

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Trauma Informed Care for female Survivors of Domestic Violence

In a shelter setting in Addis Ababa

By

Kirse Samuel

**MA Thesis Submitted to the School of Psychology in Partial Fulfillment of the
Requirements for the Degree of Master of Arts in Counseling Psychology**

May, 2025

Addis Ababa, Ethiopia

Addis Ababa University

College of Education and Behavioral studies

School of Psychology

Trauma Informed Care for female Survivors of Domestic Violence

In a shelter setting in Addis Ababa

BY

Kirse Samuel

APPROVED BY:

| | | |
|---|-----------|------|
| Chair person; Department of Graduate Committee | Signature | Date |
|---|-----------|------|

| | | |
|---------|-----------|------|
| Advisor | Signature | Date |
|---------|-----------|------|

| | | |
|-------------------|-----------|------|
| Internal Examiner | Signature | Date |
|-------------------|-----------|------|

| | | |
|-------------------|-----------|------|
| External Examiner | Signature | Date |
|-------------------|-----------|------|

Declaration

I hereby declare that the work which is being presented in this thesis entitled “ Trauma Informed Care for Survivors of Domestic Violence” Is original work of my own, except where acknowledgements of sources are made and that has not been presented for a degree to any other university and all the materials used for the thesis have been duly acknowledged?

Kirse Samuel

Date**(Candidate)**

This is to certify that the above declaration made by the candidate is correct to the best of my knowledge.

Dame Abera (PhD)

Date**(Thesis advisor)**

Acknowledgments

First and foremost, I am deeply grateful to the Almighty God for granting me the strength, wisdom, and perseverance to complete this research work.

I would like to express my heartfelt thanks to my academic advisor, Dr. Dame Abera, for his invaluable guidance, constructive feedback, and continuous encouragement throughout the course of this study. His expertise and commitment played a vital role in shaping the quality and depth of this thesis.

My sincere appreciation also goes to the Ministry of Women and Social Affairs for their kind cooperation and support during the data collection process. Their facilitation and encouragement contributed significantly to the success of this study.

Special thanks are extended to the staff and participants from “yesetoche marefiya ena lematt maheber” (Women's Shelter and Development Association) located in Akaki Kality Sub-City, Addis Ababa. Your trust, openness, and willingness to share your stories provided deep insights that are central to this research.

Finally, I am immensely thankful to all the survivors and professionals who participated in the interviews and focus group discussions. Your voices, experiences, and courage lie at the heart of this work, and I am truly honored to have had the opportunity to listen and learn from you

Table of Contents

| | |
|--|-----|
| Acknowledgments..... | i |
| Acronyms..... | vi |
| Abstract..... | vii |
| Chapter One: Introduction..... | 1 |
| 1.1 Background of the Study..... | 1 |
| 1.2 Statement of the Problem..... | 4 |
| 1.3 Research Objectives..... | 6 |
| 1.4 Research Questions..... | 7 |
| 1.5 Significance of the Study..... | 7 |
| 1.6 Scope and Delimitations of the Study..... | 10 |
| 1.7 Operational Definitions of Key Terms..... | 11 |
| Chapter Two: Review of Related Literature..... | 13 |
| 2.1 Introduction..... | 13 |
| 2.2 Concept of Trauma..... | 15 |
| 2.3 Concept of Domestic Violence..... | 16 |
| 2.4 Global Perspectives on Trauma-Informed Care..... | 17 |
| 2.5 Theoretical Framework..... | 19 |
| 2.5.1 Trauma Theory..... | 19 |
| 2.5.2 Ecological Systems Theory..... | 20 |
| 2.6 National Perspectives on Trauma-Informed Care..... | 21 |
| 2.7 Local Perspectives on Trauma-Informed Care..... | 24 |
| 2.8 Conceptual Framework..... | 26 |
| 2.9 Principles of Trauma-Informed Care..... | 27 |
| 2.10 Empirical Studies on Trauma-Informed Care..... | 28 |

