INTEGRATING THERAPEUTIC INTERVENTIONS INTO GENDER-BASED VIOLENCE CASE MANAGEMENT

NORWEGIAN CHURCH AID

actalliance

ACKNOWLEDGEMENTS

This resource represents the need Norwegian Church Aid identified to strengthen the capacity of case workers to respond to the psychological symptoms' survivors may experience through more in-depth therapeutic techniques during the case management process. Due to COVID-19 the piloting of the resource is postponed to later in 2020. It will be piloted in two NCA GBV programmes including Iraq and Bangladesh and thereafter revised where needed.

This resource aims to deepen the work GBV case workers already do with survivors in humanitarian settings and is meant to be completely integrated and complementary to the Interagency Gender-Based Violence Case Management Guidelines, 2017. This resource and the accompanying training guide are intended to be used with the GBV Case Management guidelines and process.

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*Consent was obtained for all photos used in this resource. No photos depict survivors of GBV.

Picture on front page: Havard Bjelland, South Sudan, 2019.

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Kelly Joseph, DRC, 2019

PART 1. INTRODUCTION TO THE THERAPEUTIC MODULE

THE RELATIONSHIP BETWEEN CASE MANAGEMENT AND MENTAL HEALTH AND PSYCHOSOCIAL WORK

Gender-based Violence (GBV) case management and Mental Health and Psychosocial Support (MHPSS) both operate within the psychological and social worlds of survivors of GBV. Each sector acknowledges that a survivor's distressing emotions, thoughts, behaviour and functioning are interconnected with their physical, social, familial, and spiritual environments. Psychological and social spheres are not separate, instead, they constantly influence each other.

MHPSS has traditionally been defined as *"any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders."*[1] MHPSS combines two kinds of care: Mental Health and Psychosocial. GBV case management focuses on psychosocial components whereas this guide uses the term 'therapeutic' as it is more focused word, rather than the words 'psychological', 'psychosocial' or 'MHPSS,' to highlight this resource's strong focus on therapeutic techniques and approaches to address symptoms and to distinguish it from the 'social,' or 'practical' focus of case management.

There has been an increase in the use of therapeutic interventions in GBV work as well as the publication of multiple guidelines on promising practices in the GBV field. Despite this, there continues to be a wide gap between popular practices and documented models of blended MHPSS GBV interventions. This module situates itself within global GBV and MHPSS guidance (GBV Area of Responsibility's Interagency Minimum Standards for GBV in Emergencies Programming 2019, GBVIMS Steering Committee's Interagency GBV Case Management Guidelines 2017, MHPSS.net's MHPSS Emergency Toolkit 2017, IASC MHPSS Guidelines 2007). Global MHPSS and GBV standards provide a robust framework to create new promising practices.

Currently, GBV Case Management process follows these 6 steps to meet the survivor's needs.

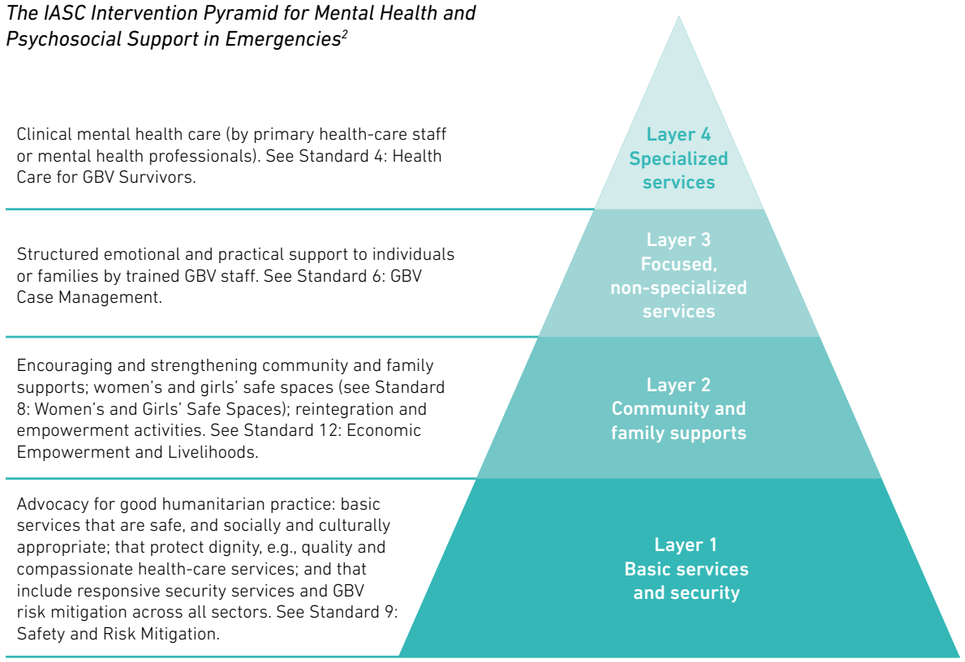
Step 1: Introduction and Engagement
Step 2: Assessment
Step 3: Case Action Planning
Step 4: Implement the Case Action Plan
Step 5: Follow-up
Step 6: Case Closure

GBV case management, when engaging with a survivor-centred approach, is considered to be a form of MHPSS, existing on the third level of the MHPSS pyramid (see below) which involves focused and non-specialised psychosocial services.

GBV caseworkers in humanitarian and many development contexts are truly the frontline staff providing life-saving services, often without the support of more specialised mental health professionals. Every day, these caseworkers are actively preventing vulnerable survivors from needing higher levels of the MHPSS pyramid, such as specialised psychologists and psychiatrists. Strengthening caseworkers' therapeutic techniques is essential and the aim of this resource (see further explanation for MHPSS pyramid in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.)

[1] IASC Mental Health and Psychosocial Support in Humanitarian Emergencies 2007, refer to page 1.

The IASC Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies[2]



Source: IASC 2007.

PURPOSE OF THIS MODULE

This resource outlines a module which includes therapeutic techniques and specific approaches to working with symptoms. This resource is not a stand-alone module. It is created for caseworkers who work with GBV survivors and should be integrated into and used together with the Interagency GBV Case Management Guidelines, 2017[3]. The practices in this module are consistent with the GBV guiding principles of right to safety, right to confidentiality, right to dignity and self-determination and non-discrimination.

This resource integrates multiple therapeutic approaches (see section on Theoretical Frameworks and Core Concepts). It does not explore the full range of complex psychosocial symptoms that GBV survivors experience; instead, it has aimed to target commonly seen symptoms in GBV survivors.

This resource aims to:

- Therapeutically deepen the GBV case management process by integrating 12 additional techniques at all levels of case management (Part 2).
- To provide knowledge and specific targeted techniques to work with 11 symptoms commonly seen among GBV survivors (Part 3).
- Utilise a pre- and post-assessment to assess and track the survivor progress and change.

[2] GBV Area of Responsibility. (2019). The Inter-Agency Minimum Standards for GBV in Emergencies Programming, page 38.

[3] Interagency gender-based violence case management guidelines, 2017.

STRUCTURE OF THIS MODULE

The resource is divided into the following 6 main sections:

Part 1: Introduction

Part 2: Therapeutic Techniques: This part outlines 12 Therapeutic techniques that caseworkers can use in their case management work with survivors.

Part 3: Working with Specific Symptoms: This part outlines information and techniques on 11 common symptoms that caseworkers encounter in their case management work with GBV survivors.

Part 4: Appendices: Handouts and exercises for survivors.

Part 5: Glossary: Important terms.

HOW TO USE THIS MODULE

Imagine that you are working closely with a survivor to create a detailed plan for them to find a job. Despite the assistance, when the time comes, the survivor fails to attend the scheduled job interview. You are confused and maybe frustrated and when you speak with her, she starts to cry, saying, "I can't do it. I am just too tired to go. I am always so tired."

This is a time in case management to ask yourself questions such as, "What else might be wrong here? What is behind what this woman is saying? What are her actions and emotions telling me that her words are not? What in this survivor's life is blocking her from moving from point A to B?"

Due to the severe psychological impact of GBV on many survivors, every caseworker will experience 'stuck moments' like this where they may not know what to do or say. In these moments, while taking a survivor-centred approach the caseworker can turn to this resource, using it as a reference guide on how to move the work forward in a way that is not too painful for the individual. The ideas and techniques in this module do not replace the 6 case management steps; instead, this resource gives caseworkers an added therapeutic dimension to their already existing case management work and skills.

Managers and/or supervisors are encouraged to train their teams on all of the techniques in the module. However, the techniques can also be taught individually. Managers/supervisors can determine which topics and techniques are suitable for their team and their context. For example, you may choose to focus on Relaxation and Grounding Techniques and deprioritise Cognitive Restructuring. Consulting local MHPSS specialists and/or Head Office specialists can guide you in making such decisions. Keep in mind that teams should be ***first*** trained on GBV Case Management and GBV Core Concepts.

Additionally, managers/supervisors can use this module—and its accompanying training materials—during individual and group supervision, as well as team meetings or other fora with caseworkers. Managers/supervisors can refer to specific sections to review core concepts or techniques, conduct a refresher training on a particular topic, or explore with caseworkers different ways they have used a technique with their clients. Reviewing techniques as a group is helpful for caseworkers to share successes and challenges when using the techniques, practice teaching and using the techniques with each other (i.e., role play), and receive feedback on how to incorporate different techniques into their ongoing work with survivors. Some of the techniques in this module can also be adapted for use in group psychosocial activities, e.g., at women's centres.

CONTEXT AND TARGET AUDIENCE FOR THIS MODULE

This resource is designed for humanitarian settings but that include both emergency and development contexts, including refugee, internal displacement, statelessness, conflict and natural disaster situations.

This resource has been written for caseworkers who are trained on the Interagency GBV Case Management Module and GBV core concepts. It is recommended that caseworkers have several months of experience delivering case management services to survivors before being trained on the techniques in this module (see Training Manual for more information).

This resource can be adapted, as needed, to meet the training needs of lay counsellors, community workers, nurses, teachers, and others who are working directly with at-risk survivors of GBV.

CULTURAL USE AND ADAPTATION OF THIS MODULE

This module acknowledges that every culture understands, expresses and heals emotional distress in different ways. Local understandings and healing strategies should, whenever possible, be merged with tools from this resource. This module also recognizes that oppression, marginalization and abuse of power cause and exacerbate the emotional distress and other psychosocial issues GBV survivors face.

A suggested framework for understanding existing power dynamics within the community is analysing prevailing Policies, Practices and Beliefs. The intersection of policies, practices and beliefs create power imbalances that ultimately cause and/or contribute to GBV, as well as other psychosocial issues that survivors may face (e.g., housing instability, food insecurity, lack of economic opportunities, etc.). Additionally, a community's policies, practices and beliefs are capable of both helping and hindering survivors' ability to recover and heal. Each survivor's unique mix of identities intersect to influence how she is affected by the policies, practices and beliefs in her community. Even if a caseworker and a survivor come from the same community, it is imperative for caseworkers to step back and examine what beliefs, practices and policies exist and how they influence this survivor specifically. It will impact how a survivor views and makes meaning of her problems. And it will shape what support caseworkers may offer her.

Sexism as Policy, Practice and Beliefs

Policy: A sexist policy is any policy that produces or sustains gender inequality, including one that fails to protect marginalized gender identities. Policies can be written and unwritten laws, rules, procedures, processes, regulations, and guidelines that govern people, and can include organizational policies, banking guidelines, rental agreements, court rulings, and religious doctrine.

Practice: Gender discrimination is the manifestation of sexist policies, i.e., the actions or practice of sexism. Everyone can discriminate through their action or inaction, but it is typically a select few people in power who create policies that produce discrimination. Violence and threats are two examples of practices.

Beliefs: A sexist belief is one that suggests one gender is inferior or superior to another gender in any way. Sexist beliefs explain the inequities caused by sexist policies.

Understanding the culture and the survivor's identities is not enough. If services are to be survivor-centred, caseworkers must extend that inquiry to themselves and critically self-reflect. Caseworkers—like survivors—are also influenced by prevailing cultural beliefs, practices and policies, and caseworkers can in turn affect survivors. Caseworkers' beliefs, identities and experiences impact the way they see and interact with survivors, as well as the way survivors see and interact with them.

Two concepts that are key to self-reflection, understanding survivors, and analysing power dynamics between caseworkers and survivors are:

- **Intersectionality:** The ways in which one's identities overlap. This contributes to a person's level of power and vulnerability in different contexts, as well as the way they experience the world. Intersectionality is important to consider when meeting with survivors. For example, a caseworker and a survivor may both be women, but their different ages or ethnic identities may change how they were socialized as women and the experiences they each have as a woman in their family and community.

- **Socialization:** The process of learning the acceptable norms and beliefs of one's culture. Put simply, how a person learns what it means to have and practice their identities. Socialization gives these identities meaning that differs from culture to culture. Based on each of their social identities, a person learns how to think about oneself and others; how to interact with others; how to understand what is expected of them; and what the outcome is if they deviate from what is expected of them. For example, someone could ask themselves "What does it mean to be a woman in my culture?" to start exploring how they were socialized as a woman.

Caseworkers help survivors navigate their world given the limitations and power afforded to them by their identities and ways they were socialized. And at times, caseworkers help survivors renegotiate their identities and redefine how they want to be, despite policies, practices and belief that may try to hold survivors back or harm them for acting differently than the norm. Intersectionality means that caseworkers may share one or more identities with survivors, but their dissimilar identities means they experience the world differently. Survivors and caseworkers also may have been socialized differently about their shared identities or have chosen to differently define what it means to be that identity. At times, the ways a caseworker has been socialized about a particular identity (e.g., an ethnic group other than their own) may lead them to value certain identities over others, which in turn can cause them to discriminate against entire groups of people based on a particular identity. That is why it is essential for caseworkers to engage in regular self-reflection by asking questions such as:

- How do my social identities shape my worldview?
- How does my own background help or hinder my connection to clients/communities?
- What are my initial reactions to clients, specifically those who are culturally different from me?
- Do I believe certain identities are better or worse than others (i.e., biases)? How does that impact how I view survivors with those identities?
- How do my identities affect my relationships with survivors?
- Do any of my identities make it harder for certain survivors to talk to me?
- How do I make clients comfortable to name their own identities?
- Which identity differences may create power imbalances between me and a survivor?
- For the identities I share with a survivor, do we define these identities differently?
- How do our other identities shape these definitions?

Additional questions that guide self-reflection can be found at the end of each section in Part 3.

Understanding culture means understanding that women's voices have historically been ignored and dismissed. Caseworkers offer survivors a different—and ultimately healing—experience. Meeting with a survivor is an opportunity to show them that their voice is important and can grow louder. A survivor-centred approach allows a survivor to define the outcomes they want in their life, not what a caseworker thinks the survivor should want. A caseworker is patient, giving the survivor the time and space to figure themselves out and reclaim their dignity. Trying to change in the context of deeply

ingrained cultural beliefs and systems of oppression is difficult, scary and takes time, so caseworkers work slowly. Caseworkers recognize that oppressive policies, practices and beliefs have caused a survivor stress. And this stress caused emotional suffering and other psychosocial issues. Whenever possible, caseworkers help survivors understand that the problem is not within themselves; it is located in the harmful beliefs, practices and policies that led to violence against them.

Throughout this module, readers should keep in mind the effects of cultural beliefs, practices and policies and adapt interventions accordingly. There are many other ways you will need to adapt this module for the local community and for the individuals you are working with. Some of the issues you should think about are as follows:

- Include appropriate local ideas, metaphors, proverbs and myths about distress and healing.
- Learn the cultural names for the mental health challenges you are discussing with survivors. There are often therapeutically useful local metaphors and stories attached to these names.
- Meet early with traditional healers, elders, or spiritual leaders to acknowledge their expertise and to convey your interest in understanding local cultural practices.
- Affirm continuity of identity across time and space. Survivors' lives did not start today (i.e. they are not *just* refugees in a refugee camp). They have a story. Work with all the layers of their cultural identity. Be especially attuned to strengths in ways of thinking and acting. These may have been overshadowed by the trauma they experienced.
- Be gently curious. Cultivate a stance of curiosity when working with survivors.
- Think carefully about how the person's therapeutic style influences their relationships with others and how their social setting influences how they think and feel.
- Explore the survivor's understanding of why they have the specific psychological symptom(s) they do. This is important as it will shape the treatment. For example, nightmares believed to be caused by a traumatic event versus djinns (evil spirits) haunting the person require different types of treatment.
- Explore if the symptoms you are seeing in the survivor are culturally normative or not (e.g., fainting, seeing spiders everywhere after it rains).
- Think about sociocultural differences in how help should be offered (e.g., groups, individuals, peers).
- Think about gender, age, religious and ethnic dynamics and what this may mean for your work.
- Understand the differences in terms of locally available resources (formal and informal) to protect people who are at acute risk of sexual and gender-based violence.
- Adapt any pictures and graphs used in this module to your context.
- Rework methods and questions according to your unique context (i.e. disaster work, or longer-term development work).

This section is an introduction to the ways in which culture and power influence affect both survivors and caseworkers and impact the therapeutic relationship. The Interagency GBV Case Management Guidelines can be helpful in exploring specific topics further, especially Part I on the survivor-centred approach, Part III on specific issues for women and adolescent girls, Part IV on working with other vulnerable groups, as well as the Survivor-Centred Attitude Scale.

TERMS USED IN THIS MODULE

A brief note on the terms used in this resource.

The term 'therapeutic' is more of a focused word throughout this document, rather than the words 'psychological', 'psychosocial' or 'MHPSS,' to highlight this resource's strong focus on therapeutic techniques and approaches to address symptoms and to distinguish it from the 'social,' or 'practical' focus of case management. Mental health services should be delivered by a specialist in mental health/psychology; however, caseworkers can be trained to work therapeutically with survivors, (level 3 in the IASC MHPSS Intervention Pyramid, see later in this module).

The term 'survivor' is used here rather than the term 'client' or 'patient,' to highlight that the techniques and tools in this resource have been created for GBV survivors' unique experiences of layered trauma.

The term 'caseworker' is used here to describe the frontline worker who is delivering therapeutically oriented case management services; however, this term can be replaced with social worker or community worker based on context.

CRITERIA FOR WHEN TO REFER PSYCHOLOGICAL CASES

A referral to psychological, psychiatric, or more focused mental health services should happen immediately if the survivor meets one of the following three criteria items:

1. If the survivor is actively suicidal or homicidal (i.e. has a plan, means, intent and/or time set).
2. If the survivor presents with signs of severe mental illness, such as psychosis, mania or mood swings.
3. If after the caseworker has attempted to de-escalate the person, they continue to stay in an extremely agitated, inconsolable state.

Supervisors should be consulted on any cases that caseworkers have questions or uncertainties about.

THEORETICAL FRAMEWORKS AND CORE CONCEPTS

The module and its accompanying training manual seek to explore and highlight the value of cultural, spiritual and indigenous philosophies and healing practices. They also introduce a wide variety of therapeutic techniques as an offering of something new or different that caseworkers can try. This is done with the understanding that not all techniques are appropriate for every context or survivor. An effective psychosocial technique is the one that the caseworker feels most comfortable using and the survivor feels best matches her needs and the ways she sees the world.

This module uses techniques primarily from Cognitive Behavioural Therapy (CBT)—a structured approach that is based on cognitive theory and behavioural theory—and modalities that are based on or draw from CBT, such as Dialectical Behavioural Therapy (DBT), Cognitive Processing Therapy (CPT), Acceptance and Commitment Therapy (ACT), and the World Health Organisation's (WHO) Problem Management Plus (PM+) intervention. The module also integrates elements of Exposure Therapy, Narrative Therapy and Motivational Interviewing. See the glossary for further descriptions and reference list for further reading.

This section details theoretical frameworks and core concepts that are used throughout the module:

Trauma

Definitions of trauma and the terms used to describe it vary across cultures and languages. The word trauma comes from the Greek word for *wound*. A simple definition of trauma could be: the result (or wound) caused by something that is overwhelming, inescapable, frightening and goes beyond what we are prepared to handle.

A wide range of experiences can be traumatic: from single events (e.g., rape, car accident, death of loved one) to multiple, prolonged or ongoing experiences (e.g., emotional abuse and neglect, intimate partner violence, harassment, group-based discrimination, war, colonization, famine). Spiritual and supernatural events may be traumatic for some people. As such, trauma can be experienced individually or collectively. Secondary (or vicarious) experiences, such as hearing accounts of violence or witnessing violence against someone else, can cause trauma. Trauma can also result from the immense daily stressors and horrors that survivors face; these stressors comprise a long sequence of small wounds or threats to their basic survival and physical existence. This may include unstable housing, poverty, hunger, unemployment, sexual exploitation, traumatized family members or communities, community insecurity, in addition to GBV. Inequalities and threats in these areas affect survivors' wellbeing and are feminist issues that can be addressed in both GBV response and prevention work.

Keep in mind that people are not equally vulnerable to or affected by potentially traumatic events, like GBV. Meaning, some individuals and communities are more likely to experience trauma than others. Also, not everyone who experiences the same situation or conditions will have the same response or suffer in the same way. Different cultures may have different beliefs about the reasons that traumatic events occur and people suffer. There are also several cultural, neurobiological, genetic, behavioural, emotional, spiritual and supernatural explanations for intergenerational trauma; that is, trauma passed down from ancestors and passed on to descendants.

Common Reactions to GBV

The ways in which individual survivors are affected by GBV varies from individual to individual and is influenced by their culture. GBV can impact survivors across various domains, including interpersonal, cognitive, emotional, spiritual, physical, behavioural, economic, and communal participation. Caseworkers can share examples of common reactions to GBV with survivors. These common reactions will typically be specific to each culture. Additionally, the words and phrases survivors use to describe their reactions will vary across cultures and languages, and may differ between genders, ages and other identities. And survivors may interpret the same reactions differently. Caseworkers should seek to understand how each survivor they support has been affected by the GBV they experienced, the words and phrases they use to describe their experience, and the interpretation (or meaning) they have given to these reactions.

One way caseworkers can view a survivor's individual reactions is as attempts to feel safe in the moment. For example, isolating from loved ones may be an attempt to create safety in a world that feels out of control or to avoid feelings of shame. Anger may help a survivor feel protected when they feel they are treated unfairly.

Though the description and interpretation of physical reactions to trauma, fear and stress may differ across cultures, the physical reactions tend to be the same for all people because human bodies are designed to try to protect themselves. These physical responses in humans are similar to those in animals. They happen fast, unconsciously, automatically and often without one's awareness. In times of danger, the body responds in one of more of the following ways:

- **Cry for Help:** This is often the first response, or it occurs at the same time as another response. A survivor may seek out others for help (e.g., yell, call) or talk to the perpetrator to try to prevent or reduce the harm.

- **Fight:** A survivor may attempt to fight back. Their body will tense in readiness, and their heart rate will increase to pump blood to areas of the body that are needed to fight.

- **Flight:** A survivor may try to run away from danger, and their body physically responds in a similar way as the fight response (e.g., muscle tension), i.e., if she were to flee.

- **Freeze:** A state that may be describe as "scared stiff" or "paralyzed by fright," in which a survivor's heartrate drops, breathing slows, temperature lowers, and muscle tense. Another form of freeze is when a survivor feels "wired" with lots of energy inside them and is ready to explode in movement when needed—a precursor to fight or flight.

- **Submit:** When no other options are available—or they are ineffective—and the threat is still present, a survivor may "submit," a state in which muscles become limp, breathing stops and they faint, heartrate drops, blood pressure falls, and contents of bowels may release. This state in a way shields them from the pain that is about to come.

No one response is better than another; each is potentially adaptive and effective, depending on the circumstances. However, survivors may feel shame about the way they responded. Caseworkers can help survivors remember that their response was instinctual, automatic and protective. The important part is that they survived. The image on page 17 describes the physiological changes that occur when a threat is perceived and fight or flight is activated.

However, the body activates its fight, flight, freeze or submit response not only in times of real danger; it can also occur when survivors perceive something as dangerous when it is not—like a job interview, travel, public speaking—or it reminds her of something that was associated with danger in the past (i.e., trigger). The term anxiety is often used to describe the uncomfortable feelings people have when

they are in fight, flight or freeze mode, though they are not in danger. The mind may worry a lot which causes it to perceive it is in danger, so the body tries to protect itself by going into fight, flight, freeze or submit as if the danger is real. Survivors may then respond to safe, everyday situations as if they were dangerous, and react in ways they do not want or understand (See section on Identifying Triggers for more information).

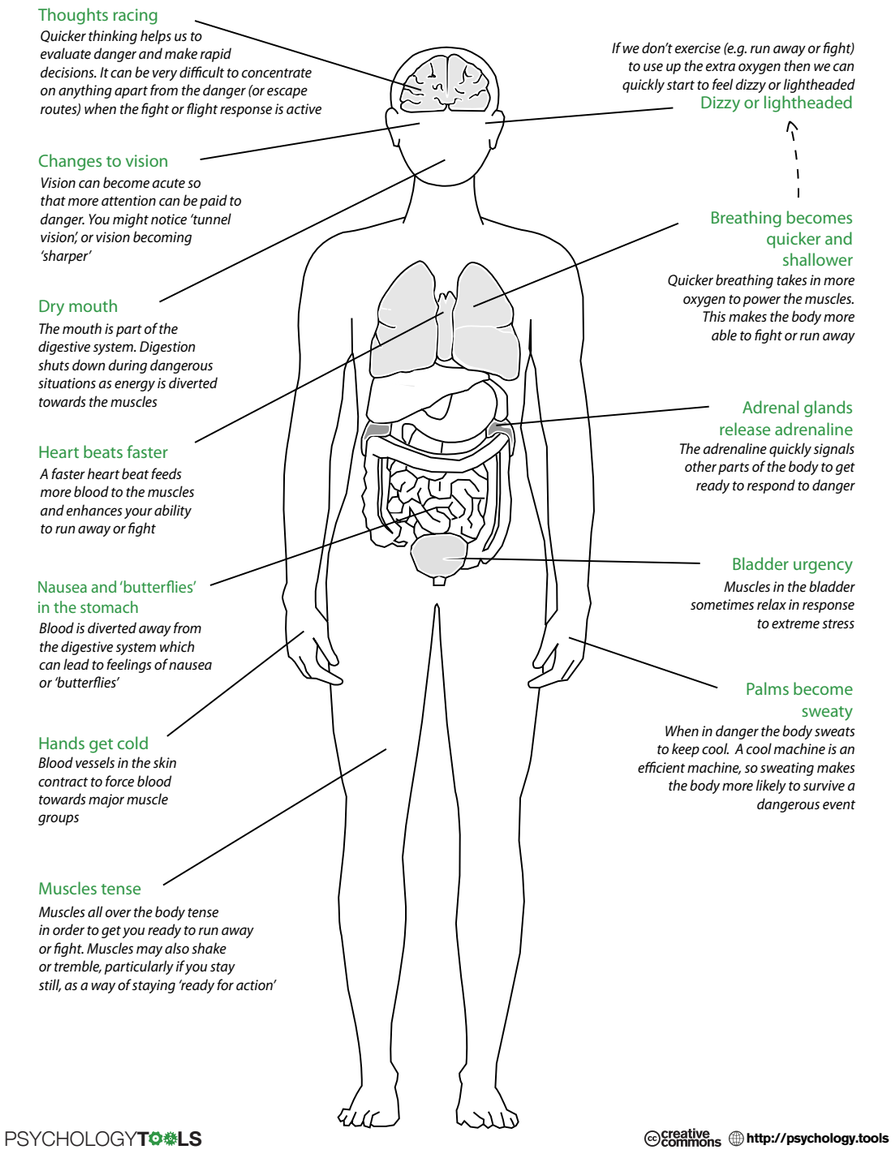
Many survivors believe there is something wrong with them for having a fight, flight, freeze or submit response or that they are "going crazy." Others may not know that what they are experiencing is related to the GBV perpetrated against them. Knowing that what they are experiencing is expected can help some survivors feel less distressed, although there is no "right" or "normal" reaction to trauma. Caseworkers may use an image like that on the next page to explain the concepts of fight, flight, freeze and submit to survivors. Caseworkers may also offer survivors examples of other common responses to GBV, such as cognitive (e.g., difficulty concentrating, flashbacks), emotional (e.g., fear, shame, worry), interpersonal (e.g., isolating from others, difficulty trusting others, disengaging from their community), spiritual (e.g., questioning faith) or behavioural (e.g., alcohol or drug use, aggression) examples.

Knowing common reactions to GBV can also help caseworkers in their work. It will help a caseworker listen to the survivor better and notice when they reference one of these reactions. Addressing these reactions may become part of the Case Action Plan. That said, caseworkers should ask a survivor what is bothering them the most. It will be different for every survivor and may not be what the caseworker would expect.

Also, many survivors will seek a caseworker's support for an issue that is not related to GBV. While meeting with the person, a caseworker may notice that they have some of the common reactions to GBV and may suspect they experienced some form of trauma or GBV. In this way, knowing common reactions to GBV can help a caseworker potentially identify GBV survivors and offer them support if they wish. Keep in mind that these common reactions are not unique to trauma and GBV. They may be due to some other issue. So, the caseworker can let the person know that they noticed they have these issues and ask what the person thinks the reason for it is. The caseworker may then ask if there are other painful events the person experienced that may have contributed to the issues, and that their feelings are not unusual, particularly if they have experienced hardships and violence before, including war-related experiences. This is a gentle approach, and caseworkers should not ask harsh questions such as "Have you been traumatized?" or "Do you need counselling?"

Fight Or Flight Response[4]

When faced with a life-threatening danger it often makes sense to run away or, if that is not possible, to fight. The *fight or flight response* is an *automatic* survival mechanism which prepares the body to take these actions. All of the body sensations produced are happening for good reasons – to prepare your body to run away or fight – but may be experienced as uncomfortable when you do not know why they are happening.



[4] Accessed via https://www.n-cbt.com/uploads/7/8/1/8/7818585/fight_or_flight_handout.pdf

Trauma and Memory

Survivors may question whether or not the GBV they experienced actually occurred. Gaps in their memory can confuse and worry survivors, and different cultures may have various explanations for this. In addition, perpetrators often deny abuse as tactic of control in abusive relationships, and important family and friends may not believe survivors when they disclose violence. These situations can cause survivors to doubt themselves and their memories. Caseworkers can remind survivors that just because they cannot fully remember what happened, it does not mean it was not real. Assure the survivor that you believe her.

Research on neuroscience and memory offers one possible explanation for memory issue. Difficulty remembering certain aspects of a traumatic event can be related to the way memories are encoded and recalled in the brain. There are two types of memory: explicit and implicit. Explicit memory encompasses the memory of general knowledge and facts, as well as the autobiographical memory of an experience, such as the who, what, where and sequence or timeline of events. Trauma can shut down or impair the part of the brain responsible for the creation and recall of explicit memory, so survivors may find it difficult to describe what happened to them. Implicit memory is nonverbal and unconscious; it encompasses emotional and procedural memory, including sensations and movements. Implicit memory is dominant during trauma and in recall. It is why survivors can often report what they smelled, sounds they heard, or the temperature of the room during the traumatic event. When implicit memory is triggered (i.e., a survivor is reminded of the trauma in some way), a survivor may experience painful emotions or become very tense and unconsciously alter their posture.

Some survivors will never fully remember what they experienced, and this may distress or disappoint them. Survivors do not need to remember everything to heal. Many find it helpful instead to understand the nature and impact of the trauma, as well as the ways they learned to cope. Eventually, a survivor can develop a narrative for their life that feels cohesive and is meaningful to them.

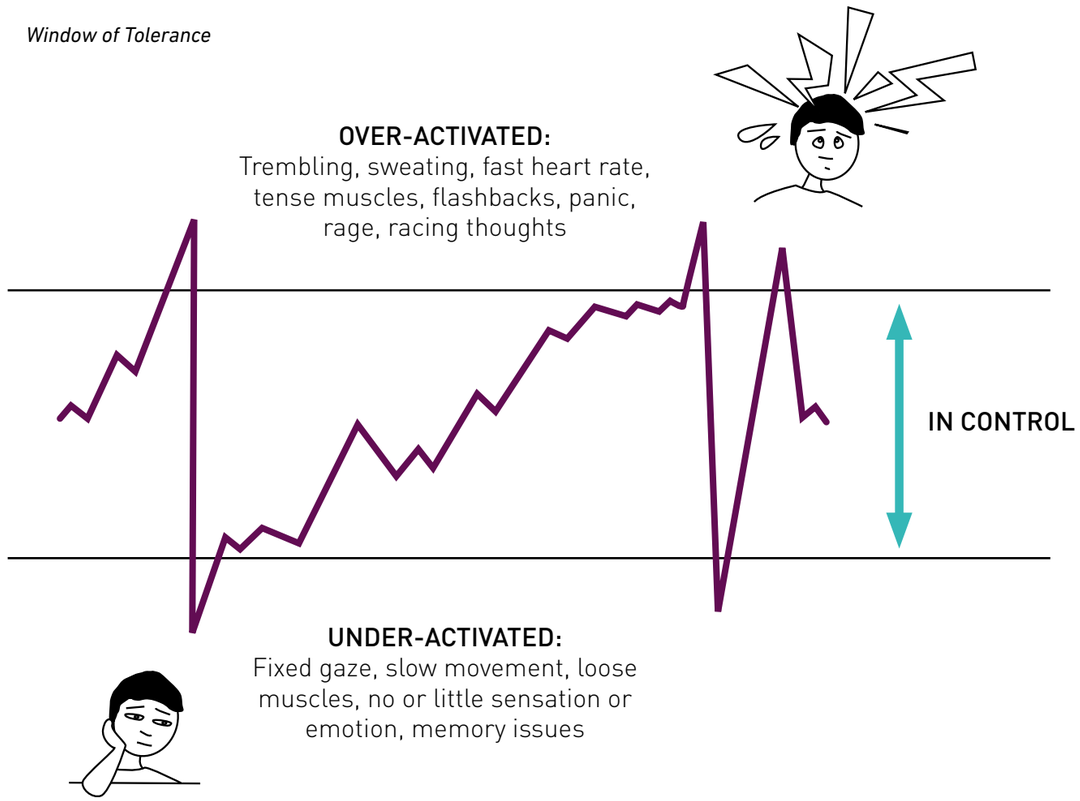
Window of Tolerance

One helpful model for understanding reactions to GBV is called the Window of Tolerance, which was coined by Dr. Daniel Siegel. It is based on the idea that every person has an amount of arousal, activation or feeling that they can tolerate or manage: their "window." When someone is inside their window of tolerance, they feel in control of their emotions, can engage with other people effectively, are aware of themselves and their environment, and can deal with complex situations. Throughout the day, everyone's level of activation fluctuates, sometimes becoming more activated and other times having low activation.

GBV—and trauma generally—causes a person's window to narrow, meaning some feelings and experiences that were tolerable before the GBV have since become too overwhelming and less manageable. Also, certain situations, emotions, thoughts and sensations cause a survivor to leave their window of tolerance. These situations or feelings are called triggers or trauma reminders.

When someone is outside their window of tolerance, they feel out of control, have trouble taking in new information, and have difficulty engaging with other people because their body has gone into its survival responses of fight, flight, freeze or submit. A person outside of their window can either be hyper-aroused (over-activated) or hypo-aroused (under-activated). Hyperarousal—or Over-Activation—is the state in which someone may be very sensitive and reactive to seemingly small things, act impulsively, have disorganized or racing thoughts, or be hypervigilant (i.e., very worried and alert, especially to any dangers whether real or imagined). They may experience intense rage or panic attacks, as well as flashbacks or intrusive thoughts. Physical signs of over-activation are trembling, sweating, increased heart rate, tense muscles, and sitting on edge of their seat. Hyperarousal corresponds with the flight, flight and freeze states. Hypoarousal—or Under-Activation—is the state in which someone may have difficulty feeling sensations or emotions (i.e., numb or "empty"), be expressionless, struggle

Window of Tolerance



to think clearly (e.g., "foggy") or concentrate, have difficulty with memory, feel confused, or even feel as though they are outside of their body. Physical signs of under-activation include fixed stare, slow movement, collapsed posture, and very loose muscles. Hypoarousal corresponds with the submit survival response.

GBV survivors are quicker to leave their Window of Tolerance than those who have not experienced GBV. GBV – and trauma generally – can also cause survivors to swing very quickly between over- and under-activated states. In one moment, they may have a panic attack and soon after they may feel numb and like they are outside of their body. Awareness of one's level of activation and its changes is crucial for GBV survivors. Using mindfulness, survivors can track their daily experiences and notice when they go higher or lower in activation. When a survivor notices their activation is rising or falling in a concerning way, they can intervene and keep themselves within their window of tolerance. Many survivors feel more empowered when they learn to track the signs of rising or decreasing activation, which may be physical, emotional, cognitive, spiritual, relational or others. This helps survivors learn when to intervene to get back inside their window of tolerance. It also helps survivors identify the situations, emotions, sensations or thoughts that cause them the most distress and cause them to leave their window.

Caseworkers too can learn each of their client's signs of high or low activation to identify if and when they become under- or over-activated during a meeting. If the survivor is over- or under-activated when meeting with a caseworker, they likely will not be able to properly concentrate, understand or remember what the caseworker shares with them. When this happens, the caseworker can pause and use a technique or skill that can help them get back inside their window. Then the meeting can proceed again. One of the best ways to help a survivor stay inside their window is for the caseworker to be inside their own window. So, it is equally important that each caseworker builds their awareness of their own window and track their level of activation throughout the meeting.

The Healing Journey

Just as there are many different responses to trauma, there are many different pathways to healing. There is no one right way to heal after GBV. The ways people choose to cope and heal after GBV will vary across cultures. Caseworkers should seek to support survivor's ideas for healing, and—if appropriate—offer new strategies that the survivor feels best matches her needs and the ways she sees the world. Survivors may ask caseworkers how they can heal and get "better." Using a survivor-centred approach means that the caseworker will first ask a survivor what "better" means for her. Each survivor will define "better" or "recovered" differently. So, ask survivors question like: What would getting better look like for you? How do you believe that happens? How can I support you with that? These questions help the survivor and caseworker together build the Case Action Plan based on the survivor's goals, not based on what the caseworker thinks they need.

