

1

Pre- and post-test:

Supporting survivors of violence: the role of linguistic and cultural mediators

Name:

Place:

Date:

1. "Sexual violence is the fault of the perpetrator": choose only one answer.

- a. Not at all
- b. Sometimes
- c. Usually
- d. Always

2. What are the possible mental or physical consequences of sexual violence? Choose all that apply.

- a. There are never consequences to sexual violence
- b. Depression
- c. Drug or alcohol abuse
- d. Anxiety
- e. Cuts and bruises
- f. Sexually transmitted infections
- g. Falling in love with the rapist

3. What are the root causes of gender-based violence? Choose only one answer.

- a. Poverty
- b. Abuse of power, inequality between men and women and disrespect for human rights
- c. Lack of education
- d. Abuse of power and poverty
- e. War

4. Which of the following are forms of sexual violence against men and boys? Choose all that apply

- a. Being forced to sexually penetrate another person
- b. Forced labour
- c. Exchanging sex for basic goods
- d. Detention in prisons
- e. Beating of the genitals
- f. Being forced to be naked
- g. Being coerced to watch the rape of another person
- h. Forced recruitment into the military

5. What is a reason that a survivor of sexual violence might not seek services? Choose only one answer.

- a. Fear of community gossip
- b. Being unaware of any services
- c. Blaming themselves
- d. Being worried about being disbelieved or shamed by service providers
- e. All of the above

6. What services do survivors of sexual violence and gender-based violence require? Choose only one answer.

- a. Health care
- b. Psychosocial support
- c. Security
- d. Legal aid
- e. All of the above
- f. None of the above

7. True or false: When a man rapes another man or boy, the survivor becomes gay.

- a. True
- b. False

8. True or false: Boys as well as girls can be sexually exploited.

- a. True
- b. False

9. Please choose the correct combination of the GBV Guiding Principles. Choose only one answer.

- a. Respect, inform the police, honesty
- b. Urgent healthcare, psychological support, compassion
- c. Confidentiality, safety, respect and non-discrimination
- d. Confidentiality and advice

10. What is a consequence of breaking confidentiality? Choose only one answer.

- a. It can destroy the trust that the survivor has in you
- b. It can put the survivor's life at risk
- c. It can contribute to gossip
- d. It can prevent the survivor from seeking care
- e. A and D
- f. A, B, C, and D

11. Please read the sentences below. Is this a linguistic and cultural mediator (LCM), an interpreter (Int) or both?

a. Makes a literal translation of spoken material from one language to another language	LCM	Int	Both
b. Provides cultural context clues	LCM	Int	Both
c. Acts as a bridge between cultures	LCM	Int	Both
d. Has a complex role, with their work centred on languages and culture	LCM	Int	Both
e. Remains impartial and neutral in all settings	LCM	Int	Both

12. If I encounter a sexual violence survivor, I feel confident that I can support the survivor emotionally.

- a. Not at all
- b. A little
- c. Somewhat
- d. Fully

13. If I am in contact with a sexual violence survivor, I feel confident that I know how and where to refer him/her for additional support.

- a. Not at all
- b. A little
- c. Somewhat
- d. Fully

14. When preparing to provide linguistic and cultural mediation services during a physical examination of a sexual violence survivor, I should: (choose only one answer)

- a. Talk to the doctor/nurse beforehand to explain my role as a mediator who will support them and the survivor during the consultation
- b. Talk directly to the doctor/nurse and tell them what happened to the survivor to spare him/her embarrassment
- c. Tell the survivor to answer all of the doctor/nurses' questions, even if he/she doesn't want to
- d. Refuse to translate some of the doctor's questions and answer the question on behalf of the survivor

15. What is the correct way to provide linguistic and cultural mediation services? Choose only one answer.

- a. Being prepared to present your diplomas to show you are certified
- b. Helping the survivor to avoid problems by not translating any shameful or illegal parts of their story
- c. Making decisions for the survivor, such as calling the police
- d. Conveying information as accurately as possible, while being faithful to the source and remaining impartial and neutral in any situation

16. Please name the four steps in psychological first aid (PFA). Choose only one answer.

- a. Listen, Call the Police, Hug, and Refer
- b. Prepare, Listen, Refer to Psychologist, and Accompany
- c. Look, Listen, Solve, and Support
- d. Prepare, Look, Listen, and Link
- e. Listen, Support, Confidentiality, and Encourage

17. What should you say if a gender-based violence survivor discloses to you? Choose all that apply.

- a. I am not a psychologist; you should only tell a psychologist this
- b. Is this a good place for us to talk? Is there another place you would prefer to talk?
- c. I'm sorry that this happened to you
- d. Don't tell anyone else about what happened: you should keep it secret
- e. You must go to the police to report this or you will get in trouble
- f. You are very brave for telling me this
- g. I believe you
- h. It was not your fault

18. Name three places where you might be able to get support to help manage stress in your personal life.

- a.
- b.
- c.

19. Name three things that you can do to reduce stress in your job.

- a.
- b.
- c.

20. What should an LCM do if they are feeling frustrated with a difficult case? Choose only one answer.

- a. Talk to their supervisor
- b. Nothing, they have to maintain confidentiality
- c. Talk with their friends and the community to find a solution
- d. Just try to ignore it; this is part of the job

2

Draft agenda: Supporting survivors of violence: the role of linguistic and cultural mediators (LCMs)

Date:

Place:

Facilitators:

Day 1

09:00- 09:30	Module 0, Topic 1: Workshop registration
09:30 – 10:00	Module 0, Topic 2: Workshop introduction
10:00 – 10:30	Module 0, Topic 3: Getting to know each other
10:30 – 11:00	Module 0, Topic 4: Introduction to the agenda and overview of course objectives
11:00 – 11:15	Break
11:15 – 13:00	Module 1, Topic 1.1: Gender-based violence (GBV) core concepts
13:00 – 14:00	Lunch
14:00 – 14:45	Module 1, Topic 1.2: Understanding the dynamics of GBV
14.45 - 15.45	Module 1, Topic 1.3: Understanding sexual violence against men and boys (SVAMB)
15:45 – 16:00	Break
16:00– 17:00	Module 1, Topic 1.4: GBV and SVAMB consequences and a multi-sectoral response

Day 2

09:00 – 09:15	Recap of day 1
09:15 – 10:15	Module 2, Topic 2.1: Self-reflection and values clarification
10:15 – 10:45	Module 2, Topic 2.2: A survivor-centred approach
10:45 – 11:00	Break
11:00 – 11:40	Module 2, Topic 2.2: A survivor-centred approach (continued)
11:40 -12:10	Module 3, Topic 3.1: The roles and responsibilities of linguistic and cultural mediators (LCMs) in supporting survivors
12:10 – 13:00	Module 3, Topic 3.2: The complex role of linguistic and cultural mediators (LCMs)
13:00 – 14:00	Lunch
14:00- 15:00	Module 3, Topic 3.3: Communication in linguistic and cultural mediation
15:00 – 15:15	Break
15:15 – 16:00	Module 3, Topic 3.4: The power of words
16:00 – 16.40	Module 4, Topic 4.1: Linguistic and cultural mediation and supporting survivors: the use of psychological first aid (PFA)

Day 3

09:00 – 09:15	Recap of days 1 and 2
09:15 – 11:00	Module 4, Topic 4.2: Case study
11:00 – 11:15	Break
11:15 – 12:15	Module 4, Topic 4.2: Case study (continued)
12:15 - 12:30	Module 4, Topic 4.3: Recap
12:30 – 13:00	Module 5, Topic 5.1: Understanding stress
13.00- 14.00	Lunch
14.00 – 14.15	Module 5, Topic 5.1: Understanding stress (continued)
14.15 - 15.15	Module 5, Topic 5.2: Self-care to manage stress
15.15 - 15.45	Module 5, Topic 5.3: Ways to manage stress at work: supervision
15.45 - 16.00	Break
16.00 - 17.00	Module 5, Topic 5.4: Workshop closing

3

Human rights: The basics

Human rights are basic rights and freedoms that every person is entitled to, such as freedom from slavery and the right to an education. Human rights are universal – every person has them, regardless of their race, ethnicity sex, gender, religion, political opinion, national or social origin, or other status. Human rights are also inalienable – nobody can take them away. Acts of gender-based violence (GBV) violate several basic human rights that are enshrined in international human rights laws. These include, among others: the right to life, liberty and security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman or degrading treatment or punishment; the right to freedom of opinion and expression; and the right to social security and to personal development.

Human Rights Guarantee: The Constitution of your country

What is the constitution?

It is a contract between the government and all of its citizens.