| | |
|---|----|
| 2.11 Gaps in the Literature and Implications of the Review..... | 30 |
| Chapter Three: Research Methodology..... | 32 |
| 3.1 Research Design..... | 32 |
| 3.2 Description of the Study Site..... | 33 |
| 3.3 Target Population..... | 34 |
| 3.4 Sampling and Sampling Techniques..... | 35 |
| 3.4.1 Sample Size Determination..... | 35 |
| 3.4.2 Inclusion Criteria..... | 36 |
| 3.5 Instruments of Data Collection..... | 36 |
| 3.5.1 Semi-Structured Interview Guide..... | 36 |
| 3.5.2 Focus Group Discussion Protocol..... | 37 |
| 3.5.3 Pretesting and Adjustment..... | 37 |
| 3.5.4 Language and Recording..... | 37 |
| 3.6 Procedure of Data Collection..... | 38 |
| 3.7 Procedure of Data Analysis..... | 40 |
| 3.8 Ethical Considerations..... | 42 |
| Chapter Four: Data Analysis and Discussion..... | 44 |
| 4.1 Analysis..... | 44 |
| 4.1.1 Introduction..... | 44 |
| 4.1.2 Summary of Key Findings..... | 44 |
| 4.1.3 Description of Participants and Cases..... | 46 |
| 4.1.4 Major Themes Based on the Research Questions..... | 48 |
| 4.1.5 Individual Survivor Cases..... | 52 |
| 4.2 Discussion of Findings..... | 54 |
| Chapter Five: Summary, Conclusion, and Recommendations..... | 62 |
| 5.1 Summary of the Study..... | 62 |
| 5.2 Conclusion..... | 63 |
| 5.3 Recommendations..... | 65 |

| | |
|---|----|
| References..... | 69 |
| Appendices..... | |
| Appendix A: Interview Transcripts..... | 71 |
| Appendix B: Interview Guide..... | 79 |
| Appendix C: Focus Group Discussion Transcript Sample..... | 81 |
| Appendix D: Research Questions (English and Amharic)..... | 83 |

Acronyms

| | |
|--------|---|
| TIC | Trauma –Informed Care |
| FGD | Focus Group Discussion |
| NGO | Non – Governmental Organization |
| IPV | Intimate Partner Violence |
| WHO | World Health Organization |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| PTSD | Post –Traumatic Stress Disorder |
| DV | Domestic Violence |
| IRB | Institutional Review Board |
| GBV | Gender –Based Violence |

Abstract

This study explores the implementation and perceived effectiveness of trauma-informed care (TIC) for survivors of domestic violence in a shelter setting in Addis Ababa, Ethiopia. The research aimed to understand how TIC principles such as safety, empowerment, and trust—are applied by service providers and experienced by survivors within the Women’s Shelter and Development Association located in Akaki Kaliti Sub-City.

A qualitative phenomenological approach was used to capture the lived experiences of participants. The study involved ten purposively selected participants—six survivors and four service providers. Data were gathered through semi-structured interviews and a focus group discussion and analyzed using Braun and Clarke’s thematic analysis method.

Findings revealed that while counseling services often incorporate TIC principles like emotional validation and confidentiality, other aspects of service delivery lack consistency. Survivors reported positive experiences within the shelter but noted limited support during reintegration. Service providers identified key challenges including inadequate training, emotional fatigue, and lack of institutional guidance. Cultural stigma and poor inter-agency coordination also hindered effective implementation.

The study concludes that trauma-informed care is only partially practiced in the Ethiopian context, often relying on personal values rather than structured systems. It recommends more consistent training, policy support, and culturally adapted TIC models to improve service delivery. These findings contribute to the limited literature on TIC in low-resource settings and

offer practical recommendations for enhancing survivor-centered care in Ethiopia.