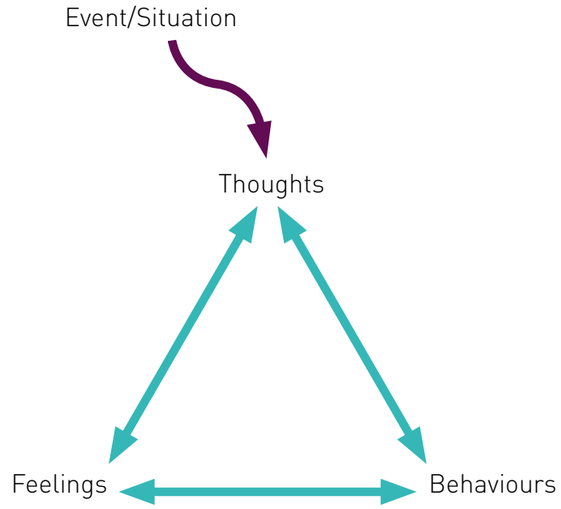
Case management addresses basic needs—like hunger, physical health and housing—that can help survivors feel safer and calmer, which is critical for psychosocial wellbeing. Often, these issues, as well as those related to the wellbeing to her family, will feel most pressing to survivors. And addressing these issues can lead to significant psychological relief. Along the way, caseworkers can also offer survivors support for their emotional distress.

Healing is not linear and does not have a timeline, though many survivors and their loved ones wish it did. Sometimes symptoms go away within a few days or weeks of a disturbing experience; sometimes they stay much longer, even for years. Caseworkers should give survivors hope without making false promises. Many survivors will find GBV case management helpful for their healing journey. However, not every survivor who receives support from formal GBV response services—like case management and counselling—will recover. Moreover, many survivors recover without the help of counselling or case management; often, they are supported in some way by their community, family, friends, faith, spiritual practices or beliefs, or other non-professional supports. Not every survivor will want counselling or case management, some will not know these services are available, and sometimes these services are not easily accessible for survivors. In fact, most GBV survivors will not seek help from formal services like yours. And while many of these survivors will recover, unfortunately many others will not. GBV programs that also strengthen community structures, advocate for better community resources, and raise awareness of GBV will ultimately help those survivors who do not seek out GBV response services.

The Cognitive Triangle

As mentioned previously, this resource module draws from approaches of Cognitive Behavioural Therapy to help survivors on their healing journey. The cognitive model that forms the basis of CBT suggests that situations prompt thoughts, which in turn give rise to emotions. Social learning theory adds that a person's behaviours also influence their mood, and the likelihood of a behaviour is determined by its consequences. So, a positive behaviour will occur more frequently when it causes a person to feel pleasure or some other positive feeling. As demonstrated in the triangle below, there is a relationship between Thoughts (including beliefs), Feelings and Behaviours. Certain thoughts can change how a person feels and behaves, and certain behaviours can make a person think and feel differently. Similarly, one's emotions affect how they think and what they do or do not do.

The Cognitive Triangle



Because emotions are difficult to change directly, many interventions seek to change thoughts and behaviours that contribute to distressing emotions. In theory, if someone can change their thoughts for the better, they will feel better and do the things they want or need to do. And if they change their behaviour for the better, it will change how they feel and what they think. This resource module includes many techniques that target a survivor's thoughts and behaviours in an effort to help them feel better. It also includes other techniques that aid in identifying thoughts and feelings (e.g., mindfulness) and reduce the intensity of emotions (e.g., relaxation and grounding techniques). Keep this triangle in mind as you review the module to identify how a technique may influence a person's thoughts, behaviours and emotions for the better.

Bellah Zulu, Zambia, 2016

PART 2. THERAPEUTIC TECHNIQUES

This section outlines 12 therapeutic techniques that caseworkers can use with GBV survivors at any stage of their case management work. These techniques can be adapted and used across varying age groups, GBV experiences, symptoms or disorders (see Cultural Use and Adaptation).

Currently, caseworkers use a survivor-centred approach[5] to holistically address the survivor's practical needs (i.e. safety, health, psychological, legal and livelihoods); however, at times, GBV survivors can be overwhelmed with psychological symptoms that prevent them from accessing needed services.

For example, imagine, a survivor comes to her second case management session and reports that talking about the GBV incident made her feel more frightened and now she is scared to leave her home. The caseworker could identify that the survivor's feelings of fear and hypervigilance are blocking her from thinking and planning for her own future. Before moving forward, the caseworker may need to teach the survivor to identify what is triggering her, as well as how to use grounding and relaxation techniques (all a part of this resource). These tools prepare survivors to feel emotionally and mentally strong enough to tell their story.

The techniques that follow can be inserted into any step of case management work. The 12 therapeutic techniques are:

1. Beginnings and Endings (Case Closure)
2. Staying Well
3. Therapeutic Stance
4. Assessing Risk and Protective Factors
5. Identifying Triggers
6. Mindfulness Techniques
7. Relaxation Techniques
8. Grounding Techniques
9. Enhancing Motivation
10. Behavioural Activation
11. Cognitive Restructuring
12. Problem Solving
13. De-escalation Techniques

[5] Interagency GBV Case Management Guidelines, refer to page 18.

BEGINNINGS AND ENDINGS (CASE CLOSURE)

When to use: The Beginnings part can be integrated into GBV CM Step 1: Introduction and Engagement. Beginnings can also be reflected upon before each time the caseworker meets the survivor.

How you first say hello to a GBV survivor matters. Many survivors have experienced pain and disruption in their lives and change can mean uncertainty and pain. It is important that when they meet with you, you convey that you are a source of help and support. Your greeting should have the goal of lessening their anxiety.

Therapeutic considerations for beginnings of sessions[6]

- **The survivor's first impression of the caseworker matters.** Be open in your greeting and pay attention to your tone of voice, and the words you use. For example, saying *"Good Morning (with a warm smile and eye contact). I am glad you are here Rita. I have prepared our space in here. You are welcome" communicates warmth, trust and safety as opposed to "Hello. Come with me."*
- **Remember the session begins when you and the survivor first see each other.**
- **Do not structure the session too quickly** before the person has begun to relax. Remember, you need to get the person to feel safe so they can talk. If you are too structured, asking too many closed ended questions or talking too much, you will not hear their story as they will simply shut down.
- **Empower the survivor to take control of the process.** Predictability is important. Explain the structure of the session, give an agenda and time frame, let them know they can stop at any time and ask them if there is anything, they need to feel more comfortable. For example, *"We are going to meet for 30 minutes. I would like to get to know you and help you with some of the strong feelings you must have. If you feel tired or want to stop at any time that is fine. I am here to help."*
- **Use short, simple sentences.** When a survivor is nervous, they often cannot process complicated ideas.
- **Make empathetic comments.** Showing you care in small ways will build the alliance you need to tackle the painful questions. Do not pretend you know what the survivor is feeling. You want to sound supportive but not false or mechanical.
- **Get the survivor's hidden thoughts and questions into the conversation.** The survivor may be thinking, *"Am I going to be hurt? Will the caseworker give me money? What will the caseworker think of me if I tell my story?"* These unanswered questions can heighten a survivor's anxiety in the beginning. Get these thoughts in the room by asking questions. Ask, *"What were you thinking as you were coming here today?"*
- **Ask broad, open-ended questions in the beginning.** This allows for the person to talk about what is most important for them or where they have the greatest distress. It also gives the person a sense of control over the session. If you ask a hard question, follow up with one or two easier ones.
- **Normalize all the survivor's feelings (anxiety, relief, sadness, excitement).** Make sure the person knows all emotions are welcome. Say, *"Anything you are feeling is okay. It is normal to feel many different emotions when we are talking about painful things."*
- **Manage expectations.** Survivors come with many hopes and expectations to their sessions. Explore these expectations. Ask, "What made you decide to come today? What are you hoping we can accomplish together today?" Agree upon realistic expectations with the person.
- **Anxiety management.** If you notice the survivor is anxious, name the anxiety and discuss what they need to feel safe. For example, if the survivor is worried about being too emotionally activated, brainstorm with the person concrete strategies to help them manage their anxiety such as deep breathes, holding a comforting object or symbol, or saying a protection prayer) **(see Relaxation Techniques and Grounding Techniques section).**
- **Explore the person's story, do not take any actions or decisions early on.**
- **With ongoing case management, create a beginning ritual with the survivor that marks the beginning of the session** (e.g., lighting a candle, singing a song, or saying a prayer). It can be anything that symbolically marks that the session is beginning.

[6] Interagency GBV Case Management Guidelines, 2017. Refer to Step 1 Introduction and Engagement, page 49.

Ending/Case Closure

When to use: Aspects of Case Closure Model can be integrated into all GBV CM steps, especially Step 6: Case Closure.

Case Closure means that the caseworker and survivor will close the case management service. GBV case closure for case management services happens under the following circumstances:[7]

1. The survivor's needs are met and/or their (pre-existing or new) support systems are functioning.
2. The survivor wants to close the case.
3. The survivor leaves the area or is relocated to another place.
4. The caseworker has not been able to reach the survivor for a minimum of 30 days.

Case closure is challenging because goodbyes are hard. The following closure model provides caseworkers with therapeutic tools to have a 'proper goodbye' of a specific incident with survivors, something that has been often lacking for survivors in the past and difficult for caseworkers to do.

It is helpful to begin talking about case closure at the first session with a survivor which is why it is included in the section of beginnings and endings). Identifying from the onset that there will be a time that these specific services will no longer continue (for this specific incident) allows for clear understanding and can assist in open communication between the caseworker and the survivor. By starting services with an understanding that there will be an end can bring hope to the survivor that they will be able to overcome the challenges that brought them to sessions in the first place. Goodbyes are particularly challenging for individuals who have experienced loss (of a home, family, job, etc.) in many ways, and being able to understand and reiterate the importance of being able to have good goodbyes can bring comfort and reassurance that the survivor can have healthy closure in the future.

This closure model acknowledges that past goodbyes for GBV survivors may have been a time of unexpected pain and loss, thus, 'a proper goodbye' is a goodbye that allows for the caseworker and survivor to review the work they have done together, to look at skills learned, to explore what the survivor has learned about themselves and how they can 'Stay Well' (see Staying Well section). The 'proper goodbye' should be a celebration, marking what you and the survivor have achieved together.

Therapeutic Considerations for Case Closure

1. **Talk through case closure with the survivor.** Explore the reasons why the caseworker or survivor thinks that closure is important. It is not a punishment. It is a time to celebrate because the survivor's case has improved. An explanation is necessary as to why the treatment is ending especially if it is an administrative decision such as a set amount of sessions.
2. **Normalize the emotions:** Validate the difficulty of speaking about emotions and difficult moments. Case closures can provoke other feeling of unresolved loss in the survivor.
3. **Explore the emotions** by saying something like, *"Goodbyes are hard for many people and can sometimes remind us of past goodbyes. What are your feelings about the end of our work together?"*
   a. Discuss past goodbyes and how the survivor can keep someone inside their heart. Sometimes certain survivors want something tangible to remember your time together. (e.g., a notebook to capture 'lessons' and techniques learned or help the person to memorize certain ideas, quotes and techniques or a symbolic object).
4. **Review the symptoms and problems:** What symptoms are still there? What symptoms have been reduced? What strategies worked and which did not work?
   a. Adapt techniques and teach new strategies according to the person's needs.
5. **Review what work was done together:** Re-examine the successes, and what was difficult.
   a. Celebrate the survivor's successes. (Adapt this to reflect the emotional style of the survivor).
   b. Identify things or new goals that the survivor can continue to work on in the future.
6. **Review specific techniques and new ideas learned:**
   a. What will the survivor take with them and bring into their life?

[7] Interagency gender-based violence case management guidelines, 2017, refer to page 88.

   b. Explore what the survivor learned about themselves that they did not know before.
7. **Offer psychoeducation on the importance of emotional release and expression:** Expressing emotions and difficult thoughts gives us heart and head space. Help the survivor think of safe people in their life who can listen and comfort them when they are stressed (have the survivor decide on two safe people). Brainstorm different ways the survivor can express their painful emotions (e.g., crying, writing, singing, praying, a creative project, a stress buddy).
8. **Anticipate difficult trauma anniversaries and important holidays:** The yearly anniversary of a traumatic event—and possibly the days or weeks before and after it—can prompt emotional and physical pain, even if the survivor has not consciously remembered it was the anniversary. Some survivors may also struggle during important holidays for a wide range of reasons. For some, holidays can prompt feelings of loneliness if the GBV they experienced led to disconnection from their family and loved ones. If seeing family, survivors may feel fear, shame, dread or ambivalence. Preparing for trauma anniversaries and holidays can help survivors feel more empowered to handle the triggers and negative feelings that may arise on those dates.
9. **Decide on a ritual or how the survivor would like to close:** Emotional closure is important for a survivor who speaks of many personal issues with the caseworker.
   a. A ritual is sometimes important for certain survivors. Ask the person what they would like to do. It is important that the ritual has meaning for the person.
   b. Examples of rituals or closure are: a special prayer or song, a letter the caseworker can write or say to the survivor, a ceremony, or inviting family and friends for the last session.
10. **Do the Closure and goodbye ritual:** Remind the survivor that they can return when they need to. Have an authentic goodbye.

Sometimes, the first meeting with a survivor is also the only meeting you will have together. For example, a survivor may decide they do not want to continue meeting with you or they may not show up to the second meeting. Caseworkers can prepare for this in several ways. In the first meeting, assure the survivor that you will be here to support them and are looking forward to seeing them again. Let them know that if they later decide they do not want to meet, you will respect any decisions they make and they can see you again in the future if they would like. At the end of the first meeting, caseworkers can consider asking the survivor what they think will be helpful to remember from the time spent together today. This gives the survivor an opportunity to review, to think more clearly, and to reflect on some of the information (e.g., coping skills, resources or referral services) the caseworker and survivor discussed. As always, caseworkers should acknowledge hope for the survivor's recovery.

THERAPEUTIC STANCE

When to use: The Therapeutic Stance can be integrated into all GBV CM steps, especially Step 1: Introduction and Engagement and Step 2: Assessment.

Survivor-centred case management[8] relies on the caseworker deeply understanding the survivor, the ways the survivor expresses distress and how their life and relationships have been disrupted by the GBV incident(s).

To understand the survivor's distress, the caseworker needs to do the 'unseen/behind the scenes work' of noticing the topics the survivor speaks about (e.g., being a mother, relationships), how they interpret the world (e.g., all men are bad, only bad things will happen to me), the way in which the survivor speaks or certain unusual behaviour they have (e.g., being unable to sit still, being extremely aggressive), and how they make the caseworker feel (e.g., helpless, sad). When the caseworker listens on multiple levels, to more than just words, it allows fresh insights to surface in the case management.

When you work with the same person from different angles, you see different things.

The therapeutic stance involves the following five levels (each of these levels are described in more detail below):

1. **Listen for patterns in the survivor's story**
2. **See the world through the survivor's eyes**
3. **Observe the survivor's appearance and behaviour**
4. **Notice what the survivor makes you feel and think**
5. **Pay attention to how your emotional reactions and behaviour are perceived by the survivor**

1. Listen for patterns in the survivor's story

What are the topics the survivor talks about? Is it always the same topic or theme or does the person jump from topic to topic? What does the person avoid speaking about? Some possible topics will be:

- Loss of loved ones
- Fear of something bad happening again
- Income
- Relationships in their life
- Providing for their children/family

The caseworker must address both emotional concerns and practical resources concerns. The survivor must see that the caseworker has a holistic interest in them.

The patterns of what the survivor talks about matter. These patterns tell you what they worry about, and what is unresolved inside of them. For example, a survivor comes to multiple case management sessions and speaks about 1) conflict with her sister, 2) the challenges of caring for her children and 3) her constant feeling that her neighbours are always taking advantage of her. What is the common theme here? Relationships. You know by the common pattern that relationships in her life are challenging. This is a part of her life where she needs skills and support from your work together.

2. See the world through the survivor's eyes

The caseworker must try to imagine what the survivors' life must be like. This is called empathy. **Empathy** means the ability to recognize, understand, and share the thoughts and feelings of another person. How does the caseworker do this?

To empathize you understand how that person feels, not how you would feel if you were that person. You are not that person. You cannot help them by imagining how you would feel in their shoes. You can only help if you can imagine how this person feels. Empathy also includes that you believe that the person has the capacity to help herself.

This is different than **sympathy** where you feel sorry for the person. You pity them. You feel the person is helpless and can only improve if someone else helps them.

To understand the survivor's world, ask the person questions to understand and picture their world and life (e.g., *"What is a day in your life like?" or "How do you feel when he calls you those names?"*). When you are struggling to understand the survivor's world, you need to ask yourself, *"What is getting in the way of me being able to empathize with this person?"*

[8] Interagency GBV Case Management Guidelines, 2017, refer to page 18.

3. Observe the survivor's appearance and behaviour:[9]

Due to high levels of stigma and fear, GBV survivors often express much of their distress through their behaviour and appearance. The caseworker should notice the survivor's general appearance, behaviour, feelings and speech. These 4 areas, commonly called the Mental Status Exam (MSE), are the psychological equivalent of a physical exam. It provides a snapshot assessment of the survivor's level of distress and functionality. Remember, sometimes a change in the way a survivor is dressed or how they walk can tell you more than the words they are saying.

The 4 core areas of the Mental Status Exam are:

1. **General Appearance:** Is the survivor clean or unbathed? Do they smell like alcohol? How are they dressed? What are their facial expressions and eye contact like?
2. **Behaviour:** How does the person walk, sit and shake your hand? For example, do they move extremely slowly or more agitated?
3. **Feelings:** What mood does the person seem to have as you sit with them? Are they extremely scared or do they seem very numb and far away?
4. **Speech:** How does the person speak? Do they whisper or speak in a monotone voice or do they speak so fast you are unable to say anything? Does the person jump from topic to topic, making you unable to follow? **(See a more detailed Mental Status Exam in Appendix A)**

When you notice changes in the survivor, you should bring this fact to the survivor's awareness by gently saying, *"Rita, I noticed today you are talking very fast. Have you noticed that too? Do you have any thoughts on why?"* or *"Today, I noticed you seem quieter than last week."*

4. Notice what the survivor makes you feel and think

Transference and **Countertransference** are two concepts in mental health work that help the caseworker understand why they may have such intense emotions and thoughts when working with GBV survivors.

You have a relationship with the survivor. That means you have an influence on how they think and feel. They also influence how you think and feel. For example, the survivor is sad, so you may feel sad.

Sometimes the way you feel tells you something about how the survivor is feeling. How you feel affects what you say or do not say. Pay attention to this. Discuss this regularly with your supervisor.

Transference is the act of the survivor putting both positive (e.g., idealisation) and unresolved painful (e.g., anger, resentment) feelings and thoughts they have toward someone else in their life onto the caseworker and unconsciously treat the caseworker as they would the other person.

Countertransference occurs when caseworkers transfer their own unresolved thoughts and feelings about someone else onto the survivor and unconsciously treat the survivor like they do the other person. As a caseworker, you may have unresolved pain inside of you and this can affect your work with survivors, specifically, how you talk to survivors, the topics you avoid and the feelings that are triggered inside of you..

An example of transference is a GBV survivor who attends weekly sessions and sits there quietly, tearfully only saying a few words. The caseworker struggles with how to respond and feels helpless. This feeling of helplessness that the caseworker feels is important information, as it may be the survivor transferring their feelings of helplessness into the caseworker. The caseworker can use that feeling to better understand the person and their needs, imagining what it must be like for the survivor to get out of bed or take care of children with such strong feelings of helplessness.

[9] Interagency GBV Case Management Guidelines, 2017, refer to page 65.

Transference and Countertransference are a normal (and important) part of case management work, especially with GBV survivors. All caseworkers will experience these moments and it is important to try to reflect on which emotions are yours and which are the survivors, to ground yourself when feeling emotionally overwhelmed and to take care of yourselves afterwards.

5. Pay attention to how your emotional reactions, responses and behaviour are perceived by the survivor

The survivor-caseworker relationship is the foundation of any case management work. If there is no relationship, no real work can be done. What you feel and think about the survivor, how you greet them and how you react to what they tell you matters. All these 'small' elements shape how safe the person may feel and what they say or do not say.

Caseworkers are people too. You each bring your own life experiences, emotional reactions and ways of coping into the room with survivors and sometimes your life experiences have been similar to the survivor. This similarity between the survivor and caseworker experiences can make it hard to be curious and survivor-centred when doing case management work. For example, think about when you are tired or when you disagree with something the survivor said, or when you want to give advice to the survivor because you have gone through the same thing. These are all moments where you may accidentally communicate your feelings through your behaviour or facial expressions. 80% of your communication to the survivor is non-verbal, so be aware of what you are communicating.

STAYING WELL[10]

When to use: Staying Well can be integrated into all GBV CM steps, especially Step 5: Case Follow-Up and Step 6: Case Closure.

This section encourages survivors to reflect on the new therapeutic techniques they have learned and the new self-care practices they may be using and to think about how they 'Stay Well'. The caseworker can begin by congratulating or praising the survivor for learning new self-care techniques and for their efforts:

Tell the survivor: *"As you are aware, today is our last session and I want to start by congratulating you on reaching this stage. You have shown a lot of courage and effort to talk about some difficult topics and to face these head-on. How do you feel about this being the last session? Are there areas that you think have improved since starting to learn this new technique? What about areas that have not improved? Do you have any ideas about what you can do to try to improve those areas?"*

Invite the survivor to continue participating in other GBV activities and that you will be available to provide further support but explain (see case management guidelines) that your one-on-one work is coming to an end.

Encourage the survivor to continue practicing the strategies to stay well. You might start by asking the person to think about what they can do to stay well.

For example: "So, we are going to talk about how you can stay well after finishing this intervention. Do you have any ideas about what you can do to stay well?"

[10] Adapted from PM+ World Health Organization 2016, refer to page 70.

An example where you might be clearer about what the survivor can do to stay well:
"I like to think that this intervention is like learning a new language. We have worked on learning some strategies to help you deal with different problems in your life. Just like learning a new language, though, you need to practise it every day if you want to speak it fluently. In the same way, if you practise these strategies as often as possible, you will have a better chance of staying well. Also, if you face a difficult situation in the future, you will have a better chance of managing it well if you have been practising the strategies regularly."

"There is nothing magical about this intervention – you have learned it all and can apply it to your life by yourself. You are your own helper now. Some people have stuck notes on their walls or put them in areas of the house where they spend most of their time, so they never forget the strategies."

- Spend some time then talking about what specifically the survivor could do if they experienced a severe stressful event or negative feelings in the future.
- Give the person the opportunity to tell you what they would do first.
- Help them to be as detailed as possible in describing how they would respond (e.g., ask them for suggestions of ways they could improve their social support rather than just saying, *"I will strengthen my social support"*).

It is not uncommon for survivors to experience difficulties in the future. You could ask the person, *"What do you think you can do the next time you experience a very difficult situation or notice negative feelings again?"* (Give specific examples relevant to the person, e.g., losing a job, conflict with a partner, feeling depressed and so on).

ASSESSING RISK AND PROTECTIVE FACTORS[11]

When to use: Assessing Risk and Protective Factors can be integrated into all GBV CM steps, especially in GBV CM Step 1: Introduction and Engagement and Step 2: Assessment.

Understanding a survivor is like exploring a darkened room holding only a candle. A central part of understanding a survivor is assessing what are 1) the things that keep them moving forward in their life (protective factors) and 2) what are the walls that block them (risk factors).

Assessing risk and protective factors allows the caseworker to understand what the survivor's therapeutic and case management needs are, what parts of their life are troubled, how their symptoms affect their life, and how these areas may fluctuate between sessions. The caseworker and survivor can then use this knowledge in case action planning, implementation and follow-up, leveraging the survivor's protective factors to help her meet her needs and heal, and use risk factors to plan for potential challenges.

What are Protective Factors?

Protective factors include skills, qualities, strengths, abilities, relationships, values and experiences, that give a survivor strength and the feeling life is worth living despite GBV experiences.

Protective factors can be external or internal. They help survivors overcome difficult life crises. Unfortunately, survivors often forget about the importance and power of their own strengths, particularly in the moments they need them the most (e.g., being stuck in a displaced persons camp or after a terrifying GBV incident).

[11] Interagency GBV Case Management Guidelines, 2017, refer to page 67.

Working together with survivors to find their strengths helps the survivor regain a balance which may connect the survivor to their potential and can bring positive changes in their feelings. If the survivor perceives their potential and utilises it; they can regain the feeling of control over their life again. Feeling some control over their life changes their outlook on life and other people notice and may start to relate differently to them (e.g., giving them responsibility rather than taking care of them as though they were sick). This can become a cycle of positive reinforcement.

The recognition of the survivor's protective factors is extremely important, as they help the survivor to:
- See the positive aspects in their life.
- Focus not only on the negative experiences and aspects.
- Feel connected to the world.
- Increase self-worth and self-confidence.
- Recognize possible ways to get out of a desperate situation.
- Feel that they can trust in something and that it is worth it to go on.
- Feel that there are people who love and need you.

What are Risk Factors?

Risks factors are people, places, things, ideas, experiences, memories, and feelings, that make the survivor more at risk of being emotionally distressed. Some examples of risk factors include: experiences of trauma, poverty, GBV incidents, poor parenting, poor social skills, an extreme need for approval and social support or low self-worth.

It is important that caseworkers explore BOTH risk and protective factors as every survivor has a unique combination of them, which interact and may also change over time.

Knowledge of the survivor's culture can also help in assessing risk or protective factors (see Part 1 on Cultural Use and Adaptation). This may include ways certain groups may face discrimination and ways that some identities may hold certain powers or privileges. A survivor's identities may make them more or less vulnerable or protected. Certain beliefs, practices and policies in the community may help or hinder their recovery. Caseworkers should seek to understand each survivor's unique experience in their community given their identities. A person's risk and protective factors will vary across time and context.

A concept that is related to protective factor is Resilience. Resilience is the ability to keep going and engage in life after a difficult experience like GBV. It is not the ability to "stay strong," because a resilient person can still experience suffering and distress. Resilience is also not static—meaning that a person can be more or less resilient at different points in their life. Resilience is shaped by the interactions of an individual with the environment they live in. And societal beliefs, practices and policies make it easier or harder for certain people to be resilient. Both trauma and resilience can be can be passed down from ancestors and passed on to our descendants: genetically, behaviourally, emotionally, culturally, spiritually. As explored in the roots of the Tree of Life activity, a survivor's ancestors may be a strong source of protection. One of the best things we can do for ourselves, our families, and our descendants is metabolise our pain and heal our trauma. Just as trauma is transmitted, so is one's emotional health and healthy genes.

There are many ways to assess risk and protective factors. To assess risk and protective factors, you can use The Tree of Life (see Appendix B) or The Lifeline (see Appendix C). These two assessment tools allow the caseworker to use creativity to do an assessment of the survivor.

Lifeline. Shiama Mohamed, Iraq, 2020

The Lifeline

The Lifeline is an exercise that the caseworker does with the survivor. The survivor makes an outline of their life with string, stones and flowers (or leaves). The string is a symbol for their life, the stones are a symbol for bad and painful events and the flowers or leaves are symbols for good events. The caseworker asks the survivor to think about their life experiences and place stones and flowers on the lifeline according to what they have experienced. The survivor and caseworker then discuss the rocks (risk factors) and flowers (protective factors) and their impact on the survivor's life.

The Tree of Life

The Tree of Life is a strengths-based exercise that invites the survivor to speak about their lives in ways that make them stronger. The survivor is invited to draw a tree. The tree represents the survivor and each part of the tree represents a different part of them.

- **Roots:** Where you come from, your roots, your ancestors that keep you strong, your family history.
- **Ground:** Who you are, where you are; your life in the present, such as daily activities and routines, important parts of your daily life
- **Trunk:** Strengths, what you are good at, skills, talents.
- **Branches:** Hopes and dreams for the future.
- **Leaves:** Special people, places, sounds, smells and tastes.
- **Fruits:** Gifts you have received in your life (remember gifts can be tangible (e.g., a ring or flowers) or intangible (e.g., happy memories, compliments).
- **Bugs:** The things, feelings, people or thoughts that 'eat'/ruin your fruit, trunk, branches and leaves.

After the tree has been drawn, the caseworker and the survivor discuss what it is like to see their life in tree form, are there protective factors or risk factors that surprised them and how can they strengthen their protective factors and decrease their risk factors.

Tree of Life[12]

IDENTIFYING TRIGGERS

When to use: Identifying Triggers can be integrated into all GBV CM steps, especially GBV CM Step 2: Assessment and Step 4: Implementing the Case Action Plan.

A trigger is something that sets off a memory or flashback, transporting the survivor feeling like they are back in the event of the original trauma and causing the person to experience overwhelming emotions, physical symptoms or thoughts. A trigger is also called a trauma reminder. The survivor will react to this trigger with an emotional intensity like the time of the trauma.

Triggers cause survivors of sexual violence (or any kind of trauma) to feel or behave in the same way they did during or immediately after the traumatic event because the brain does not differentiate what happened then from what is going on around them now. That is, triggers cause a survivor to go into fight, flight, freeze or submit. To complicate matters, survivors may or may not realise that they have experienced a trigger and be confused about their feelings or behaviour or might not even know it is happening to them. Because a trigger in the present is connected with past trauma, when the survivor encounters it in the present, they may perceive it as dangerous. Their brain is remembering this thing was dangerous in the past. They then may feel unsafe, even if there is no danger in the present.

[12] https://dulwichcentre.com.au/the-tree-of-life/in-australia/

Some symptoms of trauma triggers include: Sudden or unexplained bouts of crying, fear, paranoia, anxiety and/or panic attacks, disassociation, sudden physical symptoms such as nausea or fatigue, intrusive thoughts and hypervigilance. Triggers make a person leave their window of tolerance and become either over-activated or under-activated. If a survivor is already near the edge of their window when they encounter a trigger, the trigger will more easily make them leave their window than if they were farther away from the edge. For example, if a survivor is more tired, very stressed or even sick, they are more likely to be triggered. That same trigger may not make them leave their window of tolerance if they encountered it when they were calm and relaxed. Instead, it may only cause them minor stress that they feel more easily able to control. So, the same object may not always trigger a person, or it may not always cause the same amount of distress.

Triggers are very personal, as different things trigger different people. Triggers can fall into two main categories: internal triggers and external triggers. Internal triggers are things that you feel or experience inside your body (i.e., thoughts, memories, emotions, bodily sensations). External triggers are things that happen outside your body that you might encounter throughout your day (e.g., situations, objects, people, or places). Examples of external triggers can be a specific place, an argument, a movie that reminds the survivor about the incident.

A survivor's triggers are often activated through one or more of the five senses: sight, sound, touch, smell and taste. Sensory memory can be extremely powerful, and sensory experiences associated with a traumatic event can cause an immediate emotional reaction that bypasses the reasoning part of our brain.

Although triggers are varied and diverse, there are often common themes, as indicated below. Caseworkers should 1) explain to survivors what triggers are and why they happen; 2) work with survivors to identify which internal and external experiences trigger the survivor and how to recognize the signs they have been triggered; and 3) provide techniques to work through their triggers.

Sight
- Often, someone who resembles the abuser or who has similar traits or objects (e.g., clothing, hair colour, distinctive walk).
- Any situation where someone else is being abused (e.g., anything from a raised eyebrow and verbal comment to actual physical abuse).
- The object that was used to abuse.
- Any place or situation where the abuse took place (e.g., forest, the public toilets, holiday periods, family events, social settings).

Sound
- Anything that sounds like anger (e.g., raised voices, arguments, bangs and thumps, something breaking).
- Anything that sounds like pain or fear (e.g., crying, whispering, screaming).
- Anything that might have been in the place or situation prior to, during, or after the abuse or reminds them of the abuse (e.g., a certain song, laughter, a dog barking).
- Anything that resembles sounds that the abuser made (e.g., whistling, yelling, footsteps, tone of voice, spoken language).
- Words of abuse (e.g., cursing, labels, put-downs, specific words used).

Smell
- Anything that resembles the smell of the abuser (e.g., smoke, alcohol, specific perfumes, etc.).
- Any smells that resemble the place or situation where the abuse occurred (e.g., food cooking, wood, alcohol).

Touch
- Any type of touch or action that resembles the abuse or things that occurred prior to or after the abuse (e.g., certain physical touch, someone standing too close, petting an animal, the way someone approaches you).

Taste
- Tastes that were experienced during the abuse, prior to the abuse or after the abuse (e.g., certain foods, alcohol, tobacco).

When assessing for triggers, a caseworker can ask if the person has ever experienced a time when:
- Their reaction to a situation seemed more intense than was warranted?
- Their reaction was very different from their usual reactions or those of people around them, maybe even strange?
- They felt stuck in their reaction to a situation?
- They had a sudden flashback, like they were reliving the trauma?

The specific connection between the trigger and the past trauma may not be clear to them. Without asking them for details of the GBV incident, you can ask the person if they know how the trigger is related. However, it is not necessary to know the connection in order to identify and cope with triggers in the present.

With time, triggers become less meaningful and hold less power. The good news is that survivors can learn to identify and handle the symptoms of a trigger, perhaps eliminating them all together. Once triggers have been identified, the caseworker and survivor can problem solve ways the survivor can respond in the future when triggered, find ways to reduce the likelihood of being triggered, and learn how to re-engage with safe situations and people that remind them of the trauma. To do this, it is important that survivors practice calming and grounding themselves with grounding and relaxation techniques (see Relaxation Techniques and Grounding Techniques sections). Caseworkers may offer to teach survivors these techniques.

In some cases, caseworkers may help survivors to gradually re-engage with external triggers that are safe in the present, instead of avoiding them. For example, the trigger may be a particular location (e.g., the market) because it was either the site of the violence or reminds them of it in some way. The more a person avoids a feared situation, the more they will fear it. The same is true for triggers. Initially, it may be best to help survivors avoid triggers that cause severe reactions or to reduce how often they encounter triggers. That gives the caseworker time to help the survivor learn grounding techniques and other helpful strategies for dealing with reactions to triggers. Many triggering situations, people and objects that are now safe cannot be avoided or may be necessary for the person's daily life (e.g., the market). In this case, caseworkers can encourage survivors to confront these feared situations to learn that the fear will reduce and they are capable of staying grounded. Caseworkers can explore with survivors what will make them feel more comfortable confronting the trigger and ensure they feel comfortable using grounding techniques.

Remember, GBV survivors may be facing other traumas or major stressors that have their own triggers. For example, a survivor who is constantly worried about money may be triggered by their landlord asking for rent or by certain monthly calendar dates. It is important to support survivors with these triggering situations, too. Also, survivors may be triggered in session with a caseworker, especially if they are sharing details of the GBV incident(s). If this happens, it can be helpful to address the survivor by their name and ask them respectfully to pause what they are saying; remind them where you are (location) and the date; and ask if they would be comfortable doing a grounding technique with you.

MINDFULNESS TECHNIQUES

When to use: Mindfulness Techniques can be integrated into all GBV CM steps, especially Step 4: Implementing the Case Action Plan.

Mindfulness is the practice of being fully aware and engaged with whatever you are doing at that moment, free from judgment. It means being aware of whatever your present experience is—a thought, feeling, body sensation, image, smell, taste, movement, activity, etc.—without getting caught up in your reaction to it. Mindfulness has been an aspect of Asian spiritual practices for thousands of years; though, most religions and spiritual practices have some form of mindfulness element, as do many non-religious practices. And as long as someone has a body and is breathing, mindfulness can be used and makes sense for any human being.

Mindfulness is not a relaxation exercise, though relaxation is often a secondary benefit of mindfulness. Mindfulness also is not about trying to avoid or get rid of painful internal experiences. Instead, mindfulness is a way of being in the world and in one's life. It means being present to whatever you are experiencing no matter how upsetting it may be. When you stay with an upsetting thought, emotion or sensation, you can then realize that it passes in time or changes in some way. The mind is often preoccupied by worry and fear about the past or future, which causes suffering. Mindfulness awakens curiosity about your present experience, regardless if it is pleasant or unpleasant.

When practiced regularly, mindfulness has been shown to have numerous benefits, including improving immune system and heart health, reducing physical pain, increasing self-awareness, and improving attention. It can also help improve one's relationships, especially by allowing a person to be better attuned to others and to themselves. Mindfulness has been shown to help reduce impulsivity and emotional reactivity, and thus feel in greater control of oneself and emotions. This awareness can help a person stay regulated and promotes ownership and agency of one's body, which is especially helpful for survivors.

Formal and informal mindfulness practices help build the capacity to be mindful more easily and more often throughout a person's life. It takes time and regular practice. Formal mindfulness practices involve intentionally setting aside time to practice mindfulness. It can be a structured exercise, meditation, some forms of prayer, sitting down to focus on breathing, yoga, and body scans. Caseworkers can do formal mindfulness exercises with survivors during a meeting. Informal mindfulness practices help a person refocus during the day. They are typically short activities that only take a moment but help a person check in with themselves when experiencing higher or lower activation. An example of informal mindfulness practice is being noticing one's breathing while going about the day, being mindful when eating meals or drinking tea, or when washing dishes, listening to music or cleaning the house. Informal mindfulness practices are great suggestions for survivors to try at home.

Several examples of mindfulness are:

- Closing your eyes and feeling the morning sun on every single part of your face.
- Drinking water and feeling it trickle down your throat.
- Doing a body scan and noticing all parts of your body and the feelings you have in each part of your body.
- Clenching your fist and breathing into your fingers.

Mindfulness can be very simple. One of the most basic techniques to build a person's capacity to be mindful is called **Labelling**. Silently or out loud say "Thought" when a thought comes to mind while going about your day. It does not matter if the thought is helpful or unhelpful, pleasant or unpleasant. Just label it as a "Thought," say silently or aloud to yourself "That's a thought" or "There's that thought again," or specify it as a "sad thought" or "worrying thought." Then, return to whatever you were doing. Labelling is an *intentional* act of noticing one's experience without judgment. It can be used with thoughts, emotions (e.g., "sadness" "bored"), sensations (e.g., "tight shoulders," "hungry stomach"), images, memories, or other experiences. Studies have shown that choosing to notice and name one's distress in itself can help reduce the distress and let a person feel more in control and more organized of what is going on inside them. Labelling also helps create some space between oneself and the thought, emotion, sensation or image. With some space, the experience can be observed and then the person can make a wise decision of what to do about it. For example, often simple Labelling will be enough for someone to refocus on whatever they are doing. At other times, it may prompt them to use a Relaxation Technique – as simple as a deep breath – or Cognitive Restructuring. Remember to stay non-judgmental of the thought, emotion, sensation, etc.

Caseworkers can also help build a survivor's ability to be mindful as part of caseworker's regular work. Asking survivors simple questions (e.g., "What are you feeling now?" "What did you feel at that time?" "What are you thinking right now?") and using labelling statements (e.g., "That thought is telling you 'I can't do it,'" "Your hands are clenched tight right now and your breathing seems shallow and fast") both help survivors tune into their present experience. This builds their inner awareness—that is mindfulness!

