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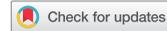
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Impact of Sexual and Interpersonal Violence and Trauma on Women: Trauma-Informed Practice and Feminist Theory

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ABSTRACT

Women experience disproportionate rates of both sexual assault and intimate partner violence (CDC, 2019). This article describes the physical, sexual, and mental health impact of these traumas for women and the parallels between feminist theory and SAMSHA's six principles for trauma-informed care that include 1. Safety; 2. Trustworthiness and Transparency; 3. Peer Support; 4. Collaboration and Mutuality; 5. Empowerment, Voice and Choice; and 6. Cultural, Historical, and Gender Issues. By utilizing a trauma-informed framework and feminist perspective, clinicians and practitioners can better conceptualize the impact of trauma and the healing journey for survivors. Future research is needed to better understand the impact of interpersonal violence across cultures and how this trauma-informed approach can be effective in recovery.

Sexual violence and intimate partner violence (IPV) are global public health crises with significant psychological and health-related consequences for women (Basile & Smith, 2011; Centers for Disease Control and Prevention [CDC], 2019; Wyatt, Davhana-Maselesele et al., 2017). Women are overwhelmingly, although not the only, targets of these types of assaults (CDC, 2019). Therefore, as clinicians and practitioners working with survivors, utilizing a trauma-informed approach that is tailored to women is essential to both understand and treat trauma. Substance Abuse and Mental Health Services Administration [SAMHSA] (2017) has outlined a trauma-informed framework for providing care for survivors of trauma. By using this framework, along with a feminist perspective, clinicians and practitioners will have a more comprehensive conceptualization regarding the impact of trauma, as well as how to help survivors heal from traumatic experiences.

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Sexual assault

Prevalence and definition

Sexual assault affects a substantial portion of women in the United States (U.S.) and globally; the lifetime prevalence of sexual assault among women is approximately 1 in 3; the prevalence of rape is estimated to be 1 in 6 among national samples of females (Kilpatrick et al., 2007; Tjaden & Thoennes, 2006). Sexual assault, or sexual behavior that occurs without consent being obtained or freely given includes rape, attempted rape, forcing the victim to perform sexual acts (oral sex or penetration), and fondling (Loeb, Gaines et al., 2011; Centers for Disease Control and Prevention, 2019; Mental Health America, 2019; Rape, Abuse & Incest National Network [RAINN], 2019). These behaviors include, but are not limited to, those involving physical force; they also include coercion, manipulation, threats, and situations in which the victim is not able to provide consent (RAINN, 2019). The perpetrator of sexual assault is usually someone known to the victim (CDC, 2019). Prevalence rates are thought to be underestimated as many victims do not report their experiences due to feelings of embarrassment and/or shame, beliefs about not being believed, fears associated with telling the police or others, and threats of harm made by the perpetrator (CDC, 2019). Sexual assault frequently co-occurs with other types of trauma, including interpersonal violence (McFarlane et al., 2005).

Sexual assault and mental health

The associations between sexual victimization and adverse psychological outcomes have been well documented. Short-term effects include feelings of shock, disbelief, confusion, shame, guilt, self-blame, withdrawal, flashbacks of the assault, and insomnia (Basile & Smith, 2011; CDC, 2019). Reports of emotional numbness, hypervigilance and avoidance of reminders of the event, as well as disruptions to daily routines, are also common (Koss et al., 1994). Frequently, survivors report intense fear of the perpetrator, fears related to another attack, and suffer anxiety regarding issues related to disclosure (Basile & Smith, 2011). Of great concern are the negative changes in world view reported by survivors and the effect these negative shifts in belief systems have on survivors' subsequent experiences (Basile & Smith, 2011).