States have obligations under international law to ensure that their citizens are protected and given certain rights. State actors are not allowed to commit human rights violations against any of their citizens. States must also take effective steps to prevent, investigate and punish any human rights violations by private individuals or groups. States have a duty (also called an obligation) under international human rights law to use prevention activities to stop human rights abuses, and to prohibit and punish human rights violations regardless of where they take place and regardless of the identity of the perpetrator.

In addition, if an individual's right has been violated, the State must ensure that the right violated is restored as far as is possible.

Universal Declaration of Human Rights

Summary

We are born free and equal; we should treat each other with human dignity.

We should not discriminate against any other groups of people.

We all have the right to life, liberty and personal security.

Slavery and servitude are wrong and are not allowed.

Torture, cruelty and degrading treatment or punishment are not allowed.

We all have the same legal rights.

Everyone can go to court if their rights are violated.

No one should be arrested, detained, put in prison or exiled without good reason.

Universal Declaration of Human Rights Summary Cont'd

We all have the right to a fair, independent and public trial.

We are all innocent until proven guilty, and we should not be convicted if our action was not a crime at that time.

We all have the right to privacy, and to keep our honour and reputation.

We all have the right to move around freely in our country and overseas.

We all have the right to asylum (safety in another country) if we are persecuted in our home country.

We all have the right to nationality.

We all have the right to marry who we choose, and men and women have equal rights in marriage and divorce.

We all have the right to own property by ourselves and with others.

We all have the right to think our own thoughts; to choose and follow our religion.

We all have the right to express our own opinions and to get information.

We all have the right to meet with other people and to join organizations.

We all have the right to take part in government, directly or by a secret vote for representatives that we choose, and we all have the right to get public services.

We all have the right to social security, to allow each of us to develop.

We all have the right to work, to equal pay for equal work; to be paid fairly for our work so that we can live; and to form and join trade unions.

We all have the right to rest and leisure, and to have holidays.

We all have the right to an adequate standard of living; mothers and children have a right to special care; children born outside marriage have equal rights.

We all have the right to education; basic education should be free; professional and technical education should be open to everyone according to merit; education should promote understanding, tolerance and friendship between people.

We all have the right to participate in cultural life and to benefit from scientific advances; authors and inventors have a right to copyright protection.

We all have the right to have social and international order where all these rights and freedoms can be enjoyed and experienced by everyone.

We all have a duty and responsibility to respect the rights and freedom of others.

4

Sexual violence against refugee and migrant boys and young men in Europe

The journeys of all refugees and migrants on the move to Europe are marked by high levels of violence, trafficking and exploitation. Children, adolescents and young people are particularly vulnerable, and some are even more vulnerable than others: those travelling alone, those with low levels of education and those undertaking longer journeys. In addition to girls and women, many boys and men are exposed to significant sexual violence on their way to Europe – as well as in their home countries and in Europe itself.

Key Figures¹

- Some 33,200 children arrived in **Greece, Spain, Italy, Malta, Bulgaria** and **Cyprus** between January and December 2019.
- 80 per cent of the unaccompanied and separated children (UASC) arriving in **Italy, Greece, Bulgaria and Malta** in 2019 were aged 15 to 17.
- Nearly two-thirds of the children who arrived in Europe through various Mediterranean routes in 2019 were boys² (63% boys; 38% girls).
- In **Italy**, 95 per cent of the children who arrived in 2019 were boys.
- In **Spain**, 75 per cent of arrivals in 2019 were adult men.
- In **Greece**, 42,500 refugee and migrant children were present at the end of 2019, up from 27,000 at the end of 2018. The majority were boys.
- In **Bulgaria**, 85 per cent of child arrivals in 2019 were boys. Most children came from Afghanistan, Iraq and the Syrian Arab Republic – all conflict-affected countries.

Throughout Europe, thousands of refugee and migrant boys and young men are living in shelters, while others are sleeping rough, and all of them are vulnerable to sexual violence, including sexual exploitation. Governments have still not managed to provide safe and child-friendly accommodation for them in a systematic way that is in line with international standards and good practices (although this varies, depending on the country and the region).

There are reports from Italy, Greece, Serbia, Bulgaria, and Germany of adolescent boys and young men being sexually exploited in the context of selling sex.³ Some are sexually abused and exploited by host communities, employers, landlords, aid workers and other refugees and migrants. Anti-immigrant sentiment has been stirred up by stories of refugee and migrant boys and young men committing rapes and harassing local women, leading to increased violence against them.⁴ This population is both vulnerable to violence and also feared as a potential cause of violence.

1 UNICEF, 'Latest statistics and graphics on refugee and migrant children: latest information on children arriving in Europe', UNICEF Regional Office for Europe and Central Asia, Geneva <www.unicef.org/eca/emergencies/latest-statistics-and-graphics-refugee-and-migrant-children>.

2 Ibid.

3 See, for example: Women's Refugee Commission, "More than One Million Pains": Sexual Violence Against Men and Boys on the Central Mediterranean Route to Italy, New York, NY, 2019 <www.womensrefugeecommission.org/research-resources/more-than-one-million-pains-sexual-violence-against-men-and-boys-on-the-central-mediterranean-route-to-italy> and Freccero, Julie, et al., 'Sexual exploitation of unaccompanied migrant and refugee boys in Greece', PLoS Med 14(11): e1002438. <<https://doi.org/10.1371/journal.pmed.1002438>>.

4 French, David, 'Have Afghan Refugees in Europe Launched a 'Rape Jihad?', National Review, 14 July 2017 <<http://www.nationalreview.com/2017/07/afghan-refugees-rape-jihad-europe/>>; Der Spiegel staff, 'Fact-Check: Is There Truth to Refugee Rape Reports?', Der Spiegel, 17 January 2018 <<http://www.spiegel.de/international/germany/is-there-truth-to-refugee-sex-offense-reports-a-1186734.html>>.

Their exposure to sexual violence and exploitation does not begin in Europe. Many adolescent boys and young men suffer sexual violence in their home countries, and throughout their journey to Europe. For some, it may be the push factor that makes them decide to leave their country of origin in the first place.

Sexual violence and exploitation against men and boys can take many forms. Consider these examples.

Afghanistan:

- Sexual abuse of so-called 'dancing boys' – Bacha Bazi – is still practiced in some areas.
- In 2019, a local NGO reported 165 cases of rape against boys in three schools in Logar province. It was reported that many of the boys were then killed to protect the 'honour' of their families.⁵

Syria:

- Sexual violence against men and boys in detention centres is commonplace. Documented forms of sexual violence include electroshock of the testicles, inserting a hose into the anus and tying the penis with a thin wire.⁶

The Democratic Republic of the Congo (DRC)

- The sexual enslavement of men and boys has been documented in eastern DRC.⁷

The migration route to Europe is also extremely dangerous, and sexual violence may be widespread, particularly in Libya:

- Some male refugees and migrants in Libyan detention centres have been forced to rape other men and women, and some have been forced to watch others being raped, including children.⁸

The violence does not necessarily end once they reach the shores of Europe. A young migrant man from Ghana, living in Rome, said:

- "Sexual violence is not just on the journey, it's not just in Libya. It's here, too. They abuse us here. We wake up without a penny in our pocket and the pain of hunger in our stomach. What can we do? We have to sleep with the white people in order to eat."⁹

How to support male survivors: insights from refugees, migrants and service providers in Italy¹⁰

In 2018, the Women's Refugee Commission undertook research on sexual violence against men and boys traveling along the central Mediterranean migration route through Libya into Italy. Researchers met with refugee and migrant men and boys as well as service providers working with refugee and migrant communities. They shared their thoughts on how best to support men and boys who had suffered sexual violence.

5 Zucchini, David, and Fatima Faizi, '3 Afghan Schools, 165 Accounts of Students Being Raped', New York Times, 25 November 2019 <<http://www.nytimes.com/2019/11/25/world/asia/afghan-schools-rape.html>>.

6 UNHCR, "We Keep It in Our Heart" – Sexual Violence Against Men and Boys in the Syria Crisis, UN High Commissioner for Refugees, Geneva, 2017 <www.refworld.org/docid/5a128e814.html>.

7 Johnson, Kirsten et al., 'Association of Sexual Violence and Human Rights Violations With Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo', Jama Network <<https://jamanetwork.com/journals/jama/fullarticle/186342>>.

8 Women's Refugee Commission, "More than One Million Pains", 2019.

9 Ibid.

10 Ibid.

Insights from refugee and migrant men and boys

"Trust is the most important thing. We don't want to talk about this in front of others, maybe I don't like this other person in the group. I don't want to say this in front of him. But one-on-one with someone I trust is OK."

"They [male survivors] don't want to talk about it. It's better to put up signs about the issue so people know that it is a problem and that they can get help. But they don't want to say the words, they just want to know where to go to get help."