For GBV survivors, sometimes it can feel like traumatic memories or powerful feelings of fear or sadness are taking over their entire mind/body and they are unable to think of anything else. Mindfulness can help the survivor to come back into the present here and now reality.

There are important considerations for using mindfulness with GBV survivors. Focusing on one's internal experience (like thoughts, feelings and body sensations) can be distressing for some survivors for various reasons. Often the body was the location of violence or a subject of verbal abuse; becoming aware of the body, traumatic sensations, thoughts and emotions can remind survivors of the abuse and potentially cause distress or trigger them to re-live the trauma (e.g., flashbacks, dissociation). So, survivors may try to avoid noticing their internal sensations. Yet, safely getting in touch with one's internal experiences can be one of the most healing aspects of mindfulness. To make formal mindfulness practices more trauma-sensitive:

- Ensure you have already taught Grounding Techniques and know which grounding technique the survivor finds most helpful. You can also review one or two ground techniques before doing any mindfulness exercise. If a survivor cannot access their window of tolerance during a mindfulness exercise, do not do it or adapt it.
- Get survivor's permission to pause the exercise and check in with them if the caseworker notices the survivor looks uncomfortable. Stop the exercise and use grounding techniques if they express distress, to get back into the Window of Tolerance.
- Explain the exercise before doing it so they know what to expect and can make an informed choice of whether or not to proceed.
- Make exercises short in duration. Go slowly. Close, sustained attention to internal experiences tends to be the part of mindfulness and meditation that has greatest risk of triggering survivors. So, use short exercises!
- Always offer a choice, such as:
  - "Would you be willing to try a short mindfulness exercise with me?"
  - "You can keep your eyes open or closed, whichever is more comfortable for you." Closing one's eyes can cause some survivors to feel unsafe or may trigger them.
  - "If at any time during the exercise you feel too uncomfortable, please let me know and we will stop." The caseworker and survivor can agree on a signal (e.g., hand gesture) that the survivor can use to indicate they would like to stop.
- At the end of an exercise, say their name and remind them where you both are, in case they either fell asleep or dissociated (See Dissociation section for more information)
- Normalize the difficulty of practicing mindfulness, especially when just learning (i.e., be non-judgmental, patient and accepting)
- Stay calm. Remember, if you are calm and confident, that will help the survivor feel calm and

confident too. Caseworkers should practice these mindfulness exercises to become familiar and comfortable with them before using them with survivors.

Below are 4 simple mindfulness exercises – formal and informal – that the survivor can use anywhere and anytime. These exercises are[13]:

5. **Mindful observation**
6. **Mindful listening**
7. **Mindful immersion**
8. **Mindful appreciation**

Appendix E has additional mindfulness techniques and exercises.

Mindful Observation

This exercise helps the survivor notice and appreciate the small, simple parts of their everyday life and natural environment.

1. Have the survivor choose a natural object from within their immediate environment and focus on watching it for a minute or two. This could be a flower, a cloud, the stars, a tree or their child's hand.
2. There is no need for the survivor to do anything except notice the thing they are looking at. Simply relax into watching it for as long as their concentration allows.
3. Encourage the survivor to look at this object as if they are seeing it for the first time.

Mindful Listening

This exercise aims to help the survivor listen to music or sounds in a mindful way and to open their ears to "feel" the music, instead of "thinking" about the music.

1. The survivor can choose any sound/song and then use their headphones or find an area that is quiet to listen to their sound/song. Once comfortable, they can play the sound/song and close their eyes.
2. Have the survivor listen to the sound/song and allow themselves to get lost in the journey of sound for the duration of the sound/song.
3. Have the survivor explore the sound/song by listening to each level of the sound/song by listening to each instrument. Have them separate each sound in their mind, one by one.
   a. If sound: Have the survivor listen to the range of tones in the sound clip. Try to separate out each of the layers of the sound.
   b. If song: Have the survivor pay attention to the vocals: the sound of the voice, its range and tones. If there is more than one voice, they can separate them out as they did above.
4. The idea here is to listen deeply. The survivor should not think but hear.

Mindful Immersion

The aim of this exercise is to help the survivor feel fewer negative feelings when involved in a daily task.

1. All survivors have routine daily tasks (e.g., washing dishes, cleaning, cooking) that they often struggle to complete due to low energy or just disliking the task.
2. Ask the survivor to choose one mundane, everyday task (e.g., washing dishes, cleaning, cooking).
3. Suggest to the survivor that by paying attention to every detail of an everyday routine task, they might be able to experience this task like they never have before.
4. Rather than treating cleaning as a regular chore, have the survivor create an entirely new experience by noticing every aspect of their actions. They can feel and become the motion when sweeping the floor, sense the muscles they use when scrubbing the dishes, and develop a more efficient way of wiping the windows clean.
5. The idea is for the survivor to get creative and discover new experiences within a familiar routine task. Instead of over thinking about finishing the task, the survivor becomes aware of every step and can fully immerse themselves in the process.

Mindful Appreciation

The point of this exercise is to help give thanks and appreciate the seemingly insignificant things in life.

1. The survivor needs to choose 3 things in their day that usually go unappreciated. Help the survivor to think of small things (e.g., having ears that allow them to hear the birds in the tree, having a home that shields them from the rain and sun, a rainbow, access to water or having a nose that lets them smell things around them).
2. Once the survivor has decided on 3 things, the caseworker can ask the person the following questions and have a conversation.
   - *How did these things/processes come to exist/how do they really work?*
   - *How do these things benefit your life and the lives of others?*
   - *What might life be like without these things?*
   - *Have you ever stopped to notice their finer, more intricate details? What are they?*
   - *What are the relationships between these things and how do they play an interconnected role in the functioning of the earth?*
3. After having this conversation, agree with the survivor that they will find out everything they can about the creation and purpose of the 3 things they identified, to truly appreciate the way in which these 3 things support the survivor's life.

RELAXATION TECHNIQUES

When to use: Relaxation Techniques can be integrated into all GBV CM steps, especially Step 4: Implementing the Case Action Plan following assessment that identifies need for relaxation.

Every time a GBV survivor feels fear or worry, their brain believes they are in danger, and stress hormones are released into their body. These stress hormones make their body and brain function different than normal (See image on page 17).

When the survivor's stress hormones increase, their alertness and energy increases. Stress hormones help them to respond quickly when they are in danger. However, if they worry or feel fear every day, stress hormones can have a negative effect. They can increase a survivor's blood pressure; make them forgetful or make it hard to concentrate; increase their blood pressure; and even decrease their sex drive.

Relaxing the body and mind helps the survivor to be healthy, to feel more in control and able to function. Survivors often have found elaborate, creative ways to relax. Caseworkers should explore and prioritize survivors' existing coping strategies. However, relaxation is not easy for every survivor and can be scary and too vulnerable for some survivors, especially if they are often hypervigilant. They may

[13] Adapted from https://www.pocketmindfulness.com/6-mindfulness-exercises-you-can-try-today/

think that if they relax, they will not be prepared in case of potential violence. Caseworkers can explain that the process of feeling relaxed is slow and gradual; it can start together during meetings if only for a few moments. Over time, they will be able to tolerate longer moments of relaxation. If they feel safe, they can start to practice the relaxation techniques at home, maybe with another trusted person.

The relaxation techniques below can be used at any time to help the survivor to manage fear or worry. Please follow these steps when teaching a survivor how to do the relaxation exercises. You do not need to follow all steps with a survivor in the same session. For example, you could teach breathing exercises in one session and visualization techniques in a follow-up session. Note that breathing techniques like the one below can raise anxiety and/or be dysregulating for some survivors. Be sure to check in with the survivor when teaching breathing techniques and be prepared to try a different technique (see Appendix F for a list of relaxation and grounding techniques). Keep in mind that a relaxation or grounding techniques that works for one person may not work for another person. Experimenting is key; it means trying it out and checking in with how it feels for the person. They may need to use it several times to see if it has an effect.

Step 1: EXPLAIN GOALS OF RELAXATION EXERCISES

The caseworker can say, *"I want to teach you 2 new skills to help you relax. These skills will teach you to use your* ***breathing*** *and* ***imagination*** *to help you relax."*

Deep slow breathing:
- Tells the brain *"You are safe,"* and helps the body relax.
- Slows down the stress response.
- Slows down the heart rate.
- Stops the production of stress hormones, adrenaline and cortisol.
- Stops the nervous survival part of the brain and activates the rational thinking part of the brain.

Imagination-Visualization:
- Soothing pictures, sounds, smells and images can relax the survivor's body and mind. Thinking relaxing thoughts can help them to feel relaxed.

Step 2: BREATHING EXERCISE

- Have the survivor sit or lay comfortably.
- Request the person to take 10 slow, deep breaths from their belly. They can place their hand on their belly to feel it expand and contract (like a balloon being blown up or letting the air out of it). If they cannot breathe from their belly easily, then they can breathe from their chest. Have them place their hand on their belly/chest to feel it expand and contract.
  1. Breathe in while counting 1-2-3-4-5.
  2. Hold their breath for 1-2-3-4-5.
  3. Breathe out slowly 1-2-3-4-5.

If the above breathing exercises do not help the survivor relax, have them try to breathe in while imagining a safe place or a favourite smell, or a colour or sound and when they breathe out slowly, they can say *"relax"* silently or breathe out negative thoughts saying, *"no more worry," "no more fear"* etc.

Step 3: IMAGINATION – VISUALIZATION

Visualization Guidelines
- Talk with the survivor about what makes them feel **relaxed and safe**. Ask for details of this feeling of safety like their favourite images, metaphors, sounds, songs, colours, smells, feelings, memories, and fantasies.
- Ask the person to take 10 slow, deep breaths from the belly. They should count to 5 as they breathe in, hold it for 5 seconds and then breathe out slowly.
- Ask the person to go on an imaginary journey using their favourite images. The journey starts in the present; takes them to a place of safety and slowly has them return to the present again.
- Use the senses – what does the survivor smell, touch, hear and see on their journey. Add bright and beautiful colours, and calming sounds and images.
- The caseworker should speak in a calm, slow voice. Take pauses between your sentences. Give them time to imagine the place.
- **IMPORTANT: If a survivor has chronic, severe levels of disassociation, flashbacks or intrusive images, it is recommended to not use this visualization technique and instead to use primarily breathing or body-based relaxation techniques (e.g., progressive muscle relaxation).**

Sample Visualization
Use the following steps to take the survivor through an imaginary journey. Make sure to take long pauses between each step:

1. *Once you feel comfortable, gradually close your eyes* ***(note; do not make them close their eyes if they don't want to. They can simply soften their gaze and stare at something unmoving in the space, such as the floor.)*** *and become aware of your breathing … allow your breathing to gradually slow down … breathe in and breathe out … breathe in and breathe out …*
2. *Now breathe deeply and imagine that you are leaving the building to travel to another place, a place of calm.*
3. *Imagine what you see as you leave the building and begin your journey…*
4. *Decide in your imagination: How do you choose to travel? Are you walking, taking a bus, flying? Is your way through a town…? or are you leaving town passing through the countryside… notice what is under your feet as you make this journey… What kind of day is it? Is it warm, cool, windy or rainy?*
5. *Now, up ahead, you see your destination, a place of calmness… Imagine what is it like when you approach this place?*
6. *You have arrived at last.*
7. *Imagine what is your place of calmness like? Is it a building? Is it outdoors? Look at this place. What do you see around you? Beneath you? Above you? When you stretch out your hands, what do you touch?*
8. *Make yourself comfortable here. Imagine if you are sitting, standing or lying down? Do you hear any sounds in this place of calmness? Birds, ocean waves, music…or is it quiet? What does it smell like in this place of calmness? Are you alone in this place, or are there other people with you? Who? If you want to invite someone to join you, do it now.*
9. *Take another minute to enjoy this place where you can feel very calm.*
10. *Now the time has come for you to leave this place, but remember, it will always be there, you can always come back to it if you want to. So, take one last look around and now start to leave. Go back the way you came, retracing all the parts of your journey. Walk, ride or fly, back across the countryside, or through the town, until you find your way back to this room and to your place in this room, and when you are ready, slowly open your eyes.*

Step 4: DEBRIEFING THE RELAXATION EXPERIENCE

- Ask the survivor how they feel and how does their body feel.
- Ask the person to share a little about where they travelled to in the visualization.
- Ask the person how and when they can use this relaxation in everyday life.

The process of teaching a technique—relaxation, grounding or others—is important. Caseworkers want to ensure the survivor knows how to do it, knows when to use it, has the capacity to use it, and is motivated to use it. To help a survivor know how to do a technique, the caseworker is advised to explain the technique in detail, practice it during the meeting, answer questions the survivor has about it, and ask them to demonstrate it for the caseworker.

To help a survivor know when to use a technique, the caseworker needs to first understand in which situations or times of day the survivor feels distress (e.g., difficulty falling asleep at night). Help a survivor understand what the signs are that they should use a particular technique (e.g., when you notice yourself getting very angry and have the urge to yell; when you notice it is hard to concentrate and you have the pain in your stomach; etc.) and understand the situation in which those signs are most likely to arise. Then, the caseworker and survivor can discuss using reminders, a schedule or set time every day, writing the technique down, have family member remind them, or other strategies.

To help a survivor have the capacity to use a technique, the survivor should practice it when they are feeling calm and relaxed. Practicing it first in a calm situation helps a person remember to use it in distressing situations when the mind has a more difficult time remembering. Caseworkers should also help survivors identify and plan for any barriers that get in the way of them using the technique.

As for motivation, this is addressed in more detail in the Enhancing Motivation section. Practicing the technique during the meeting helps; if the survivor feels relief, they are more likely to use the technique outside of the meetings. Motivation is also affected by the way caseworkers introduce a technique, the way caseworkers talk to the survivor and react to their problems, what caseworkers think about the survivor, what the survivor thinks of themselves, how important it is to them, and their self-confidence. See Enhancing Motivation section for more information.

GROUNDING TECHNIQUES

When to use: Grounding Techniques can be integrated into all GBV CM steps when the survivor is feeling overwhelmed. This technique may be most useful in Step 1: Introduction and Engagement if a survivor arrives over- or under-activated in their Window of Tolerance, as well as in Step 4: Implementing the Case Action Plan.

Grounding techniques help the GBV survivor to "anchor" or stay in the present. They help re-orient a person to the here and now present reality.

Why use Grounding Techniques?

Grounding techniques are typically the first thing caseworkers teach survivors. When a survivor is overwhelmed, they may detach from this reality (e.g., dissociation, daydreaming) and become either over- or under-activated so that they can gain control over their feelings and stay safe. GBV survivors can use grounding strategies to get back inside their window of tolerance when they go outside and to stay inside their window when at risk of going out. As such, grounding techniques can be used when survivors are feeling emotionally overwhelmed, when having flashbacks or experiencing intrusive images, or when triggered.

Many people with experiences of trauma struggle with over-activation (i.e., feeling too much, such as overwhelming emotions and memories) or under-activated (i.e., too little, such as numbing and dissociation). In grounding, the survivor can attain balance between the two – conscious of present reality and the ability to tolerate it. When survivors are grounded, they can think more clearly and make better decisions. This makes grounding techniques also useful for survivors who live in scary or dangerous situations. If survivors face persistent abuse or threats, problem solve how to stay as safe as possible and practice grounding techniques often.

Note that grounding is not the same as relaxation techniques. Grounding is much more active, focuses on reconnecting to the present and to reality. It is believed to be more effective for trauma experiences than relaxation training. Grounding is also slightly different than mindfulness. While mindfulness and grounding both focus on present awareness, a key difference is that—rather than adopting an attitude of allowing whatever wants to come up to come up, as with mindfulness—grounding techniques help survivors manage their focus purposefully and on present safety.

All grounding techniques and guidelines that follow should be adapted to fit the survivor's unique context, culture and needs. See Appendix F for a list of relaxation and grounding techniques.

Guidelines for Grounding[14]

1. Grounding can be done **any time, any place, anywhere** and no one around the survivor has to know.
2. The survivor can use grounding when they are: faced with a trigger, **having a flashback, dissociating, or when their emotional pain goes above 6 (on a 0–10 scale)**. Grounding puts healthy distance between the survivor and their negative feelings.
3. The survivor should keep their eyes open, **scan the room, and turn the light on** to stay in touch with the present.
4. The survivor can **rate their mood before and after** the test to see whether it worked. Before grounding, they can rate their level of emotional pain (0–10, where 10 means "extreme pain"). Then re-rate it afterwards. Has it gone down?
5. The person should remember that **not talking about negative feelings or journal writing** may help when they are triggered. They want to distract away from negative feelings, not get in touch with them.
6. **Focus on the present, not the past or future.**

Mental Grounding

Teach, encourage and support the survivor to:

1. **Describe their environment in detail** using all their senses. For example, *"The walls are white; there are 2 cushions, there are grey shoes …"* Describe objects, sounds, textures, colours, smells, shapes, numbers and temperature. They can do this anywhere. For example, when walking down the street: *"I'm walking on the street. I will see the corner shop soon. Those are cars. This is a bench. That shirt is blue. The sky is blue."*
2. **Play a "categories" game** with themselves. They can try to think of "words that begin with "A," "countries," "favourite songs, "or "names of birds."
3. **Describe an everyday activity in detail.** For example, they can describe a meal that they cook (e.g., *"First, I peel the potatoes and cut them into quarters, then I boil the water, then I cut the onions …"*).
4. **Visualize images that create boundaries** (e.g., change the TV/radio channel to a better show or think of a wall as a buffer between you and your pain).
5. **Say a safety statement:** *"My name is _____; I am safe right now. I am in the present, not in the past. I am located in _____ the date is _____."*
6. **Read something, saying each word to themselves.** Or read each letter backwards so that they can focus on the letters and not on the meaning of words.
7. **To use humour.** Thinking of something funny to jolt themselves out of their mood.
8. **Count to 10 or say the alphabet** very slowly.
9. **Repeat a favourite saying** to themselves over and over (e.g., the Serenity Prayer).

[14] Adapted from: Najavits, L.M. "Seeking Safety": A Treatment Module for PTSD and Substance Abuse. Guilford Press (New York).

Physical Grounding

Teach, encourage and support the survivor to:

- **Run cool water over their hands.**
- **Grab tightly onto their chair as hard as they can.**
- **Touch various objects around them:** a pen, the ground, their feet. Notice textures, colours, materials, weight, temperature. Compare objects they touch: Is one colder? Lighter?
- **Dip their heels into the floor** – literally "grounding" them! Have them notice the tension centred in their heels as they do this. Remind themselves that they are connected to the ground. If they want to remove their shoes so that their feet are on the actual ground, this can help as well (it allows for toe curling and different movement that sometimes shoes restrict).
- **Carry a grounding object in their pocket** – a small object (e.g., a small rock, a ring, or piece of cloth) that they can touch whenever you feel triggered.
- **Jump up and down.**
- **Notice their body:** The weight of their body in the chair; wiggling their toes in their socks; the feel of their back against the chair. They are connected to the world.
- **Stretch.** Extend their fingers, arms or legs as far as they can; roll their head around.
- **Walk slowly, noticing each footstep,** saying "left," "right" with each step.
- **Eat something.** Describe the flavours in detail to themselves.
- **Focus on their breathing.** Noticing each inhale and exhale. Repeat a pleasant word to themselves on each inhale (for example, a favourite, colour or a soothing word such as *"safe"* or *"easy"*).

Soothing Grounding

Teach, encourage and support the survivor to:

- **Say kind statements**, as if they were talking to a small child. For example, "I am a powerful person going through a hard time. I'll get through this." Avoid being generic. Ideally the kind statement should resonate with some inspiring experience the survivor has had, particularly using 'I' statements.
- **Think of favourites.** Think of their favourite colour, animal, time of day or memory.
- **Picture people they care about** (if this is soothing). They could imagine or look at pictures of loved ones.
- **Remember the words to an inspiring song, quotation or poem** that makes them feel better.
- **Remember a safe place.** Describe a place that they find very soothing (e.g., sitting on a favourite rock or by the river or with a loved one). They should focus on everything about that place—the sounds, colours, shapes, objects, textures.
- **Say a coping statement** (that is based in reality). "I can handle this," "This feeling will pass."
- **Plan out a safe treat for themselves**, such as, a piece of candy, a conversation with a good friend or a walk in their favourite area).
- **Think of things they are looking forward to in the next week.** Perhaps time with a friend or a cultural activity.

What if Grounding Does Not Work?

Encourage the survivor to:

- **Practice as often as possible.** Even when they do not "need" it, so that they will know it by heart.
- **Practice faster.** Speeding up the pace gets them focused on the outside world quickly.
- **Try grounding for a long time (20–30 minutes).** Repeat, repeat, repeat!
- **Try to notice whether they do better with "physical" or "mental" grounding.**
- **Create their own methods of grounding.** Any method they make up may be worth much more than those that are here because it is theirs.
- **Start grounding early in a negative mood cycle.** Start when they are have just started having a flashback.

The Importance of Practice

In the beginning, learning Mindfulness, Relaxation and Grounding techniques is awkward, difficult and may not seem all that helpful. In fact, some people may worry whether or not they are doing the basic techniques right or they may get anxious if they do not feel instantly better. That is very normal; it is a technique in development. But in time it gets easier, more automatic, and more effective because the skill set moves from a person's working memory (which is very limited) to their long-term memory (which is very vast).

A person does not learn how to drive a car by first driving on the highway; instead, they learn on quiet roads or in parking lots. It is important to learn new techniques and skills when there are fewer distractions from juggling all the parts of the new technique in one's mind. If people only practiced new techniques when they really need them—like in the middle of a panic attack, for example—it is like they are learning how to drive in the fast lane of the highway. That is not the best way to make the most of the technique. Encourage and plan with survivors to practice new techniques often, starting in times when they are calm.

Connecting Concepts: Mindfulness, Grounding, Relaxation and the Window of Tolerance
Mindfulness exercises and techniques help build the capacity to be mindful in all parts of one's life. Mindfulness helps a person track where they are in their Window of Tolerance at any given moment. When mindful (i.e., awareness of one's present experience without judgement), a person can notice when their level of activation is changing. This is done by noticing signs in the body—like changes in heartbeat, temperature, shaking, difficulty sitting still or slowing movement, posture slumping or feeling weaker. Similarly, when a person is mindful, they notice their emotions, their thoughts and how connected they feel to other people. This is all data to assess one's level of activation and if they are getting too close to the edges of their window. Based on mindfulness of where one is in their window, Grounding and Relaxation Techniques then help them intervene:

- Grounding techniques are used to get back inside the Window of Tolerance when a person has left it. When someone is outside their window, they are not fully present, and part of their brain is stuck in the past trauma. Grounding actively guides a person's attention away from thoughts about past and towards the present. Some mindfulness exercises are also grounding. In addition, grounding can be used to keep someone inside their window when they are at risk of leaving it, or when someone wants to intentionally become more present in whatever they are doing.
- Practicing relaxation techniques helps prevent a person's level of activation getting too high and helps a person widen their window so they can tolerate more and more stressful experiences over time. When a person is relaxed in their daily life, they can better tolerate stressful experiences, which prevents them going outside their window of tolerance. Relaxation helps the body feel safe and calm and helps a person connect better with other people.

ENHANCING MOTIVATION

When to use: Motivation Techniques can be integrated into many GBV CM steps, as needed. It can be especially useful during Step 2 to assess motivation to make changes, Step 3 to address ambivalence in creating a case action plan, and Step 5 to address any motivation-related issues that prevented a survivor from implementing any part of their case action plans (e.g., did not use relaxation techniques, did not go to the health clinic).

This section includes several principles and techniques to help survivors increase their natural desire to make changes in their life, no matter how big or small. This change can include using a relaxation or grounding technique, reduce their alcohol use, reach out to their social network, follow through on a referral, attend a community event, or any other part of their case action plan.

Motivational Interviewing, which is a method of communication that attempts to enhance motivation for a specific goal, offers a helpful "Spirit" called PACE that guides motivational work:

- Partnership – Work together, avoid the role of the expert.
- Acceptance – Respect the survivor's autonomy and choices.
- Compassion – Keep the survivor's best interest in mind, have empathy for them
- Evocation – The best ideas often come from the survivor, not the caseworker; recognize each survivor's wisdom

Guided by PACE, caseworkers use techniques that target the main reasons people change. These reasons include:

- They verbalize the benefits of the change
- Their values support it
- They have a good plan and adequate social support
- They are ready for it
- They think it is important
- They think they can
- They think the change will be worth it

Often the first step toward making a change is expressing ambivalence—which is when a person feels two ways about changing their behaviour. For example, a survivor might say "I know the grounding technique might help me, but why bother when I'll never feel better again?" or "I don't want to lose my job, but I need alcohol." This is normal. Caseworkers should avoid the urge to agree with the part of the survivor that wants to change. That can cause the survivor to defend the opposite part of them that is reluctant to change, which leads to decreased motivation. It also puts the caseworker in the position of persuading the survivor to change while the survivor argues to not change. That back-and-forth debate should instead occur inside of the survivor, so that they feel pulled in two directions. The caseworker should validate that the survivor is feeling two ways about the issue and be sure not to judge their reasoning. Shaming survivors for not changing is both ineffective and harmful.

Develop Discrepancies

Caseworkers can help survivors get "unstuck" from the back-and-forth pull of ambivalence by highlighting the discrepancy between the way things are and the way a survivor wants things to be. The most effective way to develop discrepancy is for the person to talk about their Reasons for Change. If they are ambivalent about using a relaxation technique, revisit the original goal of the technique. For example, it may be to prevent panic attacks. A caseworker may ask a survivor how feeling panic less often or less intensely would help them in their life? Be sure to also Explore Their Reasons. That is, ask them questions to see why they are not using the technique or why they think it will not work. Ask them what they fear may happen if they try it. Caseworkers can use their basic counselling skills here, such as open-ended questions, reflections, and validating their feelings.

Eliciting statements about her Reasons for Change increases motivation for change and decreases uncertainty about change. The survivor—not the caseworker—needs to make the argument for change. If they are currently doing something else to cope and it is not working, the casework can reflect this back to the survivor. If the survivor is not doing anything to cope or change the situation, the caseworker can assess and validate their reasons and ask them what this approach may be costing them or how it is getting in the way of what they want for themselves.

Considering the benefits and costs of changing one's behaviour is a useful technique to develop discrepancies. Appendix G - Decisional Balance is a worksheet that caseworkers can complete together with survivors during a meeting. Keep in mind that most survivors already know some of their behaviour is a problem. Their behaviour is usually helping them in some way, even if it is also harming them. For example, drinking large amounts of alcohol may provide them temporary relief from a particular distressing symptom, yet it may also be harming them medically, damaging their relationships, or cause other problems in their life. Validate that this behaviour is trying to help them, while it is also costing them things that are important to them. A person is morev likely to change when the benefits of the change outweigh the costs of staying the same. This may take time, so caseworkers should be patient.

Ask-Tell-Ask

As mentioned in the Relaxation Techniques section, motivation is affected by the way caseworkers introduce a technique. Ask-Tell-Ask is an effective tool to introduce a technique, to explain why it may be helpful, or to give advice or when a caseworker feels it would be unethical to withhold information (e.g., if there is a safety or health concern about their behaviour or someone else's behaviour).

First, ask the survivor what they already know about the topic you want to discuss. Example:

- "Have you heard of grounding techniques? What do you know about them?"
- "What do you know about the effects of alcohol on a person's health?"
- "Any idea why practicing relaxation techniques may be helpful?"

Second, **Ask** for their permission to provide the information, give advice or express concerns. If permission is given, give the information/advice/concerns in a neutral and non-judgmental manner. Examples:

- "I have some information about this technique that I can share. Would that be alright?"
- "Would you like me to share with you some information about grounding techniques?"
- "Can I tell you why practicing this technique has helped others in your situation?"
- "Would you be willing to hear some information on the health effects of alcohol?"
- "When you were telling me about your husband's behaviour, I became somewhat worried. Would it be okay if I shared my concerns with you?"

If they say yes, the caseworker can proceed and share (i.e., **Tell**). If they say no, the caseworker should respect their wishes and not share.

Lastly, **Ask** the survivor for their thoughts or reaction about the information you shared. Pay attention to their non-verbal reactions. Examples:

- "What do you make of that?"
- "I wonder if that makes any sense to you?"
- "Any thoughts about that?"

Affirmations

Affirmations are statements that recognize the strengths of the person. They can be words of encouragement, attempts, hopes, achievements, accomplishments. Caseworkers can use affirmations to bolster a survivor's motivation to change. However, it is important for affirmations to be genuine and consistent. Affirmations can encourage survivors when previous efforts have been unsuccessful and can reframe behaviours as signs of a positive quality rather than a negative one. For example:

- Highlight how great it is that a survivor tried the technique once despite the challenges
- Affirm how hard it can be or how disappointing it can be if the technique they tried does not work
- Tell them their idea for how to make the change is good and that you think it can work
- Affirm their goal for changing; for example, remind them they want to feel less anxious or more in control
- Let them know how hard you see them trying
- Appreciate them for asking for help with the technique with which they are having trouble

Supporting Self-Efficacy

Building a person's belief that they are capable of making a change is critical. Survivors often feel greater self-efficacy when they have a community of people that believe in their ability to change and their potential to contribute back to their community. Discuss with survivors who in their life they can invite in to help with their goal and who can provide them with support.

As mentioned, Caseworkers can also support a survivor's self-efficacy by exploring past successes. Ask:

- What successful changes have you made in your life in the past? What helped you to be successful then? How do you think you might be able to apply those skills to this situation?
- What strategies have you used to overcome barriers in the past?
- When a survivor has taken steps toward change, ask them how she made that happen. What happened to make that possible? How can you do it again?
- Would you be interested in hearing about things that have worked for other people? What do you think about those? What fits for you and your situation?

Caseworkers should celebrate survivors' successes and the steps they take toward change. Remind survivors of their past success, their protective factors and strengths, and the supports they have. Caseworkers need to believe that change is possible and that the survivor is able to do it. Hope and belief in survivors can help them feel hopeful and confident in themselves.

The Ruler

The Ruler (Appendix H) is a technique that can be used 1) to assess a survivor's feelings about their behaviour; 2) to draw out and reinforce positive talk about changing; and 3) to build a survivor's sense of self-efficacy. The Rules asks survivors to consider importance, confidence and readiness to change on a scale from 0 to 10. A caseworker can use one or more of the rulers, depending on the survivor and situation. For example, while showing the picture of a ruler in Appendix H, a caseworker may ask "On a scale of 0-10, where 0 is not at all confident and 10 is extremely confident, how confident are you that you could actually make that change?" Depending on the survivor's response, the caseworker could ask several follow-up questions, such as:

- Why did you choose that number? What does it mean to be [number survivor chose]?
- What makes you choose that number rather than a 0 [or a number lower than what she chose]?
- What might it take for you to get from here to [a number 2-3 points higher]? That is, what might it take for you to become a little more confident than you feel now?
- What needs to happen to get to that higher number?
- What would it feel like to be at (higher number)? How will you know when you have reached that higher number?

These questions allow for the survivor to imagine themselves becoming more confident, realize they are further along than maybe they originally thought (i.e., not at 0), and elicit ideas for how to feel more confident. The same questions can be asked about importance and readiness. Listen carefully to their responses; they will contain important information about what supports or gets in the way of changing. Then you can ask more questions and/or address any barriers to changing. Support the ideas they have on how to get from their current number to a higher one (i.e., increase importance, confidence or readiness). Each person will have different reasons for choosing their number and have different ideas for how to increase it. Affirm any reasons for changing; for example, if a survivor says they are at an 8 for importance because changing would help their family, the caseworker can reinforce this by saying, "Family is very important to you."

Remember, the goal is to encourage talk of change, not reasons to stay the same; avoid asking the survivor a question like, "Why did you choose 5 rather than 8?" as this may prompt them to share why they are not confident or cannot make the change. Also, be careful not to make them seem more ready to change than they are. After using The Ruler, caseworkers should summarize the survivor's responses and ideas, as well as express confidence in the survivor.

The Ruler can be useful during Step 2 (Assessment) of case management and can be used periodically thereafter to assess changes in importance, confidence and readiness as your work with the survivor progresses. If the survivor expresses low importance, the caseworker can highlight any ambivalence, Explore Their Reasons and work toward Developing Discrepancies. This may include asking questions like, "How bad would things need to be to make changing more important to you?" and "When you think about your loved ones, what would they say about how important it is for you to change? What are their reasons?"

If the survivor expresses that changing is very important to them but their confidence is low, the caseworker can ask survivors questions that explore previous times they have successfully made any kind of change in their life; this includes exploring what helped them be successful, what strategies they used to overcome barriers, and what protective factors they have that can help them be successful this time. Caseworkers can also explore barriers to their success (i.e., risk factors) to anticipate and plan for them. If the survivor's confidence level does not increase over time, discuss adding more support from family and friends or revisiting their goal to make it more realistic or time-bound (e.g., using grounding techniques twice a week instead of every day; or not drinking alcohol for the next month instead of forever).

When a survivor expresses high importance and high confidence, the caseworker should seek to strengthen their commitment to make a change by exploring their reasons for change and the potential impact changing will have on their life and their community.

Self-Reflection

When practicing motivational techniques, caseworkers should ask themselves these guiding questions[15]:

- Do I listen more than I talk? Or am I talking more than I listen?
- Do I keep myself sensitive and open to their issues, whatever they may be? Or am I talking about what I think the problem is?
- Do I invite this person to talk about and explore their own ideas for change? Or am I jumping to conclusions and possible solutions?
- Do I encourage them to talk about their reasons for not changing? Or am I forcing them to talk only about change?
- Do I seek to understand them? Or am I spending too much time trying to convince them to understand me and my ideas?
- Do I reassure them that ambivalence to change is normal? Or am I telling them to take action and push ahead for a solution?
- Do I remind myself that they are capable of making their own choices? Or am I assuming that they are not capable of making good choices?

BEHAVOURIAL ACTIVATION[16]

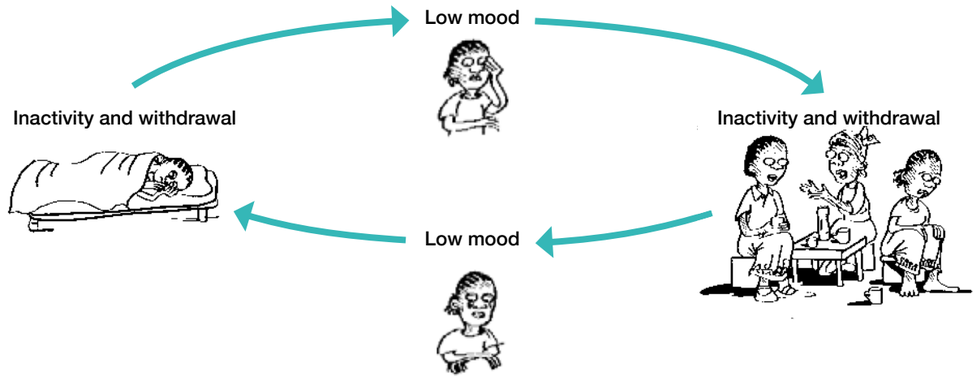
When to use: Behavioural Activation can be integrated into all GBV CM steps, especially Step 4: Implementing the Case Action Plan and Step 5: Case Follow-Up.

Behavioural Activation targets the cycle of inactivity that GBV survivors can get stuck in when they are doing fewer activities due to being social isolated, depressed or fearful of the outside world. Being inactive can maintain a low mood to block them from engaging in tasks and activities. Behavioural

[15] Adapted from Case Western Reserve University. "Encouraging motivation to change: Am I doing it right?" Retrieved from: https://www.centerforebp.case.edu/client-files/pdf/miremindercard.pdf

[16] Adapted from PM+ World Health Organization 2016, refer to page 56.

Get Going Keep Doing: The Inactivity Cycle



Activation aims to break this cycle and improve the survivor's mood and thoughts by getting them involved again in pleasant and task-oriented activities despite their mood.

Behavioural activation is when the caseworker:

- Teaches the survivor that adversity can cause people to become stuck in a cycle of low mood and inactivity (i.e., lower activation in their Window of Tolerance).
- Reassures the survivor that problems with low mood and inactivity are not uncommon.
- Teaches the person that becoming active can break this cycle of low mood and inactivity.
- Helps the person improve their mood, which can also help people feel more confident in solving their practical problems.

Examples of activities that survivors often engage in less when in a low mood:

- Pleasant events (i.e., activities they used to enjoy)
- Social events
- Essential activities for daily living, which include:
  - Household duties (e.g., cleaning, tidying the house, food shopping and preparation, child-care tasks).
  - Employment duties (e.g., reduced activity at work or in extreme cases no longer going to work regularly or at all).
  - Looking after oneself (e.g., getting out of bed, washing regularly, changing clothes and eating regular meals).

Techniques for Behavioural Activation

1. Invite a family member or friend into the room only if the survivor would like them to be present. They might be able to provide some encouragement and support the person to start doing activities again.
2. Draw the Get Going, Keep Doing: The Inactivity Cycle diagram[17] (above) for the survivor and discuss it. Have the survivor give examples of inactivity and withdrawal in their daily life. Validate this is a common reaction to GBV.
3. Explain that taking action—even when they do not feel like it—can help them feel better physically and mentally (i.e., Behavioural Activation). Explore if they have any examples of this from other points of their life and what worked for them then. Explain that Behavioural Activation starts with exploring potential activities they can do that feel most meaningful and then creating strategies that can help them start taking action.
4. Explore and validate their feelings and thoughts toward behavioural activation (e.g., worry, hopelessness, "it won't work," feels too hard)
5. Set very small, specific manageable activities together with the person to achieve over the next week (due to their poor motivation and possibly low self-worth, you want them to be able to achieve the goal). The key is that the activities should either be **pleasant** or provide them with a sense of **accomplishment** (or both). Behavioural Activation is most effective when the activities are very **meaningful** to survivors; that is, they are connected to a survivor's **values**. The outcome of feeling pleasant or accomplished or of having done something meaningful and connected to their values, reinforces a behaviour and makes it more likely that they will do it again.
6. Help the survivor choose a time and day when they will be least distracted and a time when they often feel the least tired or hopeless (e.g., mornings after the children have gone to school) to complete the activity or task.
7. Use the calendar handout to create a schedule of activities (see Appendix I). Alternatively, have survivors create a list of 5 small activities that take no more than 15 minutes each and instruct survivors to use this list as a "menu" they can refer to each morning to ask themselves: "What is one thing I can do today?" Once they are done with that activity, they are done managing their low mood for the day.
8. Use other reminders (e.g., alerts on a mobile phone if the survivor has one and it is safe to do so, scheduling tasks to coincide with community activities or mealtimes or having a friend or family member remind them are all good ways of helping the survivor to complete the task).
9. Focus on returning the person to a routine so that they are productive.
10. Do not fall into the trap of thinking that this strategy is only about the person having fun. Many situations have little opportunity for positive experiences. Being active and productive is still very useful.