National data and meta-analyses suggest that victims of rape or sexual assault are at increased risk for the development of numerous long-term adverse psychological outcomes, including posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, substance use disorders, eating disorders, sleep disorders, anxiety disorders, and suicide attempts, regardless of the age of the victim at the time of the assault (Chen et al., 2010; Sarkar & Sarkar, 2005; Zinzow et al., 2012). There is evidence that the

development of some psychiatric disorders, including depression and PTSD, may vary according to circumstances surrounding the assault; for example, the type of coercion or rape tactic the victim experienced (Basile & Smith, 2011). Rape tactics refer to the methods a perpetrator uses to coerce a victim into engagement in or exposure to a sexual behavior (Basile et al., 2014).

The relationships between the psychological and physical effects of sexual violence tend to be examined in isolation; however, these variables frequently co-occur. For instance, less frequent engagement in physical activity has been found to mediate the relationship between more severe symptoms of PTSD and depression and poorer health status (Rutter et al., 2013). Research identifying the trajectories leading to these differential outcomes is needed.

Sexual assault and physical and sexual health

Several lines of research have detailed the many deleterious physical health consequences associated with sexual violence for women. Victims may sustain injuries from the assault itself, including genital injuries (Sommers, 2007; Weaver, 2009), abrasions, and broken bones (Basile & Smith, 2011). Numerous gynecological issues that present post-rape include pregnancy, sexually transmitted infections (STIs), and HIV transmission (Basile & Smith, 2011; CDC, 2019). The transmission of STIs is of particular concern, as STIs are associated with long-term health complications, including pelvic inflammatory disease, infertility, cervical cancer, tubal or ectopic pregnancy, and perinatal or congenital infections in infants born to infected mothers (Hawks et al., 2019; National Institute of Health [NIH] & National Institute of Allergy and Infectious Diseases, 2015). Further, infection with some STIs actually increases risks of HIV transmission (National Institute of Health [NIH] & National Institute of Allergy and Infectious Diseases, 2015).

Experiences of rape also impact women's reproductive and sexual functioning. Compared to women who have never experienced rape, those that have been raped report more abnormalities with ovulation and menstruation, endometriosis, dyspareunia, and chronic pelvic pain (National Institute of Health [NIH] & National Institute of Allergy and Infectious Diseases, 2015; Weaver, 2009). Other sexual health problems include reduced interest in or avoidance of sex as well as less frequent arousal and orgasms (Becker et al., 1986; CDC, 2019). One of the strongest predictors of sexual and physical revictimization is a previous history of sexual assault (Wyatt, Loeb et al., 2012) and subsequent negative consensual sexual experiences (Loeb, Gaines et al., 2011). These behaviors, in turn, are associated with increased risk of STI transmission and unsafe sexual behaviors (Loeb, Williams et al., 2002). Posttraumatic stress disorder may be an important mediator between sexual violence and sexual health outcomes, as symptoms may inhibit the cognitive

processes necessary for accurately gauging sexual risks, negotiating safe sexual behaviors, and adopting health-promoting practices (Weaver, 2009).

Survivors of sexual violence commonly present to primary care doctors with high levels of somatic concerns; physicians who are not trained to ask about experiences of trauma may be unable to determine the etiology of these diverse symptoms (Loeb, Joseph et al., 2018; Creed et al., 2012). This can feel frustrating and may potentially leave victims feeling invalidated, and confused, as well as reduce confidence and trust in healthcare professionals. Common somatic complaints include musculoskeletal pain, headache, pelvic pain and gastrointestinal problems (Loeb, Joseph et al., 2018). Links between sexual abuse and the diagnosis of somatic disorders have also been reported (Paras et al., 2009), as have associations between histories of trauma and adversity, including experiences of sexual assault and interpersonal violence, and the severity of somatic symptoms experienced among a sample of ethnically diverse women (Loeb, Joseph et al., 2018). Symptoms of posttraumatic stress and depression have been found to partially mediate the associations between histories of trauma and adversity and severity of somatic symptoms, suggesting that both exposure to trauma and adversity as well as the development of posttraumatic and depressive symptoms influence the development of somatic concerns (Loeb, Joseph et al., 2018).