Keywords: trauma-informed care, domestic violence, survivors, Ethiopia, qualitative research

CHAPTER ONE

Introduction

1.1 Background of the study

1.1 Background of the Study

Domestic violence remains a pervasive global issue, affecting the physical, psychological, and social well-being of millions, particularly women and girls. According to recent global estimates, one in three women has experienced physical or sexual violence in her lifetime (WHO, 2022). This form of violence often results in long-lasting trauma that can significantly disrupt a survivor's mental health and capacity to reintegrate into society.

In response, trauma-informed care (TIC) has emerged as a best-practice approach globally and is increasingly being adopted in various service sectors such as mental health, child protection, and gender-based violence response. TIC focuses on promoting physical and emotional safety, empowerment, collaboration, and trustworthiness in service environments (Levenson, 2020; SAMHSA, 2014). It emphasizes understanding trauma's widespread impact and the importance of integrating this awareness into every aspect of service delivery.

Although TIC is being integrated in many countries, its application in low-income settings remains limited. In Ethiopia, domestic violence continues to be a pressing issue, despite national commitments through legal and policy frameworks such as the National Strategy on Harmful Traditional Practices (MoWSA, 2021). However, implementation of trauma-sensitive services is still in its infancy. Research by Gebreyesus and Fikadu (2023) indicates that most shelters and legal aid centers lack structured trauma-informed protocols and provider training.

Local organizations like YeSetoch Marefiya Ena Lematt Maheber in Addis Ababa provide critical services, yet operate with limited resources and little guidance on how to address the psychological aftermath of abuse. Survivors often receive basic counseling and temporary shelter, but comprehensive trauma recovery support remains insufficient.

This study explores the understanding and implementation of trauma-informed care in a women's shelter setting in Addis Ababa, with the aim of contributing localized knowledge to guide improved, culturally sensitive service models.

This study fills that gap by exploring the implementation and experience of trauma-informed care among female survivors and service providers at a local shelter in Addis Ababa. It contributes a context-specific, qualitative perspective on the strengths, challenges, and gaps in trauma-related support systems. By grounding the study in both survivor and provider narratives, and framing it within the Ethiopian socio-cultural context, this research aims to inform the development of more effective, compassionate, and locally relevant models of care. Unlike previous studies that are primarily quantitative or policy-focused, this research centers lived experience and promotes a deeper understanding of trauma-informed care as a holistic and culturally sensitive approach to supporting survivors of domestic violence.

1.2 Statement of the Problem

Trauma-Informed Care (TIC) has emerged as a critical framework in addressing the long-term emotional and psychological effects of trauma, particularly among survivors of domestic violence. Unlike traditional support models that often focus solely on immediate safety and crisis intervention, TIC emphasizes understanding trauma's pervasive impact and integrating principles such as safety, empowerment, and collaboration into all levels of care.

In Africa, while awareness of trauma's psychological impact is increasing, the integration of trauma-informed approaches into gender-based violence response services remains limited.

Many organizations across the continent continue to provide fragmented services that lack psychological depth, placing survivors at risk of re-traumatization and emotional neglect. Studies in Kenya, South Africa, and Uganda have emphasized the need for culturally adapted

In Ethiopia, although there are legal and institutional frameworks addressing domestic violence, the integration of trauma-informed principles into psychosocial services is still largely undeveloped. Support services tend to prioritize short-term interventions such as shelter and legal aid, with limited emphasis on survivors' emotional recovery. Recent studies (Gebreyesus & Fikadu, 2023) show that TIC is not systematically practiced in shelters or counseling centers, and service .

This study seeks to address this gap by examining how TIC is understood and applied in a women's shelter in Addis Ababa. It focuses on the lived experiences of both survivors and service providers to assess the presence, absence, and effectiveness of trauma-informed

practices. Without the integration of TIC, services may fall short in promoting holistic recovery, resilience, and empowerment.

1.3 Research objectives

General objective

The general objective of this study is to explore the implementation, experiences, and challenges of trauma-informed care in the context of supporting survivors of domestic violence within a selected organization in Addis Ababa, Ethiopia.

