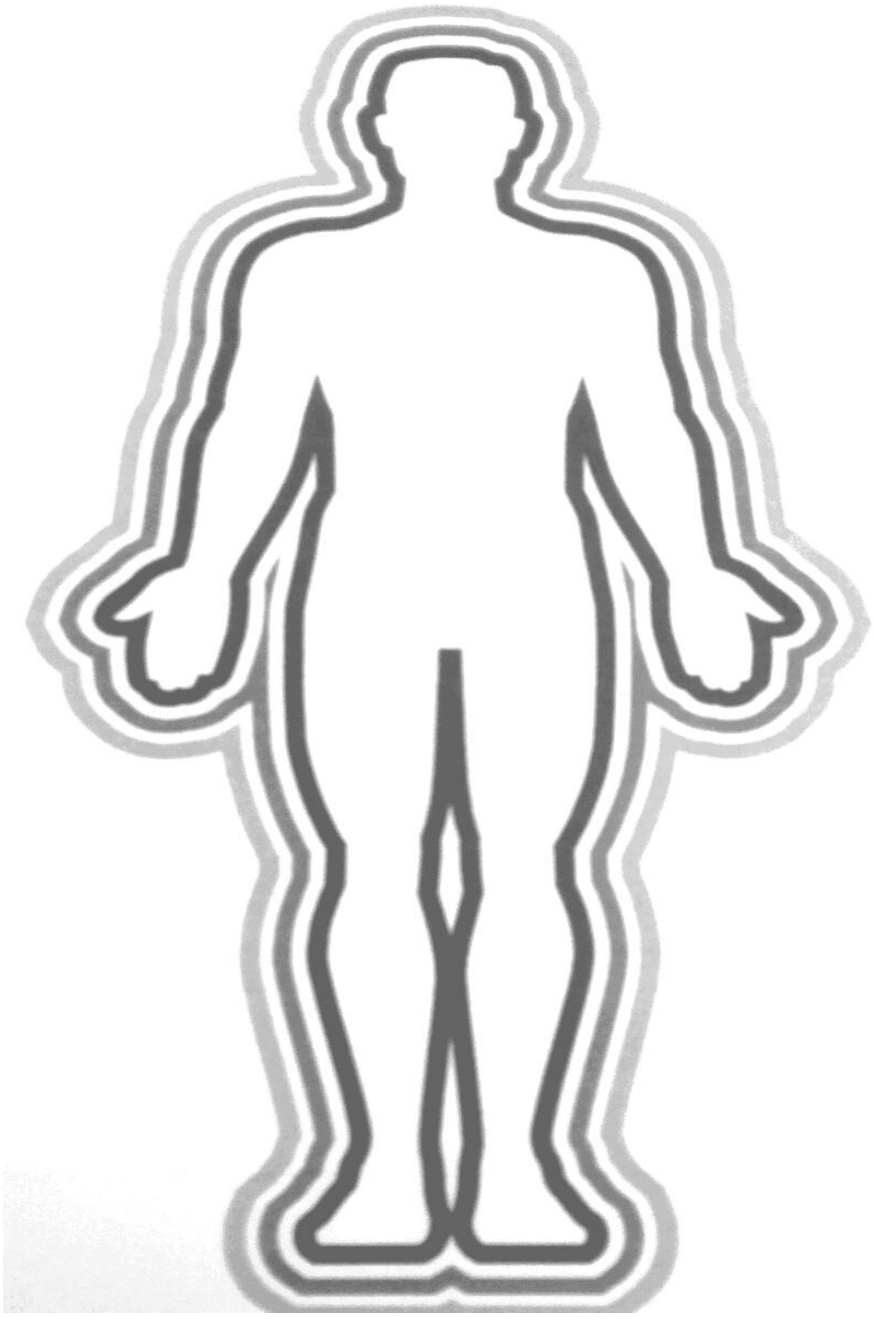
LABEL: ----------TERROR



Reflection

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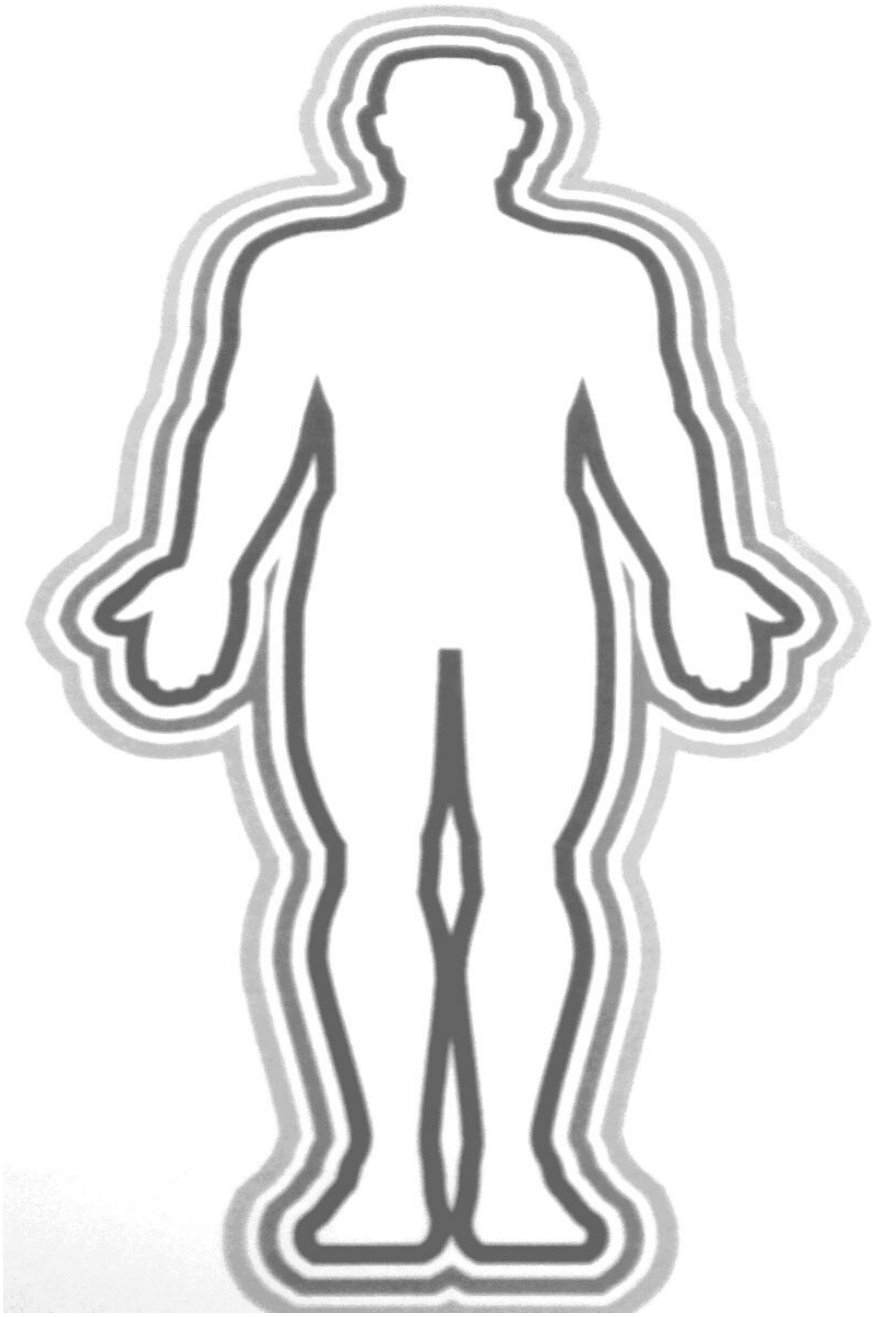
LABEL: ----------RAGE