Gastrointestinal symptoms and illnesses, including gastrointestinal disorder and irritable bowel syndrome, are also associated with sexual violence (CDC, 2019). Survivors of sexual violence have elevated risks of certain types of cancer (A. L. Coker et al., 2009), cardiovascular disease (CDC, 2019), and chronic neck, head, facial and back pain (Koss et al., 1994). Finally, survivors of sexual violence have been found to engage in negative health behaviors more frequently than women who have not experienced sexual violence. These health compromising behaviors include smoking, substance abuse, alcohol abuse, and engaging in high-risk sexual behaviors (CDC, 2019; Hawks et al., 2019; Lang et al., 2003; Weaver, 2009).

Intimate partner violence

Definition and prevalence

IPV is common, affecting approximately 1 in 4 women in the U.S. annually, causing significant physical and mental health consequences (Smith et al., 2018). Although not limited to females, women are disproportionately affected by severe physical violence by an intimate partner, with lifetime prevalence rates of 22.3% for women and 14% for men (Breiding et al., 2014). Most definitions of IPV include physical and sexual violence, psychological aggression, and stalking perpetrated by current or former spouses, boyfriends or girlfriends, dating partners, or ongoing sexual partners (Basile et al., 2014;

CDC, 2019). Different types of IPV can coexist (Smith et al., 2018). Broader specifications of the characteristics that constitute an intimate partner also exist. Basile et al. (2014) characterize an intimate partner as:

> A person with whom one has a close personal relationship that may be characterized by the partners' emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, and familiarity and knowledge about each other's lives. The relationship need not involve all of these dimensions. (p. 14)

Many victims of IPV experience significant mental and/or physical health consequences.

IPV and mental health

Female victims impacted by IPV have an increased risk of numerous mental health symptoms and disorders, including symptoms of depression, posttraumatic stress, substance abuse and low self-esteem, clinical depression, suicide attempts, PTSD, and other anxiety and substance use disorders (Devries et al., 2013, 2011; Karakurt et al., 2014). A meta-analysis by Beydoun et al. (2012) described moderate to strong associations between experiences of IPV and depression, with a substantial proportion of cases of elevated symptoms of depression, postpartum depression, and major depressive disorder due to exposure to IPV. (Physical IPV has specifically been associated with increased risks for substance use and symptoms of depression (A. Coker et al., 2002)).

Most women who experience physical violence also experience sexual violence, and those who experience both may be at heightened risk for some mental health outcomes, including PTSD, in comparison to women who experience physical violence alone (McFarlane et al., 2005). While the negative effects of IPV have been well documented, less attention has been given to identifying the trajectories of mental health effects due to one or several types of IPV (for instance, physical violence in the absence of other types of IPV) (Delara, 2016). The relationships between IPV and mental health are complex; more studies are needed to clarify relationships between different types of IPV and associated mental health outcomes. Further, specific pathways from exposure to IPV and mental health outcomes have yet to be elucidated, with numerous psychological, environmental and biological risk factors increasing the likelihood of to poor mental health (Chandan et al., 2019).

IPV and physical and sexual health

Research has demonstrated numerous deleterious health consequences associated with experiences of IPV. The most obvious immediate health problems include physical injury sustained during intimate partner violence (Campbell et al., 2002). Physical injury related to IPV is a common occurrence for women

in the U.S., affecting approximately 41% of women who are IVP survivors (CDC, 2019). Intimate partner violence can also result in death; approximately 1 in 6 homicides in the U.S. are perpetrated by an intimate partner. Intimate partners are responsible for more than half of female homicides in the U.S. for which circumstances were known (Petrosky et al., 2017). Approximately 1 million women in the U.S. have been shot or shot at by an intimate partner, and 4.5 million report having had an intimate partner threaten them using a gun (Sorenson & Schut, 2018).