"If people treat you like a human being with dignity and support, you can recover."

Insights from service providers

"Boys find creative ways to express sexual abuse, they don't say, 'I was a victim.' Like one boy from Guinea explained how he had been a slave and that one owner 'had been kind to me.' It is another way of saying he was sexually abused."

"For boys, disclosure of sexual violence is very rare. It is usually part of a general narrative of experience and implied."

"It's important to create a safe, trusting environment to give boys the safety and freedom to discuss when and how to disclose. Each has their own way."

"We found that a lot of the time male survivors are likely to come forward [to a medical clinic] because of sexually transmitted infections or fear thereof."

"Just acknowledging that such sexual violence happens to men, how hard the journey is, helps them open up."

"This idea that 'it's always hard for man to disclose to a woman about violence'—it really depends. You have to give the man the option of talking to a woman or a man. It's very much an individual preference. The main thing is you need to be trained how to receive the disclosure."

"It depends on how you create the first moment. How good you are at psychological first aid. There needs to be a good, safe setting where you can talk and listen. Then it comes out."

"Each person has a different response. Usually people do speak about their sexual violence, but it takes time. Sometimes it's very important to listen in silence. The best response is silence."

For more research and resources on male survivors, see: www.womensrefugeecommission.org/svproject

5

Consequences of gender-based violence (GBV) and sexual violence against men and boys (SVAMB)

Consequences of gender-based violence (GBV)

From: United Nations Children's Fund's 'Kit 1: Getting Started – Introduction to Gender-Based Violence in Emergencies, Learning Module, Handout 5', *Gender-based Violence in Emergencies Resource Pack*, 2020.

GBV is harmful and has a negative impact on the individuals who experience it, their families, their communities and on wider society.

- There are many short- and long-term physical, mental and social health effects and outcomes. At its worst, GBV is life-threatening.
- The nature and severity of the consequences are determined by the type, duration and severity of the violence; the individual's age and developmental level; her psychosocial circumstances; and the care and support she receives.
- The effects can be interrelated; for example, physical well-being affects psychological well-being. For this reason, it is important to view people holistically and consider all the different impacts, not just those that can be observed.
- Although the focus is often on physical outcomes of violence, there are outcomes that can't always be observed. When thinking about consequences of GBV, it's important to consider each person's physical, emotional, intellectual, social and spiritual aspects.
- The consequences can be worse in conflict- or disaster-affected settings – for example, if victims experience other forms of violence and atrocities, if there are multiple perpetrators, if the assaults are particularly brutal, if the assaults are public, if there is nowhere safe to recover, or if victims are not able to meet their basic needs.

Physical consequences

Physical effects manifest in or upon the survivor's body. Some effects are present only immediately after an incident, while others appear only at a later stage. For example, it is common for survivors to experience shock immediately after an assault; they may feel cold, faint, confused or disoriented, or they may feel sick and even vomit. In the hours, days and weeks following a sexual assault, many people report difficulty falling or staying asleep, heart palpitations and breathing difficulties, headaches or general aches and pains, feeling tired and fatigued, nausea, being easily startled by noises, general agitation and muscle tension, numbness, eating problems or oversensitivity to noise. It is also common for women to come for medical care months or even years after sexual violence. Physical effects depend on the violence itself. In cases of child sexual abuse, there may be no obvious physical signs. The absence of physical injuries or signs does not mean that violence did not take place.

Acute physical consequences	Chronic physical consequences	Reproductive consequences
<ul style="list-style-type: none"> ▪ Injury ▪ Shock ▪ Disease ▪ Infection 	<ul style="list-style-type: none"> ▪ Disability ▪ Somatic complaints ▪ Chronic infection ▪ Chronic pain ▪ Gastrointestinal disorders ▪ Eating disorders ▪ Sleep disorders ▪ Chronic fatigue 	<ul style="list-style-type: none"> ▪ Miscarriage ▪ Unwanted pregnancy ▪ Unsafe abortion ▪ Sexually transmitted infections, including HIV ▪ Menstrual disorders ▪ Pregnancy complications ▪ Gynaecological and urological disorders

Psychological and emotional consequences

Psychological effects generally refer to inner thoughts, ideas and emotions and can be less visible or even completely hidden. Very often, these effects won't be detected at all unless a survivor offers this information. The psychological and emotional effects of GBV can be immediate and longer-term. It is very important to remember that everyone shows emotions differently, and whether or not there are obvious signs does not mean that violence did or did not take place. Judging how people are responding by how they show their reactions outwardly is a mistake. People are all different, and the way they behave will depend on the individual and the context, including their culture. The reactions vary from person to person, depending on the age of the survivor, her life situation, the circumstances surrounding the violence and the response of those who should provide support.

Common psychological and emotional consequences of GBV include:

- depression
- anxiety and fearfulness
- anger
- shame, self-hate, self-blame
- self-harming and suicidal thoughts and behaviour
- low self-esteem
- sexual disorders
- traumatic stress
- eating and sleeping disorders
- substance abuse.

Social and relational consequences

Social consequences of GBV depend on the nature of the violence. Social consequences on individuals include the impact on a person's relationships within their immediate and extended family, including their relationships with husbands, intimate partners, children, parents and siblings, as well as with other people in their wider social network and community. Although social consequences can sometimes be the result of the survivor's responses – for example, stress and anxiety can affect their ability to communicate and relate to others – harmful social consequences are most often the result of how others view and treat the form of violence and those who have experienced it. For example, in many contexts, there are no negative ramifications from female genital mutilation/cutting (FGM/C), and in fact the opposite is true – there are more likely to be social consequences for a person who does not undergo FGM/C. In the case of sexual violence, victim blaming and social stigma are common and can lead to social isolation, rejection by the family, family breakdown, withdrawal from community life and loss of role function, such as decreased capacity to care for children and to work.

Common social and relational consequences of GBV include:

- blaming and social stigma
- rejection by family and community
- social isolation
- withdrawal from social and community life, including education
- reduced contribution to family and community life
- economic costs, including the costs of health and social services and the costs of lost earnings (and potential earnings in the future).

Consequences of sexual violence against men and boys

From: Women's Refugee Commission, *'Sexual Violence Against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh, Italy, and Kenya - Synthesis Report'*, New York, 2020.

The impacts of sexual violence on men and boys (and non-binary and other people with diverse gender identities) are similar to those that affect women and girls.

Mental health impacts

The mental health consequences of sexual violence on men and boys can include: anxiety, depression, post-traumatic stress disorder, dissociation, auditory hallucinations, paranoia, memory loss, confusion, suicidal thoughts and attempted (or achieved) suicide.

Male survivors may suffer from feelings of overwhelming loneliness, guilt, anger, shame and self-blame. They may experience insomnia due to hypervigilance, nightmares or intrusive thoughts or images. Other affects can include: headaches, body pains and a feeling of itchiness on the skin, the soles of the feet or even inside the body.

A survivor's gendered sense of self may be disrupted. Heterosexual male survivors may believe that rape or other sexual violence has 'turned them gay' (which is not possible), causing confusion about their sexuality. For gay, bisexual, transgender men and others, sexual victimization can trigger feelings of self-blame and self-hatred, including a sense that they somehow 'deserved' the violence as punishment for their different sexual orientation and gender identity. All forms of sexual violence can be traumatic or disruptive, including less physically violent forms such as forced nudity or sexual humiliation.

Physical health

Health consequences may include: sexually transmitted infections including HIV; anal trauma, such as fissures and fistulae; genital trauma, including penile and testicular amputation; pelvic and groin pains; haemorrhoids; urinary difficulties; and sexual dysfunction. Some survivors with rectal trauma may struggle with malodorous fecal incontinence.

Social well-being

Social impacts can include stigma and rejection by family and community members. Male survivors may be shunned, shamed and humiliated; some may be threatened with violence including death. A male survivor may be 'no longer [perceived as] a man' by community members. Families of a boy who has suffered sexual abuse and exploitation may not believe the survivor, or blame him for the assault, or eject him from the family. Gay, bisexual and transgender people may be worried that exposure of their sexual orientation or gender identity could compromise their security and well-being and that of their families. Heterosexual male survivors may be concerned about being perceived as gay. Some male survivors may flee to cities or other countries because of their sense of shame and stigma. Survivors with rectal trauma resulting in malodorous fecal incontinence may face additional social sanctions.

Economic and other impacts

Sexual victimization can comprise the ability of a survivor to earn a living. Income generation opportunities available to men often involve physical strength or close social interactions (like selling food or goods), which may not be viable for survivors, particularly those with rectal trauma. Ostracism, time spent pursuing medical and mental health care, fears of revictimization and, for survivors with fecal incontinence, a lack of incontinence products, can further compromise a survivor's ability to engage in income-generating activities. For boy survivors, the repercussions of sexual victimization can undermine their ability to perform at or stay in school. For boys suffering sexual exploitation, shame and humiliation can push them to self-isolate and disconnect from their families and communities.