Specific objectives

- 1 To identify the institutional, cultural, and contextual factors that facilitates or hinders the effective delivery of trauma-informed care.
- 2 To assess the perceived outcomes of trauma-informed services from both the perspectives of survivors and service providers.

1.4 Research questions

This study is guided by the following central and sub-questions aimed at understanding the implementation and impact of trauma-informed care in domestic violence support services:

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?
3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?
4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?
5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

1.5 Significance of the study

This study holds significance for multiple stakeholders by addressing a critical gap in trauma-informed care (TIC) services for survivors of domestic violence in Ethiopia. It contributes original, context-specific insights into how TIC principles are understood and practiced within a local women's shelter.

For service providers and shelter organizations, the findings offer practical guidance on enhancing care delivery by integrating trauma-sensitive principles such as safety, empowerment, and trust. For policymakers, the study provides localized evidence that can inform the development of national frameworks and training guidelines for TIC implementation.

For the academic community, it contributes to the limited body of qualitative research on trauma-informed practices in low-resource settings, particularly in Ethiopia. Additionally, the perspectives of survivors elevate the importance of designing services that are not only protective but also healing and empowering.

By capturing both survivor and provider experiences, the study promotes a holistic understanding of trauma-informed care and aims to support more effective, compassionate, and sustainable interventions in gender-based violence response systems.

1.6 Scope and Delimitation of the Study

This study focuses on exploring the implementation and experiences of trauma-informed care (TIC) within a single women's shelter located in Akaki Kality Sub-City, Addis Ababa. The research specifically examines how TIC principles such as safety, empowerment, and trust are applied and perceived by female survivors of domestic violence and the professionals who support them.

The study is limited to one shelter due to accessibility and resource constraints. It includes only adult female survivors and service providers who have at least one year of experience in trauma-related care. Male survivors and staff were excluded to maintain consistency with the shelter's population and services.

The research employs a qualitative, phenomenological design and does not aim for generalization. Instead, it offers in-depth, contextualized insights based on the lived experiences of participants. No clinical trauma assessments or standardized psychological tools were used; data were gathered through interviews and a focus group discussion.

These boundaries were intentionally set to ensure a focused and culturally grounded exploration of trauma-informed practices in Ethiopia.

1.7 Operational Definitions of Key Terms

Trauma-Informed Care (TIC)

An approach to service delivery that recognizes the widespread impact of trauma and seeks to actively resist re-traumatization. TIC emphasizes safety, trustworthiness, empowerment, collaboration, and cultural responsiveness, aiming to create healing-centered environments for survivors.

Survivors of Domestic Violence

Adult women who have experienced one or more forms of abuse physical, emotional, sexual, or economic within an intimate or family relationship, and who have accessed support services at the selected women's shelter in Addis Ababa.

Service Providers

Professionals including counselors, social workers, and program staff working directly with survivors at the shelter. All included participants have a minimum of one year of experience in trauma-related support services.

Domestic Violence (DV)

A pattern of coercive and abusive behaviors used by one partner to control the other in an intimate relationship. It includes physical, sexual, emotional, and financial abuse.

Shelter-Based Support Services

Services provided in a residential setting for survivors of domestic violence, including temporary accommodation, counseling, legal aid, and skills training. These services are assessed for their alignment with trauma-informed care principles.

Safety

Ensuring physical and emotional safety for survivors within the service environment, including respectful communication and secure facilities.

Trustworthiness

Establishing clear boundaries, consistent procedures, and transparency to foster trust between survivors and providers.

Empowerment

Supporting survivors to regain control over their lives by validating their strengths and involving them in decision-making processes.

Collaboration

Promoting shared decision-making between service providers and survivors, emphasizing mutual respect and partnership.

Choice

Offering survivors meaningful options in their care and respecting their autonomy in the healing process.

Cultural Responsiveness

Delivering services that are sensitive to and respectful of survivors' cultural backgrounds, values, and beliefs.