Tips to improve the likelihood of success:

- Choose few and simple activities. Having too many or too complex activities may cause the person to feel out of control and failing. The goal is to lower stress levels and increase their sense of being in control.
- Break down an activity into smaller pieces that are realistic and achievable. Due to low motivation and possibly low self-worth, caseworkers want survivors to be able to achieve the goal. For example, if the survivor wants to wash clothes, break the activity down by collecting all the dirty clothes that need washing one day, sorting the clothes into different piles another day, choosing one pile of clothing to start with and aiming to wash one item of clothing each day after that.
- Anticipate setbacks. It is normal. Discuss what survivors will do if they do not start or complete their task as planned and how they can compassionately talk to themselves or use Relaxation Techniques or Mindfulness to stay focused. Explore and problem solve what might get in the way of them starting or completing their task.
- Self-compassion. Help survivors have self-compassion for how hard it can be to get active. Remind survivors that doing any activity may feel like a really big challenge right now. That is why they will start small. Take small steps now so that they can take bigger steps later.
- Keep in mind the long-term benefits.
- Get someone else involved. Survivors can decide how their friends and family members can support them to accomplish their goals or celebrate their successes.
- Use mindfulness. Encourage survivors to check in with how they feel after they do an activity. Notice any good feelings.

[17] https://www.who.int/mental_health/emergencies/problem_management_plus/en/ page 57.

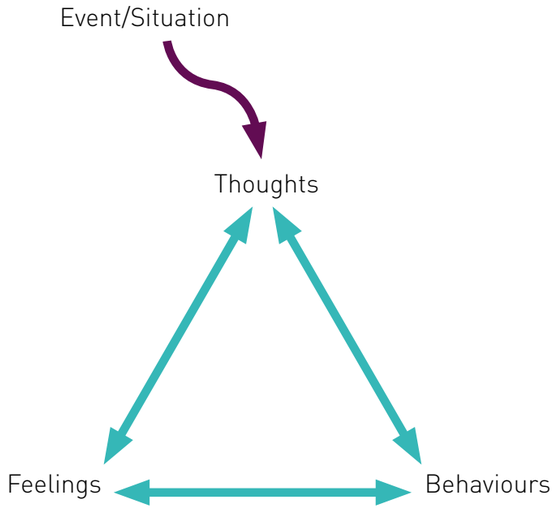
COGNITIVE RESTRUCTURING

When to use: Cognitive Restructuring can be integrated into all GBV CM steps. This technique may be most useful in Step 4: Implementing the Case Action Plan and Step 5: Case Follow-Up.

Survivors' thoughts define their reality. The trauma(s) that survivors have experienced has changed the types of thoughts they have, how they interpret experiences and how they make sense of what is happening around them. For example, a survivor may share that she has always believed that she is not beautiful or special, and after the sexual assault, she thinks "I am ruined," which reinforces the beliefs she already had, making them stronger

As mentioned in Part 1, there is a relationship between thoughts (including beliefs), feelings (emotions and sensations) and behaviours (see image of Cognitive Triangle below). Certain thoughts can change how a person feels and behaves. For example, survivors may have thoughts like "Nothing will ever get better," "If I left earlier, I would not have been assaulted," "The world is unsafe," or "No one is there for me." Different events or situations throughout the day may prompt a survivor to have one or more of these thoughts, which can cause her to feel distress and act in ways she does not prefer. Cognitive Restructuring is one way to help survivors change their unhelpful thoughts and positively affect their behaviour and feelings.

The Cognitive Triangle



The cognitive restructuring technique involves: **1) Psychoeducation 2) *Identifying* inaccurate trauma-based thoughts and core beliefs and 3) *Challenging and changing* inaccurate trauma-based thoughts and beliefs.**

The caseworker can follow the following steps to help survivors.

Step 1: Psychoeducation

Help the survivor to understand the relationship between an event/situation, thoughts, feelings and behaviours using the Cognitive Triangle. Explain that the thoughts we have are not always 100% accurate. For example, someone who was mistreated by a parent as a child might develop the belief that they are unlovable, when the actual problem was their parent.

Some examples of unhelpful thoughts are:[18]

- **Magnification and Minimization:** Exaggerating or minimizing the importance of events. One might believe their own achievements are unimportant, or that their mistakes are excessively important.
- **Catastrophizing:** Seeing only the worst possible outcomes of a situation.
- **Overgeneralization:** Making broad interpretations from a single event. *"I hate fighting with my sister. Everyone is always fighting with me."*
- **Magical thinking:** The belief that actions will influence unrelated situations. *"I am a good person—bad things shouldn't happen to me."*
- **Personalization:** The belief that one is responsible for events outside of their own control. *"My mother is always upset. It must be because I have not done enough to help her."*
- **Jumping to conclusions:** Interpreting the meaning of a situation with little or no evidence.
- **Mind reading:** Interpreting the thoughts and beliefs of others without adequate evidence. *"Everyone is always talking about me. They must be saying I am ugly."*
- **Fortune telling:** Predicting the future. Having the expectation that a situation will turn out badly without adequate evidence.
- **Emotional reasoning:** The assumption that emotions reflect the way things really are. *"I feel anxious about going outside, so it must not be a good idea to go outside."*
- **Disqualifying the positive:** Recognizing only negative aspects of a situation while ignoring the positive. One might receive many compliments on an evaluation but focus on the single piece of criticism.
- **"Should" statements:** The belief that things always need to be a certain way. *"I should never feel sad."*
- **All-or-nothing thinking:** Thinking in absolutes such as *"always"*, *"never"*, or *"every"*. *"I never do a good job on my work."*

Step 2: Identify inaccurate and exaggerated thoughts and core beliefs

Most survivors will identify with at least a few of the distorted thoughts listed above, and easily connect them with their own experiences. Together, the caseworker and survivor can create a list of the survivor's common unhelpful thoughts. Caseworkers can ask questions to see when in the survivor's daily life they last had that thought (i.e., which situations may prompt the thought). This helps identify how that thought made them feel and behave in a specific situation. In a different situation, that same thought may cause them to feel and act differently. Having a context for the thought is also helpful for Step 3. If a survivor does not have a recent event during which they had the thought, the caseworker can still ask questions about how the thought makes them feel and how they imagine it might impact their behaviour.

Alternatively, a caseworker may identify a potentially unhelpful thought while a survivor is sharing a story of a recent time they felt distressed or behaved in a way they did not want. The caseworker can ask questions assess if there was an unhelpful thought that caused their painful emotions and behaviour.

[18] Taken from https://www.therapistaid.com/therapy-worksheet/cognitive-distortions

Step 3: Challenging thoughts

Cognitive restructuring helps the survivor be mindful of their thoughts and to start to examine and question their thoughts as opposed to being subject to them. The hope is that as old, unhelpful thoughts lessen, there can be space for new thoughts, and the survivor's internal monologue can shift to become gentler and more life promoting.

The caseworker can invite the survivor to ask herself questions to explore and challenge her unhelpful thoughts. Three categories of questions can be helpful for survivors:

- Evidence Questions, such as *What is the evidence that this thought is true?*
- Alternatives Questions, such as *What would someone I trust tell me about this situation?*
- Implications Questions, such as *What is the worst that could happen if this thought were true? Could I live through it? How could I cope?*

See Appendix J – Challenging Thoughts for a detailed list of examples of each type of question. Caseworkers can keep this list with them in their office or pick 1–2 questions from each category and make a simpler list. Caseworkers can also encourage survivors to keep a short list with a few questions on them for whenever they need to challenge a thought during their day. If survivors are unable to write, they may be able to draw simple symbols that can help them recall the questions.

Step 4: Restructuring

After challenging the thought, the next step to create a realistic, more accurate, more truthful thought to replace it. It is important that the survivor comes up with the replacement thought themselves. To encourage this, caseworkers can ask:

- What can you tell yourself on such occasions in the future when a similar event/thought/feeling/behaviour occurs?
- Is there an alternate thought that might be more realistic/accurate?
- Taking the information into account, is there an alternative way of thinking about the situation?
- What may be a more compassionate or encouraging thing you can tell yourself?
- Is there a statement/saying you told yourself in the past that might be helpful here too?
- Is there a prayer or scripture that may be relevant here?

This step may take some time to find something that feels right for them. Invite the person to practice saying it out loud. A survivor may be able to generate the alternative thought though have trouble believing it at first; encourage them to say it anyway and see what happens. It is not helpful to have a replacement thought that is exaggerated or unrealistic. For example, "I will be the happiest person ever" or "Everything will go back to normal" or even "Everyone loves me."

Lastly, invite the survivor to put the new thought into the Cognitive Triangle and explore how that new thought may positively impact their feelings and behaviours. This allows the survivor to see that there is hope the situation can go differently in the future when the unhelpful thought occurs and they intervene with this new thought. In the same way as painful thoughts, encouraging thoughts can have a helpful influence on our feelings and behaviour. Practice is important; remind survivors that they need to continue to challenge their old thought to see the benefits. Practice is important for caseworkers too; use cognitive restructuring for yourself in your own life and practice it with colleagues before using it with survivors.

Revisiting Culture and Power

Sometimes, caseworkers may want to give survivors some information that can help them challenge their thought. For example, if a survivor has a self-blaming thought about intimate partner violence, a caseworker may use Ask-Tell-Ask technique from Enhancing Motivation to remind survivors that the tactics of power and control that their partner used against them can manipulate the survivor into blaming themselves for the partner's violent behaviour. Or, a caseworker may help a survivor connect a thought they are having to a larger societal issue, like sexism.

Caseworkers should be careful not to treat all negative or unhelpful thoughts and behaviours as the source of the survivor's problems. It is important to consider the survivor's various identities and how these identities shape their experience in the world. Some thoughts, feelings and behaviours that seem problematic to the caseworker may in fact be normal responses to the stress caused by discrimination and marginalization. Some examples include:

- Anger is an appropriate response to a dominant group consistently harming someone from another group in large or small ways. Allow the person to express their anger instead of quickly trying to calm them down. Affirm that their anger is justified.
- Despite the distress caused by thoughts like "the world is dangerous," these thoughts may be true given the person's lived experiences and the beliefs, practices and policies in a community that harm people with certain identities.
- In a room full of women, a survivor may have the thought "No one is going to like me. I think they're making fun of me," so she studders and constantly fixes her hair and clothing. The meaning of these thoughts and behaviours changes if the context is that she is the only person in the room from a marginalized ethnic group. Based on her lived experience and the beliefs, practices and policies in her community, these thoughts may make sense and should be respected.

Some thoughts may be caused by identity-based marginalization, discrimination or other forms of oppression. This is commonly seen with sexist beliefs that express or imply women are unequal to men. Some women may internalize these beliefs; that is, start to believe they are true. For example, the thoughts "I am powerless" and "it's my fault" likely reflect sexist societal attempts to disempower women so they are not a threat to male power. These thoughts may also be attempts to blame women for abuse so men are absolved from any wrongdoing and can maintain control. The perpetrator may have even said these things to the survivor directly. When such thoughts are identified, caseworkers can explore where the thought came from by asking questions like "How did you come to believe that thought to be true?" "When you hear that thought in your head, does it sound like your thought or someone else's?" "Have you heard someone else say that to you before?" and "What would you say if a friend in a similar situation told you they thought that about themselves?"

When using cognitive restructuring in situations involving marginalization and oppression:

- Acknowledge that lack of choice or control they may have in society.
- Make connections between their thoughts, feelings and behaviours and the larger harmful community beliefs, practices and policies. This helps survivors recognize that the problem lies in the pervasive culture of violence against women. Caseworkers can use Ask-Tell-Ask to get permission to share the connection you noticed or simply explore where and when the thought originated.
- Do not invalidate their reality. For example, do not express scepticism (or ask for evidence) of their belief that the world is dangerous when the world may truly be dangerous for them.
- Support them to expand their thought in a way that may decrease negative emotions. For example:
  - "The world is dangerous" may become "The world is dangerous, and my community will continue to fight to survive."
  - "I am powerless" may become "I have the power within me" or "I am doing my best"
  - "It's my fault" may become "It's not my fault" or "I am not to blame for his actions"
- • Highlight the survivor's strengths. Ask questions like "If that thought was true, could you handle it? In the past how have you coped with it?"
- Help them find ways to take care of herself while living in a community that does not always want them to succeed or limits them in many ways.

PROBLEM SOLVING

When to use: Problem Solving can be integrated into all GBV CM steps. This technique may be most useful in Step 4: Implementing the Case Action Plan and Step 5: Case Follow-Up

Some GBV survivors live in poverty with little access to stable work or housing and often struggling with psychological problems. In many developing countries, there are no easy solutions to these problems. Imagine a single mother who lives in an internally displaced person's camp and is depressed. Feeling hopeless and depressed can make it extremely difficult to get up every day and look for a job.

In the example above, the survivor must overcome the psychological obstacles of learned helplessness, and depression, before she can start to tackle the difficult practical challenges (e.g., unemployment) in her life. This problem-solving model helps survivors learn problem solving skills, to start to imagine new possibilities in their lives and start to feel mastery and empowerment.

Note: In the early sessions, it will be important to acquire an accurate sense of how well the person functioned prior to the trauma. The event(s) might have worsened long standing issues such as persistent sadness/hopelessness, self-devaluation, problems regulating moods, appetites. These must be taken into consideration when implementing the problem-solving model as outcome expectations might have to be lowered.

The problem-solving model involves the following 7 steps[19]:

1. **Listing Problems:** Create a list of problems with the survivor. Divide the list into solvable and unsolvable problems. In other words, does the survivor have any control or influence over the problem, or even just part of it? (e.g., war, hurricanes vs feeling more happiness in their life).

2. **Choose a problem:** Choose an easier (solvable) problem to help the survivor experience the feeling of success in the intervention (e.g., being a more patient father or having less fearful thoughts). Solving smaller problems first frees up space in the mind to think about other, bigger problems.

3. **Define and clarify the problem:** This can be one of the hardest steps. For example, a survivor might say that "feeling worthless" is a problem they want to change. But this problem is too big and vague. You need to help the survivor to be more specific and practical. To do this, you might ask some of the following questions to see different angles of the problem. Do not try to solve the problem yet. Understand it first.
   a. *When is this a problem for you? In what situations does this problem happen?*
   b. *What does this problem look like? If I were to watch you when this problem happened, what would I see, what would you look like, what would you be doing or not doing?*
   c. *How would your life (i.e. daily living) be different if you did not experience this problem?*
   d. *How does it affect your relationship with X?*
   e. *How does it interfere with how your work?*
   f. *How does it affect how your body works (e.g., sleeping, eating etc.)?*

   If the problem has many parts, break it down and deal with each part separately. Be specific, measurable and time orientated when choosing the problem.

4. **Brainstorm:**
   a. First, encourage the survivor to think of as many solutions to the problem as possible. Do not worry if the solutions are good or bad at this stage.
   b. Think of what the survivor can do by themselves and think of people who can help them manage parts of the problem.
   c. Make a big deal of existing personal strengths, protective factors or support. These will increase the likelihood of success.
   d. Help the survivor generate other options, by asking questions like, *"What have you already tried? What have other people around you tried? Can you think of other options? I have seen other people do this…? Have you ever tried this …?"*
   e. Use questions to lead the person to think of other options. Let the person do the work of finding the answers, even when we see the best option, it is important that the survivor says it themselves.

5. **Decide and choose realistic strategies:** From the list of potential solutions, choose those that are most helpful to influencing the problem.
   a. Helpful strategies have very few disadvantages for the survivor or others.
   b. Helpful strategies can be carried out (e.g., the person has the financial means, other resources or ability to carry out the solution).
   c. You can choose more than one solution.

6. **Create an action plan:** Develop a detailed plan of how and when the survivor will carry out the solutions.
   a. Help them pick the day and time when they will do this.
   b. Help them choose which solutions they will try first if there are more than one.
   c. Discuss what resources (i.e. money, transport, another person and so on) they might need to carry out the plan.
   d. Suggest aids to remind the survivor to carry out the plan (e.g., notes, calendar, plan activities to coincide with meals or other routine events).

7. **Review:** This step happens in the next session, after the survivor has attempted to carry out the plan.
   a. Discuss what they did and what effect this had on the original problem.
   b. Discuss any difficulties they had in acting on the plan.
   c. Discuss and plan what they can do next week to continue to influence and manage the problem, given what they completed in the last week.

[19] Adapted from PM+ World Health Organization 2016, refer to page 46.

DE-ESCALATION TECHNIQUES

When to use: De-escalation Techniques can be integrated into all GBV CM steps, as needed.

De-escalation techniques are non-physical, therapeutic, conflict resolution skills used to prevent a potentially dangerous situation from escalating into a physical confrontation or injury. The de-escalation techniques described below are for **caseworkers to use with survivors, family members and/or if faced by a survivor/family/community member outside of working hours.**

When a potentially violent situation is happening, verbal de-escalation techniques are an appropriate strategy. Reasoning with an angry person is not possible. The first and only objective in de-escalation is to reduce the level of arousal so that discussion becomes possible. Someone may have lost touch with reality or may be over-activated or hypervigilant. The person may show only a limited range of emotions, though that does not mean that they are not feeling anything. Grounding techniques help with someone experiencing anger, hypervigilance and anxiety.

The following warning signs may indicate a more serious mental health issue requiring higher level of care than the caseworker can offer. Caseworkers should consult with their supervisors after the survivor has been de-escalated:

1. Rapid mood swings: Increased energy, pacing, suddenly depressed or happy.
2. Inability to cope with daily tasks: Hygiene, eating, sleep problems.
3. Increased agitation, abusive behaviour: Verbal threats, violence, out-of-control behaviour, destroys property, inappropriate language, harm to self and others.
4. Loss of touch with reality: Does not recognize family or friends, has increasingly strange ideas, confused, hears voices/sees things that are not actually there.
5. Isolation from family and friends: Less interest in usual activities.
6. Unexplained physical symptoms: Facial expressions look different, headaches, stomach aches, complains of not feeling well.

De-escalation techniques feel abnormal in these situations. Stress hormones triggered by the conflict push the caseworker to fight, flight or freeze when scared or threatened. However, to effectively de-escalate a situation, you can do none of these. You must appear centred and calm even when you are terrified. Therefore, these techniques must be practiced before they are needed so that they can become, habit or 'second nature.'

Three core steps are used in all de-escalation work:[20]
- The caseworker in control of themselves
- The physical stance
- The de-escalation discussion

The Caseworker in Control of Themselves

1. Appear calm and confident even though you may not feel it. Anxiety can make the survivor feel anxious and unsafe which can escalate aggression.
2. Use an even, low tone of voice (our normal tendency is to have a high pitched, tight voice when scared).
3. Do not be defensive even if the comments or insults are directed at you, they are not about you. Do not defend yourself or anyone else from insults, curses or misconceptions about their roles.
4. Be aware of available resources (e.g., other team members, work phone, neighbours). Know that you can always leave, or seek additional support as needed, should de-escalation not be effective.
5. Set limits safely and respectfully. You want the agitated person to know that it is not necessary to show you that they should be respected. You automatically treat them with dignity and respect.

The Physical Stance

1. Never turn your back for any reason.
2. Make sure that you have a possible physical escape route (i.e., do not be backed into a corner, have your back against a wall, or allow yourself to be blocked).
3. Always be at the same eye level. Encourage the survivor to be seated, but if they need to stand, you should also stand up.
4. Allow extra physical space between you and the person – about four times your usual distance – where possible. Anger and agitation fill the extra space between you and the person.
5. Do not maintain constant eye contact. Allow the person to break their gaze and look away.
6. Do not point or shake your finger.
7. Do not touch – even if some touching is culturally appropriate and usual in your setting. When agitated, people easily misinterpret physical contact as hostile or threatening.
8. Keep hands out of your pockets, up and available to protect yourself. It also demonstrates a non-verbal ally and that you do not have a concealed weapon.

[20] Adapted from Verbal De-Escalation Techniques for Defusing or Talking Down an Explosive Situation prepared by National Association of Social Worker's Committee for the Study and Prevention of Violence Against Social Workers; Reprinted from: National Association of Social Workers – Massachusetts Chapter Copyright 2001, NASW/MA.

The De-escalation Discussion

1. Remember that there is no content except trying to calmly bring the level of arousal down to a safer place.
2. Do not get loud or try to yell over a screaming person. Wait until they take a breath; then talk. Speak calmly at an average volume.
3. Announce any actions beforehand
4. Do not restrict the person's movement
5. Respond to disorganised speech with short, simple sentences. Repeat things if needed. Allow plenty of time for responses
6. Respond selectively. Answer only informational questions no matter how rudely asked. For example, "Why can't you give me money?" This is a real information-seeking question). Do not answer abusive questions (e.g., "Why are all of you caseworkers so evil?").
7. Explain limits and rules in an authoritative, firm, but always respectful tone. Give choices where possible in which both alternatives are safe ones (e.g., "Would you like to continue this discussion calmly now or would you prefer to stop now, and we will discuss this after you get some air when things can be more relaxed?"). If the individual is younger, these statements can be repeated, as necessary. Repetition can help the individual understand what you're saying.
8. Empathise with feelings but not with the behaviour (e.g., "I understand that you have every right to feel angry, but it is not okay for you to threaten me or others. I am here to support you.")
9. Do not ask how a person is feeling or interpret feelings in an analytic way. Try to be aware of what may worsen the person's fear and aggression. Avoid those things.
10. Do not argue or try to convince. Do not challenge or try to change manic thinking/delusions
11. Wherever possible, tap into the person's cognitive mode: Do not ask "Tell me how you feel." But instead: "Help me to understand what you are saying to me." People are not attacking you while they are explaining to you what they want you to know. Attempt to get a quick sense of their reality. Focus on practical, concrete needs.
12. Suggest alternative behaviours where appropriate (e.g., "Would you like to take a break from this part of the conversation? Shall we sit down here? I just need a big breath. Do you need one too?").
13. Give the consequences of inappropriate behaviour without threats or anger.
14. Represent external controls as institutional rather than personal.

Håvard Bjelland, Pakistan, 2017

PART 3. WORKING WITH SPECIFIC SYMPTOMS

This section outlines how to work with the 11 most commonly seen symptoms across NCA GBV programmes. These symptoms were identified through consultations with NCA's global GBV programs.

1. Sleeping Problems
2. Dreams and Nightmares
3. Anger and Aggression
4. Sadness and Hopelessness
5. Anxiety and Hypervigilance
6. Negative Thinking
7. Social Isolation and Withdrawal
8. Self-Blame
9. Sexuality and Intimacy
10. Dissociation
11. Somatic Symptom

How to work with specific symptoms

The 11 symptom sheets all use the same 6 step format, outlined below.

1. **ASSESS:**
   - Survivors may come to you with many psychosocial issues, and it may not be possible to support them with everything. During the Assessment step of Case Management, it can be helpful to ask them what bothers them most right now and start there. They can always focus on a different problem at any time.
   - After the survivor has identified the distressing symptom they want to focus on, the caseworker asks focused questions and thinks together with the survivor to try to understand their distress.
   - Always go from general to specific questions. This gives the individual a chance to shape the dialogue. It enables the caseworker to pick up verbal and nonverbal cues.
   - It is often helpful to ask for and explore specific examples within the past few days when a survivor experienced the symptom. This helps the survivor see the connections between when the symptoms appear and what is happening in the survivor's mind and in their social world.
   - Remember, there are many ways to assess (e.g., a conversation, art, sand tray, drawing and painting, or symbolic objects). It is recommended that caseworkers use the Distress Assessment Tool (Appendix D) to understand the severity and how they affect the survivor's life. The tool also helps to monitor how a survivor's symptoms improve (or worsen) throughout the case management process.

When using creative approaches to assessment, it is important for the caseworker to be mindful. Using art-based approaches can be helpful for the survivor to express what they might not have the words to say; however, the caseworker needs to make sure they are not bringing their own assumptions in to the assessment. For example, a survivor might use the colour red to express feelings of love and happiness, and the caseworker might see it as violence and blood. A survivor might be playing rough with toys in the sand tray, and the caseworker might see that as anger/hate/violence, but the survivor is trying to express fast movement of something. Without training on creative approaches to assessment, a caseworker needs to help the survivor to express what the meaning is without judgement or assumptions.

2. **EDUCATE:** Provide psychoeducation. Psychoeducation helps survivors understand and normalize their reactions to stressors and to improve their healthy coping strategies. Make sure the education is personalized and connected to the person's unique complaint.

3. **DISCUSS:** Discuss existing strategies to cope with the symptom and teach and practice new strategies with the survivor. Use role plays and real-life examples.

4. **CREATE:** Create an action plan and give the survivor homework to practice the techniques at home.

5. **FOLLOW UP:** Follow up with the survivor to assess challenges and to rework techniques as needed.

6. **REFLECT:** Self-reflection/Supervision questions: The caseworker uses these questions (individually or in supervision) to explore their own personal experiences, beliefs, best practices and challenges working with the topic.

SLEEPING PROBLEMS

This sheet outlines the steps for caseworkers to use to help survivors with sleeping problems.

Being able to sleep is essential for good mental and physical health. An inability to sleep is one of the most important indicators that a person may have a problem. Many survivors, due to their traumatic experiences, struggle to fall asleep, sleep only a few hours, or sleep in a shallow way making it difficult for them to rebuild their bodies, brains and strength for the next day.

For some survivors, these sleeping problems are a result of worry about daily stressors while other survivors struggle with sleep because of living conditions which prevent them from sleeping. Some survivors are so frightened about the night that they may start sleeping during the day. They have changed the night into the day and day into night.

Follow these steps to support the survivor to sleep.

Step 1: ASSESS and identify what prevents the survivor from sleeping (use Distress Scale)

To assess means asking many questions and ***thinking together*** with the survivor to try to ***understand*** why they cannot sleep.

Remember that the sleeping quarters might have been the site of the sexual or physical assault. Explore carefully.

- Start with an empathic comment about your appreciation of the survivor's willingness to discuss painful issues with you.
- Identify the reasons why the survivor is staying awake.
  - Ask the survivor to recall their **evening routines and rituals**. What do they do before going to sleep?
  - Ask about what **thoughts and feelings** they have before falling asleep.
  - Ask about their **diet and lifestyle** (Be sensitive to their context).
  - Explore the survivor's **living situation**. Who do they live with? Is there noise, privacy, light or safety or comfort issues?
  - Ask the survivor about the reasons they believe they cannot sleep? What would the survivor's family say about why they cannot sleep?

If the survivor identifies dreams and/or nightmares as the reason they cannot sleep, (see Dreams and Nightmares section).

Step 2: EDUCATE the survivor about why they have sleeping problems

Educate the survivor about why sleeping problems happen, the role of psychosocial stressors and traumatic experiences. Use stories and examples to help the person understand.

- Many people have sleeping problems when they have worries, bad memories and difficult living situations. These are normal reactions to stressful lives.
- Survivors often stay awake due to these 4 things:
  - Anxiety and other distressing emotions and thoughts
  - Unhealthy evening routines
  - Diet and lifestyle
  - Stressful living situation
- Sleep difficulties changes how people think and feel, making them more sensitive, less able to cope with life's problems and at greater risk for health and mental health conditions.
  - People who do not sleep well are five times more likely to become depressed and 20 times more likely to develop anxiety symptoms.
  - Sleep deprivation lessens white blood cell activity and weakens the immune system, increasing the risk of all health conditions, such as diabetes, irritability, high blood pressure, impaired memory and cognitive functioning, headaches and hallucinations.

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is ***already*** using and ideas they have not tried yet, and then share new strategies (***ONLY*** the ones useful for the survivor).

The survivor can interrupt unwanted thoughts by repeating a soothing, special word or affirmation (such as 'peace,' or a religious word or prayer) to themselves

ANXIETY AND OTHER DISTRESSING EMOTIONS

When a survivor feels fear and anxiety, their body wakes up. Fear and anxiety tell the body *"Wake up. Be ready. Anything can happen. You are not safe."*

- Help the survivor to slow their body down with grounding and relaxation exercises (see Relaxation and Grounding sections).
- Brainstorm ways they can feel safer through 1) problem solving (see Problem Solving section) or 2) using spiritual/cultural protective practices (e.g., protection prayers, amulets) or 3) having their loved one sleep near them.
- Ask the survivor to reflect on their best sleep they have ever had. Ask them to describe it in detail using all senses. Imagine with the person or have the person draw a picture of this 'best sleep ever' and keep it under the pillow. Before bed each night, they can remember this memory, in detail.
- Create a wake-up recovery plan with the survivor. This plan is ***3 things the person can do*** if they cannot fall asleep or if they wake up in the middle of the night.
- Remind the person, *"When worries are out of your head, the worries will have less power over you and will not keep you awake."* Teach the person how to release their distressing emotions and thoughts in the early evening (e.g., writing, talking to a friend, praying, singing).
- When the person has a problem keeping them awake, use Problem Solving Technique and have them make action lists early in the evening to help them avoid focusing on problems when they go to bed.
- Cognitive Restructuring can also address unhelpful sleep-specific thoughts like "I'll never fall asleep" or "If I don't fall asleep soon, my day tomorrow will be a disaster."
- Explain to the survivor that it is best that when they do not fall asleep within 20 minutes, to get up and find something relaxing to do or to stay in bed and do a body scan where they progressively relax each muscle in their body, until they are tired enough to fall asleep.

DIET, LIFESTYLE AND LIVING SITUATION

Sleep quality can be affected by many factors:

- The conditions under which survivors live.
- What they eat and drink.
- The activities they do during the day.

Survivors live in many different types of environments. Some live in tents in an internally displaced person's camp or in a temporary housing unit with multiple family members. Think about how the living arrangements might be causing sleep problems. Modify your suggested interventions to take this into consideration. Only where appropriate encourage survivors to:

- Stay awake during the day, avoid naps, and try to sleep during the night if they have turned day into night.
- Get into bed only when sleepy.
- Avoid smoking or drinking caffeinated drinks (coffee, tea) before bed as these substances are all stimulants. Instead, they should try a warm milky drink, warm water, herbal tea (e.g., chamomile) or any traditional remedies that have a relaxing effect.
- Avoid alcohol. Though it may help people fall asleep, it produces poor quality, broken, shallow sleep as the body processes the alcohol and sugars.
- Stay away from eating directly before bed as it takes work to digest and may keep them awake.
- Eliminate all light. Light suppresses melatonin, a sleep-promoting hormone. Light stimulates the body to feel awake and alert.
- Avoid using the bed for anything except sleep and sex. The goal is for the mind to associate the bed with sleep. Only using the bed for sleep and sex will help build this association in the mind. Doing other activities in bed (e.g., reading, playing games on your phone) tells the brain that the bed is for being awake.
- Try to wake up at the same time every day.

DISCUSS THE SURVIVOR'S SLEEPING ARRANGEMENTS

- How can the survivor make their bed and bedding as comfortable as possible?
- Are the temperature levels as comfortable as possible? Is there enough fresh air in the room?
- If there are loud noises, the survivor can create simple earplugs by carefully placing cotton in their ears.
- If light is an issue, the survivor can tie or place a scarf or tie around their eyes to create a blindfold.
- Can the person communicate their sleeping needs to those around them? Can a sleeping schedule or routine be established with those that the person lives with?

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- Explain to the person the importance of establishing a routine to signal to their body and mind that it is time to sleep. They should try these rituals until it is established as a regular pattern.
- Work with the person to identify 3 things:
  - one helpful thing they will continue to do that helps them sleep.
  - one behaviour that they will stop doing that prevents them from sleeping.
  - one new technique they will start to do to sleep better.
- Role play any new techniques with the person
- Give the person homework to complete before the next session you have with them, and make sure you follow up during the next session (if there are complications, help them brainstorm solutions).

SAMPLE HOMEWORK

- Have the person ask loved ones to share 3 things they do to relax before bed?
- Have the person practice an agreed upon guided imagery or visualization (see Relaxation Section). The caseworker should role play this with the survivor in session.
- Have the person practice their bedtime ritual, while noticing points they get stuck or feel challenged.

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the survivor.

- Explore what was challenging and what was helpful.
- Problem solve with the person to understand why they got stuck, adapt existing techniques or suggest and practice new techniques.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences, beliefs, best practices and challenges working with this topic.

- Reflect on traditional remedies or practices in your own or in the survivor's culture that facilitate sleep.
- Think about previous survivors who struggled with sleeping issues, what helped them to sleep better?
- Think about the survivor's life in detail. Think of the many possible reasons blocking the person from sleeping (Remember, there are often more reasons than survivors are aware of).

DREAMS AND NIGHTMARES

This sheet outlines the steps for caseworkers to use to help survivors with dreams and nightmares.

Dreaming is something everyone does. Dreams can be disturbing, sad, happy or bizarre. One theory is that dreaming helps survivors process and make sense of:

1. Parts of the survivor's life that are difficult to understand (e.g., living in an internally displaced person's camp or trying to understand why innocent people have died).
2. Painful events that the survivor may not want to consciously think about and attempts to forget about (e.g., a painful insult or memory).
3. Painful or overwhelming events in the survivor's life (e.g., an experience of an earthquake or car accident).

Dreams are like a cloudy mirror to the survivor's life. They tell you what the survivor is thinking about, but often with material that is out of their conscious awareness. There are many different psychological, cultural and religious explanations about why people dream. For example, some cultures believe that dreams are like unopened letters to be interpreted. Others believe that dreams may be the way gods, or the ancestors communicate with us. While others believe that whatever happens in your dream, the opposite will happen. It is important to prioritise how dreams are perceived, interpreted and worked with in the survivor's unique cultural context. If you have that shared understanding you are better able to help the survivor make sense of the dream.

As caseworkers help survivors understand both their positive and negative dreams, you are helping them better understand themselves and their lives. This work is called Dream Work. Dream Work is something anyone can do. Dream Work is NOT dream interpretation; instead, it is assisting the dreamer to discover meaning. You are like a guide. You guide the person to explore and learn tools to understand their dreams.

Step 1: ASSESS and identify what causes the survivor distress (use Distress Scale)

Assess means asking questions and ***thinking together*** with the survivor to try to ***understand*** the meaning and reason for their dreams.

- Explain the process of working together to explore their dream.
- Explore differences within cultural, religious, familial beliefs about dreams. You can ask:
  - What did your grandparents tell you about pleasant and unpleasant dreams?
  - Did they say different things to you when you were a child versus being older?
  - What advice did they give when people were affected by bad dreams? Any protective factors in your life that can be useful for bad dreams?
- Explore the person's personal belief system about dreams. This may be different in subtle or important ways from the general cultural meaning of the dream.
  - Now that you have grown up what do you believe about dreams?

Step 2: EDUCATE the survivor on reasons why they dream

If appropriate, educate the survivor on dreams, the role of psychosocial stressors and the meaning of dreams. Use stories and examples to help the survivor to understand.

- Dreams can be upsetting or scary as survivors may believe them to be prophecies or messages from the spirits. If the survivor has religious or cultural explanations of dreams, you can say, *"In your group you attach your own meanings to dreams. There is also a psychological explanation of why we dream."*

OTHER POTENTIAL EXPLANATIONS

- Dreams and nightmares are caused by:
  1. stressful or traumatic events in our life (past and present) and,
  2. by having anxious, stressed or fearful thoughts or feelings.
- Psychologically, there is no universal meaning or no universal symbols for our dreams. Everyone makes a unique or personal relationship to symbols in their dreams.
- Sometimes we have dreams because something from our past or present is very painful and upsetting so we avoid thinking about it and it comes out in our dreams.
- Dreams can have messages for us if we take the time to understand them.
- Dreams can attempt to find an ending to something unresolved.
- Dreams sometimes can help us understand our feelings. We can use them to make sense of our lives.
- Dreams are a way to process and manage the strong emotions.
- It is normal for people to dream; however, not everyone remembers their dreams or that they even dreamt when they wake up.

Step 3: DISCUSS existing and new coping strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- Have the survivor carefully choose one distressing dream. Say, *"Is there a dream you can share with me that is not too upsetting to you?"*
- Gently explore what happened in the dream with details (colours, sounds, symbols, people, etc.). The caseworker should be able to picture the dream.
- Explore the emotions the person felt in the dream.
- Connect the dream to the person's everyday life. What in the person's life is like a symbol in the dream?
- Explore with the person and ask them: *"What might be the central message of this dream?"*
- Look for repetition: Does the person keep having the same dream or the same symbols or the same emotional state repeat in their dreams (e.g., the person always dreams about sad topics or the person is always running, or the person always sees her mother in the dreams).
- Once you have identified the possible message the dream is telling you about the survivor and their life. Support the person with empathy, acceptance or finding practical solutions to this part of their life.
- Additionally, you can work with the person to identify relaxing, fear-reducing activities to do before bed or if the nightmare wakes them up. Examples include:
  - Get out of bed and turn on a light or candle, if possible.
  - A protection prayer or reading a passage from their holy readings (Quran, Bible, etc.).
  - Keeping a calm picture of a symbol of safety underneath their pillow/reachable to their sleeping space.
  - Deep breathing exercises.
  - Visualization of a calming, safe image.
  - Listening to a song that relaxes them or makes them feel safe.
  - A mantra, such as *"I am safe, I am safe. This is a dream. This is the past."*
  - Use other grounding and relaxation techniques to get more in the present and help with fear and anxiety, such as cold water on face/neck, stretches, touch objects or pets, listen to relaxing music.
  - Imagine a big STOP sign to avoid thinking about what the dream means or replaying it in their mind. The more someone replays it in their mind, the more likely they will have the nightmare again.
  - If they awake feeling frozen and unable to get out of bed, have some objects nearby that make them feel safe and remind them of the present (e.g., recent photographs). Notice small movements at first (blinking, twitches), and then start making slow movements of hand or foot, then larger body movements.
- Some survivors fear that if they fall asleep, they will have nightmares or bad things will happen for which they will be unprepared (e.g., hypervigilance). Safety Planning is helpful to address any safety concerns survivors have at night. Cognitive Restructuring may be helpful for any thoughts and beliefs that are not helpful.