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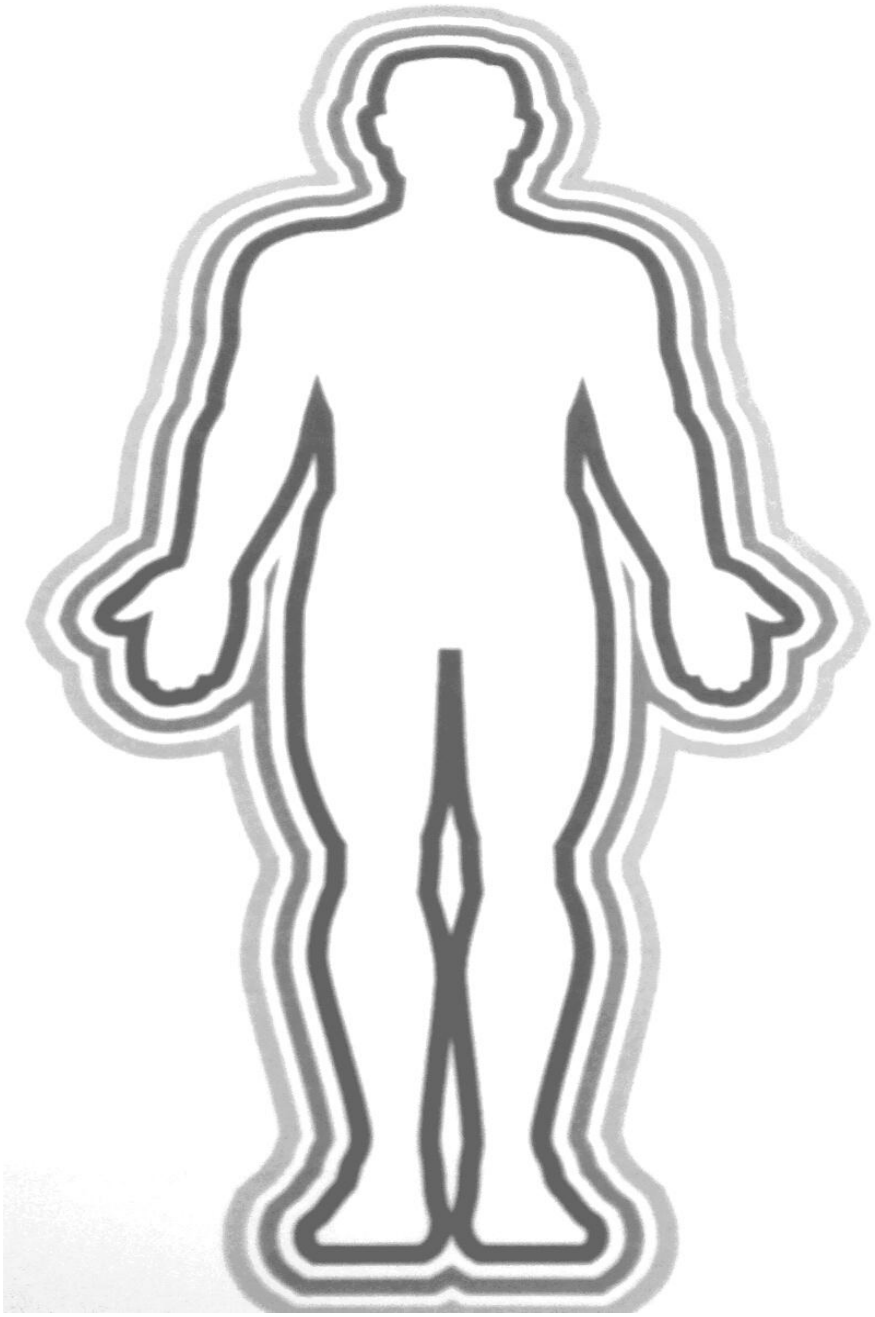
LABEL: ----------CONFUSION