CHAPTER TWO

Review of Related literature

2.1 Introduction

This chapter presents a review of recent literature related to trauma-informed care (TIC) within the context of domestic violence. It includes global, African, and Ethiopian perspectives, focusing on studies from the last five years (2019–2024). The chapter explores definitions, theoretical foundations, and empirical research while identifying critical gaps in knowledge that justify the current study.

2.2 Global Perspectives on Trauma-Informed Care

Globally, TIC is recognized as a best practice framework in supporting survivors of trauma. The SAMHSA framework (2014) outlines key principles: safety, trustworthiness, peer support, collaboration, empowerment, and cultural sensitivity. Recent studies by Levenson (2020) and Sharma et al. (2020) emphasize that TIC promotes psychological safety, reduces re-traumatization, and improves engagement in services. Research in high-income countries like the U.S., Canada, and Australia has shown that TIC improves both short- and long-term outcomes for survivors, including emotional regulation, resilience, and therapeutic alliance.

2.3 African Perspectives on Trauma-Informed Care

In the African context, TIC has gained recognition as a culturally adaptable approach to address gender-based violence. Artz et al. (2020) highlighted the potential of TIC in South African shelters, recommending a shift from reactive to preventative care through trauma training. In Kenya, Musyoka et al. (2021) emphasized community engagement and traditional healing as essential adaptations to ensure cultural alignment. Despite these advances, implementation remains fragmented across African countries, with structural and financial limitations commonly cited.

2.4 Ethiopian and Local Perspectives on TIC

Ethiopian studies (e.g., Mekonnen et al., 2021; Abebe & Tsegaye, 2022) reveal that TIC is not yet fully integrated into domestic violence services. While many shelters offer counseling and basic psychosocial support, trauma recovery frameworks are rarely institutionalized. Gebreyesus and Fikadu (2020) found that women receiving structured trauma-informed support were more resilient in post-shelter reintegration. However, local NGOs often lack formal training, and many staff rely on experiential methods. Recent reports from Addis Ababa shelters confirm the absence of national guidelines or supervision structures necessary for consistent TIC application.

2.5 Gaps in the Literature and Implications

Although global research affirms the value of trauma-informed care, there is a significant gap in local implementation evidence. In Ethiopia, most studies focus on prevalence and risk factors of domestic violence, leaving trauma recovery processes underexplored. There is also a lack of survivor-informed research that captures emotional and psychological healing in a structured TIC framework. This study aims to bridge this gap by exploring both survivor and service

provider experiences with TIC in Addis Ababa, providing practical recommendations for more effective, culturally responsive care models.

2.2 The Concept of Trauma

Trauma is broadly defined as an emotional and psychological response to deeply distressing or disturbing events that overwhelm an individual's ability to cope (American Psychological Association, 2013). In this study, trauma refers specifically to the psychological consequences experienced by survivors of domestic violence. These responses often include post-traumatic stress disorder (PTSD), depression, anxiety, emotional numbness, and psychosomatic symptoms, which can persist long after the abusive experiences have ended.

Herman (1992) described trauma, particularly within contexts of captivity like domestic violence, as deeply disempowering and fragmenting to an individual's identity and sense of safety. Courtois and Ford (2013) developed the concept of complex trauma to describe prolonged exposure to interpersonal violence and its effects on emotional regulation, relational capacity, and psychological integration. Bloom (2013) advocated for trauma-informed care models in institutional settings, arguing that survivors require supportive environments that avoid re-traumatization and promote empowerment.

Empirical studies support these theoretical assertions. A study by Warshaw et al. (2013) demonstrated that trauma-informed services led to higher engagement and satisfaction among survivors of IPV. Similarly, Levenson (2017) found that trauma-informed approaches in community-based mental health settings resulted in improved emotional outcomes and stronger

therapeutic alliances. These studies confirm the necessity of integrating trauma-sensitive principles in care services, especially for women affected by domestic violence.

2.3 The Concept of Domestic Violence

Domestic violence, or intimate partner violence (IPV), encompasses a pattern of abusive behavior used to gain or maintain power and control over a partner in an intimate relationship. It can include physical, sexual, emotional, psychological, or economic abuse (World Health Organization, 2021). Although both genders can experience IPV, global studies show that women are disproportionately affected, particularly in cultures with patriarchal structures.