AN EXAMPLE OF DREAM WORK

If a survivor talks about a dream in which she was in a small boat floating away from shore on a calm sea, the caseworker could:

1. Gather information about the scene. Ask for visual or detailed questions like *"What does the water look like?" or "Where is the boat headed?"*
2. Explore how the survivor felt sitting on the boat.
3. Explore with the person, what in their life feels like sitting on a boat at sea floating away from the shore?

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- Reassure them that it is okay if they cannot carry out the whole plan. Tell them that sometimes the plan might be too hard to do. Say, *"When we meet again, we can discuss how to modify the plan."*
- The caseworker should summarize the 3–4 main points from today's session.
- Ask the survivor what they would be willing to work on. Have the person decide on 1 strategy they will try to better work with their distressing dreams.
- Role play the relevant techniques with the survivor.

SAMPLE HOMEWORK

- Have the person notice what dreams they had all week (by writing them down, drawing them or telling a friend). After the week, see if there are any patterns to the dreams.
- Suggest the survivor to share what they have learned with you with one 'safe person'.

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session with the survivor to check what they did with the action plan and if the action plan helped them.

- Review the person's week. Explore any questions, concerns or thoughts about their dreams.
- Discuss any difficulties they faced with using the techniques and adapt or teach new techniques as needed.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences, beliefs, best practices and challenges working with this topic.

- What do elders in your cultural group believe about pleasant and unpleasant dreams?
- What advice or actions might these elders give when people were affected by bad dreams?
- Every culture or religion has stories and beliefs about dreams. What are your beliefs?
- Think back to a time when you had had a distressing dream, what did you do, what was helpful and what was not helpful?
- Think back to a time you worked with a survivor who had a distressing dream. What was helpful with this person? What was not helpful?
- Think back to several survivor's dreams that you have heard. How have the dreams related to their lives? How have the feelings in the dreams related to their lives?

ANGER AND AGGRESSION

This sheet outlines the steps for caseworkers to use to help survivors with anger and aggression concerns.

Anger is a normal emotion. It is a universal emotion. Anger changes how survivors feel, making them feel physically warm, filling their minds with angry thoughts and making their hearts beat fast.

It is important that survivors have healthy ways to release their anger. The following steps outline how to help survivors to safely understand and release their anger.

Step 1: ASSESS and understand the survivor's anger (use Distress Scale)

Assess means asking many questions and ***thinking together*** with the survivor to try to ***understand*** why they feel angry.

- It is important to convey that it is natural for the survivor to feel angry given the circumstances they are experiencing. Some people who have been abused might not feel they have a right to be angry at their abuser.
- Explore the survivor's concerns and fears about anger. Some are scared about what they are feeling and thinking when angry (e.g., wanting to physically or verbally hurt someone else or themselves). Others may believe that once they start to allow themselves to feel anger, they will not be able to stop it. Some may be afraid of feeling angry because they may think they are becoming like the perpetrator.
- Explore cultural beliefs about anger in their community. In some cultures, expressions of anger are viewed as a sign of weakness or lack of self-control. In these cultures, anger might not be expressed openly but is still felt inside the person. When anger stays inside, it does not disappear; instead, it can build up and cause unexpected explosions of anger or lead to somatic symptoms.
- Explore how anger affects how the survivor thinks, feels and acts. Using the Cognitive Triangle can differentiate between the emotion of anger, the thoughts it can cause, and behaviours it can cause. Have the person describe in detail a recent experience where they became angry. Be very supportive with both verbal and nonverbal cues.
- Ask the person questions about how often they feel angry, when they are angry, how intense their anger is (scale of 1–10), how long their angry feelings last, and does the person become aggressive.

Step 2: EDUCATE the survivor about the meaning of anger

Educate the person on what anger can mean and how psychosocial stressors and traumatic experiences affect our anger. Use stories and examples to help the person understand.

- Explain to the survivor that anger is not ***just*** an emotion. It is a messenger trying to communicate something to us. It has meaning.
- Anger can tell us what a person cares about or what is important to them. A person does not get angry about things they are not emotionally invested in.
- Anger is triggered in a person when their boundaries have been crossed in some way. This can make the person feel a loss of authority or feel they have been offended.
- Anger can be a way of protecting the self. This means it can act like a shield against other emotions, protecting the person from feeling other painful emotions. For example, sometimes it is easier to express anger than feel sadness, disappointment or shame.
- Anger can serve a protective function and keep people around the survivor at a distance which can feel safer to some people. It can be connected with the body's fight response, protecting someone from assault or loss of important people, things, or goals by urging them to threaten or attack anyone who may hurt them.
- Anger can be a sign of life. It can indicate a passionate feeling about something (i.e., self-worth).
- When someone is hungry, tired, sick or taking substances and feeling angry, this may make a person more impulsive and vulnerable to expressing anger in ways they would not prefer.
- For men, anger can be a way to maintain masculinity (e.g., virility, strength, toughness). Expressing anger for men might be easier than showing tender emotions, like sadness or shame. Anger can however be very costly, if not well managed.

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is ***already*** using and then share new strategies

- Help the person to identify their anger triggers. These triggers are activities, actions, times of day, people, places, or situations that trigger angry feelings (see Identifying Triggers section).
- Identify the survivor's anger warning signs (e.g., warm face, clenched fists, quick movement, etc.).
- Explain to the survivor that everyone needs a safe way to express their anger, rather than having it build up inside of them. Role play or practice ways to communicate her anger that will honour her emotions and be effective in influencing others, if needed.
- Help the survivor explore and try to explain the root of what makes them angry. Help the person explore the feelings behind the anger.
- Have the survivor count down from 100. Every 10 numbers, they should take a deep breath until they feel the anger pass. This can allow the person to refocus, slow down and move their mind away from the stressors.

- Physical activity can provide an outlet for person's emotions.
- Remind the person to take a few moments to collect their thoughts before reacting or speaking.
- Use their senses. Help the survivor take advantage of the relaxing power of their senses of sight, smell, hearing, touch, and taste. Try other grounding and relaxation techniques, like Paired Muscle Relaxation or Willing Hands from Appendix F.
- Use Mindfulness skills, such as Labelling. Remember not to judge anger.
- Use Cognitive Restructuring to address thoughts that may be prompting anger; for example, a survivor who is angry at someone for not helping them may have a replacement thought that helps become more understanding of the other person (i.e., try to see the other person's point of view rather than blaming them). Be careful to make sure the survivor's replacement thought does not blames themselves for something that was not their fault or responsibility.
- Use the problem-solving model for the times when the person's anger gets out of control (see Problem-Solving section). A caseworker can use De-Escalation Techniques when extreme anger arises during a meeting with a survivor.

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life
- Create with the survivor a list of 3 actions they can do to better manage their anger.
- Work with the person to develop some activities to channel their anger.

SAMPLE HOMEWORK
- Have the survivor notice the changes that happen in their body when they are angry.
- Have the person create a list of their triggers and bring the list back to discuss in the next session.
- Have the person think about how their caregivers expressed anger. Do they agree with that approach? Why or why not? How does the person ***want to*** express their anger?

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the person
- Have follow-up sessions with person to check if their anger plan helped them.
- Talk about how this plan is only one example of how survivors can take action to have some control over their lives and fears. Help survivors to understand they can use the problem-solving model to take control over different problems or fears (see Problem Solving section).
- Encourage the survivors to use other techniques to reduce their anxiety like relaxation, grounding, cognitive restructuring or mindfulness.
- Encourage survivors to have family meetings where they can share their new knowledge with their friends and/or family to add or change it based on their ideas.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.
- What is anger? What is aggression? How do men and women show anger or aggression in different ways?
- What are your beliefs about anger and how you express it? Where are your beliefs coming from (e.g., gender, family, culture, religion)? That is, how were you socialized about anger? Think about how your caregivers expressed anger or how they reacted when you (and your siblings, if applicable) were angry. What did this teach you about anger? What message did this give you about anger as a child? Do you agree or disagree with these messages?
- How might your beliefs about anger impact your work with a survivor who feels angry? Will it make it more or less likely for them to tell you about their anger? Will it affect the questions you ask them or do not ask them? What will you think about a survivor if they tell you they feel angry in their daily life?
- Anger can be a defence. It can serve a protective function, protecting the person from other difficult emotions. What does this mean? Think and share several examples with colleagues.
- Think about previous survivors who have had angry outbursts. What was that like for you? What was challenging? What skills did you use?

SADNESS AND HOPELESSNESS

This sheet outlines the steps for caseworkers to use to help survivors with sadness and hopelessness.

Sadness and hopelessness are core emotions that signal that a survivor has lost something. A survivor can lose things that are visible and concrete (e.g., a job, a loved one, a home) as well as things that are invisible (e.g., a dream for the future, the feeling of safety). Grief is related to sadness. Every culture and spiritual or religious tradition has its own ways of mourning (i.e., understanding and coping with grief). Caseworkers can explore this and encourage survivors to try these ways.

Sadness is a normal part of life. Sometimes it is brief; other times, it lasts a while. Persistent sadness can affect a survivor's ability to function in different parts of their life, such as at work or in their relationships. The effects of sadness may vary across cultures, and different cultures may have many different words to describe states that are similar to sadness and hopelessness (e.g., depression). Feelings of sadness and hopelessness are often accompanied with low energy and reduction or discontinuation of many activities. This coincides with the lower part of the Window of Tolerance.

NOTE TO THE CASEWORKER: The caseworker needs to feel calm inside their heart and mind to be helpful to survivor. Before exploring the themes of sadness and hopelessness, caseworkers can:
1. Take a deep breath.
2. Ground yourself.
3. Remind yourself of the function of sadness and tears.
4. Use a calm silence.
5. Remind yourself that you are separate from the survivor.
6. Remember your task is to help the survivor better understand and manage her emotions. You cannot 'fix' or 'erase' someone's sadness.
7. Tell her – if appropriate – that you feel sad with her.

Sometimes when a survivor feels hopeless, the caseworker can feel that way about them too (see Transference in the section on Therapeutic Stance). The survivor may notice this, which can make them feel worse. It is important to recognize this if it happens and instead help give the survivor hope without making false promises. A caseworker might say, "I know it's really hard to imagine things getting better right now, and that's OK. I have so much hope for you, and I will hold onto my hope until one day you find hope for yourself."

Use short, simple sentences. When a survivor is talking about painful topics, they often cannot process complicated ideas.

Step 1: ASSESS and identify the survivor's feelings of sadness and hopelessness (Use Distress Scale)

Assess means asking questions that encourage the survivor to think with you about why they are feeling sadness and hopelessness.

- Have the survivor describe in detail a recent experience where they started to feel sad, tearful or hopeless.
- Explore how their sadness and hopelessness affects how they think, feel and act.
- Ask the person questions about their sadness/hopelessness:
  - How often do they feel sad and/or hopeless? (everyday, all day long? Several times a week?)
  - How intense is their sadness and/or hopelessness (scale of 1–10)?
  - How long do their sad feelings last?
  - When did they first start to feel sad and hopeless?
- Help the survivor see the connections between when the symptoms appear and what is happening in the survivor's mind and in their social world.
- If appropriate, assess for suicidal thoughts, which can accompany feelings of hopelessness (see Case Management guidelines for information on suicide assessment and safety planning).

Step 2: EDUCATE the survivor on why they may feel sad, tearful and hopeless

Educate the survivor on sadness, the role of psychosocial stressor and the meaning of sadness. Use stories and examples to help the survivor understand.

- It is normal for a survivor to feel sad or hopeless sometimes in reaction to an event or a comment that someone said, but when the survivor feels stuck inside sadness and hopeless, this is different than everyday feelings of mild sadness.
- Sadness can be a response to a loss. A survivor can lose things that are visible (e.g., a loved one, a home) or invisible (e.g., pride, hope or dreams for the future).
- Remind the survivor that sadness is brief, it passes and is often a reaction to an event. It may become a problem when it is more intense, lasts a long time and affects areas such as sleeping, eating and activity levels.
- Redefine sadness for the survivor as something adaptive. Sadness can point them towards what they need to do to take care of themselves (e.g., grieving).
- **Tearfulness:** Tears are an external expression of the survivor's inner sadness. Remember everyone expresses their sadness in different ways. Some people cry, others become quiet and withdraw and other people avoid talking about anything sad and difficult. Encourage the survivor to express sadness in any way that they might need to do. Remember:
  - Tears serve a cathartic function. Tears help release pain out of the body.
  - Crying lets others know how you feel. It creates social connection and communicate distress to others. Crying can be saying, *"I am sad. Give me support. Do not leave me alone."*
  - Tears contain stress hormones. Crying reduces the levels of stress chemicals in the body and which could, in turn, reduce stress. Crying also stimulates the body's 'happy hormones' (oxytocin and endorphins).
  - Tears soothe. Crying activates the parasympathetic nervous system and helps the body return to a state of homeostasis after being overly aroused, thereby relaxing and regulating the entire system.
  - Tears can signal an opening and vulnerability. They may possibly tell you that the survivor feels safe enough to cry with you. Tears can communicate, *"I am taking off my mask to release some pain."*

Step 3: DISCUSS existing and new coping strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- The caseworker should normalize and create a safe and supportive space for expressions of sadness such as crying. You can say something like, *"I am here."*
- The caseworker can also tell the survivor, *"We all feel sad sometimes. Allow yourself to be sad. Denying such feelings may force them underground, where they can do more damage with time. Cry if you feel like it. Notice if you feel relief after the tears stop."*
- Based on the Step 1 (Assess), talk with the person about:
  - What their sadness feels like?
  - Remind them that sadness is a messenger, so, what might their sadness be trying to tell them?
  - Explore what they did last time they were sad? What helps? What does not help?
  - Help the survivor to speak freely about the topic(s) that makes them sad. You can ask questions. Often just by talking about the pain with a safe person, the survivor can feel better.
- Work with the survivor to identify their triggers for sadness. Triggers for sadness or hopelessness can be activities, people, comments, emotions, memories, places, or situations (see Identifying Triggers section).
- Explain to the survivor the need to regularly release their unresolved pain. Say, *"Pain takes up space in the heart and mind, slows down our thinking, affects our ability to concentrate, affects our ability to live our life. We all need regular ways to release our pain, so that we do not feel heavy. What can you do?"*
  - Brainstorm with the survivor ways they can ***regularly*** release their pain (e.g., prayer, talking to a loved one, drawing, crying, exercise, etc.).
- Sometimes with sadness, there is a lot of silence and tears in the session. This is okay and healing because tears are often releasing something unspeakable, something that has no words. You can say these things to a survivor who is very hopeless or tearful: *"Tears sometimes release what we don't have words for,"* or *"Take your time,"* or *"It's okay,"* or *"That's why we have tissues,"* or *"That is why we are in this quiet room".*
- Use Behavioural Activation if feelings of persistent sadness have caused them to reduce or stop doing pleasant, social or essential activities. Try integrating motivation techniques, if needed. Also, see Social Isolation and Withdrawal section for more information specific to that topic.
- Cognitive Restructuring and Mindfulness can be useful for survivors whose sadness is accompanied by self-critical thoughts or thoughts of worthlessness, hopelessness or other preoccupations (e.g., about past mistakes and self-blame).
- Grounding techniques may be helpful when sadness and hopelessness causes a survivor to become under-activated outside their Window of Tolerance, or if they have difficulty concentrating, memory issues, and preoccupied thoughts.
- Problem Solving technique may be helpful for those whose sadness contributes to indecisiveness.
- Ask her questions to help build hope:
  - How do you keep going, day after day, when it feels like there is no hope for you?
  - What does that say about you that you came here today?
  - How come things are not worse than they are?
  - What would [a loving friend or family member] say?
  - What is meaningful and important to you?

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.
- Explore with the person what was most interesting/powerful for them from today's session.
- Have the person decide on 2 strategies they will use to regularly release their sad feelings.

SAMPLE HOMEWORK
- Ask the person to notice when they are triggered (the time of day, who is around them, what are they feeling and thinking, and where they are when they start to feel sad or hopeless).
- Ask the person to share what they are learning about sadness with one safe person.
- Create a suicide prevention safety plan, if appropriate (see Case Management guidelines).

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the survivor.
- Review the person's week. Explore any questions, concerns or thoughts.
- Discuss any difficulties with their plan and rework or teach new techniques so that the survivor can use them in their life.

Step 6: REFLECTION: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.
- What are the thoughts and feelings that come to mind when you hear the word sadness?'
- How have you learned sadness 'should' be expressed and responded to? What is the psychological function of sadness and hopelessness?
- What feelings and thoughts do you have when survivors cry? Think of a few examples.
- What does the grieving process look like in survivors' cultural groups and your cultural group?
- How are they different? What are the expected ways of grieving? Is it different for men and women?
- In survivors' cultures are there expected ways of expressing sadness versus ways that might be concerning or pathological?
- Think about how you manage your own feelings of sadness. How does this influence how you work with survivors who are sad or depressed?

ANXIETY AND HYPERVIGILANCE

This sheet outlines the steps for caseworkers to use to help survivors with anxiety and hypervigilance.

When a survivor witnesses or experiences GBV, they experience intense feelings of fear. Sometimes this fear can cause them to stay stuck or blocked in an over-activated state (see Window of Tolerance in Part 1). The term *anxiety* is often used to describe the uncomfortable feelings people have when they are in fight, flight or freeze mode (i.e., over-activated), though they are not in danger. The mind may worry a lot about the past or the future, which causes it to perceive it is in danger. Survivors may then respond to safe, everyday situations as if they were dangerous, and react in ways they do not want or understand. Hypervigilance is the over-activated state of increased alertness, characterized by extreme sensitivity to one's surroundings. It can make a person feel like they are alert to any hidden dangers, whether from other people or the environment. Hypervigilance may be accompanied by fast heart rate, fast or shallow breathing, jumpy reflexes, panic, tense muscles, mood swings, outbursts of emotions, or even emotional withdraw. If someone is hypervigilant, certain triggers may cause them to overreact, such as if they hear a loud bang or if they misunderstand a co-worker's statement as rude. These reactions may be violent or hostile in a perceived attempt to defend themselves. When the survivor feels intense hypervigilance, fear or anxiety in the present, it is going to be difficult for them to function well.

Caseworkers can help survivors to feel less hypervigilant and anxious using the following 5 steps.

Step 1: ASSESS the reasons for the survivor's anxiety and hypervigilance (use Distress Scale)

Assess means asking many questions and ***thinking together*** with the survivor to ***understand*** their anxiety.
1. Have the person describe in detail a specific time they were fearful or hypervigilant. Explore how fear affects their thoughts, emotions and behaviours.
2. Ask the person questions about how often they feel anxiety or fear, how intense their anxiety or fear is (scale of 1–10), and how long do their fearful feelings last.
3. Help the person to list their anxiety and hypervigilance warning signs (e.g., warm face, heart beating fast, looking for exits, etc.) and identify triggers that cause these responses (see Identifying Triggers section).
4. Ask the survivor about their sleep and interpersonal relationships. When a survivor is hypervigilant, they often have sleeping problems and interpersonal challenges due to their high emotional arousal levels.

Step 2: EDUCATE the survivor on why they may feel anxious or fearful

Educate the survivor on the meaning of anxiety and how psychosocial stressors and anxiety interact. Use stories and examples to help the survivor to understand.
- Living with hypervigilance, anxiety or fear can look like being unusually alert and sensitive to the environment. For example, small sounds, behaviours, smells, colours and people can trigger traumatic reactions in the survivor.
- These feelings of anxiety and fear are the body's way of saying, *"I was not ready last time, but next time I will be ready."* You can tell the person, *"Your hypervigilance is your survival strategy."*
- Anxiety is the mind's attempt to prepare for the unknown and to feel a sense of control over the world. It is too overwhelming for the person to accept the idea that 'sometimes bad things unexpectedly happen to good people' and the idea that they do not control their world 100%.
- Being hypervigilant and anxious affects every part of a survivor's life. It can create problems around sleeping, eating and relating to others. It can lead to thinking excessively about how things can go bad.
- Remind the person that their emotional reactions may feel more intense than before the GBV incident. This is normal. You can say, *"Because of what you've been through your feelings cannot always be trusted. We will help you differentiate when they are accurate and when they are letting you down."*

- Explain the relationship between anxiety and avoidance. An anxiety-producing situation (like a trigger, a work assignment, or attending a women's centre event) leads to uncomfortable feelings like worry, fear, racing heartbeat and sweating. Avoiding anxiety-producing situations is one way people try to control these uncomfortable feelings. However, while avoidance may provide short-term, immediate relief from anxiety, this is only temporary. The fear that led to avoidance will worsen, and the person will feel more anxious next time they encounter that situation. This will lead to more avoidance. So, disrupting this cycle of anxiety and avoidance is important. Survivors can learn to engage with – instead of avoid – anxiety-producing situations in safe and supportive ways (e.g., by using grounding techniques).
- Many survivors have real, practical fears (e.g., rebel groups returning to their region or another earthquake happening). Remind the survivor that even when there are real threats, it may not help them to constantly think about that threat. The survivor can learn to focus on what they can control and not get lost in the uncertain parts of their life.

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- Explore what safety means to the survivor. There is no absolute safety, but there are moments of safety, such as safe people, places, things, songs, times of day, animals, prayers, movies, and books. Ask the person, *"When you hear the word 'safe,' what do you think of? Tell me what things in your life are safe."* With the person, make a list of different elements of their life that are safe (e.g., my bed, my dog, the shopkeeper at the corner, and when I pray at night).
  - Talk with the person about how to: 1) avoid dangerous situations, 2) identify warning signs of danger that a crisis may occur (thoughts, times of day, moods, behaviours, situations), 3) coping strategies (people, places, things) and 4) prepare a plan for the dangerous situation (see Safety Planning in the GBV Case Management Guidelines).
- Identify the anxiety and fear triggers. Make an anxiety trigger list. Remember triggers can come from inside the survivor in the form of thoughts, memories and feelings. Triggers can also come from outside of the survivor in the form of people, places, things, smells and sounds (see Identifying Triggers section).
- Use Problem Solving or Cognitive Restructuring. After identifying the triggers, make two lists: 1) the real, practical fears and 2) the exaggerated, trauma-based fears. For real, practical fears do problem solving (see Problem Solving section) and Safety Planning. For the trauma-based fears, use cognitive restructuring (see Cognitive Restructuring section) and other interventions (e.g., mindfulness labelling, grounding and relaxation techniques).
- Problem Solving gives survivors step by step tools to sort out their concerns and solve them. Cognitive restructuring helps the survivor to check if their thoughts are rooted in reality or in their traumatic experiences.
- Relaxation techniques can help survivors lower their baseline level of stress. Relaxation is not easy for every survivor and can be scary and too vulnerable for some survivors, especially if they are often hypervigilant. They may think that if they relax, they will not be prepared in case of potential violence. Explain that the process of feeling relaxed is slow and gradual; it can start together during meetings if only for a few moments using a technique from Appendix F. Over time, they will be able to tolerate longer moments of relaxation. If they feel safe, they can start to practice the exercises at home, maybe with another trusted person.

GROUNDING techniques calm the mind, heart and body and bring the survivor back into the present when overwhelmed. Grounding techniques can be used to disrupt anxious thoughts, think more clearly, and bring survivors back into their Window of Tolerance when they have become hypervigilant and over-activated. They can also be used to help survivors re-engage with external triggers that are safe in the present, instead of avoiding them (see Identifying Triggers section). Staying grounded when encountering a trigger can help survivors learn that the fear and anxiety caused by the trigger can reduce over time. Here are two grounding techniques (see Appendix F for more):

a. Tell the survivor, *"Describe your environment in detail using all your senses."* For example, *"The walls are white. There are five pink chairs. There is a wooden bookshelf against the wall ..."* Have the person describe objects, sounds, textures, colours, smells, shapes, numbers and temperature. Tell the survivor, they can do grounding anywhere. For example, on the street, she can say: *"I'm on the street. I will cross the bridge soon. Those are trees. This is a bench. The sun is yellow. That car is honking its horn."*
b. The second grounding strategy mixes both imagery and mindfulness techniques. Tell the person to imagine, *"You are walking down a spiral staircase. Imagine that within you is a spiral staircase, winding down to your very centre. Starting at the top walk very slowly down the staircase, going deeper and deeper within yourself. Notice the sensations. Rest by sitting on a step or turn on the lights on the way down if you wish. Do not force yourself further than you want to go. Notice the quiet. As you reach the centre of yourself, settle your attention there - perhaps on your gut or your abdomen."* (See additional strategies Grounding section).

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- When a survivor is in danger, the brain works differently, and they cannot always think clearly. Having a plan to keep themselves safe helps them to stay calm, to think clearly and to act in a safer way when in distress.
- Work with the survivor to identify 3 things:
  - One helpful thing they will continue to do that helps them to feel less anxious or fearful (e.g., saying protection prayers, going for long walks).
  - One behaviour that they will stop doing that makes them feel anxious (e.g., isolating themselves, staying inside of their worries).
  - One new technique they have learned they will start to use to feel less fearful (e.g., trying grounding strategies or deep breathing).
- Role play new techniques with the person
- Give the person homework to complete before the next session you have with them.

SAMPLE HOMEWORK

- Have the survivor teach and practice one of the techniques they have learned in session with a loved one. Have the loved one and the survivor practice together.
- Have the person make a list of the things that they have done in the past or present to feel safer.

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the survivor.

- Talk about how this is one example of how the person can take action to have some control over her life and fears. Help the person to understand that they can make additional problem-solving plans to take control over different problems or fears.
- Encourage the person to also use other techniques to reduce their anxiety like relaxation, grounding, cognitive restructuring, and mindfulness.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.

- Reflect on a time when you were hypervigilant or anxious. How did it shape your perception of the world around you? How might this be similar or different to what the survivor is experiencing?
- Practice empathy. Think about one person who lives with fear or anxiety. Spend 2 minutes thinking about their life. What must it be like to live with chronic fear? In what ways must that disrupt their life? Share your reflections with colleagues or your supervisor.
- Think of metaphors and stories that help explain how fear changes the functioning of the brain. Share with your colleagues. Practice telling them the metaphors and stories.

NEGATIVE THINKING

This sheet outlines the steps for caseworkers to use to help survivors with negative thinking.

Negative thoughts can lead to worry, anxiety and poor self-worth. Some examples of negative thoughts are thinking over and over:

- *"I am useless, I am useless. I have no control over my life. I am useless, I have no control over my life."*
- *"I brought shame to my family. I brought shame to my family. I brought shame to my family."*
- *"I am dirty, I am dirty, I am dirty, I am dirty, I am dirty."*

When survivors have negative thoughts, and repeat them over and over in their minds, they can hold themselves back from positive action. Negative thoughts can prevent people from functioning fully in their daily lives.

Every culture has names for their psychological distress. For example, in Zimbabwe, kufungisisa is a popular term used to describe 'thinking too much' which is understood as the cause of many mental health problems like anxiety and depression. It is important that caseworkers ask survivors what names they use to describe their psychological distress and not assume it.

Step 1: ASSESS the reasons for the survivor's negative thoughts (use Distress Scale)

Assess means asking many questions and ***thinking together*** with the survivor to try to ***understand*** why they have negative thoughts.

- Ask the survivor questions about their negative thoughts:
  - How often do they have negative thoughts (everyday, all day long? Weekly?)
  - How intense are there negative thoughts (scale of 1-10)?
  - How long do their negative thoughts last?
  - When did they first start to feel negative?
  - Give feedback to the person about any connections you notice between when the symptoms appear and what is happening in the person's inner or outer world.

Step 2: EDUCATE the survivor on why they have negative thoughts

Educate the survivor on meaning of negative thoughts and how psychosocial stressors and negative thoughts interact. Use stories and examples to help the person understand.

- Negative thoughts trigger the brain to release stress hormones, which pushes survivors into a hypervigilant fight or flight state.
- Thoughts are powerful. Tell the person, *"Be careful which ones you start thinking about. Choose them wisely. They have great power over you."*
- Choosing an intervention to use depends in part on the type of negative thought. Teach the survivor the difference between the following:
  - Negative beliefs: about oneself, other people or the world (e.g., "I am unlovable," "everyone is untrustworthy" or "the world is unsafe")
  - Worry: future-oriented, may or may not happen ("I won't be able to handle going back to work. I will fail")
  - Concern: present-focused and solvable (e.g., concerned about not having enough food to feed their family, or about the perpetrator planning to return and harm them)
- Explain that negative thoughts are often in some way trying to help them, despite the pain they may cause. For example, the worry thought "I'm going to fail" may not want the person to be surprised if they do fail, or the thought wants to make them prepare more. Knowing how the thought may be trying to help the person can help during Cognitive Restructuring when creating a replacement thought that is more balanced and compassionate.
- Help the survivor think about spiritual and cultural quotes, stories or prayers that allow them to shut down negative thinking. An example of this is the serenity prayer, *"God grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference."*
- Thoughts, feelings and behaviour affect each other (see Cognitive Triangle in Part 1 and Cognitive Restructuring section in Part 2). When a survivor thinks anxious thoughts, they will often feel anxious and behave in an anxious manner. For example, a survivor thinks about losing a loved one (thoughts), feels sad (feeling) and then cries and stays home all day (behaviour).

Step 3: DISCUSS existing and new coping strategies

Discuss strategies the survivor is ***already*** using and then offer to teach the survivor the following:

- For solvable concerns, use the Problem Solving technique or Safety Planning (see GBV Case Management Guidelines)
- Mindfulness skills can help a survivor identify and label negative thinking, as well as the emotional and physical effects negative thoughts have on them.
- Grounding techniques can help bring a survivor back to the present when worrying about the past or future or when they are preoccupied with negative beliefs.
- Use Cognitive Restructuring for worry thoughts and negative beliefs (see Cognitive Restructuring section). Often, evidence, alternatives and implications questions can help survivors challenge these unhelpful thoughts and realize they may not be 100% true. There may be a more balanced way of thinking that makes them feel better and less overwhelmed.
- Remind survivors of their protective factors (see Assessing Risk and Protective Factors section)

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the person's life.

- Explore with the person what was most interesting/powerful for them from today's session.
- Have the person identify 2 situations (times of day, places etc.) where their negative thoughts control them and where they will practice one of the above techniques.

SAMPLE HOMEWORK

- Tell the survivor *"Our negative thoughts are heavy. They weigh us down. Let us see how heavy yours are."* Ask the person to keep track their negative thoughts for one day. Tell the person that every time they have a negative thought, they should pick up a small rock and put it in their bag or pocket. Have the person bring all the rocks to the next session.
  Adaptations: Have the survivor use a notebook and make a line every time a negative thought happens or use a rubber band and snap it every time, they have a negative thought.
- Ask the survivor to find two occasions where they have negative thoughts that week to stop and then reflect on what was happening (inside or outside) of the survivor directly before the thought.
- Ask the survivor to notice if there are certain thoughts that repeat themselves. Explore with the survivor if they can notice a pattern to their negative thoughts?

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework techniques and the 3 Action Plan if needed.

- Review the person's week. Explore any questions, concerns or thoughts.
- Discuss any difficulties or obstacles they faced that affected their ability to practice the techniques.

- Rework and adapt the techniques taught OR teach the person new techniques that help them to release strong emotions.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.

- What cultural and traditional strategies are suggested for those who worry too much about life?
- Think of possible metaphors or stories that help you to explain how negative thinking affects the survivor's body, brain and behaviour.
- Reflect on the best conversation you have had with a survivor about negative thinking? What specific things made it the best conversation? How might you be able to learn from this for work other survivors?

SOCIAL ISOLATION AND WITHDRAWAL

This sheet outlines the steps for caseworkers to use to help survivors with social isolation and withdrawal.

Social Isolation and withdrawal involve the survivor removing themselves from all things external, such as people, places and events. It can look like: staying home much of the time, refusing interpersonal interaction, and avoiding social situations, especially ones that involve close intimacy (both emotional and physical). Many times, this behaviour can be triggered by painful life events that leave the person feeling shame, fear or worry.

It is important to distinguish between

1. normal, reactive withdrawal and
2. a more worrisome, chronic withdrawal

Reactive withdrawal is when someone isolates or pulls back from the world to recover from a painful event, such as, having a fight with a loved one, feeling shameful or experiencing sexual assault. This kind of withdrawal is a reaction to an event and lasts a short period of time before the person re-enters their normal way of living and connecting to the world.

Chronic withdrawal is longer term and involves creating a lifestyle that is isolated from people and activities. Chronic withdrawal is often accompanied by other psychological symptoms and and/or mental health disorders.

***Start Small**. When a survivor has been isolated for a long time, it can be hard to connect to their life again. In these instances, help the survivor to do small actions that can start to connect them with others. For example, they could look outside a window at people passing, smile at familiar people or they could make eye contact with safe people.*

Step 1: ASSESS and understand the reasons for the survivor's social withdrawal (use Distress Scale)

Assess means asking questions and ***thinking together*** with the survivor to ***understand*** what is creating their social withdrawal.

- Explain that you are trained in how to help with social isolation, share the steps you will follow together. Answer any questions the survivor has.
- Explore when the survivor first started to withdraw and changes in the person's life before and during when the withdrawal occurred.
- Look for exceptions. Are there any times when the person does not withdraw? Why not?
- Identify the specific things the person may be avoiding.
- Why does the person think that they isolate?
- Have they withdrawn like this in the past? What did they do about it then? Do their family members withdraw in a similar way?
- How does self-isolation and withdrawal affect the survivor's thoughts, feelings and behaviours and relationships with other people?
- Are there any cultural or religious reasons why they may choose or be compelled to socially isolate?
- Is anyone in their life forcing or coercing the survivor to isolate? Assess for intimate partner violence and any other tactics of power and control.

Step 2: EDUCATE the survivor on why social withdrawal and isolation happens

Educate the survivor on the meaning of social withdrawal and how psychosocial stressors can cause isolation. Use stories and examples to help the survivor understand.

- Social isolation and withdrawal are often triggered by painful life events that leave the person feeling shame, fear, worry and a lack of safety.
- Withdrawal is a way of signalling that the world feels unsafe and unpredictable. Withdrawing is often an attempt at creating safety in a world that feels out of control.
- Help the survivor understand the difference between **normal reactive withdrawal**, a shorter-term reaction to a painful event, such as a loss of a loved one versus more **chronic withdrawal** which is longer term and involves creating a lifestyle isolated from people and activities.
- Being socially isolated can cause a person to be flooded with strong emotions or to get caught in negative thought loops (e.g., 'I will never feel better' or 'I should just give up.').
- When a person is flooded with negative emotions and thoughts, it fills their body with stress hormones that 1) suppresses their immune system, and 2) makes them more reactive to events and less able to rationally think through things. So, isolation puts a person more at risk for becoming physically or emotionally sick.
- Social Isolation results in heightened sensitivity to noises, comments, looks, conversations and emotions. This can result in the outside world feeling too overwhelming.
- In the case of intimate partner violence, often the perpetrator intentionally attempts to isolate a survivor from their support systems or damage their relationships so the partner can maintain more power and control over the survivor. The partner may even try to convince a survivor that no one cares about them, and the survivor may come to believe that.

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- Be gentle. Move slow. After being socially isolated, everything in the world feels brighter, louder and sometimes unbearable. When helping a survivor reintegrate and become active in their life again, the exposure to the outside world must be gradual to not flood the person with too many stimuli, forcing them to retreat into isolation.
- Assist the person to connect to anything that is outside of them. Anything. It can be an animal, a picture, a poem, a plant or a person. Isolation constricts and narrows the person's world. Connecting to something outside of themselves reminds the person that they are more than their thoughts, that the world is big and that not everything in the world is unsafe.
- Help the person to identify what makes them withdraw. What emotions (e.g., shame or fear), thoughts (e.g., the world is not safe, something bad will happen at any time), and people, places, and activities cause them to want to isolate (see Identifying Triggers section).

Among the displaced Rohingya in Bangladesh (and in many other communities globally), a woman's menstrual cycle marks a time where girls and women are culturally required to self-isolate. During this time, in some communities, it may be forbidden for girls and women to look at the sky or trees, to go to school or to be outdoors at all. Instead, menstruating girls and women may be required to stay inside their homes in isolation (sometimes in a separate room or building). It is believed that during this time, girls and women may be more at risk of having evil spirits harm or possess them. This cultural practice of isolation due to menstruation is different than someone who isolates due to sadness. It is important that caseworkers ask questions to understand the reasons behind the survivor's self-isolation.

- Explore the specific things the person is avoiding. Why are these things scary or overwhelming? What will it take for the person to gradually face these things?
- Discuss what safety feels like and looks like, ask the person to reflect on a memory where they felt completely safe. Create a visualization around this safe memory (see Relaxation section).
- Often social isolation decreases when the person feels safer. Help the person to identify the source of fear, warning signs, coping strategies and safe people places and things.
- Use the Behavioural Activation technique. It pushes the person to engage more in activities that give them pleasure or sense of accomplishment to help reconnect them to the world (see Behavioural Activation section).
- Cognitive Restructuring can help survivors who have thoughts that get in the way of feeling connected to others. For example, the thought "I stopped returning her calls. She must hate me now."
- Relaxation and grounding techniques can be helpful if the survivor feels unsafe or anxious before, during and after their attempts to be social again.
- Motivation techniques can be helpful, such as affirmations for attempts they make, developing discrepancies (pro/cons of being social again), and using the ruler to assess their motivation to be social (see Enhancing Motivation section). Ask-Tell-Ask can be used to share information about why reconnecting with friends, family, and society can be important. In cases of IPV, caseworkers can also use Ask-Tell-Ask to share the ways they have noticed the survivor's partner trying to isolate them from their social support system.
- Use the Social Connections Map (Appendix K). Some survivors find it helpful to step back and look at their relationships to see where there are strengths and gaps. this can be a helpful assessment and problem-solving tool for survivors who struggle with social isolation or relationship issues, or for survivors who are not using social supports to help with their problems.
- Use the Problem Solving technique to help the survivor brainstorm ways in which they can start to re-engage with other people.

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the person's life.

- Work with the person to identify the following 3 action steps they will take:
  1. One helpful thing they will continue to do that helps them feel less isolated.
  2. One behaviour that they will stop doing that makes them withdraw even more.
  3. One new technique they will start to do to feel less isolated.
- Role play any new techniques (e.g., relaxation techniques) you have shared with the person.
- Give the person homework to complete before the next session you have with them.

SAMPLE HOMEWORK

- Have the person think about and practice the 3 actions steps (listed in step 4).
- Have the person practice a relaxation technique every morning.
- Have the person ask a loved one about a time in their life when they socially withdrew and how they overcame it.
- Have the person take pictures, write down or just take mental note of thoughts, places or people that make them want to isolate.

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the survivor.