Reflection

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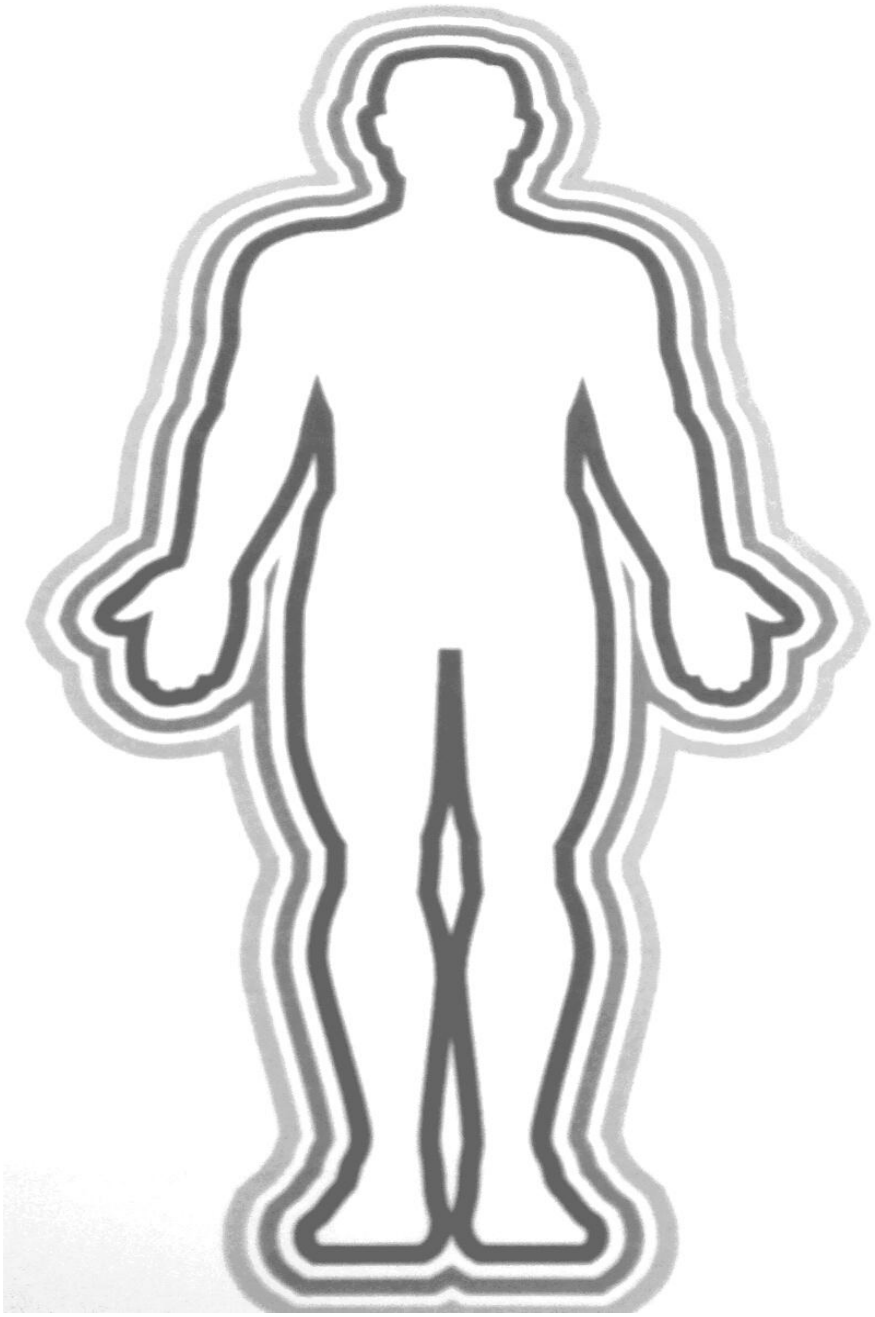
LABEL: ----------JOY



Reflection

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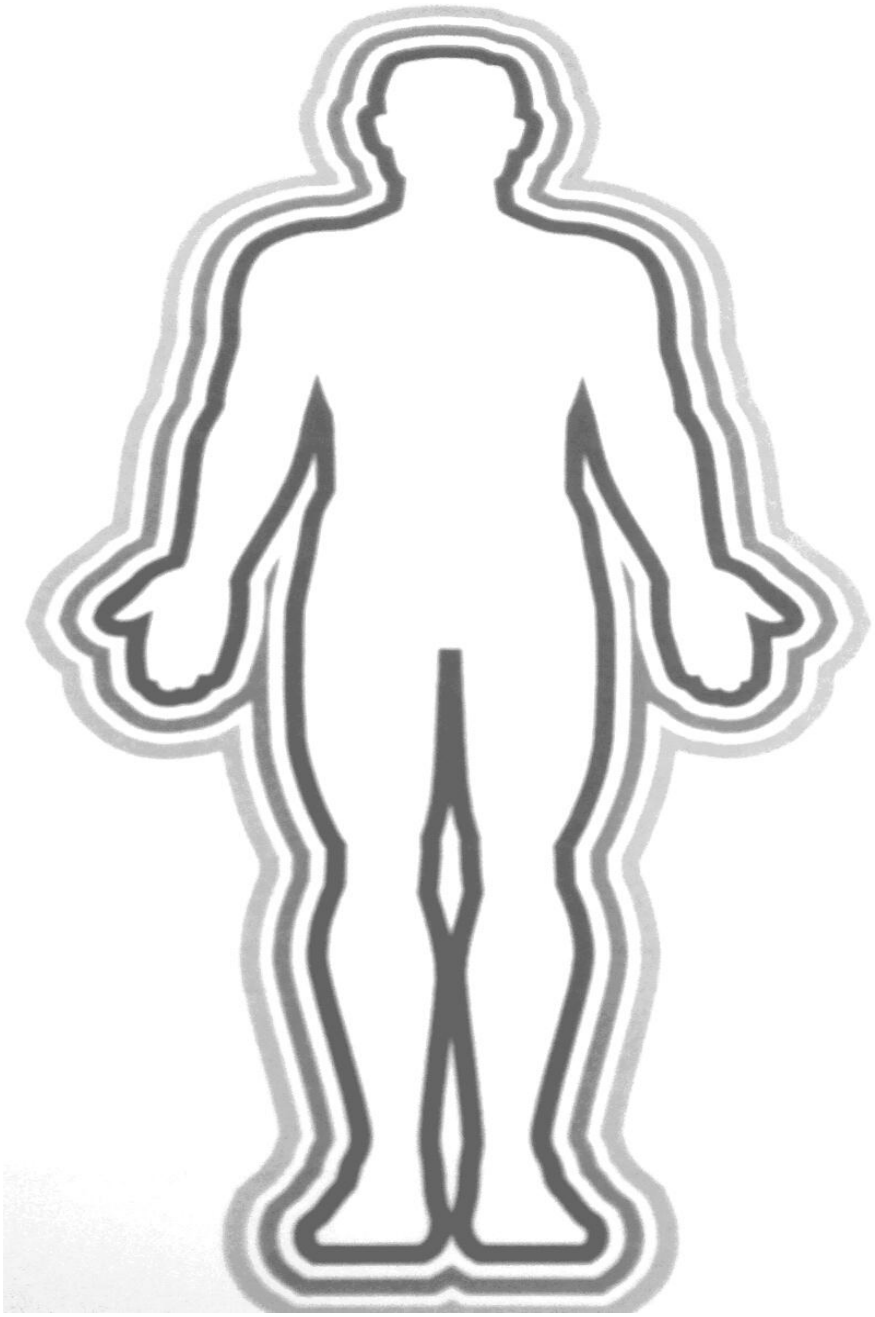
LABEL: ----------SHAME