Physical violence has been associated with health problems, measures of poor health, and increased risks for chronic diseases (A. Coker et al., 2002; Matthew, Smith, Marsh, & Houry, 2013). Intimate violence victims are at increased risk for chronic pain, cardiovascular, gastrointestinal, musculoskeletal, nervous system, and gynecological problems (Campbell et al., 2002; CDC, 2019). Female survivors of IPV are also at higher risk for engaging in health compromising behaviors, including substance abuse, binge drinking, smoking, and high-risk sexual behaviors (CDC, 2019). Intimate partner violence is common in pregnancy, with lifetime prevalence rates ranging between 3% and 13% percent (Campbell et al., 2002). Numerous pregnancy-related risks have been documented, including inconsistent or delayed pre-natal care, engaging in sexual risks, and poor personal health behaviors, including poor diet, smoking, use of alcohol and substance use (Alhusen et al., 2015). Experiencing IPV during pregnancy is also associated with increased symptoms of depression, PTSD, homicide, and suicide (Alhusen et al., 2015). Although studies do not always specify which specific IPV behaviors are responsible for negative health outcomes, there is evidence that women who experience both sexual and physical violence are at increased risk for both immediate and long-term health problems (Campbell et al., 2002).

Trauma-informed practice and feminist theory

Given that sexual assault and interpersonal violence impact women at dis-proportionate rates compared to men and are coercive, interpersonal attacks that result from power inequities, the healing journey for survivors must take such issues into account. By utilizing SAMSHA's (SAMHSA, 2016, 2017) trauma-informed care framework and feminist theory, clinicians are afforded a comprehensive approach in understanding of the impact of trauma on women's overall health and how best to help them deal with the aftermath. Many of the hallmark concepts of feminist theory are encapsuled within SAMSHA's trauma framework. SAMSHA's six principles of trauma-informed care include: 1. Safety; 2. Trustworthiness and Transparency; 3. Peer Support; 4. Collaboration and Mutuality; 5. Empowerment, Voice and Choice; and 6. Cultural, Historical, and Gender Issues (SAMHSA, 2017).

Safety

Starting with safety, enhancing a sense of physical and emotional safety is priority. The continued aftermath of symptoms following victimization that include hypervigilance, intense fear of the perpetrator, fears related to another attack, and anxiety regarding issues related to disclosure (Basile & Smith, 2011; Koss et al., 1994) create continued feelings of being unsafe. Using psychoeducation regarding the impact of trauma on emotional, mental, neurobiological, and social functioning can help normalize many of the victim/survivor experiences that contribute to such feelings of lack of safety and can increase self-compassion (Brown, 2006). Trauma-informed feminist practitioners can assist clients understand how their symptoms and behaviors are a means of coping with the traumatic experiences. This non-pathological and non-victim-blaming approach enables the client to be less judgmental and more empathic regarding their trauma-responses (Walker, 1990). Interventions that can be effective in enhancing safety are included in the evidence-based treatment program for victims of trauma, Seeking Safety (Navajitz, 2002). By increasing safer and healthier coping skills to manage anxiety, depression, and other mental and physiological symptoms, the survivor can begin to experience more emotional and physiological stability. Feminist practitioners also help their clients to understand the cognitions they hold regarding their trauma experiences (Walker, 1990). Cognitive behavior therapy interventions that include trauma narratives and cognitive restructuring are helpful for practitioners in utilizing effective trauma-informed approaches that incorporate feminist therapy values. Another important component for practitioners to address with their traumatized clients is environmental safety. Is the client currently in a violent relationship? Is the perpetrator a continued threat? Developing a comprehensive safety plan that addresses safety in the current relationship, safety from physical threats, cyber threats, etc. is critical to minimize risk and help the client establish safety. Such safety plans are readily available on-line, in the research literature, and can be tailored to meet the needs of the client.