6

6. Values clarification exercise

DO NOT WRITE YOUR NAME ON THIS

	Agree	Disagree
1. Having sex to pay for your journey to Europe is not violence.		
2. Men cannot be raped.		
3. Flirting and dressing in a sexy way is saying okay to sex.		
4. Being lesbian, gay, bisexual or transgender is not natural and is a choice.		

7

Seven guiding principles for working with child survivors

Consequences of gender-based violence (GBV)

Excerpt from: IRC and UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings* (2012), pp. 88-90.

Service providers caring for child survivors should adhere to a common set of principles to guide decision-making and the overall quality of care. And there are seven guiding principles that set out the ethical responsibilities and behaviours of service providers that deliver direct services to children and families who are seeking assistance.

These seven principles assure service providers that the actions they take on behalf of their child clients are supported by standards of care that aim to benefit the health and well-being of those clients. These guiding principles ensure that all actors are accountable for minimum standards in their behaviour and actions and, because of that accountability, that children and families receive the best possible care.

- 1. Promote the child's best interest.** A child's best interest is central to good care. A primary best-interest consideration for children is securing their physical and emotional safety — in other words, the child's well-being — throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with the participation of the child and their caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that the child's rights to safety and ongoing development are never compromised.
- 2. Ensure the safety of the child.** Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard their physical and emotional well-being in both the short and long term.
- 3. Comfort the child.** Children who disclose sexual abuse require comfort, encouragement and support from service providers. This means that service providers should be trained to handle the disclosure of sexual abuse appropriately. Service providers should believe children who disclose sexual abuse and never blame them in any way for the abuse they have experienced. A fundamental responsibility of service providers is to make children feel safe and cared for as they receive services.
- 4. Ensure appropriate confidentiality.** Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring the confidential collection of information during interviews; that any sharing of that information is in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child and/or caregiver; and that case information is stored securely. In places where service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.
- 5. Involve the child in decision-making.** Children have the right to participate in decisions that have implications for their lives. The level of a child's participation in decision-making should be appropriate to their maturity and age. Listening to children's ideas and opinions should not interfere with the rights and responsibilities of caregivers to express their views on matters affecting their children. While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent manner and with maximum respect. In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

6. **Treat every child fairly and equally (the principle of non-discrimination and inclusiveness).** All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.
7. **Strengthen children's resilience.** Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the natural strengths of the child and their family as part of the recovery and healing process. Factors that promote children's resilience should be identified and built upon during service provision. Children who have caring relationships and opportunities for meaningful participation in family and community life, and who see themselves as strong, will be more likely to recover and heal following abuse.

8

Mandatory reporting

Adapted from: IRC and UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings* (2012), pp. 91-95.

Mandatory reporting refers to state laws and policies that mandate certain agencies and/or people in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, or unlawful sexual intercourse).

Mandatory reporting requirements

One of the main differences between working with children and working with adults is the need for health and psychosocial providers to comply with laws and policies that regulate responses to the suspected or actual abuse of children. These laws and policies are often referred to as 'mandatory reporting laws' and they vary in scope and practice across humanitarian settings.

To comply with mandatory reporting laws, service providers must have a thorough understanding of these laws in their setting. In settings where laws and systems exist, service providers should have established procedures in place for reporting suspected or actual abuse before providing services directly to children. First, actors should answer the question: Does a mandatory reporting law or policy exist in my setting? If yes, actors should establish procedures based on answering these key questions.

- Who is required to report cases of child abuse?
- Who are the officials designated to receive such reports?
- When is the obligation to report triggered (i.e., with suspicion of abuse?)
- What information needs to be shared?
- What are the reporting regulations regarding timing and other procedures?
- How is confidentiality protected?
- What are the legal implications of not reporting?

Reporting cases of child sexual abuse

If service providers are required to report cases of child sexual abuse to local authorities (and reporting systems are established and functioning), then they must follow the local protocol and explain this clearly to the client. Reporting suspected or actual cases of sexual abuse is very sensitive and the report should be handled in the safest and most discreet manner possible.

Mandatory reporting in cases of child abuse is not the same thing as referring a child for immediate protection if they are in imminent danger. If a child is in imminent danger, then caseworkers should take actions to secure their safety (through referral to local police, protection agencies, etc.) before making a mandatory report to the designated mandatory reporting agencies. Once the child is safe, caseworkers should proceed with mandatory reporting procedures. The elements of best practice for reporting cases of child sexual abuse (in settings where mandatory reporting systems are functioning) are as follows:

- include protocols to maintain the utmost discretion and confidentiality for child survivors
- know the case criteria that warrant a mandatory report
- make verbal and/or written reports (as indicated by law) within a specified timeframe (usually 24 to 48 hours)
- report only the minimum information needed to complete the report
- explain to the child and their caregiver what is happening and why, and
- document the report in the child's case file and follow up with the family and relevant authorities.

Strategies for reporting abuse while maintaining discretion and the confidentiality of child survivors and their families should be discussed and agreed upon by key actors in the field. Examples of how to best uphold discretion and confidentiality in mandatory reporting circumstances should include: agreeing with other actors on the minimum amount of information that needs to be shared; reporting to only one mandatory reporting entity/person; and establishing guidelines to regulate how third parties store information.

Maintaining children's best interests in mandatory reporting procedures

Mandatory reporting requirements can raise ethical and safety concerns in humanitarian settings, where governance structures often break down and laws exist in theory but not in practice. In emergency settings – where established and safe mechanisms to report child sexual abuse might not exist and where the situation is insecure, unstable and dangerous – mandatory reporting can set off a chain of events that has the potential to expose the child to further risk of harm, and as such it may not be in the child's best interest to initiate a mandatory report. If, for example, investigators show up at a child's home, they risk breaching a child's confidentiality at the family or community level and prompting retaliation. Services for children may also be non-existent, which creates additional risks (e.g., separation from family, placement in institutions or confiscation of private records). The local authorities may themselves be abusive or simply ignorant of best-practice procedures or guiding principles.

If the following criteria are present (even if a mandatory law exists in theory) service providers are advised to use the central guiding principle – the best interests of the child – to guide decision-making in child-centred service delivery:

- authorities lack clear procedures and guidelines for mandatory reporting
- the setting lacks effective protection and legal services to deal properly with a report
- reporting could further jeopardize a child's safety at home or within their community.

If these criteria are present, service providers should follow a decision-making process that first considers the child's safety and then the legal implications of not reporting. Supervisors should always be consulted in decision-making to determine the best course of action.

Service providers are advised to follow these three steps to determine the best course of action.

STEP 1

Use these questions to guide decision-making.

- a. Will reporting increase the risk of harm for the child?
- b. What are the positive and negative impacts of reporting?
- c. What are the legal implications of not reporting?

STEP 2

Consult with the programme case-management supervisor and/or manager to make a decision and develop an action plan.

STEP 3

Document with a supervisor or manager the reasons to report the case; otherwise, document the safety and protection issues that rule out making a report.

Explaining mandatory reporting at the very beginning of care and treatment

If mandatory reporting policies and laws are in place and practiced, service providers are required to explain to the child and caregiver their reporting responsibilities from the outset. This can be done in conjunction with an initial informed consent procedure for the services that are being offered.

If a mandatory report is required, service providers should share the following information with children and caregivers:

- the agency/person to which/whom the caseworker will report
- the specific information being reported
- how the information must be reported (written, verbal, etc.)
- the likely outcome of the report
- the rights of the child and family in the process.

Children, particularly older children (adolescents) and caregivers should be part of the decision-making process on how to address mandatory reporting in the safest and most confidential way. This means that service providers should seek and consider their opinions and ideas on how to draft the report. This does not mean the caregiver and child can decide whether or not a report is made; rather, they can help decide how and when the report is made. Service providers who are equipped with in-depth knowledge about mandatory reporting procedures are best positioned to work with children and family clients to manage this procedure as necessary.

SUMMARY OF KEY COMPETENCIES FOR MANDATORY REPORTING

Service providers must be able to:

- demonstrate an accurate understanding of the mandatory reporting laws and policies in their context
- analyze specific criteria to determine whether reporting is in the child's best interest, and document and report this information to supervisors and/or the child's case response team
- explain mandatory reporting requirements to children and caregivers at the outset of service delivery.

Remember: The most beneficial and least detrimental course of action for the child, and the least intrusive one for the family, should be employed, as long as the child's safety is assured.