- Check in and review the person's week, their mood. Explore any general questions, concerns or thoughts.
- Review the homework. Discuss any difficulties or obstacles they faced that affected their ability to practice the techniques.
- Adapt the techniques taught OR teach the person new techniques so that they are useful for the person.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.

- Think of a time that you were socially isolated (hours or days). Reflect on your what type of emotions and thoughts you had during that time of isolation. What was it like to come back into the world after this period of isolation? How might remembering this better help the survivor?
- Survivors socially isolate for many reasons. Create a list of all the possible reasons why a survivor might withdraw? Think about past survivors, friends, family and yourself.
- Are there any cultural or religious reasons why certain individuals you work with may socially isolate?
- Think about past survivors who have isolated in 1) a short term, reactive way as well as 2) a longer-term, chronic way. What was the difference between these two forms of isolation? How did you work with them differently? What strategies worked and what did not?

SELF-BLAME

This sheet outlines the steps for caseworkers to use to help survivors with self-blame.

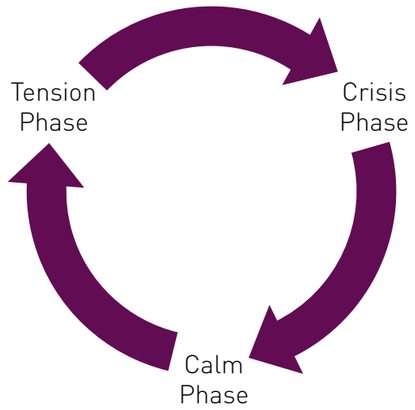
Self-blame is a way of thinking when the survivor feels excessively responsible for the occurrence of a stressful event. Survivors of gender-based violence often blame themselves for the harm perpetrated against them, which can cause them to feel low self-worth. As caseworkers, it is important to help survivors 1) realize they are self-blaming and 2) to have a more balanced, realistic view of the experiences of their life and to 3) realize this is common in many people who have been abused.

Abusive relationships can keep someone locked into a chronic cycle of self-blaming. The person may accept intimate partner violence as normal because it has happened for so long. Abusive relationships can cause co-dependency, people-pleasing, feeling helplessness, traumatic bonding, poor boundaries, inability to say no and self-erasure. Blaming their partner who harmed them can be very uncomfortable for some survivors, so they may blame themselves instead. For some survivors, self-blame can be a way to feel like they never lost control over their situation. Blaming themselves can make a person feel less vulnerable while also creating pain. Understanding the various tactics of power and control used by abusive partners can help caseworkers see what caused survivors to self-blame. Caseworkers can then help survivors recognize that abusive behaviours are the source of

harm, not themselves. Two useful tools to do this are the Power and Control Wheel and the Equality Wheel (see Appendix L).[21]

Deeply engrained cultural and patriarchal beliefs, practices and policies often contribute to survivors blaming themselves for violence and other things. Caseworkers should be firm in their belief that violence, threats and intimidation are never OK and are always the fault of the person who chose to use them; yet, caseworkers also need to be patient with survivors as it may take time for them to recognize that for themselves. Focus on their partner's behaviour as being the problem, instead of saying their partner is inherently a "bad person." Keep in mind that many IPV survivors simultaneously love and are hurt by their partners.

It can also be helpful for IPV survivors to understand the "Cycle of Violence," which is a theory developed in 1979 by Dr Lenore Walker to explain the complexity of abusive and loving behaviour in IPV relationships. This model helps explain why it is often difficult for IPV survivors to leave their relationships and break the cycle of violence. Self-blame may be present during each phase. Note that not every abusive relationship will follow this model:



Tension Phase: In this phase, their partner's behaviour gradually intensifies and reaches a point where a release of tension is inevitable. Their partner may become very sensitive, yell, withhold affection, make threats, criticise the survivor, or use any other tactics of power and control (see Power and Control Wheel). A survivor may feel they need to be very careful around their partner, that everything needs to be perfect, try to calm their partner, reason with them, satisfy them, or avoid them. Survivors may blame themselves for their partners behaviour or make excuses for it.

Crisis Phase: The peak of the violence is reached in this phase, including sexual and physical violence of any kind toward the survivor and/or their children or other family members. The survivor may try to protect themselves, reason with or calm their partner, leave, or even fight back. Their partner's behaviour is made riskier if a weapon, alcohol or drugs are involved. Over time as the cycle continues, violence used in this phase may become more extreme or life-threatening. Alternatively, survivors may fear this phase so much that the threat of this phase is often enough to solidify their partner's sense of power and control over them.

Calm Phase: After the crisis, their partner may express remorse, feel ashamed, withdraw, justify their violence or blame other things (e.g., work stress, alcohol, etc.). They may apologize, promise not to do it again, declare their love for the survivor, want to be intimate, buy gifts, help the survivor with their daily activities/chores, or make promises to get help. Survivors may feel hopeful that their partner has changed and relief that the violence ended, while also feeling confused and hurt. Survivors may forgive their partner, agree to return home if they had left, or drop any legal charges they filed. In this phase, both the survivor and their partner may deny the severity of the violence, increase their intimacy, feel happier and want the relationship to continue, thereby ignoring the possibility that the violence could happen again. However, over time, this phase passes and the cycle may begin again.

[21] Domestic Abuse Intervention Programs. *Wheels*. The Duluth Model. Retrieved from https://www.theduluthmodel.org/wheel-gallery/

Step 1: ASSESS and explore the survivor's self-blame (use Distress Scale)

Assess means asking questions and ***thinking together*** with the survivor to ***understand*** the reasons for their self-blame.

- Have the person describe in detail a recent experience where they started to blame themselves (or others blamed them). Explore how their self-blame affects how they think, feel and act.
- Ask the person questions about their self-blame:
  - How often they feel self-blame? (How many times a day or days of the week?)
  - How intense is their self-blaming (scale of 1–10)?
  - How long do their self-blaming feelings last?
  - There are many cultural and religious reasons why a person may blame themselves. Explore these possible reasons with the survivor.
- Identify the person's triggers. Self-blaming triggers are activities, people, comments, emotions, memories, places, or situations that trigger self-blaming feelings.
- Explore when the person first started to self-blame.
  - Was it after the traumatic event or has it been for as long as they can remember?
  - Did someone else lead you to believe it was your fault?
- Seek to recognize a pattern of self-blame. They may also blame themselves for things other than the GBV they experienced. Notice this with them if it comes up during a meeting.

Step 2: EDUCATE the survivor on psychological reasons for self-blame after GBV experiences

Educate the survivor about why self-blame happens and how psychosocial stressors and traumatic experiences can trigger self-blame. Use stories and examples to help the person understand.

- Explain the difference between the two thinking styles: self-blaming thinking versus self-reflection (i.e., thinking about one's choices, actions and feelings). Examples include:
  - I can't do anything/I'm useless vs. I made a mistake/I tried my best
  - It's my fault vs. I'm not responsible for his violent behaviour.
- Self-blaming thinking is connected to self-blaming and self-harming behaviour (e.g., cutting, self-hitting, substance use, etc.).
- Self-blame may show up as being very critical of themselves. Some people assume that blaming themselves will help them learn and do better next time. However, often it causes them to feel shame, which can prevent the brain from thinking clearly and learning. Being kind to oneself when a person makes mistakes and having a more balanced view of who is responsible can help.
- If the person is in an abusive relationship help them to name how it is affecting them. The person might not recognize that they are in an abusive relationship. In this case, it can be helpful to have a conversation around healthy relationships and healthy communication. If appropriate, review the Cycle of Violence, the Power and Control Wheel and the Equality Wheel with the survivor and have a discussion about it.
- Many who self-blame often struggle with difficult and intrusive emotions (e.g., shame, anxiety, loneliness).

Step 3: DISCUSS existing and new coping strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- Chronic self-blaming is connected to low self-worth and self-doubt. Help strengthen the person's self-worth and their ability to believe in their resilience and strength (e.g., chant, hymn, positive self-care, words of loved ones, prayer).
- Use cognitive restructuring to create more balanced replacement thought to self-blame. Cognitive restructuring can be especially helpful if they are using **black and white thinking**. Black and white thinking means that the person thinks in strong extremes. A person who chronically self-blames may think, *"I always fail," "I can never do anything right," "I'm always incorrect,"* or *"Others always know better."* If something is not perfect, everything is perceived as bad (see Cognitive Restructuring section).
- Mindfulness can initially help survivors recognize when they are blaming themselves. However, this awareness needs to be without judgement. Labelling can be helpful: "That's a self-blame thought."
- Help the person interrupt the self-blaming with distraction (e.g., playing a song, going for a walk, calling a friend) or a grounding technique.
- Use affirmations. What does the person want to believe about themselves? Have the person start the morning by repeating affirmations (e.g., *"I am a strong woman who is learning how to dream again. I am patient."*)
- Remind the person of their protective factors (see Tree of Life, Appendix B or Lifeline, Appendix C).
- Have the person identify 2–3 loved ones who can remind them of their gifts. These loved ones do not need to be alive or physically there. You can ask the person to *"imagine what they might tell you."*
- Show the survivor compassion. And encourage them to find ways to be kind to themselves when they notice a self-blaming thought. They can try silently telling themselves that they are not alone in the suffering they have in their life, that other people suffer also. Then they can place a hand on their heart and ask themselves, "What do I need to hear right now to express kindness to myself?" There may be a phrase that speaks to them in your particular situation, such as:
  - May I give myself the compassion that I need
  - May I learn to accept myself as I am
  - May I forgive myself
  - May I be strong
  - May I be patient[22]

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- Explore what the person is taking away from the session.
- Have the person decide on 2 strategies they can do to reduce their self-blame.
- Role play the relevant techniques with the person.

SAMPLE HOMEWORK

- Ask the person to notice when they are triggered, the time of day, who is around them, what are they feeling and thinking, and where, when they start to self-blame.
- Ask the person to share what they have learned this session with one 'safe person'.

[22] From Neff, K. Self-Compassion Break. https://self-compassion.org/exercise-2-self-compassion-break/

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session with the person to check if the 2 Things Action Plan helped them.

- Review the person's week. Explore any questions, concerns or thoughts.
- Discuss any difficulties or obstacles they faced that affected their ability to practice the techniques.
- Rework and adapt the techniques taught OR teach the person new techniques that help them to release strong emotions.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.

- What have been some of your unique challenges of working with survivors who self-blame?
- Why do you think many survivor's self-blame in your cultural community?
- What have your previous survivors taught you about working with self-blame?

SEXUALITY AND INTIMACY

This sheet outlines the steps for caseworkers to use to help survivors with sexuality and intimacy problems. Basic information regarding sexual and reproductive health can be found after this section to support case workers when discussing these topics.

After someone has an experience of sexual violence, a very common traumatic reaction is to be distrustful, fearful and avoidant of others. This specific form of violence changes how a survivor understands and relate to their body, to others, to sexuality and to physical and emotional intimacy.

Some common concerns that survivors experience include:

- Avoiding or being afraid of sex
- Approaching sex as an obligation
- Difficulty trusting others
- Experiencing negative feelings such as anger, disgust, or guilt with touch
- Having difficulty becoming aroused or feeling sensation or feeling pain
- Feeling emotionally distant or not present during sex
- Experiencing intrusive or disturbing sexual thoughts and images
- Engaging in compulsive or inappropriate sexual behaviours
- Difficulty establishing or maintaining an intimate relationship

Sex and intimacy can be hard to talk about for the caseworker and the survivor. It is important that we gently explore this part of the survivor's life.

Step 1: ASSESS and identify what causes the survivor distress about sex/intimacy (use Distress Scale)

To assess means asking questions and ***thinking together*** with the survivor to ***understand*** why their distress around sex and intimacy.

- **Create Safety.** The person needs to feel safe to talk to you about sex and intimacy. Think about,

what does the person need to feel safe to talk?
- Ask questions about the person's feelings and core beliefs about sex (e.g., sex benefits only one person or sex is an obligation). For example, *"What do you think about intimacy and sex? Is it something you enjoy or is it challenging?"*
  - Identify their core beliefs about sex and intimacy.
  - Ask the person: If they have always had these beliefs? How have they changed due to their sexual violence experiences?
- **Identify and create a list** of the specific distressing thoughts and feelings around sexuality and intimacy.

Step 2: EDUCATE the person on their distress reactions to intimacy and sexuality

Educate the survivor on the ways traumatic experiences can impact intimacy and sex. Use stories and examples to help the survivor understand.
- Remind the person that sexual violence has psychological, emotional, spiritual, and physical effects.
- **Every survivor reacts differently to sexual violence.** Some express their emotions and tell others right away what happened while others prefer to keep their feelings inside, waiting weeks, months or years before sharing. Some never share their story. There is no correct response.
- Explain to the person that after a sexual assault it is normal to have reminders or triggers of the experience. **Triggers** or memories or flashbacks, transporting the person back to the event of the original trauma and causing the person to experience overwhelming emotions, physical symptoms or thoughts.
- **Triggers** cause a survivor to feel or behave in the same way they did during or immediately after the traumatic event because the brain does not differentiate what happened then from what is going on around them now. It is important to help the person identify what their triggers are (see Identifying Triggers section).
- It is normal to have **automatic, negative reactions to any kind of touch**, such as a flashback, a panic attack, sadness or freezing. These reactions are unwanted and upsetting, however, with time and healing they can diminish. It can be even more challenging when the survivor had difficulties with sexual feelings or intimacy before their unwanted experience.

Step 3: DISCUSS existing and new coping strategies

Discuss strategies the survivor is ***already*** using and then share new strategies
- Discuss the person's current ways of navigating intimacy and sexuality.
  - Explore if they understand the basics of sex.
  - What is challenging?
  - What is enjoyable?
  - Explore how they feel about their body?
  - Should they be able to feel sexual pleasure?
- Explore the list of **the specific distressing feelings and thoughts (or core beliefs)** the person has about sexuality and intimacy (created in Step 1).
- Help the person think about how they might feel about sex if they had never been sexually assaulted or abused. Consider how they want to think and feel about sex in the future.
- Help the person identify their **triggers**. Remind the person that triggers can be anything that was present before, during or after their sexual assault experiences. Triggers are activated through one or more of the five senses: sight, sound, touch, smell and taste (e.g., a certain song, the smell of cookies or a bottle of alcohol).
- Help the person take an active role in sexual activity. Help them to communicate with their partners about: how they are feeling, their preferences, what they do not like, what makes them uncomfortable and their desires. This might be a new experience for them but is a way to feel more in control.
- If the person is triggered while being intimate with a partner, the person can discuss with their partner what they would like them to do when they have this automatic reaction (e.g. stop what

Sexual Orientation and Gender Identity:

Sexual orientation refers to emotional, romantic and/or sexual attractions to other people. Sexual orientation ranges along a continuum, from attraction to people of a different sex or gender, to exclusive attraction to people with the same sex or gender. A wide variety of terms are currently used to address and refer to persons of diverse sexual orientation, which vary from context to context as well as vary from person to person. Some common terms that are used include: heterosexual/straight (having emotional, romantic or sexual attractions to members of a different gender or sex), gay/lesbian (having emotional, romantic or sexual attractions to members of one's own sex or gender) and bisexual (having emotional, romantic or sexual attractions to both men and women, or to any gender identity).

Gender identity refers to a person's internal sense of what their gender is, which may or may not be the same as the sex they were assigned at birth; gender expression refers to the way a person shows gender identity externally through behaviour, clothing, hairstyles, voice or body characteristics, which is different for every context and is based on prevailing cultural beliefs and norms of what it means to be a particular gender.

LGBTI is an acronym for people who identify as 'lesbian, gay, bisexual, transgender and intersex.' It is used as an umbrella term to describe diverse groups of people who do not conform to conventional or traditional notions of male and female gender roles. In every context, caseworkers should make sure they are aware of what terms are appropriate to use and what terms are considered derogatory and should be avoided. When you are working with an LGBTI individual and do not know what term to use, simply ask them.

LGBTI people around the world are killed or endure hate-motivated violence – including various forms of GBV, torture, detention, criminalization and discrimination in jobs, housing, health care and education – because of their real or perceived diverse sex, sexual orientation or gender identity. They may also face abuse and rejection from their family. In the office or on the phone, caseworkers can offer LGBTI survivors a safe space, free from violence and discrimination, where they can heal. LGBTI people exist in every community in every country, including in rural and urban communities. Their visibility within communities may vary. Welcoming survivors to share their diverse sex, sexual orientation and gender identity with caseworkers is critical to providing effective assistance. Many people are scared to inform caseworkers that they are LGBTI because they fear discrimination, breaches of confidentiality or being barred from services. Ensuring confidentiality is most critical to gaining trust. LGBTI people must feel certain caseworkers will not share private information with family members or the community. And caseworkers can help LGBTI persons to understand the protective factors and resilience they have that has allowed them to survive and thrive, despite challenges in society.

It is important for a caseworker to first become aware of what common beliefs, practices and policies exist in their community that may be harmful and violate the human rights of LGBTI people. Then, reflect on the beliefs and behaviours you as an individual have toward people of various gender identifies and sexual orientations. Caseworkers may hold discriminatory beliefs that change the way they speak to and provide support for people of certain identities, with the potential to cause harm, neglect their concerns, and treat them unequally to others (see section in Part 1 on Cultural Use and Adaptation of this Module). This can complicate working with people who have gender identities or sexual orientations different from one's own, especially when discussing sexuality and intimacy. The caseworker's goal is to treat all survivors equally and professionally, regardless of personal and societal beliefs. Caseworkers can discuss if this is a barrier for them (e.g., during supervision), and how they can educate themselves to be able to work with people who may differ from them.

**For further understanding of working with individuals from the LGBTI community, see Part IV of the GBV Case Management Guidelines, IOM's LGBTI training package,[23] and resources from UNHCR.[24]*

[23] https://lgbti.iom.int/lgbti-training-package

[24] https://emergency.unhcr.org/entry/221506/lesbian-gay-bisexual-transgender-and-intersex-lgbti-persons

they are doing, hold them, talk to them etc.). The person can also ask their partners to watch for signs that they are having an automatic reaction, and to stop sexual activity or use agreed alternatives immediately.
- Suggest the idea of taking a timeout from sex until the person feels ready. This may allow the person to get to relearn their bodies and feel comfortable with partners without the pressure of sex.
- Encourage the survivor to take their time and find their own pace in relation to intimacy and sex. It is essential they feel in control.
- Teach the person grounding techniques if they are triggered, such as: Five Things Grounding Technique (see Grounding Techniques section).
  - Name 5 things you can see around you
  - Name 5 things you can feel right now (feet on the floor, soft shirt)
  - Name 5 things you can hear right now (TV, birds outside)
  - Name 5 things you can smell now

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.
- Ask the person what they have learned from today's session.
- Have the person decide on 3 practical strategies they can do to feel more empowered and in control with their sexuality and intimacy.
- Role play the relevant techniques with the person.
- Give Homework.

SAMPLE HOMEWORK
- Ask the survivor to think about what felt confusing, challenging, or triggering about the conversation today and to write it down, think about or to talk to a safe person in their life about their thoughts.
- What have they learned from their caregivers, friends or spiritual and/or cultural groups about sex and intimacy? What do they think about what they have learned?

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session with the survivor to check if the 3 Things Action Plan helped them and to discuss challenges, susses and to adapt any techniques for the survivor.
- Review the person's week. Explore any questions, concerns or thoughts
- Discuss any difficulties and rework or adapt techniques to fit the person's life.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences and beliefs, best practices and challenges working with this topic.
- How do you feel about talking about sex and intimacy?
  - Is this conversation a challenge for you? If so, why?
- With survivors, how do gender roles impact how intimacy and sexuality is spoken about and expressed?
- What strategies do you use to make a survivor feel safe to talk about a sensitive topic? What strategies have made a survivor feel unsafe?
- Reflect on the best conversation you have had with a survivor about sexuality and intimacy.
  - What specific elements made it best?

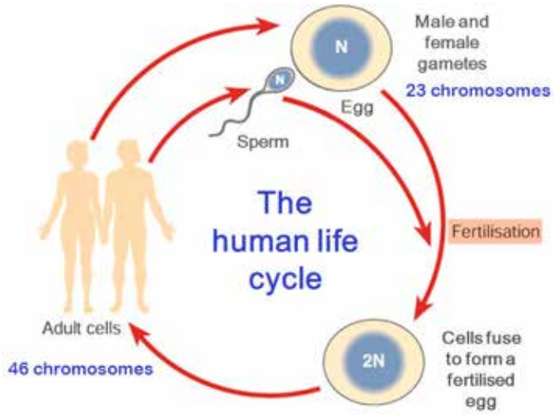
REPRODUCTIVE HEALTH INFORMATION[25]

WHAT IS REPRODUCTIVE HEALTH?
Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.[26]

SEXUAL HEALTH
Sexual health is fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health, when viewed affirmatively, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[27]

WHAT IS REPRODUCTION?
Reproduction is the process by which organisms make more organisms like themselves. In the human reproductive process, two kinds of sex cells, or gametes are involved. The male gamete, or sperm, and the female gamete, the egg or ovum, meet in the female's reproductive system. When sperm fertilises (meets) an egg, this fertilised egg is called a zygote (pronounced: ZYE-goat). The zygote goes through a process of becoming an embryo and developing into a foetus. The male reproductive system and the female reproductive system are both needed for reproduction.

The human life cycle[28]



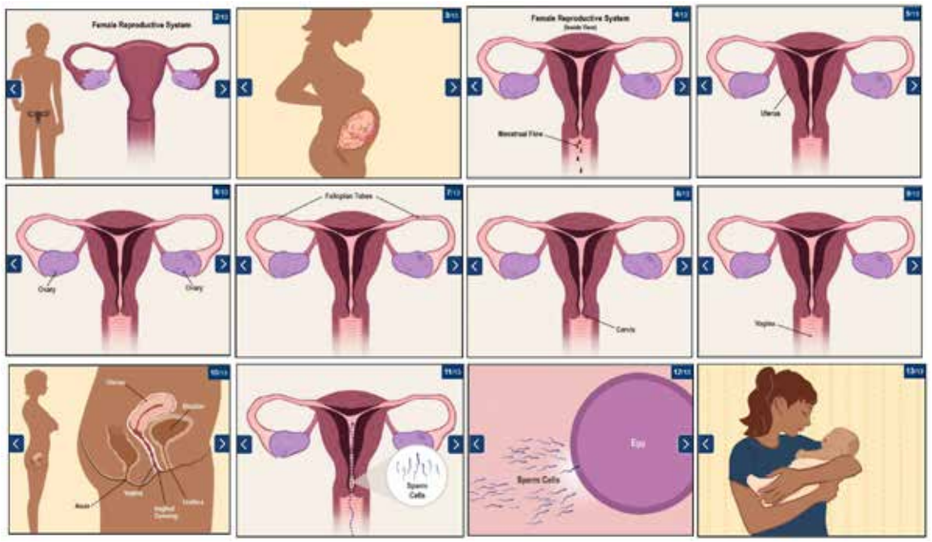
[25] Adapted from Nemours Foundation, 2020. https://kidshealth.org/en/teens/female-repro.html
[26] https://www.who.int/westernpacific/health-topics/reproductive-health
[27] https://www.who.int/health-topics/sexual-health#tab=tab_1
[28] https://slideplayer.com/slide/9305391/

THE FEMALE REPRODUCTIVE SYSTEM

The female reproductive system enables women to produce eggs (ova), have sexual intercourse, protect and nourish a fertilised egg until it is fully developed and give birth. It includes several parts;

- The female reproductive system includes a group of organs in a women's lower belly and pelvis.
- It is called the reproductive system because it supports the development and growth of a baby.
- The system is also responsible for a female's monthly period, called **menstruation**.
- The **uterus**, which is where a foetus or baby grow. It is a hollow, pear-shaped organ with a muscular wall.
- There are **two ovaries**, one on either side of the uterus. Ovaries make eggs and hormones like oestrogen and progesterone. These hormones help females develop and make it possible for a woman to have a baby. The ovaries release an egg as part of the menstrual cycle. When an egg is released, it is called ovulation. Each egg is tiny – about one-tenth the size of a poppy seed.
- **Fallopian tubes** go from the uterus to the ovaries. During ovulation, an ovary releases an egg into the fallopian tube next to it.
- The **cervix** is the lower part of the uterus that opens into the vagina. During childbirth, the cervix expands about 10 centimetres so the baby can travel from the uterus through the vagina and into the world.
- The **vagina** is a tube that connects the uterus to the outside of the body. The entrance to the vagina is on the outside of the body. It is called the vaginal opening.
- The **vaginal opening** is a hole between a female's legs, below her urethra (where pee comes out) and above her anus (where poop comes out).
- During sex, sperm cells travel through the vagina to the uterus and fallopian tubes. In the fallopian tube, the sperm meets the egg that was released from the ovary during ovulation.
- If a sperm cell fertilizes the female's egg, it is the first step in reproduction (getting pregnant).
- If all goes well, in 9 months, a baby will be born.

The Female Reproductive System[29]



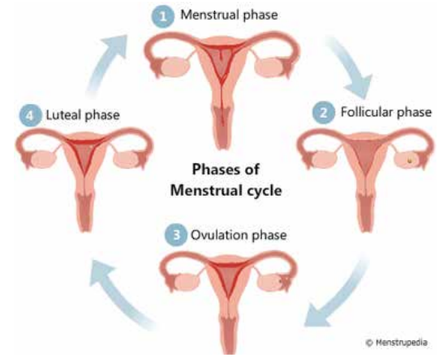
[29] Nemours Foundation, 2020. https://kidshealth.org/en/teens/female-repro.html

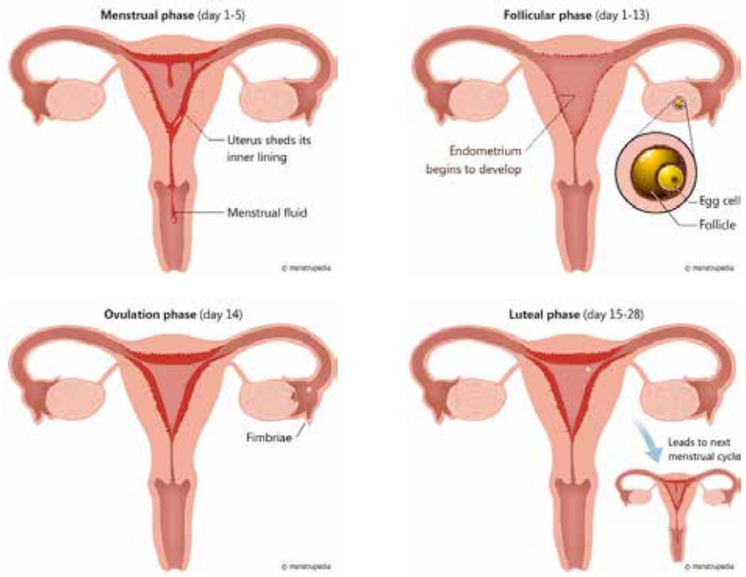
MENSTRUAL CYCLE

About once a month, during ovulation, an ovary sends a tiny egg into one of the fallopian tubes. If the egg is not fertilized in the fallopian tube, the egg leaves the body about 2 weeks later through the uterus – this is menstruation. Blood and tissue from the inner lining of the uterus combine to form the menstrual flow. For most females this lasts between 3–5 days. It is common for women and girls to experience discomfort in the days leading to their periods – both physical and emotional symptoms such as bloating, tiredness, backache, sort breasts, headaches, constipation, diarrhoea, irritability and trouble concentrating and handling stress.

If the egg is fertilised, pregnancy occurs and lasts on average 280 days, about 9 months.

Menstrual cycle[30]





[30] https://www.menstrupedia.com/articles/physiology/cycle-phases

DISSOCIATION

This sheet outlines the steps for caseworkers to use to help survivors with dissociation.

One definition of dissociation is a mental process that involves disconnecting memories, feelings, thoughts, or sense of self and not being in the present. Many people experience it at some point in their lives. A mild dissociation that is experienced by most people, including stable and healthy individuals, is forgetting a common experience, such as locking a door. The event is so repetitive in daily life that a specific instance of locking a door may be forgotten. Persistent, frequent, or extended periods of dissociation can be symptoms of a larger mental health problem, such as a dissociative disorder. Dissociation might look like: daydreaming, spacing out, or eyes glazed over, acting different, or using a different tone of voice or different gestures, switching between emotions or reactions to an event, such as appearing frightened and timid, then becoming violent. A survivor who dissociates may say that sometimes they feel their body is not real, or that they are outside of their body. Or they may mention that everything around them seems foggy or unreal, as well as other seemingly strange situations, like finding themselves somewhere but not remembering how they got there or having things that they do not remember buying. Dissociation occurs outside a survivor's Window of Tolerance. Many survivors, due to their traumatic experiences, struggle with dissociation.

Different communities and cultures may have other explanations for these same symptoms, as well as various terms to describe it. There may also be non-psychological interventions used to address dissociation (e.g., spiritual or religious ceremony).

While Clinical Dissociation should be treated by a specialist, there are different ways that a caseworker can support a survivor who is experiencing issues with dissociation. Follow these steps to support the survivor who is experiencing dissociation.

Step 1: ASSESS and identify what triggers dissociation

To assess means asking many questions and thinking together with the survivor to try to understand what is happening for them and why they think this might be happening.

Remember that different senses might have been a connection to the sexual or physical assault (different smells such as perfume or alcohol, how someone touches them, etc). Explore carefully.

- Start with an empathic comment about your appreciation of the survivor's willingness to discuss painful issues with you.
- Identify the reasons why the survivor is dissociating (i.e., triggers) and use the Distress Scale to assess the severity of the dissociation.
  - Ask the survivor to recall if they can remember what happened before the dissociative event.
  - Ask about what **thoughts and feelings** they have before the event.
  - Ask about their **diet and lifestyle** (be sensitive to their context). They could be 'spacing out' if they have not been able to eat or drink enough, so it is important to see if that is the underlying issue, or if it is related to the issue that brought them into services with you.
  - Ask the survivor about the reasons they believe this is happening (rule out any cultural/religious beliefs).

Step 2: EDUCATE the survivor about dissociation

Educate the survivor about why dissociation happens, the role of psychosocial stressors and traumatic experiences. Use stories and examples to help the person understand.

- People have dissociative experiences when parts of their brain are trying to keep their body safe. It can be related to their fight or flight modes when they think they might be in danger, even if they are not in danger in the present, but they are being triggered from past events. These are normal reactions to stressful experiences.
- **Triggers cause a survivor of sexual violence to feel or behave in the same way they did during or immediately after the traumatic event because the brain does not differentiate what happened then from what is going on around them now. It is important to help the person identify what their triggers are (see Identifying Triggers section).**
- **It is normal to have automatic, negative reactions to any kind of touch, such as dissociation, a flashback, a panic attack, sadness or freezing. These reactions are unwanted and upsetting, however, with time, work, and healing they can diminish.**

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is already using and then share new strategies (ONLY the ones useful for the survivor).

Some strategies that can be used to help cope with stress and anxiety that might trigger dissociation include:

- Getting adequate sleep each night.
- Eating a balanced diet.
- Getting regular physical activity (physical exercise can help in many ways).
- Using relaxation techniques to help cope with stress.
- Identifying and avoiding or managing triggers.
- Practicing grounding techniques that can help bring the survivor back to the present moment. **This is often the most effective strategy to address dissociation while it is happening.**
- Watch for signs of dissociation since it is possible to experience this without being aware of it. Sudden mood changes, difficulty remembering personal details about themselves or their life, and feeling disconnected are all signs that the survivor might be experiencing dissociation. Notice when these occur and look for potential triggers..

If a survivor starts to dissociate during a meeting, the caseworker can help bring them back to the present moment by: saying their name, reminding them where they are and the day/time, having them grip the chair, having them tap on their legs or push their feet into the floor, asking them to name things of specific colours in the room, having them stand up and walk around, or use other basic grounding techniques.

Help survivors track and watch for signs of dissociation since it is possible for survivors to dissociate without being aware of it. Sudden mood changes, difficulty remembering personal details about themselves or their life, and feeling disconnected are all signs that the survivor might be experiencing dissociation. Notice when these occur and look for potential triggers

Anxiety and other distressing emotions

When a survivor feels fear and anxiety, their body wakes up. Fear and anxiety tell the body *"Wake up. Be ready. Anything can happen. You are not safe."*

- Help the survivor to slow their body down with grounding and relaxation exercises (see Relaxation and Grounding sections).
- Brainstorm ways they can feel safer through 1) problem solving (see Problem Solving section) or 2) using spiritual/cultural protective practices (e.g., protection prayers, amulets).
- Create a recovery plan with the survivor. This plan is ***3 things the person can do*** if they feel like they are getting triggered in a way that usually results in dissociation.
- Teach the person how to release their distressing emotions and thoughts in the when they come up (e.g., writing, talking to a friend, praying, singing).
- Have the person use the cognitive restructuring technique for painful thoughts (see Cognitive Restructuring section).

Step 4: CREATE a plan if they notice they are getting triggered/ if they notice they are starting to dissociate (note that it is not always possible for a person to notice on their own)

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- Explain to the person the importance of establishing a routine to signal to their body and mind that they are not in the past traumatic experience. They should try these rituals until it is established as a regular pattern.
- Work with the person to identify 3 things:
  - One helpful thing they will continue to do that helps them when they notice they are getting triggered.
  - One behaviour that they will stop doing that prevents them from slowing down when they notice they are being triggered.
  - One new grounding technique they will start to do if they notice dissociation happening.
- Role play any new techniques with the person.
- Give the person homework to complete before the next session you have with them, and make sure you follow up during the next session (if there are complications, help them brainstorm solutions).

SAMPLE HOMEWORK

- Have the person ask loved ones to share 3 things they do to calm themselves down.
- Have the person practice an agreed upon guided imagery or visualization (see Relaxation Section). The caseworker should role play this with the survivor in session.
- Have the person practice their preferred grounded and relaxation techniques.

Step 5: FOLLOW-UP

Have a follow-up session to discuss challenges, successes and to rework and adapt techniques for the survivor.

- Explore what was challenging and what was helpful.
- Problem solve with the person to understand why they got stuck, adapt existing techniques or suggest and practice new techniques.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences, beliefs, best practices and challenges working with this topic.

- Reflect on traditional remedies or practices in your own or in the survivor's culture that facilitate grounding and relaxation when triggers happen.
- Think about previous survivors who struggled with dissociation issues, what helped them to slow down before they got triggered and dissociated?
- Think about the survivor's life in detail. Think of the many possible reasons blocking the person from being able to remain in the present moment (Remember, there are often more reasons than survivors are aware of).

SOMATIC SYMPTOMS

This sheet outlines the steps for caseworkers to use to help survivors with somatic symptoms.

Somatic symptoms are physical symptoms that are caused by psychosocial problems such as living in poverty or experiencing a sexual assault. Somatic symptoms tell the caseworker that something is bothering the survivor. The physical complaints symbolize these problems.

Somatic symptoms and complaints hurt. However, they may have no medical reason. The reason for the pain is psychological. Some common somatic symptoms among GBV survivors are: headaches; pain in the belly or genital area; pain in arms, legs or joints; nausea and vomiting; body pain and muscle discomfort; fainting spells; heart palpitations; difficult menstruations; and pain before, during or after sexual relations.

IMPORTANT: All survivors who appear to have somatic symptoms should, as a priority, be seen by a medical professional prior to the caseworker working with them. This approach allows for the medical professional to make sure there are no medical reasons for the person's symptoms.

Once medical reasons are excluded, to help the survivor, we can make a connection between the person's somatic symptom and their GBV and life problems.

Often for GBV, the body was the location of violence or a subject of criticism and verbal abuse by the perpetrator or another form of control. A survivor may also feel disappointed in their body for the way they responded to the violence (e.g., freezing instead of fighting). Some survivors may then treat their body poorly, for example, by not nourishing it with healthy food (if they have access to healthy food), using drugs or alcohol, or stopping physical activity. Some survivors may be critical of parts of their body, angry with it at times for not working the way they want it to. This prevents survivors and others from realizing that their bodies are constantly changing sources of intelligence, information and energy. Our body are always supporting us and have the capacity to help us heal and thrive. Part 1 of the module explained the Fight, Flight, Freeze, Submit responses in the face of threat or danger, as well as the body's very specific physical responses in the face of danger (see image on page 17). These responses are intended to protect a person and ready them for a fight, flight or freeze response. If a survivor reports these somatic symptoms in the present, a caseworker may suspect that they were triggered by something or are stressed/worried about something.

Step 1: ASSESS why the somatic symptom may be there (use Distress Scale)

Assess means asking many questions and ***thinking together*** with the survivor to ***understand*** why they have somatic symptoms.

- Explore in detail only ***one*** of the survivor's distressing somatic symptoms.
- Help the person identify any triggers or warning signs that the somatic symptoms are coming.
- Explore when the symptoms first appeared and changes in the person's life before the somatic symptoms occurred.
- Explore when the symptoms appear and when not. Can the pain be expected? Look for patterns.
- How does the symptom affect the person's thoughts/feelings/behaviours and relationships with other people?
- Explore the severity of the symptoms and how it impacts their daily life.
- Explore current and past psychosocial stressors.
- Identify the cultural beliefs of the person and their family members towards the somatic complaints.
- Ask questions about the person's reactions to and coping with symptoms (e.g., use of traditional remedies). Be sure not to invalidate traditional remedies and healing practices. These are valuable

resources for survivors, and caseworkers can support survivors with the emotional aspect of somatic symptoms at the same time that survivors are receiving other forms of support.
- Explore if the person has other symptoms besides the somatic symptoms. Some survivors with persistent sadness and anxiety present with somatic complaints.

Step 2: EDUCATE the survivor on why somatic symptoms exist

Educate the survivor about the meaning of somatic symptoms, how psychosocial stressors create somatic symptoms, and the mind-body relationship. Use stories and examples to help the survivor understand.

- Somatic symptoms, also known as somatisation, is when psychological problems and distress get "converted" or turned into physical symptoms (e.g., fainting, pain in the body).
- All human beings somatise. Somatization happens because of the mind-body connection which is the back and forth communication between the mind and body. Emotions are expressed in our bodies. For example, survivors may get headaches because of stress or a stomach-ache after a fight with someone. These somatic symptoms hurt and for some people get in the way of everyday life and needs to be treated.
- Survivors may develop somatic symptoms when they avoid emotions like sadness and anger and shame and pretend those feelings are not there.
- Survivors may have single or repeated somatic episodes. Symptoms can be vague somatic complaints (e.g., nausea or feeling tired) or they can be specific areas of the body (e.g., back pain, stomach pain).
- Family members may model and duplicate somatic symptoms based on each other.
- In cultures where mental health is not openly discussed due to stigma or in rigid, repressive contexts, distress is primarily expressed through the body as it may be safer and more socially acceptable.
- Somatic symptoms can happen even when the survivor is expressing whatever needs to be expressed or even when the survivor knows why they are stressed. This is because sometimes the stress is too intense and comes out of the body. In this way, somatic symptoms can be understood like an excess.