Trustworthiness and transparency

As victims of trauma are often victimized from known perpetrators, the external world can feel unsafe. Trustworthiness and transparency are important factors as many victims have experienced trauma at the hands of a "trusted" person (CDC, 2019; Conley & Griffith, 2016). This continued stance of being unsafe and the inability to trust others is exacerbated when survivors seek medical attention for somatic complaints that are associated to the trauma but misdiagnosed by physicians (Loeb, Joseph et al., 2018). Therefore, the ability to trust becomes impaired, including trusting clinicians and practitioners as well as mental health providers. A trauma-informed feminist approach can

build trust through clear and explicit expectations and policies, thereby effectively being transparent on the part of the clinician. Clinicians can create safety for survivors by approaching them with acceptance, validation, belief in their experiences, and having a non-judgmental stance that can otherwise further a survivors' feelings of guilt and shame. Further, self-awareness on the part of the clinician and practitioner can promote role modeling for survivors and increasing protect against potential unconscious bias (Brown, 2006). Feminist therapists may utilize self-disclosure as a means of enhancing trustworthiness and transparency and achieving a more egalitarian relationship (Bohan, 1992). Further, treatment goals are driven by the client, not imposed by the therapist; feminist therapists work in collaboration to build the therapeutic relationship. In some instances, and not uncommon, the client's goal may be to remain in a violent relationship. Even in these conditions, the trauma-informed feminist practitioner respects the client's decisions and assists the client in achieving their goals of treatment.

Peer support

An atmosphere of peer support is important as it combats tendencies toward isolation and withdrawal and builds a network and community for survivors. As noted, survivors often experience shame, guilt, and self-blame (Basile & Smith, 2011; CDC, 2019). Parsons et al. (1998) emphasize how building connections through small groups can provide validation for the survivor's traumatic experiences and can help in decreasing self-blame and enhance mutual support. Brown (2004) highlights the focus in feminist therapy on the importance of networking for social change and the positive impact of normalizing trauma experiences through social connection. This can be done both in encouragement in individual work, but is also incredibly impactful through group work. Effective group interventions that are both trauma-informed and have feminist underpinnings can focus on sharing personal experiences, cultural values, and current and past traumatic experiences. In doing so, clients will notice similarities in their experiences and support each other in developing and achieving personal goals. Group members can also gain a better and mutual understanding of not only their unique personal, familial and cultural experiences, but the group as a whole can come together and understand the experience of womanhood in the community and social context and how this larger context is related to traumatic experiences. These experiences can combat a tendency to isolate in recovery.

Collaboration and mutuality

Given that sexual and interpersonal traumatization places women in a position of submission and coercion, counteracting these experiences through collaboration and mutuality is important (SAMHSA, 2017). Collaboration and

mutuality can be accomplished with an approach of partnering with survivors in shared decision making in their treatment, whether medical or mental health. Feminist practice embraces equality in the therapeutic relationship, partnering and collaborating as a means of enhancing empowerment (Worell & Johnson, 1997) which is consistent with mutuality. The relationship between therapist and client can be healing as the trauma-informed feminist practitioner creates an equal partnership with the victim/survivor that can serve as a model for other relationships with partners, families, and society. The practitioner encourages self-expression, assertiveness, and a space to question and challenge discussions, belief systems, and experiences. This strength-based approach is compassionate and empathic, and meets the client where they are at in their lives and experiences (Brown, 2004; Courtois & Ford, 2009; Herman, 1997). Further, Sommers-Flanigan and Sommers-Flanagan (2004) emphasizes the need for the practitioner to honor the client's trauma and experiences, reformulate and redefine mental illness, and participate in a comprehensive understanding of trauma and oppression.