9

The survivor-centred approach and the gender-based violence (GBV) Guiding Principles

Excerpt from: *UNICEF Gender-Based Violence in Emergencies Resource Pack; Kit 1: Getting Started – Introduction to Gender-Based Violence in Emergencies, Guidance Book, pp. 140-141.*

A survivor-centred approach to GBV response is based on a set of guiding principles that guide the work of all helpers – no matter what their role is – in all of their interactions with GBV survivors.

Survivor-centred principles are interrelated and mutually reinforcing; for example, confidentiality (principle 2) is essential to promote safety (principle 1) and dignity (principle 3). The principles are described below.

Principle 1: Right to safety

Safety refers to both physical security as well as a sense of psychological and emotional safety. It is important to consider the safety and security needs of each survivor, their family members and those providing care and support.

In the case of conflict-related and politically motivated sexual violence, the security risks may be even greater than usual.

Every person has the right to be protected from further violence. In the case of child survivors, every child has the right to be protected from sexual and other violence; as adults, we all have responsibilities to uphold that right.

Why is safety important?

Individuals who disclose sexual violence or other forms of GBV may be at high risk of further violence from the following people:

- perpetrators
- people protecting perpetrators, and
- members of the survivor's own family as a result of notions of family 'honour'.

Principle 2: Right to confidentiality

Confidentiality promotes safety, trust and empowerment. It reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned.

Why is confidentiality important?

- Confidentiality promotes safety, trust and dignity.
- Confidentiality reflects the belief that survivors, including children, have the right to privacy and to choose who should about what has happened.
- Breaching confidentiality inappropriately can put the survivor and others at risk of further harm.
- If service providers and other helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help.

Exceptions to confidentiality

There are exceptions to confidentiality in some specific situations, and it is very important that survivors, including children and their caregivers, are not led to believe that nothing they say will be shared.

Helpers need to understand and communicate the exceptions to confidentiality, such as:

- situations in which there is the threat of ongoing violence or harm to a child, and the need to protect the child overrides confidentiality
- situations in which laws or policies require mandatory reporting of certain types of violence or abuse
- situations in which the survivor is at risk of harming themselves or others, including thoughts of suicide, and
- situations involving sexual exploitation or abuse by humanitarian or peacekeeping personnel.

Principle 3: Dignity and self-determination

- GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in supporting their dignity and self-determination. For example, survivors have the right to choose whether or not to access legal services and other support services.
- Failing to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame, reduce the effectiveness of interventions, and cause re-victimization and further harm.

Principle 4: Non-discrimination

- All people have the right to the best possible assistance without unfair discrimination on the basis of sex, gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation, status or social class.

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Example of a linguistic and cultural mediator (LCM) job description

The main duties and responsibilities of the linguistic and cultural mediator (LCM) are to:

- welcome the patient and/or health- and social-services users
- provide cultural mediation in compiling medical files/history
- provide cultural mediation before and during the medical examination
- in agreement with the doctor (where present) and the nurse, propose treatment options and provide health care education where necessary
- accompany patients who need hospital treatment and assist with reception and admissions procedures
- lead health and social services orientation activities: the creation of individual itineraries to helping people integrate; advice on regulations and rights on health or residency issues; cooperation with regional public and civil services (registry office and health service registration, services dedicated to migrants, police station, prefecture, etc.)
- ensure the correct use of the computerized management system (collection of patients' clinical data and processing of statistics), for which specific training will be provided
- if necessary, contribute to the management of certain administrative or logistical aspects of the project (cash flow, budget control, purchases, transport, etc.)
- at the request of the Coordinator, participate in inspections to evaluate other possible sites where the service may be required.

All personnel should also:

- respect the safety rules established by the organization, designed to protect both the individual and the project as a whole
- be autonomous, flexible and capable of managing stressful situations
- work in accordance with standardized clinical and operational protocols
- behave in an open and cooperative way, both towards the work of the team and in other areas of community life
- have good communication skills and a positive attitude towards training
- respect and take an interest in the local culture and traditions.

Note: Developed from actual job description in Italy

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Tips for remote linguistic and cultural mediation

Before the interview

1. Check the functionality of the internet connection and of the communication device.
2. Speak with the service provider before the mediation to get information on the country of origin of the client/user and their specific situation.
3. Make sure that all participants have an adequate location (a safe and peaceful place).
4. Ask the client if they want the community in which they live to know about the appointment for the interview.
5. Contact (if applicable) the reception centre to make sure that the client has a secure room for privacy.
6. Safeguard confidentiality and personal data: the privacy of the space where the service provider is located must be guaranteed.

During the interview

1. Initial briefing to introduce everyone and to be sure to speak the same language.
2. Make sure that the client is in a tranquil situation, and feels at ease and is able to speak freely.
3. If possible, everyone should have their camera on, so that all participants can understand any non-verbal communication.
4. Ask what type of device the client has available and whether this will enable an effective session: find solutions if there are problems.
5. Explain to the participants the rules of the interview: the mediator must translate all content of both the specialist and the client/user; privacy and consent.
6. Informed consent: to inform the client of all aspects of a remote mediation interview.

The linguistic and cultural mediator should

1. Be very focused.
2. Pay close attention to physical movements, gestures, expressions, etc.
3. Ask the client if they are alone, and stop the interview every time someone enters the room.
4. Always translate what is being said, both by the client and the service provider.
5. Respect the alternation of speech between the client and the service provider.

12

Glossary of terms

Unless otherwise noted, definitions are from: *GBVIMS, Interagency Case Management Guidelines: Providing care and case management services to gender-based violence survivors in humanitarian settings, 2017* or *IASC, GBV Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, 2015*.

Common terms and definitions are defined below. These are not legal definitions and are not intended as such.

Adolescent: Any person between the ages of 10 and 19 years old.

Adult: Any person aged 18 years and older.

Attitude: Opinion, feeling or position about people, events and/or things that is formed as a result of one's beliefs. Attitudes influence behaviour.

Belief: An idea that is accepted as true and that may or may not be supported by facts. Beliefs may stem from, or be influenced by, religion, education, culture and personal experience.

Bisexual: A person who has the capacity to form enduring physical, romantic and/or emotional attractions with those of the same gender or to those of another gender. People may experience this attraction in differing ways and degrees over their lifetime. Bisexual people need not have had specific sexual experiences to be bisexual; in fact, they need not have had any sexual experience at all to identify as bisexual.¹

Caregiver: This term describes the person who exercises day-to-day care for another person. He or she is a parent, relative, family friend or other guardian; but the term does not necessarily imply legal responsibility. Caregiver is also a term that is used to describe a person who provides day-to-day care for a child/children or for a person with a disability (for those who need such support).

Case conference/meeting: Case conferences are small meetings with appropriate service providers (e.g., those already involved in the person's care) that are scheduled when the person's needs are not being met in a timely or appropriate way. The purpose of the case conference is to gather the appropriate service providers (and people who provide support in the person's life as appropriate) to identify or clarify ongoing issues regarding the person's care. Case conferences provide an opportunity to review activities, review progress and barriers towards goals; map roles and responsibilities; resolve conflicts or strategize solutions; and to adjust action plans.

Case management: GBV case management, which is based on social work case management, is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for: ensuring that survivors are informed of all the options available to them; ensuring the identification and follow up of issues and problems faced by a survivor and her/his family in a coordinated way; and providing the survivor with emotional support throughout the process.

Caseworker: An individual working within a service providing agency who has been tasked with the responsibility of providing case management services to clients. This means that caseworkers are trained appropriately on client-centred case management; they are supervised by senior programme staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers or case managers, among other terms.

Child: Any person under the age of 18. Children have evolving capacities depending on their age and developmental stage.

¹ GLAAD, 'Media Reference Guide – Lesbian / Gay / Bisexual Glossary of Terms', New York, <<https://www.glaad.org/reference/lgbtq>>.

In working with children, it is critical to understand these stages, as it will determine the most effective method of communication with individual children. It will also allow the caseworker to establish an individual child's level of understanding and their ability to make decisions about their care. As a result, the caseworker will be able to make an informed decision about which method of intervention is most appropriate for each individual child.

The following definitions clarify the term 'child' in relation to the age/developmental stages to guide interventions and treatment:

Children = 0–18, as per the Convention on the Rights of the Child

Young children = 0–9

Early adolescents = 10–14

Later adolescents = 15–19.

Child sexual abuse: This is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing, touching and oral, anal or vaginal sex. Not all sexual abuse involves physical contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts ('flashing'), verbally pressuring a child for sex and sexually exploiting children (including for pornography) are also acts of sexual abuse.

Child/early marriage: A child or early marriage is a formal marriage or informal union before the age of 18. Even though some countries permit marriage before age 18, international human rights standards classify these as child marriages, reasoning that those under age 18 are unable to give informed consent. Therefore, early marriage is also a form of forced marriage as children are not legally competent to agree to such unions.