Reflection

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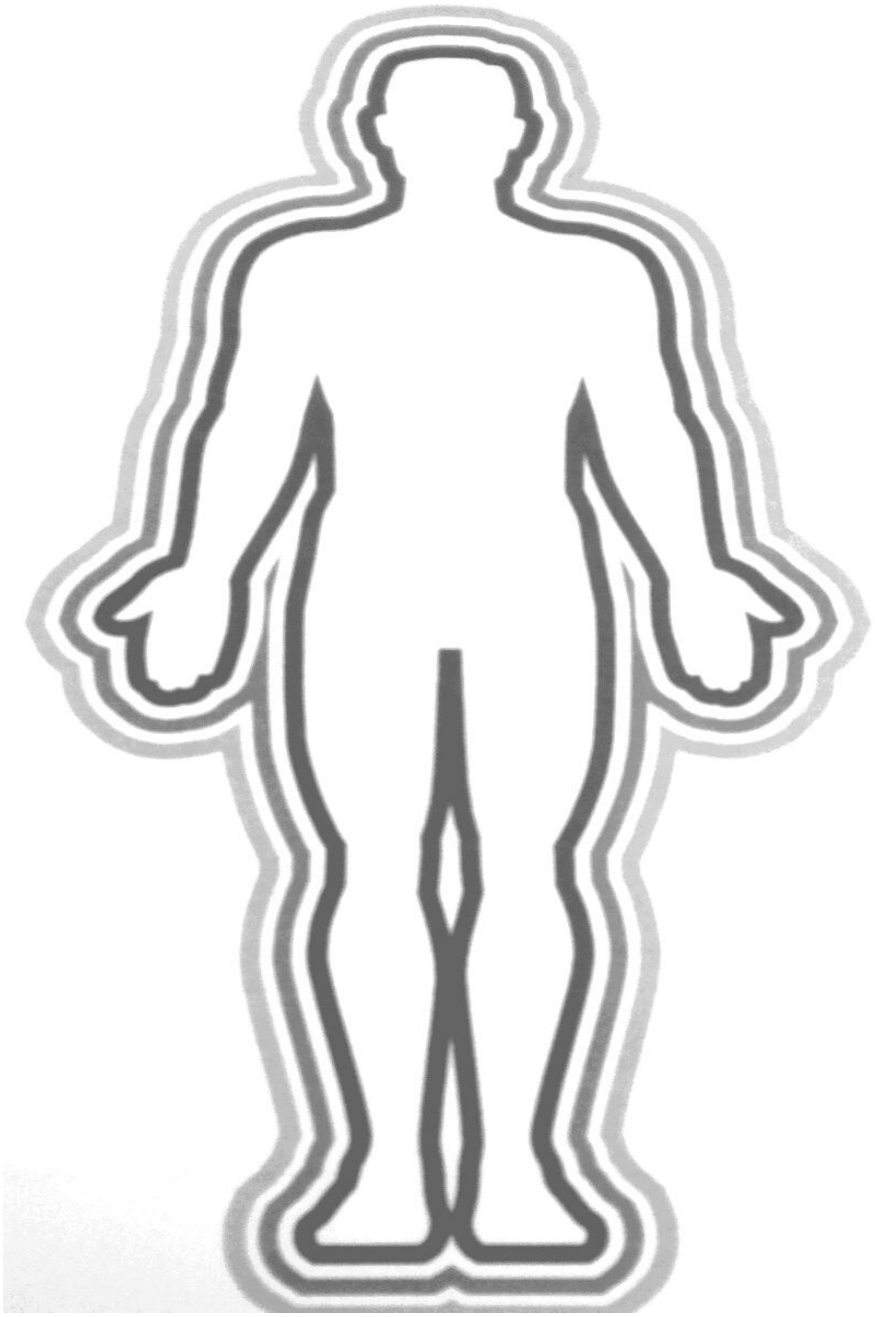
LABEL: ----------SURPRISE



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IX. Focusing on sensations -- awareness of the felt sense

Instructions:

There is no right or wrong approach to this focusing exercise; it is a process piece. Whatever you create will be right and appropriate.

EXERCISE#1

On the body map, colour in the areas where you most often experience discomfort, tension, tightness, or pain. Color in the areas where you are presently experiencing discomfort, tension, tightness, or pain. Use those colour and the type of strokes that you feel best represent the particular body sensation that you are experiencing in each area of the body. For example, if you feel jittery and nervous in the stomach, you might pick a bright colour and draw something that represents electricity in the stomach area. If you feel flighty and not really present, you might choose a light colour and draw wispy lines wherever that sensation is noted.

Once you have completed the body map, you will be using your nondominant hand to label the coloured areas with emotion word (s). Finally, on the back of the page with your dominant hand, write down any observations you have about your body map.

X. Body scan body map -- awareness of the felt sense

Exercise

Part one:

Allow yourself to be comfortable…either lying down or sitting up with your back, neck, and spine fully supported. Knowing that you will not be interrupted for the next little while, begin by gently closing your eyes. Now begin to bring your attention to your breath -- the direct experience of your breath -- however it is. …and however it changes. Allow yourself to softly focus your awareness on to the breath that is arising right now…the in-breath and the out-breath...the rising and the falling. If you can, try to follow one full cycle of the breath from the beginning of the in-breath and through its entirety. Allow yourself the time and the space to be in direct contact with the breath throughout one entire cycle. Now starting at the crown of your head, gently guide your focus down your entire body, noticing and then noting any and all sensations. Notice any tension, tightness, and any pressure; notice any sensations of warmth, coolness, pain, or areas of numbness, feelings of softness or pleasure and relaxation. Just note what is. Continue to scan, noticing any other identifiable sensations. Allow yourself to label them, and then gently bring your attention back to the direct experience of the sensations themselves. When you've completed the journey through the entire body, bring your attention back to the room.

Using the following body map, colour in all areas of the body that were calling to you…any signals of pain, pressure, tension, tightness, clam, relaxation, etc. Use those colours and the type of strokes that you feel best represent the particular

body sensation that you are experiencing in each area of the body. For example, if you feel jittery and nervous in the stomach, you might pick a bright colour and draw something that represents electricity in the stomach area. If you feel flighty and not really present, you might choose a light color and draw wispy lines wherever that sensation is noted.

Part two:

Choose the area that was signalling the loudest -- the one with the strongest sensations of pain, tension, or tightness. In the outline below, mark that body area.

Part three:

In the space provided, you will be writing out a dialogue between you and that body part. You will be using both hands, therefore both hemispheres of your brain. With your dominant hand, you will write out the questions, and with your nondominant hand you will answer the questions:

- What are you?
- How are feeling?
- How long have you been feeling bad?
- What has you feeling like that?
- Is there something you want or need from me? Is there something I can do to help you?
- Is there something I need to know from you?
- It is okay to stop now?
- Should I check in again?

DOMINANT HAND QUESTIONS	NONDOMINANT HAND ANSWERS

XI. Yoga

The effects of trauma are primarily physiological -- leaving an indelible biological imprint. Trauma can cause an inflammatory response that leads to increased fibrosis, loss of available movement between layers, and stickiness to interstitial elements, resulting in chromic conditions of structural abnormality. Trauma disrupts clients' relationships to their bodies and emotions, leaving them feeling constricted, tense, helpless, disconnected, hurt, agitated, frantic, and in conflict with themselves, others, and the world.