Empowerment, voice and choice

SAMSHA's principles of empowerment, voice and choice overlap with the fundamental core tenets of feminist theory (Enns, 2011). The act of victimization through sexual assault and interpersonal violence takes place as a result of coercion, disempowerment, and control. Not only is the victim unable to protect themselves, they are often silenced through coercion and/or shame, and often re-victimized (Wyatt, Loeb et al., 2012). Heath et al. (2011) describe the importance of helping survivors challenge oppressive beliefs that may have contributed to traumatization. The feminist idea of empowering individuals by helping them identify the power relationship inequities in society and how to create social change can be beneficial for survivors of trauma (Gutierrez & Lewis, 1999), especially by paralleling these inequities to the trauma experience. Walker (1990) describes the importance for feminist practitioners to help women learn how to gain and use power in relationships, and how to enhance and utilize their strengths. The relationship between the therapist and client provides the opportunity for empowerment. Given the inherent power inequity that exists between therapist and client, by identifying such inequities in relationships and providing a collaborative, supportive and strong therapeutic alliance, the client can be empowered and able to use these strengths in other relationships (Sommers-Flanigan & Sommers-Flanigan, 2018). Bohan (1992) also emphasizes the importance for practitioners to be cognizant of the impact of the power differentials within the family, and the reality of the roles the client has in terms of caretaking, decision making, finances, and employment, as well as gaining an

understanding of what it means to be a woman within the societal context. As the practitioner listens, questions, and helps the client analyze these issues in the session, power and empowerment can be gained through the therapeutic relationship as the client becomes more aware and better able to understand their familial and social context and how traumatic experiences have impacted their lives. A further understanding can be gained for many women who continue to be victims in violent relationships. Lack of employment, caretaking responsibilities and a lack of financial resources are often legitimate reasons that create barriers for women who may want to leave an IPV relationship but are unable to (Whiting, 2016). Assisting women in looking at options and creating resources may be helpful in providing some hope and possibilities for change.

Enhancing self-esteem is a key factor in helping traumatized victims gain empowerment, voice and choice. Years of victimization often results in feelings of low self-worth, not valued as a human being, and often times feeling like the abuse and assault may be deserved (Whiting, 2016). Common self-beliefs that include feeling worthless, damaged, and at fault lead to an inability to create change or having a life driven by their choosing and control (Cravens et al., 2015). Therefore, interventions aimed at improving hope and a strong sense of self are beneficial. Practitioners can help clients focus on strengths, accomplishments, and self-compassion. Interventions aimed at developing and enhancing assertiveness skills, including role-playing, can strengthen their voice. Highlighting the importance of self-care and self-nurturance can be effective as well in enhancing self-esteem and creating empowerment and voice. Often, women are bombarded by their many roles that require caretaking of others. For many women, caretaking of the self is not considered and may even feel selfish or not deserved (Whiting, 2016). Developing a daily routine of self-care and beginning to regard one-self as a priority can begin the journey toward self-worth and value, from victim to survivor. A sense of choice can also be enhanced by utilizing decision tree activities, in which clients can routinely discuss and delineate situations that arise and the pros/cons related to the various options in addressing them.

Cultural, historical, and gender issues

Finally, SAMSHA's principle of cultural, historical, and gender issues in the understanding and treatment of trauma addresses the importance of incorporating an inclusive environment that respects, honors, and embraces diversity. This highlights the need to use approaches that are relevant to the varied cultural and language needs for healing. It is also helpful in providing

a framework to identify the intersectionality, a multicultural feminist theoretical concept (Collins, 2000), of culture, gender and the social climate that place women at risk for sexual and interpersonal victimization. Although sexual and interpersonal violence can potentially affect all women, there are economic, ethnic, and geographical disparities in exposure rates (Hart & Klein, 2013). Native American, Black and Latina females tend to experience higher rates of IPV than white women; however, some research suggests that poverty, rather than ethnicity, is a powerful contributor to these rates. Further, poverty exacerbates the challenges faced by victims of IPV due to lack of accessibility and resources both in the prevention and recovery of trauma (Hart & Klein, 2013). The social climate plays a role in perpetuating violence against women, such a climate includes rape culture. Conley and Griffith (2016) describe rape culture as:

> The societal conditions that allow sexual violence to take place. These societal conditions include, but are not limited to, (a) tolerance of sexual harassment and violent pornography, (b) the belief that women who have consumed alcohol are sexually available, (c) restrictive ideas about masculinity (e.g., men don't cry), (d) the belief that women should be responsible for keeping themselves safe (e.g., victim blaming), (e) jokes about rape, and (f) the belief that certain groups are better than others (e.g., sexism, racism). (p. 279)

Taking an educative stance regarding rape culture and the societal conditions that perpetuate violence against women is imperative in the healing and empowerment of survivors (Conley & Griffith, 2016). Further, the political and social climate that rejects immigrants and undocumented individuals can also place these marginalized women at increased risk for sexual and interpersonal trauma (Kaltman et al., 2011). The feminist idea that focuses on the personal as political enables survivors to identify both internal and external conditions associated with trauma (Nylund & Nylund, 2003).

Future directions

Recommendations for future research on the impact of sexual and interpersonal trauma on women's health include primarily focusing on SAMSHA's last principal of cultural, historical, and gender issues. This review of the research through the feminist lens confirms a lack of diversity found throughout traditional conceptualizations of sexual and interpersonal violence, which disproportionately affect women and have misconceptualized, minimized, and at times blamed victims while dismissing the pervasive impact of the patriarchial societal power structure on violence against women.

Conducting a gender, cultural, and historical analysis in the therapy session with victims and survivors of sexual and interpersonal trauma can

be helpful in increasing an understanding of these issues. For example, a gender analysis that looks at how the division of labor, roles and responsibilities in the family, availability of resources, and their position in their families and society can contribute to continued disempowerment can be eye-opening for many women, trauma victims and survivors in particular. Bohan (1992) described the importance for feminist practitioners to understand the impact of sexism inherent in our society and thereby promote roles for trauma victims and survivors that go beyond cultural or gender stereotypes. Bohan (1992) encourages clinicians to help clients participate in their gender role journey. Such a journey would need to include the messages that come from their particular culture, religious beliefs, and historical experiences based on their race and ethnicity that can impact and sustain traumatic experiences.

Conclusion

Given the prevalence of sexual assault and interpersonal violence against women, it is important to identify the health and mental health implications. For women, the intersectionality of gender, race, and social climate play a role in their risks for victimization. Therefore, in working with women survivors, the trauma-informed framework (SAMHSA, 2017) and feminist theory can help clinicians and practitioners gain a comprehensive understanding of the impact of trauma and the necessary components toward healing. By incorporating the principles of Safety; Trustworthiness and Transparency; Peer Support; Collaboration and Mutuality; Empowerment, Voice and Choice; and Cultural, Historical, and Gender Issues (SAMHSA, 2017) in therapy with trauma victims and survivors, feminist tenets and theoretical underpinnings are woven throughout the framework. This approach enables trauma victims and survivors to experience a more respectful, accepting, non-judgmental egalitarian relationship between the therapist and client that enables healing and empowerment, unlike traditional hierarchical therapist-client relationships.

Practice implications include a therapeutic approach of validation, acceptance, respect, and non-judgment that honors and empathizes with the client's experiences. Psychoeducation and evidence-based practices such as Cognitive Behavior Therapy and Seeking Safety can be useful in establishing safety and an understanding of the impact of trauma. A collaborative partnership enables the client to establish and set their own goals. Skill-based interventions such as role-playing can be effective in increasing assertiveness thereby enhancing empowerment, voice and choice. Finally, by addressing the cultural, historical, social/political and gender issues in the context of sexual and interpersonal trauma among women, as a result, the client can gain a holistic understanding

of how the intersectionality of these issues impacts their journey from victim to survivor.

Funding

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