Cisgender: A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.²

Confidentiality: An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down in case files. Maintaining confidentiality means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are, however, limits to confidentiality when working with children.

Disclosure: The process of revealing information. Disclosure in this context refers to a survivor voluntarily sharing with someone the fact that she/he has experienced or is experiencing GBV or sexual violence.

Empathy: 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 non-verbal communication.

Economic violence/abuse: An aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working, controlling their own earnings, achieving self-sufficiency or gaining financial independence. It is one form of intimate partner violence.

Emotional violence/abuse (also referred to as psychological abuse): The infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. It is one form of intimate partner violence.

Femicide: the intentional murder of women/girls because they are women/girls. Femicide is usually perpetrated by men, but female family members may sometimes be involved.³

2 Human Rights Campaign, 'Glossary of Terms', Washington, D.C. <www.hrc.org/resources/glossary-of-terms>.

3 WHO and PAHO, 'Femicide', Understanding and Addressing Violence Against Women Information Sheet Series, World Health Organization and Pan American Health Organization, Geneva, 2012 <www.who.int/iris/bitstream/10665/77421/1/WHO_RHR_12.38_eng.pdf?ua=1>.

Gay: The adjective used to describe people whose enduring physical, romantic and/or emotional attractions are to people of the same gender (e.g., gay man, gay people). Lesbian is sometimes the preferred term for women.⁴

Gender-based violence (GBV): An umbrella term for any harmful act perpetrated against a person on the basis of 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 female genital mutilation.

Heterosexual: An adjective used to describe people whose enduring physical, romantic, and/or emotional attraction is to people of another gender. Also 'straight'.⁵

Homosexual: This is an outdated term considered derogatory and offensive. Instead, use gay, lesbian or bisexual or queer (as appropriate) to describe people attracted to members of the same gender.⁶

Informed assent: The expressed willingness to participate in services. This applies to younger children who are, by definition, too young to give informed consent, but old enough to understand and agree to participate in services. In such cases, the child's 'informed assent' is sought and refers to the expressed willingness of the child to participate in services.

Informed consent: The voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. To ensure consent is 'informed', service providers must:

- provide the survivor with all the possible information and options available to them so that they can make choices
- inform the survivor that they may need to share their information with others who can provide additional services
- explain to the survivor what will happen as they work with them
- explain the benefits and risks of services to them
- explain that they have the right to decline or refuse any part of any services
- explain the limits to confidentiality.

Intersex: An umbrella term describing people born with reproductive or sexual anatomy and/or a chromosome pattern that is not classified as typically male or female.⁷

Intimate partner violence: This applies specifically to violence that occurs 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.

Lesbian: A woman whose enduring physical, romantic and/or emotional attraction is to other women. Some women prefer to be referred to as 'gay' or 'gay women'.⁸

LGBT/LGBTI/LGBTIQ: An acronym for 'lesbian, gay, bisexual and transgender' people. Those who are intersex or who identify as queer or 'questioning' are sometimes included, in which case the acronym becomes LGBTIQ.

Mandatory reporting: State laws and policies that mandate certain agencies and/or people in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected forms of interpersonal violence (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

Queer: A term people often use to express fluid [gender] identities and [sexual] orientations. Often used interchangeably with LGBT.⁹

4 Human Rights Campaign, Glossary of Terms.

5 GLAAD, Glossary of Terms.

6 Ibid.

7 Ibid.

8 Ibid.

9 Human Rights Campaign, Glossary of Terms

Parent: A child's mother or father. Note that in some societies it is common for girls and boys to spend time with other members of their extended family and sometimes with unrelated families. For our purposes, the term 'parent' generally refers to the biological parent. In some cases, it may refer to those who assume the child's care on a permanent basis, such as foster or adoptive parents, or extended family members who provide long-term care.

Perpetrator: A person who directly inflicts or supports violence or other abuse against another person (and against that person's will).

Physical assault: An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. It is often one form of intimate partner violence.

Psychosocial: A term used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects relate to our functioning, such as our thoughts, emotions and behaviour. Social surroundings concern our relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work.

Sexual violence: Any sexual act (or 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 of relationship to the victim, in any setting (including but not limited to home and work). Sexual violence includes rape/attempted rape, sexual abuse and sexual exploitation.

Sexual exploitation: Any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category.

Sexual consent: An agreement to participate in a sexual activity. Such consent must be freely given, reversible, informed, enthusiastic and specific (FRIES).¹⁰

Sexual orientation: Each person's capacity for profound emotional, and sexual attraction to, and intimate relations with, individuals of a different gender or the same gender or more than one gender.

Survivor/victim: A person who has experienced gender-based violence or sexual violence. The terms 'victim' and 'survivor' can be used interchangeably, although 'victim' is generally preferred in the legal and medical sectors, and 'survivor' in the psychological and social support sectors.

Trauma: Traumatic experiences usually accompany a serious threat or harm to an individual's life or physical well-being and/or a serious threat or harm to the life or physical well-being of the individual's child, spouse, relative or close friend. When people experience a disturbance to their basic psychological needs (safety, trust, independence, power, intimacy and esteem), they experience psychological trauma.

Transgender: An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.¹¹

Vicarious trauma: Vicarious trauma refers to the emotional residue of exposure carried by service providers who listen to people's suffering and become witnesses to the pain, fear and terror that they have endured. It is a state of tension around, and preoccupation with, the struggles and difficult experiences described by clients. Other terms used include secondary traumatic stress and secondary victimization.

10 Planned Parenthood, 'Sexual Consent' web page, New York, NY <www.plannedparenthood.org/learn/relationships/sexual-consent>.

11 Human Rights Campaign, Glossary of Terms.

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Case study of Omid and Azar

Omid and Azar, Part 1: Handling a disclosure of violence

Omid is a young Afghan man who lives in an informal settlement near a bus station. According to his residence permit, he is 19. Omid speaks some of the local language and attends a school near the station. Azar is an LCM who works for a local health clinic. Twice a week, she and the rest of a team from the health clinic – composed of Azar as a Pashtu-speaking LCM, a social worker and a nurse – provide outreach services around the station, sharing information about access to health services for young people like Omid. He knows Azar because they have interacted a few times. In recent weeks, his appearance has changed: he has lost weight and his beard has grown long and unkempt.

While her colleagues are talking with a man who lives nearby, Azar and Omid begin to talk, and she asks him how he feels and how things are going. At first, Omid is vague, and he seems hesitant to talk to her. He is apparently troubled and seems worried about something. Omid tells her that no one should know what he is about to tell her: not her colleagues or any of the other Afghan men and boys in the area.

Omid tells her about some practices in his area of Afghanistan. Some adult men go to parties where boys dance for them and sometimes the men expect the boys to have sex with them. He was one of those boys. Omid also tells her that during the journey to this country, he began to exchange sex for money, food and phone top-ups.

Question 1: Please describe, step-by-step, what Azar should do to apply psychological first aid (PFA). In addition, provide examples of how she can practice the Guiding Principles.

Omid tells Azar that he is feeling depressed and has not felt well for some time: he is always tired and often feels so nauseated that he cannot eat. Azar asks him if he has seen a doctor recently and he replies no, because he doesn't really trust doctors. Azar gives him precise information on where Omid can go to see a doctor at a nearby clinic and suggests that he make a visit. Omid says – again – that he does not want to go to the clinic and that he doesn't trust doctors. Azar mentions that the clinic also offers other services and support.

Question 2: What should Azar do when Omid refuses to go to the clinic? What Guiding Principle becomes particularly relevant?

Omid and Azar, Part 2: Collaborating with other professionals in the support process

The day after Azar and Omid meet, Omid decides to go to the clinic. Azar is there, working her normal shift and is happy to see him. She explains to him that because she works there, she can help him during his visit, if he would like that. Omid agrees. Azar asks him if it is okay for her to tell the doctor they have previously met, and he agrees, but tells her that he does not want the doctor to know about his past. Once in the room, the doctor examines Omid, with Azar interpreting questions and answers. Omid does not talk about his experience of violence during the visit. The doctor prescribes some tests. Once the visit is finished, Azar helps Omid to fill in some forms and helps him to get a follow-up appointment for the test results.

Question 3: What should Azar do and say to the doctor before the consultation? What should Azar do and say once they are in the medical room? Which LCM role is Azar playing?

Omid returns to the clinic to receive the results of the medical tests. With Azar's support, the doctor informs Omid that he has Hepatitis B. He must follow a special treatment that requires him to come to the clinic regularly and he should not miss any appointments. When Omid asks what kind of illness Hepatitis B is, the doctor gives him a pamphlet on the consequences of the viral infection and the ways it can be contracted – including sexual transmission. The doctor reads out the information to Omid, who becomes very agitated and looks worried when he learns the ways in which the virus is transmitted. At this point Omid abruptly says 'Yes, I got this virus because they turned me gay', using an offensive term in his language.