By now, one can hardly doubt that state of mind and state of body are intimately related. When the mind is relaxed, the muscles relax. When stressed, a state of physical and mental tension is produced. As stated by one of the giants in mind-body medicine, Dr. Candace Pert:

All systems of the body exchange neuropeptide information, and it is the internal feeling state (emotions) that elicits the neuropeptide response. This is the mind-body connection in which every change in the mental-emotional state causes a change in the body physiology. Likewise, every change in the body physiology causes a change in the mental-emotional state.

Although yoga takes many different forms, most Westerners already identify yoga with Hatha yoga, a yoga that seeks to promote health hand well-being through physical exercise. With its profound effect on the circulation and on the functioning of the inner organs, glands, and nerves, a regular practice of asanas (postures), and breathing exercises (pranayama) makes the physical body strong, supple, and healthy. In addition, yoga offers psychological and spiritual benefits as well. Addressing the body's deep sensations and emotions, Hatha yoga helps clients to address their autonomic nervous system symptoms of hyperarousal, process their traumatic memories, and gain mastery over the posttraumatic legacy of self-doubt and despair, thus appreciably changing how they organise themselves in relation to the world and aiding in reclaiming autonomy and authority over their own lives.

The Trauma Center at Justice Resource Institute (JRI) in Massachusetts has conducted preliminary research investigating Hatha yoga's effect on some common symptomatology of PTSD. The research bears out yoga's efficacy on core physiologic parameters associated with PTSD including heart rate variability (HRV).

Yoga for PTSD

"An essential aspect of recovering from trauma is learning ways to calm down or self-regulate. For thousands of years, yoga has been offered as a practice that helps one calm the mind and body. More recently, research has shown that yoga practices, including mediation, relaxation, and physical postures, can reduce autonomic sympathetic activation, muscle tension, and blood pressure, improve neuroendocrine and hormonal activity, decrease physical symptoms and emotional distress, and increase quality of life. For these reasons, yoga is a promising treatment or adjunctive therapy for addressing the cognitive, emotional, and physiological symptoms associated with trauma, and PTSD specifically."

-Excerpted from the *International Journal of Yoga Therapy*

Yoga is recognised as a form of mind-body medicine. The relaxation induced by meditation helps to stabilise the autonomic nervous system with a tendency toward either sympathetic or parasympathetic dominance. Because yoga decreases the amount of catecholamines produced by the adrenal glands during stress, it offers a host of psychological benefits. By lowering the hormone levels of the neurotransmitters norepinephrine and epinephrine, yoga produces as increased feeling of calm and well-being. Additionally, yoga is likely to reduce anxiety and depression by boosting oxygen levels to the brain.

Spiritually, a yoga practice can counter the sense of isolation often experienced by trauma clients, offering instead a sense of connection to the Divine Being or a feeling of transcendence. Yoga is the one single technique that combines and provides the benefits of breathing exercises, stretching, fitness programmes, and meditation. Because it is a system for restoring balance to the body, mind, and spirit, yoga is an ideal modality for trauma clients. By working with the body and the breath in a series of postures (asanas), yoga enables them to release muscle tension, gain flexibility and strength, and quiet the mind, helping practitioners to become more resilient to stressful conditions. Yoga can also reduce the risk of developing certain diseases such as those of the cardiovascular system.

EXERCISES

What follows are some example of posture (asana) groups with some basic instruction. Feel free to experiment. As with most things, one size does not fit all. A yoga practice should be individualised for each person. Although it's true that every posture (asana) may not be right for every person, some seem to be particularly useful to most people.

Restorative postures are poses that aim to soothe the nervous system and release muscle tension.

Examples include **Sitting/Easy Pose** and **Corpse Pose.**

Sitting/Easy/pose (Sukhasana) is a simple sitting pose.

This pose is a good starting position that will help to focus your awareness on to your breath and body, while strengthening your lower back and opening both the groin and hips.

1. Sit back on your heels, with hands resting on your thighs or cross-legged with hands resting gently on your knees.
2. Focus on your breath-however it is and however it changes.
3. Keep your spine straight, while gently pushing your sit bones down into the floor.
4. If you are seated, allow your knees to gently lower toward the floor. If your knees rise above your hips, sit on a cushion or block to help support your back and hips.
5. Take a few slow, deep breaths.

6. With the next inhale, gently raise your arms over your head.
7. Exhale while bringing your arms down slowly.
8. Repeat a few times.

As with any pose, if you find it difficult or painful, feel free to try different variation (s). In this case, it's the half-lotus posture. Instead of placing both feet on the thighs, only one foot is placed on top of the opposite thigh and the other is placed under the opposite thigh. Feel free to alternate positions to allow both knees to be stretched.

Remember, yoga should NOT BE PAINFUL !

Seated neck rolls

1. Begin by sitting in Easy Pose (Sukhasana).
2. Slowly allow your chin to sag gently toward your chest.
3. On the inhale, roll your left ear toward your left shoulder. On the exhale, come back to center.
4. On the inhale, roll your right ear toward your right shoulder. On the exhale, come back to center.
5. Continue slowly rolling your head from side to side for a few breaths, noticing any sensations that arise, including any tension, tightness, soreness, or numbness that may be there.
6. Notice your neck muscles as they contract and relax with the movement. Experiment with bigger or smaller movements' as you continue to pay attention to the effects of each movement.
7. When you are ready, gently guide your chin back to center, lifting your head up and back to center.

Corpse pose (Savasana) is a resting pose (a fully present, fully aware resting pose) that provides the body the time necessary to process and integrate information at the end of the practice.

1. Begin by gently lying down on your back. Breathing deeply in and out through your nose, gently allow your feet to fall out to either side.
2. Slightly separate your arms from your body, allowing them to rest comfortably alongside your body, with your palms facing up. If that doesn't feel comfortable to you, you might try placing your arms across your chest or lying on your side.
3. If you like, allow your eyes to close.
4. Begin to bring your awareness to your breath. Allow it to be natural---however it is….and however it changes.
5. Let your body feel heavy as you become aware of it resting on the floor. You may wish to set a timer (from a minute to several minutes).

6. After the set period, you should begin to come out of the pose, by first beginning to deepen your breath. Take a few deep breaths, as you begin to move your fingers and toes, reawakening the body.
7. When you feel ready, bring your knees into your chest and roll over to one side, slowly bringing yourself back up into a sitting position.
8. While sitting in this way, become aware of any sensations that arise.

Standing mountain pose

Standing mountain pose is a basic standing pose that improves posture, stability, and balance, centering the body and calming the emotions. It also serves as a starting position for all other standing poses. So take some time with this one.