According to Garcia-Moreno et al. (2013), 30% of women globally have experienced physical or sexual violence by an intimate partner. In Ethiopia, Tiruneh et al. (2017) found that over 60% of ever-married women have faced at least one form of domestic violence. These findings reflect a significant public health and human rights issue, exacerbated by societal norms that justify or minimize abuse.

Gebreyesus and Fikadu (2020) examined shelter-based support in Addis Ababa and found that many survivors received limited psychosocial care, with little emphasis on trauma recovery. Mekonnen et al. (2021) further observed that service providers often lacked trauma-specific training, leaving survivors without the necessary emotional and psychological support. The existing studies underscore the urgent need for more integrated, trauma-informed responses to domestic violence in both policy and practice.

2.4 Theoretical Framework

a theoretical framework provides the foundation upon which a research study is constructed. It serves as a lens through which the research problem is examined, interpreted, and analyzed. For this study, which focuses on trauma-informed care for survivors of domestic violence, the theoretical framework is rooted in two major theories: Trauma Theory and Ecological Systems Theory. These theories provide valuable insights into understanding the complexity and multidimensional nature of domestic violence and the holistic approaches required in providing effective support and interventions.

2.4.1. Trauma Theory

Trauma Theory focuses on understanding the psychological, emotional, and physiological impacts of trauma on individuals. It posits that exposure to traumatic events, such as domestic violence, can result in long-lasting and sometimes debilitating effects on a person's mental health, physical well-being, and social functioning. The theory highlights how traumatic experiences disrupt an individual's sense of safety, control, and trust, which are essential for healthy psychological functioning.

In the context of domestic violence, Trauma Theory offers a vital framework for understanding the lived experiences of survivors. It emphasizes the importance of recognizing trauma symptoms such as hyper arousal, avoidance, re-experiencing, and dissociation—and how these symptoms can affect an individual's capacity to engage in therapeutic interventions. Trauma-

informed care, therefore, is an approach that seeks to acknowledge and address the effects of trauma by fostering a safe, supportive, and empowering environment.

2.4.2. Ecological Systems Theory

Developed by Urie Bronfenbrenner (1979), Ecological Systems Theory explains how human development is influenced by different types of environmental systems. The theory outlines five environmental systems that interact to influence individuals: the microsystem, mesosystem, exosystem, macro system, and chronosystem. Each of these systems plays a role in shaping the individual's experiences, behaviors, and coping mechanisms.

In the context of trauma and domestic violence, this theory underscores the importance of considering the broader social, cultural, institutional, and familial influences that impact a survivor's life. For instance, the immediate environment (microsystem) may include family dynamics, while the mesosystem might involve interactions between family and support services. The exosystem could represent larger social support systems, and the macro system includes cultural norms and societal attitudes toward domestic violence. The chronosystem captures the dimension of time and the cumulative impact of life events and transitions.

By applying Ecological Systems Theory, this study takes a comprehensive approach in exploring the complex interplay between individual experiences of trauma and the systemic responses provided through trauma-informed care. It also highlights the necessity of coordinated interventions that consider all levels of a survivor's environment.

Together, Trauma Theory and Ecological Systems Theory form a robust theoretical framework for understanding trauma-informed care for survivors of domestic violence. These theories guide the research in identifying relevant variables, designing the methodology, interpreting findings, and recommending interventions that are sensitive to the multi-layered realities of survivors' lives. The integration of these frameworks ensures that the study remains holistic, person-centered, and aligned with best practices in trauma-informed support services.

In terms of psychosocial response, trauma-informed care remains largely underdeveloped in Ethiopia. Existing services for survivors are often focused on immediate safety, legal redress, and basic shelter, with limited integration of trauma recovery frameworks. Mekonnen et al. (2021) noted that most counselors and social workers in shelters lack formal training in trauma theory or trauma-sensitive approaches. Their findings indicate that while service providers are generally empathetic, they often lack the tools and knowledge to support long-term emotional healing.