Question 4: What should Azar do when Omid expresses this point?

Omid and Azar, Part 3: Self-awareness

Omid eventually discloses to the doctor and tells him about the violence he endured when he was a child and the way he was able to survive during and after his migration. Azar's translation makes it clear that he is deeply ashamed and blames himself. He is visibly distressed and speaks of Hepatitis B as a punishment for his guilt.

The doctor listens carefully and when Omid finishes his story, the doctor tells Omid that he is not to blame for the many forms of violence and abuse he has experienced. The responsibility lies with those who have abused him. The doctor tells Omid that many other boys and young men have been similarly abused – he is not the only one and he is not alone. He also explains that the fact that Omid has been abused has no bearing on his sexual orientation.

At this point, Azar begins to fidget in her chair, and she has a frown on her face. She asks the doctor to repeat what he has said, and she interprets everything back to Omid, very precisely. There is some tension, but the consultation ends on a positive note. The doctor suggests to Omid the possibility of having psychological support and having an interview with the social worker, and Omid agrees. At the end of the consultation the doctor and Azar have a short debrief.

Question 5: Taking into consideration the Guiding Principles and Azar's roles and responsibilities, what are the most important things that Azar should do during the session? What could Azar have done differently?

Question 6: During the debrief with the doctor, what should Azar discuss with the doctor?

14

Dos and don'ts of linguistic cultural mediation

Do	Don't
<p>Do interpret everything that is said accurately, without skipping anything.</p> <p>"I'm telling you this, but please don't translate it" is not acceptable.</p>	<p>Do not accept assignments for which you know you are unqualified or not prepared.</p> <p>For example: Don't agree to interpret from a language in which you are not proficient.</p>
<p>Do interpret words, and attitudes, in each language, and explain cultural differences or practices as needed.</p>	<p>Do not take assignments if you risk being biased or face a conflict of interest (e.g., a family member or a close friend is involved).</p>
<p>Do give additional support, as well as conveying information if requested.</p> <p>For example, you can help to fill out forms.</p>	<p>Do not repeat what you have heard to friends, relatives or anyone else.</p>
<p>Do correct yourself if you make a mistake, and ask for clarification if there is something you don't understand.</p>	<p>Do not use your position to exercise power over or put pressure on any speaker or listener.</p>
<p>Do respond to racist or abusive language by highlighting its offensiveness with the speaker and checking if that is what they really want to say before interpreting it.</p> <p>Report such behaviour to the person's supervisor.</p>	<p>Do not use your position to gain favours, including financial ones, from any speaker or listener.</p>
<p>Do use all the resources available. For example, use glossaries or reference material to improve your understanding and knowledge.</p> <p>Many terms, particularly in relation to GBV and medical care, are not used in everyday conversation.</p>	<p>Do not hold a separate conversation with one speaker without interpreting for the others.</p>
<p>Do ensure that your appearance is appropriate and adapted to the context (decent and neutral).</p>	<p>Do not show your feelings or express your opinion. It is important to remain neutral.</p>

15

Sample Code of Conduct (CoC) for Linguistic and Cultural Mediators (LCMs)

With regard to this code of conduct:

1. LCMs shall always act with integrity and in accordance with the high standards appropriate to practitioners within the profession.
2. LCMs shall not accept any work which would, directly or indirectly, infringe on the CoC, and shall not knowingly act in contravention of the CoC, even if asked or instructed to do so by a service provider they are interpreting for, a supervisor, or any other person.

Overarching principles for LCMs:

1. Promote the rights, strengths and wellbeing of migrant and refugee individuals, families and communities through respectful and professional communication.
2. Support migrants' and refugees' wellbeing, recognizing and adopting an approach centred on their needs and wishes.
3. Promote migrants' and refugees' access to services and support in an equal and inclusive manner.
4. Contribute to enhanced intercultural communication and integration.
5. Contribute to the protection of refugees and migrants through the provision of correct information, linking them to protection services and facilitating access and understanding.
6. Support service providers' competences with linguistic and cultural competences in the most adequate and respectful way.

Professional principles for LCMs:

1. **Effective communication skills:** Actively listen to understand people, using a range of appropriate communication methods to build relationships between all parties involved and to enable full participation of clients in discussions and decision-making, being proactive in assisting and instructing service providers to act in a culturally competent way.
2. **Accuracy and fidelity:** Strive to render all messages in their entirety accurately, as faithfully as possible and to the best of one's abilities without addition, distortion, omission or embellishment of the meaning, and explaining in the most appropriate way possible cultural connotations explicitly mentioning this intent.
3. **Confidentiality:** Manage information about people with sensitivity and maintain complete confidentiality at all times — in line with the laws and policies — all information learned, either uttered or written in the performance of their professional duties, treating any information that may come to them in the course of their work as privileged information, not to be communicated to any third party without prior authorization for further distribution.
4. **Impartiality/Neutrality:** Maintain impartiality by showing no preference or bias to any party involved in the interpreted encounter. LCMs must not act in any way that might result in prejudice or preference on the grounds of religion or belief, race, politics, gender, age, sexual orientation, disability or other grounds. LCMs' personal, private, religious, political or financial interests should not conflict with their duties and obligations to their clients. If such a conflict arises, it should be declared to the beneficiary and to the third party of the conversation, and if the conflict is unacceptable or cannot be resolved, the LCM should withdraw from providing service.
5. **Professionalism:** Act in a professional and ethical manner at all times. LCMs should avoid actions or situations that are inconsistent with their professional obligations. If members find themselves in such a situation, they should remove themselves from it as soon as possible.

6. Respect: Respect all parties involved in the interpreted encounter. In their professional relationship with clients, LCMs will not:
 - i. abuse, neglect, discriminate, exploit or harm anyone, or condone this by others;
 - ii. abuse their power by asking for or receiving services, benefits, gifts, rewards or bribes of any kind from anyone taking part in the session, for himself/herself or to the benefit of a third person.
7. Maintain role boundaries: LCMs must strive to perform their professional duties within their prescribed role and refrain from personal involvement. They must maintain professional relationships with people and ensure that they understand the roles and duties of an LCM.
8. Accountability: LCMs are responsible for the quality of interpretation provided and accountable to all parties and organizations engaging the LCM's service. They are responsible for the quality of the information they provide to clients and colleagues, if this is part of their job description.
9. Continued learning: LCMs must commit to ongoing learning in recognition that languages, individuals and services evolve and change over time and a competent LCM strives to maintain the delivery of quality interpretation both in the vehicular language and mother tongue, both for written and non-written languages:
 - i. Update your knowledge of specific normative and administrative processes and update all relevant services information for migrants and refugees.
 - ii. Establish and maintain skills in information and communication technology and adapt your practice to new ways of working, as appropriate.
 - iii. Use supervision and feedback to critically reflect on and identify personal learning needs.

Name _____

Signature _____

Date _____

Note regarding the Code of Conduct

This Code of Conduct attempts to structure an ethical reference for LCMs. As a profession that continues to evolve and that depends on the country context as well as the specific environment, differences and potentially gray areas continue to exist. This must be considered when using and potentially adapting the CoC.

To compile the CoC, different examples were used. In particular, CoCs of interpreters and translators, as well as those of humanitarian aid workers, social and health workers, were considered.

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16

Stress, distress and disorder

Adapted from *Caring For Survivors – General and Psychosocial Module*, a product of the Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action with support from the Gender-based Violence Area of Responsibility (GBV AoR). *Caring for Survivors* was endorsed by the IASC Sub-Working Group on Gender in Humanitarian Action in November 2009.

Definition of stress

- **Stress** is an immediate, biological, physiological, social and psychological response to a change in the situation around us. It is an 'alarm-reaction' when we are confronted with something that might be a threat. This threat might be a change in our internal or external environment to which we have to adapt, and with which we have to cope. Every person reacts differently to stress: people have different thresholds. Not everyone feels stress in the same situation.
- Stress is a normal and natural response designed to protect, maintain and enhance life. If our ways of managing stress are adaptive and healthy, we may find that stress is a positive thing: a 'challenge'. Stress that we cannot manage well is experienced more negatively. This is sometimes known as distress.