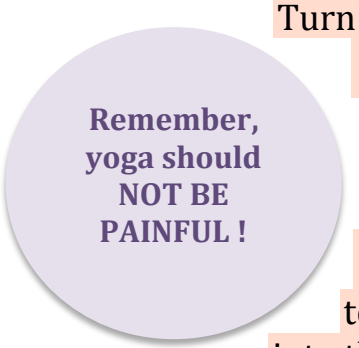
1. Begin by standing with your feet shoulder-width apart, taking notice of your feet placed firmly on the ground.
2. Rest your attention on your feet, while observing anything that comes into your awareness.
3. When you are ready, begin to slowly roll your weight onto your toes, and then come back down again. Observe any sensations…paying particular attention to the connection your toes make with the ground.
4. With your feet firmly planted on the ground, shift your awareness to the top of your head. Notice
5. Taking a slow, deep breath, begin lifting up through your core to the top of your head. Notice this feeling-a feeling of being firmly rooted to the ground-while extending your body toward the sky. Notice any sensations or emotions that accompany this standing position.
6. With your feet planted firmly under your extended body, bring your attention to the area just below your navel.
7. Rest your awareness here—your center of gravity, your core. Remain here for a moment, noticing your center.
8. Observe any sensations or emotions or emotions that accompany this position.
9. As you inhale, imagine the breath coming up through the floor, rising through your legs and torso and up into your head.
10. Reverse the process on the exhale and watch your breath as it moves down from your head, through your chest and stomach, legs and feet.
11. Hold this standing – tall posture for 5 to 10 breaths.

Remember, yoga should NOT BE PAINFUL !

Forward bend

Forward bend is a tension- releasing pose for the back, spine, shoulders, and upper body area for increasing the flow of prana or vital life force.

1. Begin by standing with your feet shoulder-width apart, taking notice of your feet placed firmly on the ground.
2. Take a breath in, bend your knees slightly, and on the exhale, gently bend forward from the hip joints, not from the waist, allowing your hands to be dangle freely in front of you (or hold the opposite forearm),as you gently reach toward the floor. If touching the floor isn't possible, you may want to cross your forearms and hold opposite elbows.
3. Press your heels firmly into the floor and lift your sit bones toward the ceiling. Turn the top of your thighs slightly inward.



4. Notice any sensations that accompany this folded-over position. Notice where your weight is, and what happens when you shift slightly to the left, right, front, or back.
5. With each inhale, lift and lengthen the front torso just slightly; with each exhale, release a little more fully into the bend, allowing your torso to oscillate with the breath.
6. Let your head hang from the root of the neck, which is deep in the upper back, between the shoulder blades. If you like, begin to move your head slightly from side to side and/or up and down, while taking notice of any sensations or emotions that arise.
7. When you are ready (of after a minute or so), gently and slowly begin to roll your spine up, once again coming into a standing position (mountain pose).
8. If you notice any tension/tightness or discomfort in your low back, place your hands on your thighs supporting yourself as you ascend.
9. Once back in mountain pose, allow your breath to return to "normal" while paying attention to how your body feels in this position.

Child's pose

Child's Pose (Balasana) is a resting pose that happens to be a great beginning yoga pose for newcomers to yoga exercises.

1. Begin by coming down onto the floor into a kneeling position. Touch your big toes together and sit back on your heels.
2. Spread your knees about as wide as your hips.
3. Exhale and lay your torso down between your thighs.
4. Gently stretching, lengthen your tailbone away from the back of the pelvis, while lifting the base of your skull away from the back of your neck.

5. Feel how the weight of the front shoulders pulls the shoulder blades wide across your back. Remain in this pose anywhere from 30 seconds to a few minutes. Stretch to the left, then the right. Remain in each pose anywhere from 30 seconds to a few minutes.
6. When you are ready to come up, first lengthen the front of your torso.
7. Take a slow deep breath as you lift from the tailbone as it presses down and into the pelvis.
8. Return to the starting position.

Cat tilt

Cat tilt (Bidalasana) is one of the simplest, yet most beneficial of all poses for releasing the muscles of the neck and upper back, increasing the mobility of the pelvis, and creating space in the joints of the shoulder and hips, while opening the lower back.

1. Start on your hands and knees. Position your hands directly beneath your shoulders and your knees directly beneath the hips. Spread your fingers out.
2. In this neutral position, you try to keep your back flat, spine fully extended, as you gaze toward the floor.
3. Press downward into the floor, as you begin lifting upward out of your shoulder and lengthen your arms.
4. Inhale deeply. As you exhale, tilt your hips by gently pulling the abdominal muscles backward toward the spine.
5. Tuck the tailbone (coccyx) down and under as you gently tighten the buttocks.
6. Press down firmly with your hands, while pushing the middle of your back up toward the ceiling. Round your spine upward, as you curl your head inward. Keeping your gaze on the floor.
7. Return to the starting position.

Remember, yoga should NOT BE PAINFUL !

XII. Finding your voice: expanding the throat

Individual or group

Most of us habitually squeeze and compress our throats, which unfortunately affects and impairs our breath, voice, and ability to swallow. The following exercise is designed to improve your ability to control and expand the size of the throat, which results in the release of the deeply held tension within the mouth and around the larynx.

1. Allow yourself to be comfortable…either lying down or sitting up with your back, neck, and spine fully supported. Knowing that your will not be interrupted for the nest little while, begin by gently closing your eyes.
2. Now begin to bring your attention to your breath—the direct experience of your breath—however it is...And however it changes. Allow yourself to softly focus your awareness on to the breath that is arising right now…the in-breath and the out-breath and the rising and the falling. If you can, try to follow on full cycle of the breath from the beginning of the in-breath and through its entirety to the beginning of the out-breath and through its entirety. Allow yourself the time and the space to be in direct contact with the breath throughout on entire cycle.
3. Now begin to focus attention on the space inside your mouth. Allow yourself to sense or visualise the space the runs down your throat and into your lungs.
4. Begin gently and slowly to squeeze the muscles of your throat and mouth, making them tighter and tighter, creating more and more tension. Notice as the tension expands and spreads into your neck, shoulders, and face.
5. Keeping your lips tightly pursed, begin to reverse the process by gently relaxing all of the muscles in and around your mouth and throat. Expand the space, allowing more and more.
6. Continue to alternately tighten and loosen the muscles, expanding and collapsing the space inside.
7. Now, with the space in your mouth closed, lips tightly pursed and your throat constricted, attempt to vocalize sounds. Begin with your name or "Hello." Pay attention to quality of the sounds that you make. Notice the vibrational difference between your normal speech and this constricted one.
8. Now, Once again, rest for a moment, and once again return your attention to the breath that is arising right now….the in-breath and the out-breath…the rising and the falling. Allow yourself the time and the space to be in direct contact with this one breath throughout its entire cycle.
9. Once again begin to expand your throat and repeat the same sounds or words. Notice the difference in the sound. Notice the difference in your chest, shoulders, and neck, as well as your jay and face.
10. Continue to alternate between expanding and constricting our throat, while experimenting with different sounds until you've developed not only awareness but conscious control over the habitual pattern of constriction and tension.