Furthermore, there are no national guidelines or institutional protocols that mandate trauma-informed service delivery. As a result, the quality of care varies significantly across organizations. A qualitative study by Abebe and Tsegaye (2022) found that survivors often felt unsupported in shelter environments due to judgmental attitudes, lack of confidentiality, and limited opportunities for empowerment. These experiences not only hinder recovery but can lead to re-traumatization and service disengagement.

Compounding the challenge is the broader societal silence around mental health and trauma. Traditional beliefs may attribute abuse to fate or family issues rather than structural inequalities, reducing the urgency to address emotional consequences. According to Alemu and Tadesse (2019), community attitudes often discourage disclosure and view psychological distress as a private or spiritual issue, limiting survivor access to professional care.

Despite these obstacles, some organizations have begun incorporating elements of trauma-informed care into their work. NGOs such as the Ethiopian Women Lawyers Association and regional women's shelters have piloted programs that emphasize survivor empowerment, group counseling, and community education. However, these efforts remain fragmented and heavily dependent on external funding and project-based support.

In summary, the national landscape in Ethiopia reflects a growing recognition of the need for survivor-centered care, but trauma-informed approaches are not yet systematically adopted. There remains a critical gap in training, policy guidance, and culturally relevant frameworks to support emotional recovery for survivors. Addressing these gaps requires multi sectorial collaboration, investment in mental health infrastructure, and a shift in societal attitudes toward trauma and healing.

2.7 Local Perspectives: Trauma-Informed Care in Addis Ababa

While national data highlight the widespread nature of domestic violence in Ethiopia, the lived realities and service responses at the local level particularly in urban centers like Addis Ababa provide a more focused understanding of the challenges and opportunities surrounding trauma-

informed care (TIC). As the capital and most urbanized area in the country, Addis Ababa houses several shelters and non-governmental organizations (NGOs) dedicated to supporting women who experience domestic violence. Despite their important role, these local service providers often operate in fragmented systems, with limited resources, minimal coordination, and little formal integration of trauma-informed practices.

Organizations such as YeSetoch Marefiya Ena Lematt Maheber, located in Akaki Kality Sub-City, offer temporary shelter, legal support, vocational training, and basic psychosocial counseling for women fleeing abusive relationships. However, studies and reports suggest that trauma-informed care, as a structured and theory-based approach, is largely absent or inconsistently applied within these shelters. For example, Gebreyesus and Fikadu (2020) found that while survivors in Addis Ababa shelters often receive counseling, it is rarely grounded in trauma-specific models or sustained over time. As a result, emotional healing is often superficial, and deeper psychological needs remain unmet.

A field study by Mekonnen et al. (2021) further revealed that shelter staff often has limited training in trauma theory or clinical mental health practices. Most rely on informal counseling methods shaped by experience rather than standardized practices. Service providers expressed empathy and commitment, but they also reported feeling ill-equipped to handle the complex trauma that many survivors exhibit. Without structured TIC frameworks, interventions can unintentionally trigger painful memories or reinforce survivors' feelings of powerlessness and shame.

Survivors themselves have also voiced concerns about shelter environments. In a qualitative study by Abebe and Tsegaye (2022), women described challenges such as lack of privacy, rigid routines, staff insensitivity, and absence of long-term emotional support. These experiences can result in disengagement from services, mistrust in institutions, and increased risk of re-traumatization. The study emphasized that many survivors leave shelters without meaningful emotional recovery or a plan for psychological well-being.

Despite these challenges, some local initiatives show promise. Several shelters in Addis Ababa have begun integrating group counseling sessions, empowerment workshops, and survivor-led peer support activities. These efforts, while not always labeled as 'trauma-informed,' align with key TIC principles such as empowerment, voice, and choice. However, the sustainability and scalability of these interventions remain limited due to reliance on donor funding and lack of national oversight or standardization.