Definition of distress and extreme distress

- **Distress** is the temporary disruption of our coping and problem-solving skills as a reaction to a very stressful situation. Distress covers a wide range of feelings, from powerlessness, sadness and fear to anxiety and panic. As well as affecting your feelings, distress may also affect such areas of your life as your thoughts and behaviours.
- **Extreme distress** or traumatic stress can occur after an extremely stressful event (also called a traumatic event) when you, or someone close to you, faced the threat of injury or death. Reactions can be physical, emotional, cognitive, behavioural and/or social and include extreme fear, re-living the event, hyper-arousal (such as being very jumpy), depression, severe relationship difficulties and substance abuse. People in extreme distress may experience a confused mental state as a result of intense stress (also known as shock). An extremely stressful event, such as sexual violence, is often so 'shocking' and painful that it can overwhelm the person going through it. When this occurs, the person is, at that moment, unable to cope as they would in other situations.

Every person reacts differently to extreme stressors

- The capacities and coping mechanisms of a person can determine how they react after stressful events.
- The social context (the reactions of people close to the survivor, the level of social support provided, etc.) has an important impact on the physical, emotional, cognitive, social and behavioural reactions.
- Culture also determines the way survivors respond. In some cultures, a failure to act in specific ways (which may be seen as being 'crazy'), may lead to the belief that the survivor was complicit in the crime and, therefore, increase victim blaming by the family and community as well as self-blame by the survivors themselves. In addition, the social need for 'obvious' signs of distress may mask the severe and chronic, but less visible internal distress (a sense of emptiness or hopelessness, lack of trust, fear for children and fears for the future, etc.) experienced by the survivor.
- For most survivors, reactions of distress or extreme distress are normal reactions to extremely stressful events. With social and emotional support, in particular, many survivors learn to cope and their distress decreases over time.

The difference between distress and extreme distress lies in the gradation of the severity of the events/stressors and of the reactions to these events/stressors.

Definition of a mental disorder that can develop after extremely stressful or traumatic events

- Reactions to extreme stressors will decrease naturally in most cases, without outside intervention, after the stressor has disappeared. However, traumatic events can sometimes lead to internal psychological dysfunctions, also called mental disorders.
- Such dysfunctions are reactions that continue long after the events and/or the conditions have changed.
- A mental disorder is a group of symptoms or reactions, called a syndrome, that form a 'dysfunction in the individual'. It also leads to the impairment of the survivor's ability to continue to perform daily tasks such as work, caring for others, schooling, etc.

It is important to make the distinction between distress and disorder because survivors with a disorder are unlikely to be able to cope on their own and will need specialized professional help (mental health evaluation and treatment). Survivors suffering from distress or extreme distress will also benefit from emotional and social support, although they can, for the most part, also rely on their own coping mechanisms and capacities.

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Factors that promote coping, resilience and recovery

Adapted from IASC, *Caring for Survivors* Training Pack, 2009.

Definitions

Resilience is a person's ability to 'bounce back', to overcome difficulties and adapt to change and challenges. It is determined by the characteristics of the survivor and a number of outside factors.

Coping refers to the specific efforts (behavioural, psychological and social) that people use to master, tolerate, reduce or minimize stressful events.

- There are different types of coping strategies. The most important are problem-solving strategies – efforts to do something active to ease stressful circumstances – and emotion-focused coping strategies, which aim to regulate the emotional consequences of stressful or potentially stressful events.
- The type of coping style used depends on the characteristics of the person as well as on the type of stressful event and the social environment.¹

Both individual factors and factors in the environment have an impact on coping, resilience and recovery.

Individual factors:

- The skills, knowledge and personality of the survivor.
 - Characteristics like high self-esteem, self-control, positive coping skills, sense of optimism and the ability to seek help and assistance will have a positive impact on coping, resilience and recovery.
- Their personal history: Did the survivor grow up in a safe environment? Have they experienced earlier incidents of abuse or sexual violence?
 - If a survivor has experienced (sexual) violence and/or abuse and neglect earlier in life, especially during childhood, their coping skills may be affected.

Environmental factors:

- Social networks and support: Can the survivor rely on support from their immediate/extended family and community? What is the place of the survivor in their community? What is their socio-economic situation and that of their family? Do they have a source of income?
 - The presence of a social network (family, friends) will make it easier for the survivor to deal with reactions and seek help. Strong social support can facilitate coping, resilience and recovery.
- Societal factors, culture and religion: Is there peace and security? How is sexual violence perceived by the society of the survivor? What are its traditional ways of dealing with violence? Is the survivor religious? Traditional forms of self-expression and rituals, both religious and secular, often play a part in culturally accepted ways of coping with difficult situations. Rules for the expression of emotions such as anger and sorrow, which vary greatly from culture to culture, may also influence coping and recovery. Religion can offer a sense of purpose that can facilitate coping.

1 The MacArthur Foundation Network on Socioeconomic Status and Health, 'Coping strategies' <<https://macses.ucsf.edu/research/psychosocial/coping.php>>

18

Self-care assessment worksheet

Source: *Transforming the Pain: A Workbook on Vicarious Traumatization*. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently

4 = Occasionally

3 = Rarely

2 = Never

1 = It never occurred to me to do this

Physical self-care

Eat regularly (e.g., breakfast, lunch and dinner)	<input type="checkbox"/>
Eat healthy food	<input type="checkbox"/>
Exercise	<input type="checkbox"/>
Get regular medical care for prevention	<input type="checkbox"/>
Get medical care when needed	<input type="checkbox"/>
Take time off when needed	<input type="checkbox"/>
Get massages	<input type="checkbox"/>
Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun	<input type="checkbox"/>
Take time to be sexual – with yourself, with a partner	<input type="checkbox"/>
Get enough sleep	<input type="checkbox"/>
Wear clothes you like	<input type="checkbox"/>
Take vacations	<input type="checkbox"/>
Take day trips or mini-vacations	<input type="checkbox"/>
Make time away from telephones.	<input type="checkbox"/>

Psychological self-care

Make time for self-reflection	<input type="checkbox"/>
Have your own personal psychotherapy	<input type="checkbox"/>
Write in a journal	<input type="checkbox"/>
Read literature that is unrelated to work	<input type="checkbox"/>
Do something at which you are not an expert or not in charge	<input type="checkbox"/>
Decrease stress in your life	<input type="checkbox"/>

- Let others know different aspects of you
- Notice your inner experience – listen to your thoughts, judgements, beliefs, attitudes, and feelings
- Engage your intelligence in a new area, e.g., go to an art museum, history exhibit, sports event, theatre
- Practice receiving from others
- Be curious
- Say “no” to extra responsibilities sometimes.

Emotional self-care

- Spend time with others whose company you enjoy
- Stay in contact with important people in your life
- Give yourself affirmations, praise yourself
- Love yourself
- Re-read favourite books, re-view favourite movies
- Identify comforting activities, objects, people, relationships, places and seek them out
- Allow yourself to cry
- Find things that make you laugh
- Express your outrage in social action, letters and donations, marches, protests
- Play with children.

Spiritual self-care

- Make time for reflection
- Spend time with nature
- Find a spiritual connection or community
- Be open to inspiration
- Cherish your optimism and hope
- Be aware of non-material aspects of life
- Try at times not to be in charge or the expert
- Be open to not knowing
- Identify what is meaningful to you and notice its place in your life
- Meditate
- Pray
- Sing
- Spend time with children
- Experience awe
- Contribute to causes in which you believe
- Read inspirational literature (talks, music, etc.).

Workplace or professional self-care

Take a break during the workday (e.g., lunch)	<input type="checkbox"/>
Take time to chat with co-workers	<input type="checkbox"/>
Set aside some quiet time to complete tasks	<input type="checkbox"/>
Identify projects or tasks that are exciting and rewarding	<input type="checkbox"/>
Set limits with your clients and colleagues	<input type="checkbox"/>
Balance your caseload so that no single day or part of a day is 'too much'	<input type="checkbox"/>
Arrange your work space so it is comfortable and comforting	<input type="checkbox"/>
Get regular supervision or consultation	<input type="checkbox"/>
Negotiate for your needs (benefits, pay raise)	<input type="checkbox"/>
Have a peer support group	<input type="checkbox"/>
Develop a non-trauma area of professional interest.	<input type="checkbox"/>

Balance

Strive for balance within your work-life and working day	<input type="checkbox"/>
Strive to strike a balance across your work, family, relationships, play and rest.	<input type="checkbox"/>



19

Evaluation: Supporting survivors of violence: the role of linguistic and cultural mediators

Name:

Place:

Bad Not too bad Neutral Good Very good

How would you rate the usefulness of this training for your work?

Comments:

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.....
.....

How would you rate the time allocation? (Was the training too long/too short, was there enough time for each session, etc.?)

Comments:

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.....
.....
.....

Did the course deliver its objectives?

Comments:

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.....
.....

Did you learn something new? If so, what?

Comments:

.....
.....
.....
.....

5. What aspects of the training were the best?

6. What could be improved for next time?