XIII. Revealing and liberating the shadow: a waking dream technique

Group

Facilitator gives the following instructions:

We are going to meditate briefly on the shadow.

Begin to conjure up your shadow self. Allow it to emerge however it chooses.

With it present, answer the following questions:

- Is it associated with a particular feeling or state?
- Is it linked to a particular place in your body?
- Intensify and stay with those feelings. When did you first experience this during your life?
- Now let the image become separate from your body; allow it stand beside you. How big is it?
- What is it made of?
- What is its connection to your body?

Begin a conversation with the shadow.

- Ask of it its purpose.
- What does it do for you?
- Why did it emerge at that particular time in your life?

Now, allow a spiritual mentor to stand with you and your shadow. Let this mentor fill you with a spiritual peace. Now, allow yourself to absorb all of its wisdom and energy.

Signal your openness, allowing the mentor to:

- Reveal to you the vision of your Higher Self(i.e., you as a completely evolved spiritual being)
- Explain how the shadow will be incorporated into that self.
- Explain the shadow's role in your spiritual evolution.
- Precisely reveal the concrete steps that your evolution will take.

Step into the Higher Self for a few moments and realize the joy, wisdom, humor, love, and opportunities lying in wait for you with this evolution.

Now ask the shadow to merge with the Higher Self. Remind it that the new self fulfills its needs and intentions in every way.

Once the shadow has merged with the Higher Self (possibly not on the first attempt of this exercise) then step into the Higher Self. Reconnect with it -- see, hear, feel your connection with it. Wait for a few moments while your Higher Self integrates with your body.

Now, allow it to give you its important spiritual message, which is of concern to you.

Slowly and gently return to this room.

XIV. Stages of forgiveness

Exercise:

This experiential format helps in understanding forgiveness as a stage model, similar to the stages of grief.

Instruction:

1. Invite each participant to choose a forgiveness issue that (s) he is currently dealing with, or is considering dealing with.
2. Print, distribute, and have participants read the worksheet, **The Stages of Forgiveness**. Print the following pages. Each page contains one of the stages of forgiveness:

Stage one: identify the perpetrator and the transgression

- I know who it was that has affected me negatively.
- I know what specific behavior (s) it was that has been physically, emotionally, or spiritually damaging to me.

Stage two: identify, experience and process the emotions

- I have felt the emotions associated with the offensive, damaging behavior. I have found a safe place to process these feelings.
- If it was safe to do so, I have spoken to the person regarding the adverse effects I endured as a result of his/ her behavior.
- If it was not safe to do so, I was able to do it in therapy using an imaginary technique (e.g., role playing, psychodrama, the empty chair, etc.).

Stage three: Understand the need for forgiveness

- I understand the benefits of forgiveness.
- I have reached a point where I recognise what has transpired, have begun developing compassion for myself, and am now able to see the perpetrator as a human being.

Stage four: Set clear boundaries

- I have set clear boundaries with the perpetrator.
- I understand my need and my right to protect myself.

I **feel** competent in setting and maintaining these boundaries to keep me physically and emotionally safe.

Stage five: integrate the past and begin recreating the future

- I have made an internal choice to forgive and have a willingness to recreate a meaningful life for myself.

3. Read each stage aloud; then place the corresponding page onto the floor.

4. Invite each participant to walk around the room, to reread each one.

5. Once read, with regard to his/her perpetrator, the participant should then choose the stage that(s) he feels (s) he is in presently.

7. Once all of the participants are in a designated area, ask the question, "Why have you chosen this stage?" Invite them to think about the answer.

8. After a few moments of reflection, instruct participants to walk to the area designated to the next stage (e.g., if participant is standing at stage one, then move to stage two, if standing in stage three, then move to stage four, etc,).

9. Once all participants have moved, ask these questions:

- Could you foresee yourself moving onto the next stage in reality?
- If so, what would need to happen for you to do that?

10. Invite them to think about their answer (s).

11. Invite participants to return to their seats.

12. Process the experience in two go-rounds:

- First go-round: invite participants to share their answer to one or both questions.
- Second go- round: invite participants to share thoughts and feelings regarding any aspect of the exercise and /or any aspect of the stages of forgiveness.

CONCLUSION

One can say a programme, organisation or system for women who have suffered acid violence and burns is truly trauma-informed when it:

- ✓ fully understands the centrality of violence in their experiences
- ✓ registers the import and intensity of the impact of trauma in their lives
- ✓ recognises the signs and symptoms of trauma they exhibit
- ✓ explores potential paths for the holistic healing of women in partnership with them
- ✓ fully integrates knowledge about trauma into its every policy, procedure and practice, and
- ✓ attempts to reintegrate women into their everyday social and community life

By integrating the efforts of health facilities, service providers, women survivors and their families and communities, this approach is one that is inclusive and integrated, where everyone has a role to play and their efforts are mutually and collectively beneficial.

This approach has proven to be truly restorative in settings where it has been applied (mental health facilities, for instance) as it a survivor-centered one. When used to heal women victims of acid and burns violence it can go a long way to restore a sense of self to women who have suffered an erosion of identity (by allowing her to rebuild her life and sense of worth with her own efforts), break down barriers of social isolation (by involving families in women's recovery) and re-integrating women into community life (by persuading entire communities to change attitudes on VAW and assist in giving women their rightful place in the community).

In the long run, trauma-informed care can help societies interested in delivering 'health with care' reach a tipping point as it paves the way for different agencies and groups to come together around a common concern. In a trauma-informed framework, health facilities, prevention programme, human rights organisations, government agencies, and civic groups get a change to work together to create healthier, safer, more healing and more productive communities. As individuals, groups, and organisations become aware of trauma and its consequences, new forms of collaboration emerge and people work together to prevent violence and trauma and to respond effectively when it does occur.

Using our own work as a pathway and through a review of innumerable academic reports, research papers and publications, we have in this sourcebook attempted to collate a range of practical, evidence-based methods, tools, strategies, resources and models to build capacity for trauma-informed approaches, care and trauma-specific services within existing health care facilities and recovery centres. We hope that it helps our intended audience and forges new partnerships to strengthen this approach.

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Appendix

Valuable information for this sourcebook and TICK -- that ASFI has developed for hospitals, service providers, acid and burns survivors and their families, with assistance from PCVC -- has also emanated from the questionnaires that we specially designed to elicit an understanding of the ground realities in our area of study and draw out feedback from stakeholders.

Our sample questionnaires are provided below to provide an inkling of how we undertook research.