Step 3: DISCUSS existing coping strategies and new strategies

Discuss strategies the survivor is ***already*** using and then share new strategies.

- Since somatic reactions are a protective shield, the survivor can use these reactions to avoid thinking about unpleasant events or unwanted feelings. You can help the person by gently helping them face the thing they are avoiding. Simply put, somatic symptoms get better when the person gets help for their emotional pain.
- Create safety. Remember the more a person feels safe, the more they will give up somatization and instead express their distress in anger, tears and grief. The so called 'fear of feeling something' will diminish.
- The unwanted feelings and thoughts that survivors avoid are often expressed by the body. Help the person identify some of the distressing feelings and thoughts they have been experiencing recently.
- Have the person record when the somatic symptoms appeared in the last few weeks. They can try to notice any common people, places or things that appeared during the times the symptoms were present.
- Usually the physical complaints are really about problems of the mind. Try to find the reasons and discuss them with the person.
- Carefully explore the original connection of symptoms and psychosocial stressors. How is the symptom helping the person to cope?
- The survivor may be afraid that they cannot handle the problem they are faced with. Remind them of their strength (see Assessing Risk and Protective Factors section).
- Regular exercise will make the person feel much better.
- Encourage regular activities that help them express themselves, such as writing, singing, praying, talking with a trusted loved one.
- Encourage the person to care for and manage somatic symptoms (e.g., by using relaxation and grounding techniques), rather than trying to cure them.
- Many survivors face many daily traumas. This may cause their body to constantly be in fight, flight, freeze or submit mode. Caseworkers can help survivors build their relaxation and grounding techniques and find small moments of calm in their day, so their body can reset and rest. At first, that may only be for a few minutes during the meeting. Over time, hopefully the survivor can find more and more moments outside of your meetings to practice.
- Help survivors reshape their relationship with their bodies and recognize how their body is also an incredible and wise resource:
  - Frame somatic issues as the body's way of trying to tell them something important, requesting them to listen
  - Use the body to help, like relaxation or grounding techniques that use the body (breath, using 5 senses, pressing feet into the floor, stretching)
  - Practice gratitude toward parts of the body for helping them throughout the day (e.g., feet for helping them walk to work, arms for helping them hold their baby, mouth for helping them taste delicious food)
  - Build strength and flexibility through regular exercise or stretching
  - Encourage them take care of their body: grooming, showering, eating enough and nutritious food, seeking medical care when necessary, dressing appropriately for the weather, sleep better, reducing alcohol and drug use, practicing safe sex. Self-care builds self-respect and self-confidence.

Step 4: CREATE an Action Plan

Create a plan so that the new knowledge and skills can be integrated into the survivor's life.

- Ask the survivor what they have learned from today's session.
- Brainstorm with the person about ideas from their lives, what they may have witnessed others do or things discussed during this session. Also, ask for ideas that they think the family will find useful.
- Work with the person to decide on 3 strategies to decrease their somatic concerns.
- Role play the relevant techniques with person.
- Give the person homework to complete before the next session.

SAMPLE HOMEWORK

- Have the survivor create a list of their triggers and bring the list back to discuss.
- Ask the person to notice the time of day, who is around them, what are they feeling and thinking, and where they are when they get the somatic symptoms.
- Ask the survivor to notice in detail what happens in their body when they feel their somatic symptom. For example, do they notice any heaviness, tingling, tension, tightness, temperature change etc?
- Have the person teach loved ones what they learned in today's session and practice the techniques with them.

Step 5: FOLLOW-UP on Action Plan

Have a follow-up session to discuss challenges, successes, to review homework and to explore the 3 things chosen to decrease the survivor's somatic symptoms (prior to the session the caseworker should review the Identifying Triggers section).

- Review the person's week. Explore any questions, concern or thoughts.
- Discuss any difficulties they faced that affected their ability to practice the techniques.
- Rework the techniques taught or teach the person new techniques that helps them to release strong emotions.

Step 6: REFLECT: Self-Reflection/Supervision Questions

Use these questions (individually or in supervision) to explore the caseworker's personal experiences, beliefs, best practices and challenges working with this topic.

- Have you, your loved ones or previous survivors experienced somatic symptoms after a distressing experience? What somatic symptoms do you remember? What helped ease the symptoms?
- Are there certain spiritual or cultural reasons that survivors often use to explain somatic symptoms (e.g., djinn possession or being cursed)?
- Why do you think women experience their distress through somatic symptoms more often than men do?
- When there are no words, somatic symptoms often appear. It is the body's way to communicate distress. What might the survivor not be saying or not be able to say?
- Does the survivor's focus on somatic symptoms make it harder for the clinician to relate to them/understand them?

Hamid Haji, Sinjar Mountain, 2019

PART 4. APPENDICES

APPENDIX A: MENTAL STATUS EXAM (MSE)[31]

The Mental Status Exam (MSE) is the psychological equivalent of a physical exam. It provides a snapshot assessment of the survivor's level of distress and functionality. It encourages caseworkers to closely observe 4 core areas: appearance, behaviour, feelings and speech. For example, sometimes a change in the way a survivor speaks, or walks can tell you more than the words they are saying.

Caseworkers should use the Mental Status Exam as a brief assessment tool during every interaction with a survivor. There are no questions that need to be asked of the survivor, instead, the MSE is something that guides what the caseworker notices and pays attention to.

The Mental Status Exam (MSE)

GENERAL APPEARANCE

1. **Appearance (age):** Does the person appear to be younger, or older than the chronological age?
2. **Attitude:** Friendly, co-operative, hostile, alert, confused, eye contact, rapport, indifferent etc.?
3. **Body:** Tall, short, thin, obese?
4. **Clothing:** Appropriate to age, season, setting and occasion? Clean, neat, tidy, meticulous, worn, properly worn? Are the colours worn: bright, dull, drab?
5. **Hygiene:** Does the person appear clean, dirty, un-bathed? Meticulous? Neat, dirty, well groomed?
6. **Odour:** Perspiration, alcohol, perfume, cologne, shaving lotion?
7. **Facial expressions:** Does the person appear sad, perplexed, worried, fearful, scowling, excited, elated, preoccupied, bored, suspicious, smiling, responsive, interested, animated, blank, dazed, or tense?
8. **Eye Contact:** Indirect, fixed, fleeting, glaring, darting, no contact?

BEHAVIOUR

1. **Style of walking:** Brisk, slow, hesitant, propulsive, shuffling, dancing, normal, ataxic, uncoordinated?
2. **Handshake:** Firm, weak, warm, cool, resistant, heavy, refused, prolonged, seductive?
3. **Abnormal movements:** Grimaces, tics, twitches, foot tapping, hand wringing, ritualistic behaviour, mannerisms, posturing, nail biting, chewing movements, echopraxia (the involuntary repetition or imitation of another person's actions)?
4. **Posture:** Stooped, relaxed, stiff, shaky, slouched, bizarre mannerisms, posturing, crouching, erect.
5. **Speed of movements:** Hyperactive, slow, retarded, agitated?
6. **Co-ordination of movements:** Awkward, clumsy, agile, falling easily?

FEELINGS

1. **Appropriateness of feeling:** Appropriate or inappropriate to situation. Congruous /incongruous?
2. **Range of feeling:** Lively, flat, normal, blunted, superficial, constricted?
3. **Attitude toward caseworker during encounter:** Frank, open, warm, fearful, suspicious, hostile, angry, evasive, playful, seductive, guarded, friendly, pleasant, ingratiating, negative, shy, overly familiar, co-operative, withdrawn?
4. **Specific mood or feelings observed or reported:** Sadness, irritability, anger, fear, regret, elation, miserable, puzzled, optimistic, pessimistic, hopelessness, depressed?
5. **Anxiety level:** Rate as mild, moderate, severe, panic?

SPEECH

1. **Speed of speech:** Rapid, slow, ordinary?
2. **Flow of speech:** Hesitant, expansive, rambling, halting, stuttering, lilting, jerky, long pauses, forgetful?
3. **Intensity of volume:** Loud, soft, ordinary, whispered, yelling, inaudible?
4. **Clarity of speech:** Clear, slurred, mumbled, lisping, rambling, relevant, incoherent?
5. **Liveliness of speech:** Lively, dull, monotonous, normal, intense, pressured, explosive?
6. **Quantity:** Responds only to questions; offers information; scant; mute; verbose, repetitive?

[31] Adapted from Richard Lakeman © 1995.

APPENDIX B: TREE OF LIFE

WHY THE TREE OF LIFE IS DONE WITH SURVIVORS?

The Tree of Life is an activity that helps survivors remember what protective factors they have. Protective factors are skills, qualities, strengths, abilities, relationships, values and experiences, which give a person the feeling that life is worth living. Protective factors can be external or internal. They help the survivor to overcome difficult life crises. Unfortunately, survivors often forget about the importance and power of their own resources, particularly in the moments when they need it the most: when they feel overwhelmed with emotion.

The recognition of protective factors for the survivor is so important, as they can help the survivor:

- To see the positive aspects of their life
- To focus not only on the negative experiences and aspects
- To feel connected to the world
- To increase their self-worth and self confidence
- To recognize possible ways to get out of a desperate situation
- To feel that they can trust in something and that it is worth it to go on
- To remember that there are people who love and need them

TREE OF LIFE ACTIVITY

The Tree of Life activity can be individually with survivors or in a group of survivors.

Materials needed: Piece of paper, crayons/paint or just a pen/pencil, a picture of old tree that has broken branches (that is still alive).

1. Show a picture of an old tree with falling leaves and cut branches. The tree will have roots that are not broken, and although there are falling leaves and cut branches, there are also a few small signs of new life, such as, a small flower bud beginning to grow from one part of the tree, and fruit hanging from the remaining branches.

2. Ask the survivor: *"What do you see?"*

3. Then ask: *"Is the tree still a tree even though it has lost its leaves?"* Point out that the tree is still a tree because it still has its inner core - it still has the heart or soul of a tree.

4. Refer to the cut branches and ask the survivor: *"What can this mean? We as people can feel like a part of us has been cut off. When we lose people we love, we can feel like part of us is missing. Often, we also have lasting physical injuries, which feels like we have lost a part of who we used to be. We can also have emotional injuries, which although people cannot see, we can feel like we are missing a piece of ourselves."*

5. Ask the person, *"How does this relate to your own feelings?"* Empathize and validate.

6. Refer to the roots of the tree: Ask the survivor, *"What functions do the roots perform?"* The roots give nourishment to the tree; the roots are the foundation of the tree; the roots help the tree to remain standing etc.

7. Point to the fruit of the tree: *"Ask, how does the tree still produce fruit, even if it has had a broken branch?"* The tree still has roots that keep it alive and able to draw nutrients to produce the fruit, even if a branch is cut, it can grow back and continue to produce fruit.

8. Ask the person, *"What about for you, how are you like the tree?"* Invite the survivor to now draw their own tree.

9. Explain what each part of the tree represents to the survivor:
   - **Roots:** where you came from, your ancestors, your family history
   - **Ground:** who you are, where you are; your life in the present, such as daily activities and routines, important parts of your daily life
   - **Trunk:** Strengths, what are you good at (how long you been good at it, who taught you, what do they think about how good you are at it)?
   - **Branches:** Hopes and dreams for the future
   - **Leaves:** Special people, places, sounds, smells
   - **Fruits:** Gifts you have received in your life (Gifts can be tangible or intangible. They can be compliments, happy memories or physical things)
   - **Bugs:** The things, feelings, people or thoughts that 'eat' the fruit, the leaves, the branches, etc.

10. Have the person draw the tree (using crayons, water colour or just a pencil/pen).

11. Facilitate a conversation with the survivor about:
    a. how they feel looking at their tree,
    b. does anything stand out,
    c. go through what they have drawn starting with roots to bugs (go one by one),
    d. explore how they are feeling, how can they reduce the 'bugs' that are eating their joy.

12. Decide with the survivor where you are going to put this tree of life (leave at the centre or put in a special place in their home where they can be reminded). If doing the Tree of Life activity in a group, give option for survivors to take the Tree home OR to create a Forest of Life where they can put all their trees together.

Tree of Life

APPENDIX C: LIFELINE

The Lifeline can be used for multiple objectives. It is very important the caseworker is clear on why they are doing the lifeline. The lifeline can be used to:

1. To assess for resources.
2. At intake or early in counselling to have an overview of the survivor's life.
3. To assess how a survivor perceives and understands their life
4. To normalize suffering and hardships.
5. To prepare someone to learn skills to cope with handling the rocks (hardships).

In this exercise the survivor tries to make an outline of their life with a rope, stones and flowers (if these items are not available, drawing can stand in their place):

- **String:** a symbol for the life where the end of the rope represents their future.
- **Stones:** symbols for bad events.
- **Flowers/leaves:** symbols for good events.

Guidelines

Say to the survivor, *"Today I would like to do a small exercise with you. I brought along a string and stones and flowers/leaves with me. The string is a symbol of your life. Look here where the string begins is the moment you were born. Look where you are today. This is your past and this symbolises your future."*

1. Let us have a look at the stones and flowers. The stones are symbols for bad events. The big stones are for the very difficult and bad events. The smaller stones are for events which were bad but not as bad as the big ones.
2. The same goes for the flowers, there are bigger ones and smaller ones.
3. Now I want to ask you to think about your life and put the stones and flowers on the string according to what you have experienced.
4. Do you understand the exercise?
5. Do you have any question?
6. Do you want to start now?

There is a clear beginning (the birth) then the survivor follows their own life experiences and puts flowers and small or bigger stones on the string in a timeline. The end of the string should be coiled up (to represent the future).

The caseworker and survivor then look together at the lifeline the survivor has made. The caseworker can ask the survivor *"what do you feel as you look at your life represents by rocks and flowers?" "Does anything surprise you, overwhelm you?"*

Adaptations

The lifeline can be used in many ways. If the caseworker would like to explore the strengths the survivor has, you might just ask the survivor to only put the flowers on the happy moments in their life. However, if the caseworker has the objective of getting to know the survivor at intake, for example, they might ask the survivor to place the rocks and flowers on the lifeline and to choose which 'rock' is affecting them the most. **This would not be the time to address the story behind the rock in depth because rapport has generally not been built enough to allow the survivor to feel safe to share. As an opening conversation, the caseworker could address that in further sessions, when the survivor is comfortable, they can talk more in depth about the 'rock'. For the time being, they might give the rock a specific name, but not speak more in depth about it, and that is okay. Be creative. Trust your instinct and refer to supervision for support.**

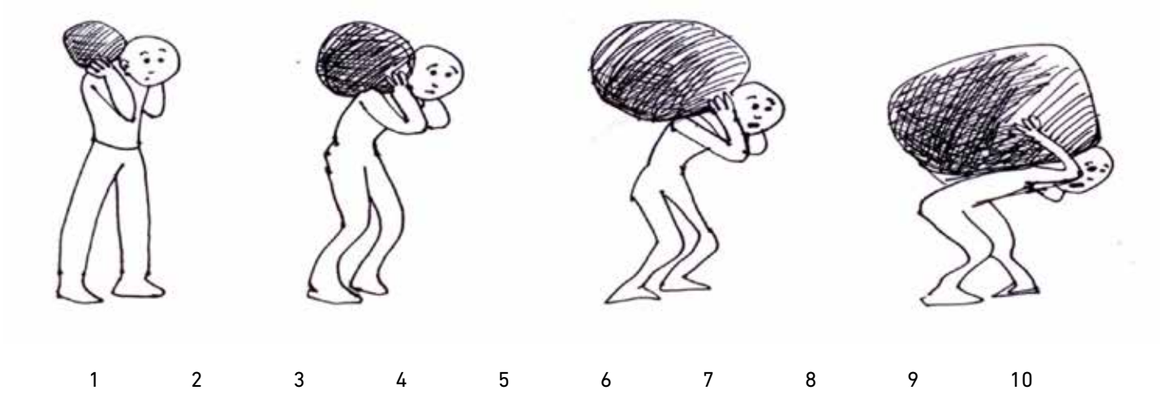
Lifeline exercise
Shiama Mohamed, Iraq, 2020

APPENDIX D: DISTRESS ASSESSMENT

At the beginning of working with any psychological symptom, the caseworker must assess how the symptom affects the survivor and their life. The Distress Assessment (below) allows the caseworker:

1. to understand how severe the survivor's symptoms are,
2. to understand how much the symptom(s), affects the survivor's life and,
3. to be able to monitor how a survivor's symptoms improve (or worsen) throughout the case management process.

The Distress Assessment should be used in the 'Assess' section (part 1) of each symptom sheet located in Part 3: Working with Specific Symptoms. To use the distress assessment, the caseworker asks the survivor to choose the picture or say the number (1-10) that best captures how severe their symptom is and how much it affects their life.



1 2 3 4 5 6 7 8 9 10

APPENDIX E: MINDFULNESS EXERCISES

Mindful Breathing

Tune into your breath 4–5 times per day and just be mindful of one or two full cycles of breath, noticing the rise and fall of your chest and stomach when you inhale and exhale.

Thanking Your Thoughts

Taking Labelling a step further, try saying "Thank you mind for that thought!" or "There's my beautiful mind making thoughts again!" when you notice an unpleasant or pleasant thought. This brings some positive energy and nonjudgmental stance that can help reduce the intensity of an upsetting thought or emotion. Alternatively, you can use your creativity and imagine the thought written on the wall – how big is it? What color is it written in? Wave hello to it! Or, try to imagine the emotion in front of you right now, and give it a shape and a color.

Orienting to the Room (Mindful Observation – External)

This exercise involves looking around the room and noticing that certain objects make us feel different sensations in our bodies. Are you willing to try? We can stop at any time if you become uncomfortable, just let me know.

Get comfortable in your chair and take a few deep breaths. And first just notice how you feel in the chair, how your body is supported by the chair. [Pause] Notice the comfort you feel in your body as the chair is supporting you. [Pause]

Now take a moment and just look around the room, letting your eyes go wherever they want to. [Pause] Notice the things that your eyes are attracted to, notice what's appealing to your eyes. Take your time doing this. [Pause]. As you're looking around the room, choose one thing in particular you are attracted to visually and focus on it. And while you're looking at this, notice how you're feeling in your body. [Pause] Notice where you feel comfortable, more relaxed, or calm. Identify where that's located in your body and how that calm or relaxation is showing up. Maybe there's a warmth in your chest, or your shoulders relaxed a little, maybe it caused you to smile. [Pause]

Now notice if there's anything else in your body in terms of relaxation. [Pause] Chances are you're feeling a little more relaxed than when we started, that's the hope.

Again, take a moment and look around the room, slowly noticing your environment, finding things that are attractive to your eyes. [Pause] Maybe you linger on an object that's pleasing and allow your body to naturally relax even further. [Pause] And whenever you're ready, you can re-focus on me.

Boats on a River (Mindful Observation – Internal)

This exercise involves us closing our eyes, imaging a river, and placing our thoughts, feelings, sensations and images onto boats in the river. Are you willing to try? We can stop at any time if you become uncomfortable, just let me know.

I invite you to sit in a comfortable yet upright position in your chair, with your feet flat on the floor, your arms and legs uncrossed, and your hands resting in your lap.

Let your eyes gently close, or if that's uncomfortable, you can stare at a point on the floor in front of you. [Pause] Take a couple of gentle breaths in [pause], and out. [Pause.] Notice the sound and feel of your own breath as you breathe in [pause], and out. [Pause]

Now, I'd like you to imagine that you are standing by the edge of a gently flowing river watching the water flow. [Pause.] Imagine feeling the ground beneath you, the sounds of the water flowing past, and the way the river looks as you watch it. [Pause] Imagine that there are small wooden boats of all different colors floating past on the river and you are just watching these boats float by. This is all you need to do for the time being. [Pause]

Start to become aware of your thoughts, feelings, or sensations. [Pause.] Each time you notice a thought, feeling, or sensation, imagine a nearby boat floats in front of you as you place the thought, feeling or sensation on the boat and let it float down the river. [Pause] Do this regardless of whether the thoughts, feelings, or sensations are positive or negative, pleasurable or painful. [Pause.] Even if they are the most wonderful thoughts, place them on a boat and let them float by. [Pause] If your thoughts stop, just watch the river. Sooner or later your thoughts will likely start up again. [Pause]

Allow the river to flow at its own rate. [Pause.] Notice any urges to speed up or slow down the river and place these thoughts on a boat as well. Let the river flow how it will. [Pause] If you have thoughts, feelings, or sensations about doing this exercise, place these on boats as well. [Pause] Maybe you have the thought, "this is boring" or "this exercise won't help." Place that thought on the boat and allow it to naturally float down the river.

If a boat gets stuck or won't go away, let it hang around. For a little while, all you are doing is observing this experience; there is no need to force the boat down the river. [Pause] If you find yourself getting caught up with a thought or feeling, such as boredom or impatience, simply acknowledge it. Say to yourself, "Here's a feeling of boredom," or "Here's a feeling of impatience." Then place those words on a boat and let them float on by. [Pause] You are just observing each experience and placing it on a boat on the river.

It is normal and natural to lose track of this exercise, and it will keep happening. When you notice yourself losing track and no longer seeing the river, just bring yourself back to the image of watching the boats on the river. [Pause] Notice the river, and place any thoughts, feelings, or sensations on the boats and let them gently float down the river. [Pause]

Finally [say their name], allow the image of the river to dissolve, and slowly bring your attention back to sitting in the chair, in this room in [name the location, like Women's Centre]. [Pause.] [Say their name], gently open your eyes and notice what you can see here in this room with me, [say your name]. Notice what you can hear. Push your feet into the floor and have a stretch. Notice yourself stretching. Welcome back!

Mindful Eating (Immersion)[32]

This mindfulness activity incorporates something we do every day: eat. In this activity, I will ask you to eat either a piece of fruit or a piece of chocolate in a way you're likely not used to. I will give you instructions to hold, smell, bite, chew and shallow, and at each stage I'll ask you to notice what sensations and feelings you're having. Are you willing to try? We can stop at any time if you become uncomfortable, just let me know.

[Put a small piece of fruit and a small piece of chocolate on a plate or napkin in front of the person.]

Throughout this exercise, many thoughts and feeling might arise. Let them come and go, and keep your attention on the exercise. If you realized your attention has gone to something else, label what distracted you as a thought or a feeling, then bring your attention back to the food.

Close your eyes and take a few deep breathes. [Pause] Open your eyes and look at what's on the plate. Notice what thoughts come up. Notice if you feel more drawn to the fruit or the chocolate. Notice if any memories come up of times when you had one or the other. [Pause] Notice if you have any concerns about the fruit or chocolate.

[32] Any food or drink (e.g., tea) can be used for this activity, and you do not need to give two choices as the script indicates. Adapt the script according to your available resources and the survivor's food/drink preference.

Take whichever piece you are most drawn to in your hands. First look at it as if you are a curious scientist who has never seen this food before. Notice its shape, color, the different shades of color, the part where light hits the surface, the edges of the food. [Pause]

Notice the weight of the food in your hand. Feel it against your fingers, its texture, its temperature

Raise it to your nose and smell the food. Notice the aroma. [Pause]

Without biting into it, raise it to your mouth and pause. Bring your attention to what's happening inside your mouth. Notice the saliva around your tongue and the urge you have to bite into it.

Now put the food in your mouth but don't chew or swallow. How does it feel? What's happening in your mouth? What's the taste or texture? Roll it around with your tongue slowly. [Pause]

Begin chewing very slowly without swallowing. Notice your upper and lower teeth touching each other as you chew. Feel the food fall into your tongue. Notice the taste and texture. Become aware of the movement of your jaw and the sound the chewing makes, how your tongue shapes the food.

Notice your urge to swallow. And as you swallow now, notice the movement in your throat and the sound it makes.

After you've swallowed, pause and notice the way the taste gradually disappears from your tongue. Notice your urge to eat the other half. [Pause] And now you can eat the other half in the same way on your own.

Mindful Walking (Immersion)

We will spend a few minutes walking and noticing how we walk and as we walk, I'll direct you to notice certain parts of the body as they move. Are you willing to try? We can stop at any time if you become uncomfortable, please let me know.

Start standing, noticing weight of the body on your feet, slowly rock side to side, front to back, feeling the weight on different parts of your feet and all the bones and muscles that support you.

Begin walking at a fairly slow but normal pace and walk in your normal way. We are not going to change the way that we walk. We are just going to be more aware of it.

First, keep your attention to the bottom of your feet. Notice your foot as the heel first makes contact with the floor, then your foot rolls forward onto the ball of your feet, then lifts up and travels through the air. Be aware of all the different sensations in your feet, the space between your toes, the feeling inside your shoes, the fabric of your socks.

Let your ankle joints be relaxed. Become aware of your lower legs and any sensations there. The temperature on your skin, clothing touching your legs. Be aware of the muscles in your lower legs that are working to help you walk. Notice your knees and any sensations there.

Then notice your thighs, be aware of the skin, the temperature and the contact with your clothing. Notice the muscles in the front of thigh working there as your move. Notice the muscles in the back of the thigh.

Notice your hips and the muscles around your hips. See if you can relax them. Even when you think you relaxed them, relax them more. Notice how that changes how you walk. Notice the rhythm and gait of your walk. Notice your spine. It is constantly swaying side to side as you walk

Without trying to change it, notice your breathing as your walk and how it makes your chest and stomach move. Notice how your shoulders move to the rhythm of your walking. Let your shoulders be relaxed and your arms hang by your sides swinging naturally. Notice the motion of your arms as they swing through the air, feeling the air on the hands, forearms, and upper arms.

Become aware of your neck and the muscles that support your head. Relax your jaw muscles. Relax the muscles around your eyes.

Notice if anything in the body feels pleasant or unpleasant. Don't try to change it, just notice.

Notice any emotions that are coming up. Are you bored? Are your happy? Are you irritated? Just notice any emotions without trying to change them. Giving those emotions permission to be present because they already are present.

Notice any thoughts you're having. Is your mind busy with lots of thoughts? Or is it calm? Are you thinking about things other than this exercise? Maybe thinking about what you're doing to do after the training? Or thinking about this walking exercise. Just notice those thoughts without judging them, without trying to pushing them away. Don't ignore any thoughts, notice them.

In a few seconds, I will ask you to stop walking and you can stop walking naturally, not suddenly freezing in place. Do that now, come to a natural stop. And just become aware of your body standing. Notice what it's like to no longer be in motion. Maybe it's a little harder to keep yourself upright. Again, feel the weight on your feet. Simply standing.

Body Scan (Mindful Observation)[33]

We will spend a few minutes noticing 3 different sensations of your choice in your body. I will lead you through this, starting from finding a sensation in the feet and noticing it for a few moments, then doing the same in the legs, stomach and back, and lastly in the upper body. Are you willing to try? We can stop at any time if you become uncomfortable, just let me know.

Close your eyes or look down at the floor, whatever you are most comfortable with. Bring your attention to your feet and find any sensation that stands out from the rest. Maybe it's a tingling, itch, pain, warmth, or pressure. Or maybe it's the sensation of the socks or shoes on your skin. Pick one sensation in your feet and take a moment to notice it. Notice where you feel the sensation, notice where it begins and ends, and notice what the sensation is like. [Pause]

Feel free to change your posture if you need to, get comfortable. Now move your attention up your legs and notice any sensation there. Keep scanning your body for sensations up through the core of your body: up until the stomach and lower back. Are there any sensations you notice there? If you have several sensations that stand out, just pick one. Let the other sensations know that they are noticed but you're going to pay attention to only one right now. Focus your attention on that one sensation. Where exactly do you feel what you feel? What does it feel like? Maybe it's a sensation on the skin or deeper within. [Pause]

Then move up into the upper part of your body and into your head, arms and hands. Do you notice any sensations in those places? If you notice more than one, acknowledge them and focus on one. And see if you can notice that one sensation with curiosity. Don't dismiss it. Treat it like you're a scientist that is very interested in it. Notice where the sensation begins and ends. What is it like? [Pause]

Finally, let's just take a breath and feel what it feels like to breathe in and breathe out, and whenever you are ready, open our eyes or look up. You're here in the [location] with me [your name].

[33] Body scans can be difficult for many survivors and may cause distress. Yet, it can be a very healing practice. Often, it can be helpful to start with mindful movement (e.g., walking). This will help survivors build their awareness and comfort with internal body sensations until they feel ready to do a formal body scan more easily. Start with a brief body scan and over time you can lengthen it

APPENDIX F: RELAXATION AND GROUNDING TECHNIQUES

Relaxation Techniques

Every time you feel fear or worry, your brain believes you are in danger, and stress hormones are released into your body. If you worry or feel fear every day your stress hormones can have a negative effect on you. They can increase your blood pressure; make you forgetful or make it hard to concentrate; and increase your blood pressure.

Relaxing the body and mind helps you to be healthy, to feel more in control and able to function. The relaxation techniques below can be used at any time to help you to manage fear or worry.

This sheet includes many different relaxation techniques caseworkers and survivors can try. After doing a relaxation or grounding exercise, debrief with the survivor by asking questions such as:

- How do you feel and how does your body feel?
- Can you share a little about where you travelled to in the visualization?
- How and when can you use this relaxation in everyday life?

EXERCISES:

Breathing Exercise
Have the survivor sit or lay comfortably.

Request the person to take 10 slow, deep breaths from their belly. They can place their hand on their belly to feel it expand and contract (like a balloon being blown up or letting the air out of it). If they cannot breathe from their belly easily, then they can breathe from their chest. Have them place their hand on their belly/chest to feel it expand and contract.

1. Breathe in while counting 1-2-3-4-5.
2. Hold their breath for 1-2-3-4-5.
3. Breathe out slowly 1-2-3-4-5.

If the above breathing exercises do not help the survivor relax, have them try to breathe in while imagining a safe place or a favourite smell, or a colour or sound, and when they breathe out slowly, they can say "relax" silently or breathe out negative thoughts saying, "no more worry," "no more fear," etc.

Imagination-Visualisation Exercise
Instruct everyone to get comfortable in their seat. Close their eyes or keep their eyes open but soften their gaze and focus on one location in the room that is unmoving (e.g., the wall, the floor, etc.). Explain to participants that sometimes when people have experienced trauma in their lives that they might not feel safe to close their eyes. Play calm relaxing music and dim/turn off the lights.

Read the following text:
Become aware of your breathing … allow your breathing to gradually slow down … breathe in and breathe out … breathe in and breathe out… Now breathe deeply and imagine that you are leaving the building to travel to another place, a place of calm.

Imagine what you see as you leave the building and begin your journey… Decide in your imagination: How do you choose to travel? Are you walking, taking a bus, flying? Is your way through a town…? or are you leaving town passing through the countryside…

Notice what is under your feet as you make this journey… What kind of day is it? Is it warm, cool, windy or rainy? Now, up ahead, you see your destination, a place of calmness… Imagine what is it like when you approach this place?

You have arrived at last. Imagine what is your place of calmness like? Is it a building? Is it outdoors? Look at this place. What do you see around you? Beneath you? Above you? When you stretch out your hands, what do you touch? Make yourself comfortable here. Imagine if you are sitting, standing or lying down? Do you hear any sounds in this place of calmness? Birds, ocean waves, music…or is it quiet? What does it smell like in this place of calmness? Are you alone in this place, or are there other people with you? Who? If you want to invite someone to join you, do it now. Take another minute to enjoy this place where you can feel very calm. Now the time has come for you to leave this place, but remember, it will always be there, you can always come back to it if you want to. So, take one last look around and now start to leave. Go back the way you came, retracing all the parts of your journey. Walk, ride or fly, back across the countryside, or through the town, until you find your way back to this room and to your place in this room, and when you are ready, slowly open your eyes.

Paired Muscle Relaxation (PMR)[34]
When you are starting, practice in a quiet place to reduce distractions, and make sure that you have enough time. As you improve with practice, you will want to practice in many different kinds of places, so that you can relax effectively when you most need to.

Remember that effectiveness improves with practice. If judgments arise, observe them, let them go, and return to your practice. If you become anxious, try focusing on breathing in to the count of 5 and out to the count of 7 (or the counts you have already determined for paced breathing), breathing all the while into your belly until you can return to relaxation exercises.

Now that you are ready to begin

- Get your body into a comfortable position in which you can relax. Loosen tight clothing. Lie or sit down, with all body parts uncrossed and no body part supporting any others.
- For each area of the body listed below, gather tension by tightening muscles. Focus on the sensation of tightness in and around that area. Hold the tension as you inhale for 5–6 seconds, then release and breathe out.
- As you release, say in your mind very slowly the word "Relax."
- Observe the changes in sensations as you relax for 10–15 seconds then move on to the next muscle:
  - Hands and wrists: Make fists with both hands, pull fists up on the wrists.
  - Lower and upper arms: Make fists, bend both arms up to touch shoulders.
  - Shoulders: Pull both shoulders up to your ears.
  - Forehead: Pull eyebrows close together, wrinkling forehead.
  - Eyes: Shut eyes tightly.
  - Nose and upper cheeks: Scrunch up nose; bring upper lips and cheeks up toward eyes.
  - Lips and lower face: Press lips together; bring edges of lips toward ears.
  - Tongue and mouth: Teeth together; tongue pushing on upper mouth.
  - Neck: Push head back into chair, floor, or bed, or push chin down to chest.
  - Chest: Take deep breath and hold it.
  - Back: Arch back, bringing shoulder blades together.
  - Stomach: Hold stomach in tightly.
  - Buttocks: Squeeze buttocks together.
  - Upper legs and thighs: Legs out; tense thighs.
  - Calves: Legs out; point toes down.
  - Ankles: Legs out; point toes together, heels out, toes curled under.

Once you are good at this, practice tensing your entire body at once. When you tense your entire body, you are like a robot – stiff, nothing moving. When you relax your entire body, you are like a rag doll – all muscles drooping down.

[34] From Linehan, M. (2015). DBT skills training handouts and worksheets, 2nd Ed.

Once you can relax all your muscles, practice three or four times a day until you can routinely relax your entire body rapidly. By practicing pairing exhaling and the word "Relax" with relaxing your muscles, you will eventually be able to relax just by letting go and saying the word "Relax."

Centring Exercise
Used when we need to feel more connected to ourselves when feeling distressed or thrown off balance. Your physical centre of gravity is a few inches below the belly button, so self-touch can really help bring you back to yourself.

- Place one hand on your lower belly and one on your heart. Or try both on your heart or both on your lower belly. Notice which feels best for you.
- Close your eyes for a moment if you're comfortable
- Notice the temperature under your hands, and notice line of energy between the hands at core of your body that helps you elongate
- From the centre of your body explore the width of your body, to the right side body, the left side body, front body and back. Notice your right to take up space.
- Stay here for as long as you need. Open your eyes. Remind yourself that you are not alone in feeling thrown off balance at times.

Body Hold Exercise
Used to reduce high activation in the body.

- Sit on a chair with your ankles cross
- Place hands under opposite armpits
- Drop chin to chest and slow down your breathing. Keep your eyes open or closed, whichever feels best.
- Notice how in this position you can keep out what you don't want in, keep in what you don't want out.
- Stay here for at least 30 seconds until you notice a shift (e.g., yawn, swallow, sigh, deep breath, shoulders drop, any relaxing or expansion in the body).

Willing Hands[35]:
This exercise can be done in three different ways:

- Standing: Drop your arms down from your shoulders; keep them straight or bent slightly at the elbows. With hands unclenched, turn your hands outward, with thumbs out to your sides, palms up, and fingers relaxed.
- Sitting: Place your hands on your lap or your thighs. With hands unclenched, turn your hands outward, with palms up and fingers relaxed.
- Lying down: Arms by your side, hands unclenched, turn your palms up with fingers relaxed

Containment Exercise:
Wrap yourself in a blanket, towel or scarf. Pull it tight so it feels good to you and feel as though you are being swaddled like a baby and very snug. Rock back and forth or side to side, if it feels good. Stay here for as long as you need. Caseworkers can do this with a survivor during a meeting, too!

Grounding Techniques

Grounding techniques are ways to help us to find inner calm through 'anchoring' or connecting us to the present and to reality. When survivors are overwhelmed, they may disconnect from reality in an attempt to gain control over their feelings and stay safe. GBV survivors and caseworkers can both use grounding techniques when feeling emotionally overwhelmed, when having flashbacks or intrusive images, or when triggered. These are great to use when someone is outside of their Window of Tolerance, either over- or under-activated. Grounding is not the same as relaxation techniques. Grounding is much more active, focuses on strategies to bring a survivor to the present moment. It is believed to be more effective for trauma experiences than relaxation training. Grounding techniques can be categorised into three types: mental, physical and soothing.

[35] From Linehan, M. (2015). DBT skills training handouts and worksheets, 2nd Ed.

EXERCISES:

Mental Grounding

Five Senses Exercise

- Name 5 things you can see.
- Name 4 things you can touch (e.g., textures, objects, the chair, clothes)
- Name 3 things you can hear
- Name 2 things you can smell
- Name 1 thing you can taste

Other mental grounding techniques encourage survivors to:

- **Describe their environment in detail** using all their senses. For example, *"The walls are white; there are 2 cushions, there are grey shoes..."* Describe objects, sounds, textures, colours, smells, shapes, numbers and temperature. They can do this anywhere. For example, when walking down the street: *"I'm walking on the street. I will see the corner shop soon. Those are cars. This is a bench. That shirt is blue. The sky is blue."*
- **Play a "categories" game** with themselves. They can try to think of "words that begin with "A," "countries," "favourite songs, "or "names of birds."
- **Describe an everyday activity in detail.** For example, they can describe a meal that they cook (e.g., *"First, I peel the potatoes and cut them into quarters, then I boil the water, then I cut the onions..."*).
- **Visualize images that create boundaries.** (e.g., change the TV/radio channel to a better show or think of a wall as a buffer between you and your pain).
- **Say a safety statement:** *"My name is _____; I am safe right now. I am in the present, not in the past. I am located in _____ the date is _____."*
- **Read something, saying each word to themselves.** Or read each letter backwards so that they can focus on the letters and not on the meaning of words.
- **Use humour.** Thinking of something funny to jolt themselves out of their mood.
- **Count to 10 or say the alphabet** very slowly.
- **Repeat a favourite saying** to themselves over and over (e.g., the Serenity Prayer).