Before giving out these questionnaires to different stakeholders we defined Trauma Informed and Trauma Awareness for every one of them. Their definitions are given below.

Trauma Informed: ***refers to all of the ways in which a service system is influenced by having an understanding of trauma, and the ways in which it is modified to be responsive to the impact of traumatic stress. A programme that is "trauma-informed" operates within a model or framework that incorporates an understanding of the ways in which trauma impacts an individual's socio-emotional health. This framework should, theoretically, decrease the risk of re-traumatisation, as well as contribute more generally to recovery from traumatic stress. (Harris & Fallot, 2001)***

Trauma Awareness: ***Trauma-informed systems incorporate an awareness of trauma into their work. This may include establishing a philosophical shift, with the overall system taking a different perspective on the meaning of symptoms and behaviors. Staff training, consultation, and supervision are important aspects of organisational change to incorporate trauma awareness. Practices within the agency should also reflect an awareness of the impact of trauma, including changes such as screening for trauma history and increasing access to trauma-specific services and staff self care to reduce the impact of vicarious trauma.***

SURVEY FORM
(Hospitals for Acid and Burns Survivors Care)

So what is trauma informed care for acid and burns survivors and how do I know if I am providing it?

Safety-Ensuring Physical and Emotional Safety

1. How safe is the area around the organisation's building?
2. What kinds of safety measure are taken inside the premises?
3. How would you describe the reception and waiting area? What measures are taken to make it comfortable and inviting?
4. Is staff attentive to signs of patient discomfort or unease? Do they understand these signs in a trauma-informed way?

Trustworthiness-Maximising Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

5. To what extent do the programme's activities and settings maximise trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate?
6. How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can you maximise honesty and transparency?"

Choice-Maximising Patient Choice and Control

7. To what extent do the programme's activities and settings maximise patient's experiences of choice and control?

8. How can services be modified to ensure that patient's experiences of choice and control are maximised?"

Trauma Screening, Assessment, Service Planning and Trauma-Specific Services

9. To what extent does the programme have a consistent way to
   a. identify individuals who have been exposed to trauma,
   b. to conduct appropriate follow-up assessments
   c. to include trauma-related information in planning services with the patient
   d. to provide access to effective and affordable trauma-specific services?

10. To what extent do programme or organisation administrators support the integration of knowledge about violence and abuse into all programme practices?

Staff Trauma Training and Education

11. To what extent have all staff members received appropriate training in trauma and its implications for their work?

12. To what extent and how are trauma-related concerns made part of the hiring and performance review process?

SURVEY FORM

(Service Provider in the Field of Acid and Burns Survivors Care)

So what is trauma informed care for acid and burns survivors and how do I know if I am providing it?

Safety-Ensuring Physical and Emotional Safety

1. How safe is the area around the organisation's building?
2. What kinds of safety measure are taken inside the premises?
3. How would you describe the reception and waiting area? What measures are taken to make it comfortable and inviting?
4. Is staff attentive to signs of patient discomfort or unease? Do they understand these signs in a trauma-informed way?

Trustworthiness-Maximising Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

5. To what extent do the programme's activities and settings maximise trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate?
6. How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can you maximise honesty and transparency?"

Choice-Maximising Patient Choice and Control

7. To what extent do the programme's activities and settings maximise patient's experiences of choice and control?

8. How can services be modified to ensure that patient's experiences of choice and control are maximised?"

Trauma Screening, Assessment, Service Planning and Trauma-Specific Services

9. To what extent does the programme have a consistent way to
- identify individuals who have been exposed to trauma,
- to conduct appropriate follow-up assessments
- to include trauma-related information in planning services with the patient
- to provide access to effective and affordable trauma-specific services?

10. To what extent do programme or organisation administrators support the integration of knowledge about violence and abuse into all programme practices?

Staff Trauma Training and Education

11. To what extent have all staff members received appropriate training in trauma and its implications for their work?
12. To what extent and how are trauma-related concerns made part of the hiring and performance review process?

SURVEY FORM
(For Acid and Burns Survivors)

So what is trauma informed care for acid and burns survivors and how do I know if I got it?

Assessing survivor level satisfaction with respect to hospital services

Safety-Ensuring Physical and Emotional Safety

1. How safe did you feel around the hospital building?
2. Were doctors, nurses and attending staff attentive to your signs of discomfort and unease? Were they compassionate and considerate towards you?
3. Did you have any fears (legal, police/case related, injury related, children/home related) that we were not addressed by the hospital staff .

Opinion about admitting & registration procedures

4. How difficult or easy did you and your family members find the admission and registration procedures at the hospital?
5. How would you describe the reception and waiting area? What measures were taken to make it comfortable and inviting?

Opinion about services in burns ward, nursing services, cleanliness, linen etc.

6. Was the treatment plan shared and discussed with you and your family/attendants? Did you feel involved in your treatment?
7. Were you satisfied with the level of cleanliness maintained inside the ward and toilets, linen etc.?
8. How was the quality of food and dietary plan?

Opinion about physical and emotional safety

9. How safe did you feel inside and around the hospital building?
10. Were doctors, nurses and attending staff attentive to your signs of discomfort and unease? Were they compassionate and considerate towards your emotional needs?

Opinion about Discharge and Post Hospital Care

11. Was the discharged plan shared and discussed with you and your family/attendants?
12. Was the post hospital care and plan discussed with you and your family/attendants?
13. In you opinion what changes can be made or services be included to make this more beneficial to survivors of acid and burns?

Assessing survivor level satisfaction with respect to service providers

1. Did you go to or join any organisation for post hospital care of wounds and mobility? If yes please share
    a. Name or nature/type of organisation?
    b. Duration of stay/joining
    c. Type of services received
2. How did you get referred to the organisation/service provider?

Opinion about admitting & registration procedures

1. How difficult or easy did you and your family members find the admission and registration procedures at the organisation?
2. How would you describe the reception and waiting area? What measures were taken to make it comfortable and inviting?

Opinion about services in the organisation

3. Was the treatment plan shared and discussed with you and your family/attendants? Did you feel involved in your treatment?
4. Were you satisfied with the level of cleanliness maintained inside the institution and toilets?
5. How was the quality of food and dietary plan? (in case your were a resident client)

Opinion about physical and emotional safety

6. How safe did you feel inside and around the building of the institution?
7. Were doctors, nurses and attending staff attentive to your signs of discomfort and unease? Were they compassionate and considerate towards your emotional needs?

Opinion about Discharge and Post Hospital Care

8. Was the discharged plan shared and discussed with you and your family/attendants?

Opinion about benefits of joining such an institute

9. Do you think the services provided to you at the institute were beneficial to you? Elaborate.
10. In you opinion what changes can be made or services be included to make this more beneficial to survivors of acid and burns?