Physical Grounding

Standing Exercise

- Stand barefoot, feet shoulder length apart pointing forward. Relax and soften your feet
- Slowly rock side to side, front to back, feeling the weight on different parts of your feet and all the bones and muscles and tendons that are supporting you.
- Bend your knees slightly and then push against the ground with the soles of your feet to straighten your legs. Do this a few times. Then stand straight again.
- Shift weight from leg to leg and then find balance between them. Stand still and sense or imagine the pull of gravity holding you to the ground.
- Take four deep breaths and imagine with each inhale that you are drawing breath up through soles of feet and into the rest of your body and on the exhale, you're sending that breath down through pelvis, legs and feet and back into the ground to wrap around the roots and rocks deep in the earth.

Sitting Exercise[36]

- Sit on your chair. Feel your feet touching the ground. Stamp your left foot into the ground, then your right. Do it slowly: left, right, left. Do this several times.
- Feel your thighs and buttocks in contact with the seat of your chair (5 seconds). Notice if your legs and buttocks now feel more present or less present than when you started focusing on your legs.
- Now move your focus to your spine. Feel your spine as your midline. Slowly lengthen your spine and notice if it affects your breath (10 seconds).
- Move your focus toward your hands and arms. Put your hands together. Do it in a way that feels comfortable for you. Push your hands together and feel your strength and temperature. Release and pause, then push your hands together again. Release and rest your arms.
- Now move your focus to your eyes. Look around the room. Find something that tells you that you are here. Remind yourself that you are here, now, and that you are safe. Notice how this exercise affects your breathing, your presence, your mood, and your strength.

Partner Hand Hold Exercise

Stand across from your partner. Place one hand on their heart. Have them place one hand on your heart. Make eye contact if comfortable. Match each other's breathing. Feel the sensation of the hand on the chest.

Partner Leaning Exercise

Stand side by side with your partner, the side of your arm and leg touching the side of their arm and leg. Lean gently against each other. Match each other's breathing. Feel the sensation of the contact between your bodies

Pushing Exercise

- Start by slowly moving your fingers and toes. Then add your wrists and ankles, maybe slowly scan the room with your eyes as you start to move more muscles.
- Stand up and approach a wall. Place both hands on the wall and start pushing. Don't simply rest or lean on the wall. Instead, activate your legs in a strong stance in which both arms, legs and your core are working. Ground your heels and firm your arms.
- Experiment with pushing in different ways, like pushing your side body against the wall or pushing your back or buttocks against the wall.
- Notice your muscles, your breath, and your energy while doing this

Head Hold

With one hand, hold back of skull at the top of the neck. Place the palm of the other hand on your forehead. Close eyes or keep them open. Stay here for as long as is comfortable and/or until you notice a shift.

Straightening the Back Exercise

We carry ourselves with our spines. We can react to danger by collapsing the spine, and this affects our posture. By changing our posture, we give ourselves new strength and can more easily contain and manage our experiences. We give ourselves a stronger back and reconnect with our bodily resources.

- Collapse your chest and back. Notice how it feels. Pause. How does it affect your breathing? Pause again. Be aware of your feelings and mood. Pause. Be aware of your body. Pause. Be aware of your thoughts. Now say: "I am happy!" Say again: "I am happy!" Do you feel happy? Does it feel right to say you are happy?
- Now slowly lengthen your spine until you are comfortable. Adjust and experiment until your spine feels aligned and naturally lengthened. Be aware how you feel now. Be aware of your breathing. Pause for five seconds. Be aware of your feelings and mood. Pause. Be aware of your body. Pause. Be aware of your thoughts. Pause. Now say: "I am sad!" Say several times. "I am sad!" Do you feel sad? Does it feel right to say that you are sad?

Self-Hug

- Place your right-hand palm on your left side body, a few inches below the armpit. Place your left-hand palm on your right upper arm.
- Squeeze gently or simply allow your hands to rest where they are.
- Close your eyes or keep them open. Stay here for as long as is comfortable and/or until you notice a shift.

Butterfly Taps

- Put your right-hand palm down on your left shoulder. Put your left-hand palm down on your right shoulder.
- Choose a sentence that will strengthen you. For example: "I'm a good enough helper." Say the sen-

[36] From Jacobson, Edmund. 1974. Progressive Relaxation. Chicago: The University of Chicago Press, Midway Reprint

tence out loud first and pat your right hand on your left shoulder, then your left hand on your right shoulder.
- Alternate the patting. Do ten pats altogether, five on each side, each time repeating your sentences aloud.

Squeeze or Tap Yourself Awake
Use your hand to either squeeze or tap the muscles all over your body – head, face, neck, arms, back, hands, chest, belly, hips, arms, legs, feet. Pay attention to the sensations

Mirror Exercise
Do this either with a partner or alone in front of a mirror. It is a great one to do with children. Have your partner (child) mirror or copy your movements. You can then switch up who plays the mirror and who leads.
- Start with your face by moving your jaw and making different expressions, feeling different parts of jaw and adding sounds (like animal sounds)
- Then work with eyes, making them big and small
- Then ears: pull your ears back or make circles with them
- Then tongue, bringing your tongue out and then let it be soft and let belly be soft with it. Maybe say tongue twister phrases while holding your tongue (e.g., Sally sells sea shells by the sea shore)
- Then mobilise your arms, shoulders and hands. For example, you can dance, flow, make swimming motions, punching. Add in the hips, legs and feet. Add in spontaneous words and sounds, shouting and whispering.
- Be playful and experiment with it!

Humming or Voo-ing Exercise
Choose either to hum, make the sound Voo (pronounced like two but with a v), or another chant you prefer
- Take an easy full breath in and on the exhale hum or make the sound as if it is coming from the belly, like a horn. Let the breath go all the way out naturally, take in a new full breath to fill the belly and chest and repeat the sound or hum. Do it several times
- Go at your own rhythm and focus your attention on the vibrations it causes in your belly.
- Now rest, notice sensations, feelings, thoughts, images, pictures.

Drumming
While this exercise can be effective when used alone, it is great to do with someone else who is calmer and more grounded than you in this moment. You can use their heartbeat to help you 'regulate' or 'tune' your own internal system.
- First find your heartbeat
- Using the table, your lap, a drum, or any other surface, drum at the rhythm of your heart as it is right now (or the rhythm of your partner's heart)
- Then drum a little faster and notice how it feels.
- Then drum even faster and notice again how it feels
- Then drum again at your original heartbeat rate.
- Then drum very slowly and notice how it affects energy levels.
- Experiment and find a speed that feels most comfortable for you and drum there for a while. You can be creative and mix up the rhythm, hum along, or sing.

Horse Lips Exercise
Breathe in deeply. When exhaling at a natural rate, vibrate your lips together like a horse, which makes sound like a motor. Do this several times while noticing the vibrations in your face, chest and stomach. It's OK to laugh!

Other physical grounding techniques encourage survivors to:
- **Run cool water over their hands.**
- **Grab tightly onto their chair as hard as they can.**
- **Touch various objects around them:** a pen, the ground, their feet. Notice textures, colours, materials, weight, temperature. Compare objects they touch: Is one colder? Lighter?
- **Dip their heels into the floor** – literally "grounding" them! Have them notice the tension centred in their heels as they do this. Remind themselves that they are connected to the ground. If they want to remove their shoes so that their feet are on the actual ground, this can help as well (it allows for toe curling and different movement that sometimes shoes restrict).
- **Carry a grounding object in their pocket** – a small object (e.g., a small rock, a ring, or piece of cloth) that they can touch whenever you feel triggered.
- **Jump up and down.**
- **Stretch.** Extend their fingers, arms or legs as far as they can; roll their head around. Stretch any part of the body that needs it.
- **Walk slowly, noticing each footstep**, saying "left," "right" with each step.
- **Eat something.** Describe the flavours in detail to themselves.
- **Focus on their breathing.** Noticing each inhale and exhale. Repeat a pleasant word to themselves on each inhale (for example, a favourite, colour or a soothing word such as "safe" or "easy").

Soothing Grounding

Creating a Safe Space
- Feel and relax your body, your head, your face, your arms, spine, stomach, buttocks, thighs, legs. Choose whether you want to close your eyes or keep them open during this exercise.
- Think of a place in which in the past you were calm and confident and safe. It may be outdoors, at home, or somewhere else. It can be a place to which you have been once or many times, which you saw in a film or heard about, or imagine. You can be there by yourself or with someone you know. It can be private, unknown to others, somewhere that no one can find without your permission. Or you can decide to share it with others.
- This place must suit you and meet your needs. You can constantly recreate or adapt it. It is comfortable and richly equipped for all your wants. Everything you need to be comfortable is present. It is somewhere that fits you. It shuts out every stimulus that might be overwhelming.
- Imagine this place. Imagine you are there. Take time to absorb it in detail: its colours, shapes, smells and sound. Imagine sunshine, feel the wind and the temperature. Notice how it feels to stand, sit or lie there, how your skin and your body feel in contact with it.
- How does your body feel when everyone is safe, and everything is fine? In your safe place you can see, hear, smell and feel exactly what you need to feel safe. Perhaps you take off your shoes and feel what it is like to walk barefoot in the grass or in the sand.
- You can go to this place whenever you want and as often as you want. Just thinking about it will cause you to feel calmer and more confident.
- Remain there for five more seconds. Then prepare to return to this room, open your eyes, stretch yourself, do what you need to return to the present.

Spiral Staircase Visualisation
- You are walking down a spiral staircase. Imagine that within you is a spiral staircase, winding down to your very centre. Starting at the top walk very slowly down the staircase, going deeper and deeper within yourself. Notice the sensations.
- Rest by sitting on a step or turn on the lights on the way down if you wish. Do not force yourself further than you want to go. Notice the quiet.
- As you reach the centre of yourself, settle your attention there – perhaps on your gut or your abdomen

Other soothing grounding techniques encourage survivors to:
- **Say kind statements**, as if they were talking to a small child. For example, "I am a powerful person going through a hard time. I'll get through this." Avoid being generic. Ideally the kind statement

should resonate with some inspiring experience the survivor has had, particularly using 'I' statements.

- **Think of favourites.** Think of their favourite colour, animal, time of day or memory.
- **Picture people they care about** (if this is soothing). They could imagine or look at pictures of loved ones.
- **Remember the words to an inspiring song, quotation or poem** that makes them feel better.
- **Say a coping statement** (that is based in reality). "I can handle this," "This feeling will pass."
- **Plan out a safe treat for themselves**, such as, a piece of candy, a conversation with a good friend or a walk in their favourite area).
- **Think of things they are looking forward to in the next week**. Perhaps time with a friend or a cultural activity.

APPENDIX G: DECISIONAL BALANCE (MOTIVATION)

Instructions:

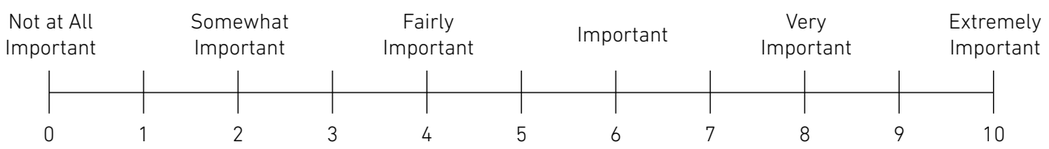
1. Write or draw the change you want to make on the line next to: "The change I am considering is"
2. Then fill in the boxes:
   a. In the top left box, write or draw all of the benefits of making the change you just wrote in Step 1. Include everything you can think of, big or small.
   b. In the top right box, write or draw down all of the downsides of making this change and what it will cost you.
   c. In the bottom left box, write or draw all of the benefits of not changing. That is, the benefits of doing what you are doing now, staying the same.
   d. In the bottom right box, write or draw the costs of not changing, the consequences of staying the same or continuing what you are doing now.
3. After you finish, look at the paper and all you wrote. Ask yourself:
   a. What do you feel when reading it? What thoughts come into your head?
   b. What, if anything, have you realized from this that you didn't realize before?
   c. What do your responses tell you about what you value and what is important in your life?

The change I am considering is: _____

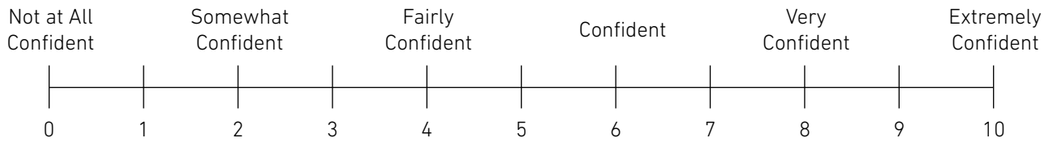
	BENEFITS	COSTS/CONSEQUENCES
MAKING A CHANGE		
NOT CHANGING		

APPENDIX H: THE RULER (MOTIVATION)

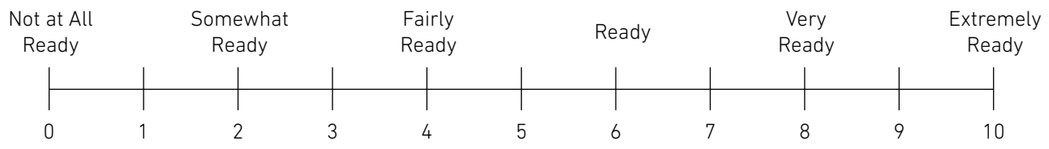
1. How **important** is it that you make this change?



2. If you decided to make this change, how **confident** are you that you could actually do it?



3. How **ready** are you to make this change?



APPENDIX I: BEHAVIOURAL ACTIVATION CALENDAR

The Behavioural Activation Calendar helps the caseworker and survivor create a schedule of activities that will lead the survivor to having more positive experiences in their day. It is important to start small, including just one or two easy activities in the beginning (i.e. everyday chores and other activities that bring pleasure). The caseworker can gradually add activities until the survivor has a full and active life. It is important to not create stress for the survivor as having more activities than they can cope with will make matters worse. Below table sourced from PM+ World Health Organisation (2016).

Time	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Early morning 7am to 10am							
Mid-morning 10am to 12noon							
Lunchtime 12noon to 2pm							
Afternoon 2pm to 5pm							
Evening 5pm to 8pm							
Late evening 8pm to 11pm							

Behavioural Activation Calendar

APPENDIX J: CHALLENGING THOUGHTS (COGNITIVE RESTRUCTURING)

Evidence Questions:

- What is the evidence that this thought is true?
- Do I know for certain that…?
- Am I 100% sure that this thought is true?
- What is the evidence that this thought may not be true?
- What evidence do I have that the opposite is true?
- Do I have a crystal ball? How can I be certain that this will happen?
- Am I blaming myself for something that is not my fault?
- Am I expecting myself to be perfect?
- Have I confused a thought with a fact?

Alternatives Questions:

- Is there an alternative explanation for this situation? Is there another point of view?
- Does _____ have to lead to or equal _____? What else could it mean?
- How much do I believe this thought?
- What would I tell _____ (friend or family member) if they were in this same situation?
- What would someone I trust tell me about this situation?
- How would I have viewed this if I were not already feeling overwhelmed/anxious/panicked?

Implications Questions:

- What is the worst that could happen if this thought were true?
- What would have to occur in order for the worst to certainly happen?
- What is the realistic probability (0-100%) of the worst happening?
- Am I confusing "possibility" with certainty?" It may be possible, but is it likely?
- What is the best that could happen?
- What is the most realistic (likely) outcome?
- Could I live through it? How could I cope?
- What is the effect of believing the automatic thought?
- What will happen if I choose not to believe this?
- What could be the effect of challenging my thoughts?
- What should I do now? (problem solving)
- Is focusing on this helping me? Will I feel differently if I focused on something else?

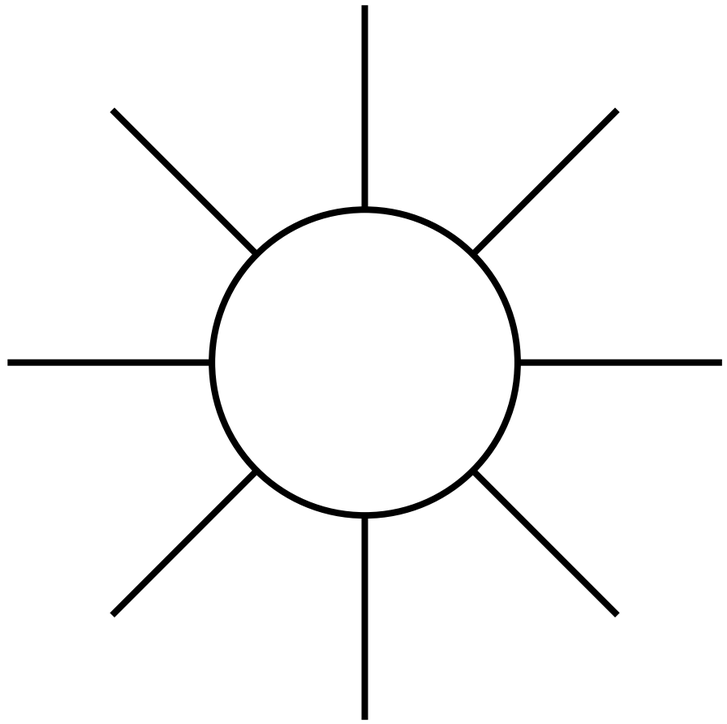
APPENDIX K: SOCIAL CONNECTIONS MAP

Adapted from: Berkowitz, S. et al. (2010) *Skills for Psychological Recovery: Field Operations Guide*. National Center for PTSD and National Child Traumatic Stress Network. Available on: www.nctsn.org and www.ptsd.va.gov.

Having healthy connections with family, friends, and others is very helpful for people recovering after trauma. Yet people often have upsetting emotional and physical reactions that may affect their relationships with family members, friends, and others close to them. Trauma may have physically separated you from one another, making it hard to communicate and creating lots of problems that take up your time and energy. You can take simple, concrete steps to rebuild your social connections and reach out to the people in your life whom you may not have thought of as supports.

1. Develop a Social Connections Map

Write your name in the centre of the circle, and then write in the names of people, pets, professionals, or organizations that are part of your social network. Add more lines as needed.



2. Review Social Connections Map

PART A: Different people and relationships provide different types of support. Take a look at your Social Connections Map to help answer the following questions.

Who are your most important connections right now?	
With whom can you share your experiences or feelings?	
From whom can you get advice to help with your recovery?	
Whom do you want to spend time with socially in the next couple of weeks?	
Who might be able to help you with practical tasks (errands, paperwork, homework)?	
Who might need your help or support right now?	

PART B: Write down **who or what is missing or needs to be changed** in your network. To help you decide, ask yourself: Are there types of support missing? Are there loved ones or friends with whom you wish to reconnect? Whom do you want to spend more or less time with? Are there some relationships you want to improve? Do you want to help others, but aren't sure how to go about doing it? Do you want to have more social activities? Do you want to do more for others by joining a community group?

_____

_____

_____

3. Make a Social Support Plan

Now come up with a plan for what you are going to do and when you will do it.

_____

_____

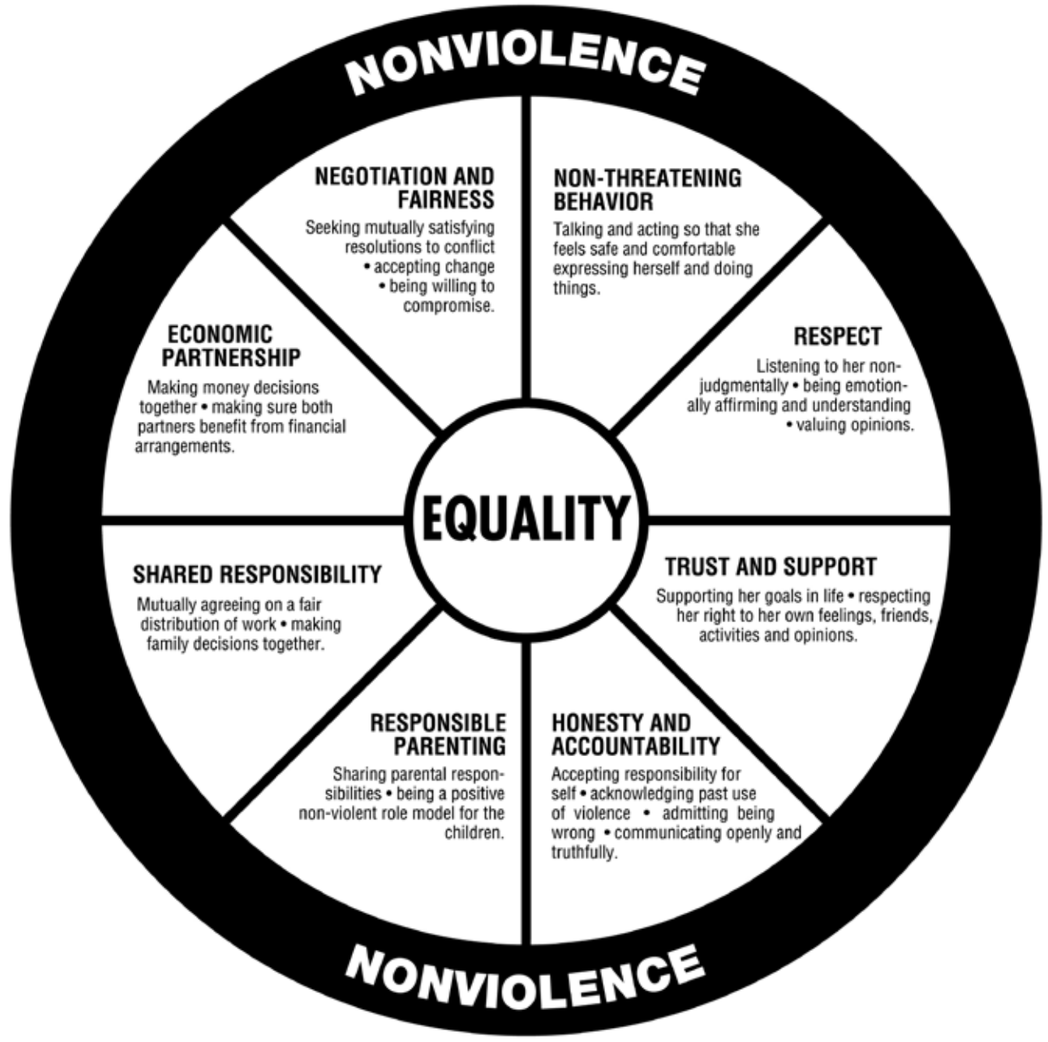
_____

4. Put the plan into action!

APPENDIX L: POWER AND CONTROL WHEEL & EQUALITY WHEEL

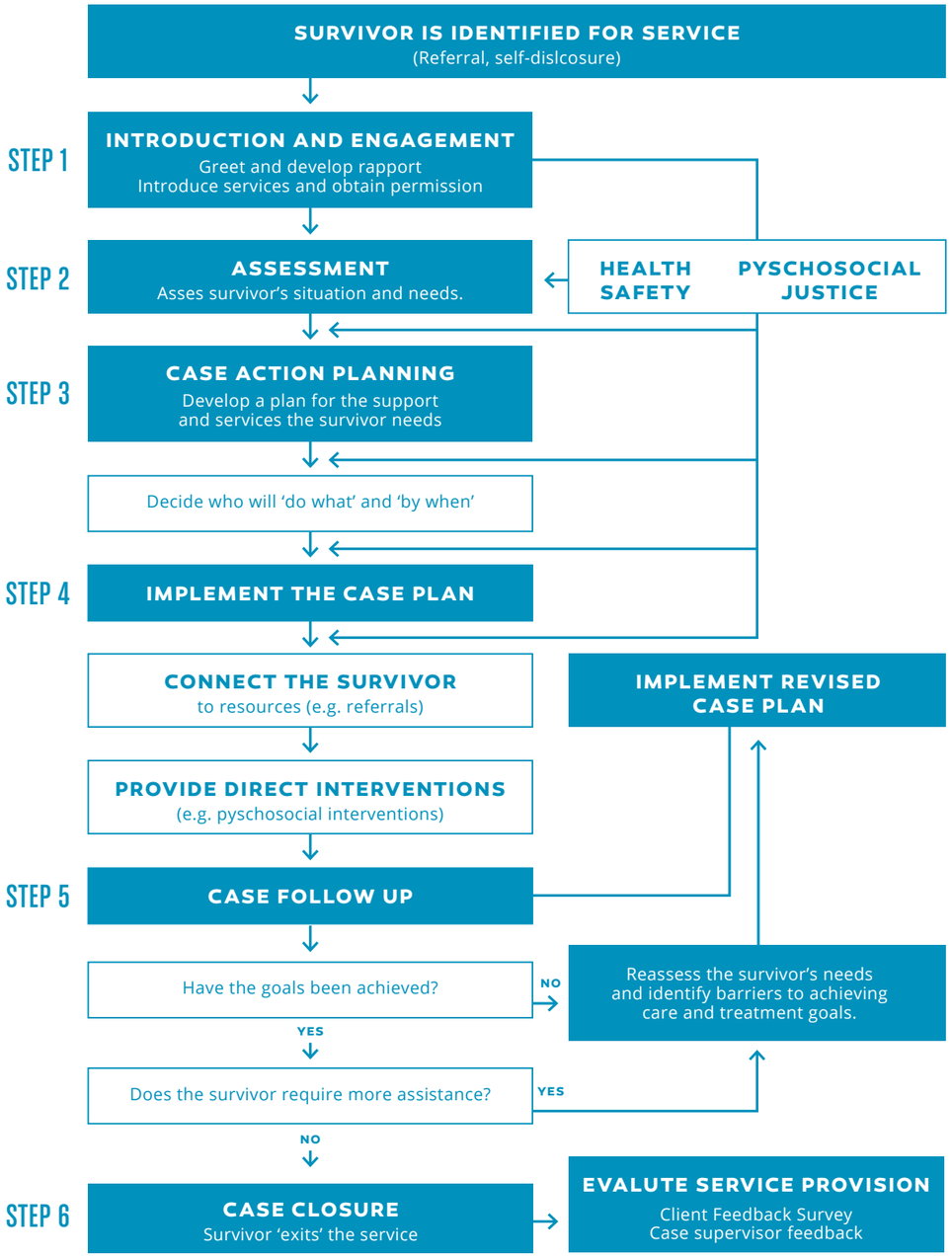
From the Domestic Abuse Intervention Programs: https://www.theduluthmodel.org/wheel-gallery/

For wheels in other languages and for more specific forms of GBV, visit: https://www.theduluthmodel.org/wheel-gallery/ and http://www.ncdsv.org/publications_wheel.html



APPENDIX M: FLOWCHART FOR GBV SERVICES[37]

The following flowchart outlines how a survivor moves through the GBV case management system.



[37] IASC GBV case management guidelines, page 45.

APPENDIX N: PRE- AND POST ASSESSMENT MEASURE FOR THE PSYCHOLOGICAL INTERVENTION

To understand the impact of this therapeutic module on the lives of survivors, there will be pre- and post-assessment of this intervention which will be implemented when 1) a caseworker starts to work on a survivor's psychological concerns using the techniques in this module as well as 2) when the caseworker stops working on the psychologically focused concerns of the survivor. It can also be used during the course of case management as a check-in.

The Psychological Outcome Profiles Questions (PSCYHLOPS) will be used for the pre- and post-assessment tools. PYSCHLOPS was developed by the School of Population Health and Environmental Sciences at King's College London. It is recommended for the problems for Questions 1a and 2a to come from the case management Assessment (e.g., nightmares, stress headaches, fear of going to the market, sadness, strained relationship with a friend, always angry at self, isolating, feeling like a burden, etc.) and be addressed in the Case Action Plan. PSYCHLOPS can be self-administered by the survivor or the caseworker can read it to the survivor and record their responses.

PSYCHLOPS: Before Case Management (before-CM)

Instructions in *italics* are to be read to the client. Other instructions are for the assessor only.

The following is a questionnaire about you and how you are feeling. First, I will ask you some questions about the problems you are currently experiencing. Please think about these problems, no matter how big or small they may be.

Question 1

a. *Choose the problem that troubles you most.* (Please write it in the box below.) **This problem should be addressed in some way by the Case Action Plan.**

b. *How much has it affected you over the last week?* (Please tick one box below.)

Not at all affected	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Severely affected

Question 2

a. *Choose another problem that troubles you.* (Please write it in the box below.) **This problem should be addressed in some way by the Case Action Plan.**

b. *How much has it affected you over the last week?* (Please tick one box below.)

Not at all affected	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Severely affected

Question 3

a. *Choose one thing that is hard to do because of your problem (or problems).* (Please write it in the box below.)

b. *How hard has it been to do this thing over the last week?* (Please tick one box below.)

Not at all hard	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Very hard

Question 4

How have you felt this last week? (Please tick one box below.)

Very good	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Very bad

Client ID	

Case Worker Assessment Form – Before Case Management (before-CM)

To be completed by the Case Worker and attached to the completed questionnaire.

Case Worker ID	

Client ID	

date before-CM PSYCHLOPS completed	

date of first session (unless same as above)	

Scoring PSYCHLOPS

- PSYCHLOPS has been designed as a mental health outcome measure. As such, the before-CM score is compared with subsequent scores (during CM and after-CM). The difference is the 'change score'.
- All of the responses in PSYCHLOPS are scored on a six-point scale ranging from zero to five. The higher the value, the more severely the person is affected.
- Not every question in PSYCHLOPS is used for scoring. Only the questions relating to Problems (Questions 1b and 2b), Functioning (Question 3b) and Wellbeing (Question 4) are scored. Other questions provide useful information but do not contribute to the change score.
- The questions used for scoring are indicated with the symbol: ⌊___⌋ This symbol appears after the scoring boxes. The caseworker may find it helpful to insert the score inside this symbol.
- PSYCHLOPS therefore consists of three domains (Problems, Functioning and Wellbeing) and four questions which are scored.
- The maximum PSYCHLOPS score is 20.
- The maximum score for each question is 5.
- If both Q1 (Problem 1) and Q2 (Problem 2) have been completed, the total score is: Q1b + Q2b + Q3b + Q4.
- If Q1 (Problem 1) has been completed and Q2 (Problem 2) has been omitted, the total score is: (Q1b x 2) + Q3b + Q4. In other words, the score of Q1b (Problem 1) is doubled. This ensures that the maximum PSYCHLOPS score remains 20.
- Other questions provide useful qualitative information but do not contribute to the score.

Total PSYCHLOPS before-CM score: _____

PSYCHLOPS: During and After Case Management (CM)

Instructions in *italics* are to be read to the client. Other instructions are for the assessor only.

The following is a questionnaire about you and how you are feeling. First, I will ask you some questions about the problems you are currently experiencing. Please think about these problems, no matter how big or small they may be.

Question 1

a. *This is the problem you said troubled you the most when we first asked.* **(Case Worker – please write the first problem the client identified in the before-CM PSYCHLOPS in the box below before administering this form.)**

b. *How much has it affected you over the last week?* (Please tick one box below.)

Not at all affected	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Severely affected

___/

Question 2

a. *This is the other problem you said troubled you when we first asked.* **(Case Worker - please write the second problem the client identified in the before-CM PSYCHLOPS in the box below before administering this form.)**

b. *How much has it affected you over the last week?* (Please tick one box below.)

Not at all affected	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Severely affected

___/

Question 3

a. *This is the thing you said was hard to do when we first asked.* (Case Worker – please write the client's answer to this question from the before-CM PSYCHLOPS in the box below before administering this form.)

b. *How hard has it been to do this thing over the last week?* (Please tick one box below.)

Not at all hard	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Very hard

___/

Question 4

How have you felt this last week? (Please tick one box below.)

Very good	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Very bad

___/

Question 5

Compared to when you started case management, how do you feel now? (Please tick one box below.)

Much better	Quite a lot better	A little better	About the same	A little worse	Much worse
☐	☐	☐	☐	☐	☐

Client ID	

Case Worker Assessment Form – After CM or During CM)

To be completed by the Case Worker and attached to the completed questionnaire.

Case Worker ID	

Client ID	

date after-CM (or during-CM) PSYCHLOPS completed	

date of first session (unless same as above)	

Validation question

Now that case management has finished (or is part way through), how would you describe the client overall? (Please tick one box below.)

Much better	Quite a lot better	A little better	About the same	A little worse	Much worse
☐	☐	☐	☐	☐	☐

Scoring PSYCHLOPS

- PSYCHLOPS has been designed as a mental health outcome measure. As such, the before-CM score is compared with subsequent scores (during CM and after-CM). The difference is the 'change score'.
- All of the responses in PSYCHLOPS are scored on a six-point scale ranging from zero to five. The higher the value, the more severely the person is affected.
- Not every question in PSYCHLOPS is used for scoring. Only the questions relating to Problems (Questions 1b and 2b), Functioning (Question 3b) and Wellbeing (Question 4) are scored. Other questions provide useful information but do not contribute to the change score.
- The questions used for scoring are indicated with the symbol: ___/ This symbol appears after the scoring boxes. The caseworker may find it helpful to insert the score inside this symbol.
- PSYCHLOPS therefore consists of three domains (Problems, Functioning and Wellbeing) and four questions which are scored.
- The maximum PSYCHLOPS score is 20.
- The maximum score for each question is 5.
- If both Q1 (Problem 1) and Q2 (Problem 2) have been completed, the total score is: Q1b + Q2b + Q3b + Q4.
- If Q1 (Problem 1) has been completed and Q2 (Problem 2) has been omitted, the total score is: (Q1b x 2) + Q3b + Q4. In other words, the score of Q1b (Problem 1) is doubled. This ensures that the maximum PSYCHLOPS score remains 20.
- Other questions provide useful information but do not contribute to the change score. There are two validation questions: one (Question 5) for the client and one for the caseworker. These are used to assess whether the client's and caseworker's perception of change over the course of case management, matches the client's before- and after-CM PSYCHLOPS scores.

Total PSYCHLOPS after-CM score: _____

APPENDIX O: ADDITIONAL RESOURCES

The following resources helped inform this module and the accompanying training materials. They can also be used to explore specific topics in more detail.

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SHE project, Tanzania, 2016

PART 5. GLOSSARY

Adrenaline: is a hormone your body makes in moments of crisis. It makes the heart beat faster and work harder, increases the flow of blood to the muscles, makes you more alert, and causes other changes to prepare the body to meet an emergency. It is also a chemical messenger in the brain.

Behavioural Activation (BA): is a specific CBT skill. It can be a treatment all by itself or can be used alongside other CBT skills such as cognitive restructuring. This strategy entails getting survivors to be more active and involved in life by scheduling activities that have the potential to give them pleasure and thus improve their mood.

Cognitive Behavioural Therapy (CBT): is a short-term, goal-oriented therapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking and behaviour that are behind a person's difficulties, to change the way the person feels.

Cognitive Processing Therapy (CPT): is short term, CBT, trauma focused treatment model. CPT teaches the person how to evaluate and change the upsetting thoughts that have developed since their traumatic experience. The belief is that by changing thought patterns, associated feelings will change to.

Cognitive Restructuring: is the process in cognitive behavioural therapy of finding and changing unhelpful negative thoughts that can lead to distress.

Countertransference: is a psychological process that occurs when the caseworker transfers their own unresolved thoughts and feelings onto the survivor.

Chronic withdrawal: is longer term withdrawal and involves creating a lifestyle that is isolated from people and activities. Chronic withdrawal is often accompanied by other psychological symptoms and and/or mental health disorders.

De-escalation: techniques are non-physical, psychological and conflict resolution skills used to prevent a potentially dangerous situation from escalating into a physical confrontation or injury.

Dialectical Behavioural Therapy (DBT): is a type of CBT that is skills focused and teaches people healthy coping strategies, how to live in the present, how to regulate emotions, and improve their relationships with others.

Empathy: is attempting to see things from the survivor's point of view and sharing that understanding with the survivor. Empathy can be communicated through verbal and nonverbal communication. Empathy is should not be confused with sympathy. Sympathy is feeling compassion, sorrow, or pity for the hardships that another person encounters.

Gender-based violence (GBV): is an umbrella term for any harmful act perpetrated against a person based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private spaces. Common forms of GBV include sexual violence (rape, attempted rape, unwanted touching, sexual exploitation and sexual harassment), intimate partner violence (also called domestic violence, including physical, emotional, sexual and economic abuse), forced and early marriage and FGM.

Grounding: help GBV survivors to "anchor" or stay in the present. They help reorient a person to the here -and -now reality.

Intimate partner violence: applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is defined as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. This type of violence may also include the denial of resources, opportunities or services.

Mental Status Exam: is a structured assessment of the survivor's behaviour and cognitive functioning. It is the psychological equivalent of a physical exam. It includes descriptions of the patient's appearance and general behaviour, speech and mood and emotions.

Mindfulness: is the practice of being fully aware and engaged with whatever they are doing at that moment, free from distraction or judgment, and aware of thoughts and feelings without getting caught up in them.

Narrative Therapy: is a strengths-based, long term method of therapy that separates the person from their problem. It assists people to change the stories they tell about themselves by encouraging stories of strength, survival and hope.

Problem Management Plus (PM+): Problem Management Plus is a highly accessible, short-term, 30-40-minute session model that can be integrated into other systems (e.g., primary health care). Additionally, PM+ is widely known for reducing levels of generalized distress in GBV survivors.

Protective factors: Also known as resources, include skills, qualities, strengths, abilities, relationships, values and experiences, which give the survivor protection and resilience against difficult psychosocial experiences.

Psychosocial: A term used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to our functioning, such as our thoughts, emotions and behaviour. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work.

Reactive withdrawal: is when someone isolates or pulls back from the world to recover from a painful event, such as, having a fight with a loved one, feeling shameful or experiencing sexual assault. This kind of withdrawal is a reaction to an event and lasts a short period of time before the person re-enters their normal way of living and connecting to the world.

Risk factors: Risk factors for mental health disorders are different personality traits, thoughts, emotions, and attitudes that could make a person more likely to develop a mental health disorder.

Sexual violence: is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes, at least, rape/attempted rape, sexual abuse and sexual exploitation.

Survivor-centred Approach: aims to create a supportive environment in which each survivor's rights are respected and in which the person is treated with dignity and respect. A survivor-centred approach recognizes that every survivor has equal rights: to care and support irrespective of their age and circumstances, to decide who should know about what has happened to them and what should happen next.

Trigger: is also known as a trauma reminder. Something that sets off a memory or flashback, transporting the survivor back to the event of the original trauma and causing the person to experience overwhelming emotions, physical symptoms or thoughts.

Transference: is the act of a survivor putting intense, unresolved feelings and thoughts onto the caseworker.

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