In conclusion, the local perspective in Addis Ababa reveals a service landscape that is committed but under-resourced. While there is growing recognition of the psychological impact of domestic violence, trauma-informed care is not yet a formalized or consistently practiced approach. This underscores the need for structured training, contextually appropriate TIC models, and policy support to ensure that services do more than protect they must also heal.

2.8 Conceptual Framework

This study's conceptual framework is grounded in Trauma Theory and Ecological Systems

Theory to understand the multidimensional nature of trauma recovery among survivors of domestic violence. At its core, the framework places the survivor at the center, surrounded by various layers of influence that impact their recovery journey and access to trauma-informed care (TIC).

Trauma Theory helps explain the psychological, emotional, and behavioral responses of survivors to abuse, and why service approaches must be sensitive to trauma's effects. Ecological Systems Theory, developed by Urie Bronfenbrenner (1979), provides a structural lens to view how multiple social systems interact to shape the survivor's experience.

In this framework, the survivor is embedded within five interconnected ecological levels:

1. **Microsystem:** Immediate relationships and environments, such as interactions with family members, children, and direct service providers (e.g., shelter staff, counselors).
2. **Mesosystem:** The relationships between various microsystems, such as coordination between health services and legal aid or between shelters and community organizations.
3. **Exosystem:** Institutions and social structures that indirectly influence the survivor, including policies of shelters, media representations, and social services.
4. **Macro system:** Cultural values, social norms, and beliefs regarding gender, violence, and mental health that shapes attitudes and policies.
5. **Chronosystem:** The dimension of time, capturing changes in the survivor's environment and personal development over time, including long-term recovery.

Trauma-informed care principles such as safety, trustworthiness, choice, empowerment, and collaboration are embedded across all ecological levels. These principles shape how services should be designed and delivered to avoid re-traumatization and promote healing.

This framework guided the research in exploring both the personal experiences of survivors and the structural responses of service providers. It served as a basis for understanding the interplay between individual trauma and systemic support, and for identifying opportunities to enhance trauma-informed practices in Ethiopia.

2.9 Principles of Trauma-Informed Care

Trauma-informed care (TIC) is an approach grounded in understanding the widespread impact of trauma and recognizing paths for recovery. It involves integrating knowledge about trauma into policies, procedures, and practices to avoid re-traumatization. Studies affirm the effectiveness of TIC in creating supportive environments that foster healing and resilience among survivors of domestic violence.

Trauma-informed care is guided by principles such as safety, trustworthiness, choice, collaboration, and empowerment. These principles help service providers create environments that support healing and avoid re-traumatization. Organizations adopting trauma-informed practices aim to recognize the widespread impact of trauma, integrate knowledge about trauma into policies and procedures, and seek to actively resist re-traumatization.

2.10 Empirical Studies on Trauma-Informed Care

Empirical studies provide concrete insights into the practical application and effectiveness of trauma-informed care in addressing the needs of domestic violence survivors. A variety of global and regional studies highlight how trauma-informed approaches impact the psychological, emotional, and social recovery of survivors, while also offering best practices for implementation in service delivery settings.

For instance, a study conducted by Warsaw, Sullivan, and Rivera (2013) emphasizes the critical role trauma-informed care plays in improving service outcomes for survivors of intimate partner violence. The research revealed that when service providers integrate trauma awareness into their practices through empathy, active listening, and nonjudgmental support survivors report feeling safer, more understood, and more willing to engage in ongoing support services.

In a different context, Elliott et al. (2005) studied mental health service systems across the United States and found that trauma-informed care practices significantly reduced re-traumatization during service delivery. The incorporation of practices such as consent, choice, and emotional safety resulted in improved psychological outcomes among clients who experienced prior abuse and trauma.

From an African perspective, Nnadi (2012) conducted a study in Nigeria on the cultural dimensions of domestic violence and highlighted the importance of community-based interventions. The study concluded that trauma-informed approaches especially those that engage traditional leaders and integrate local healing practices are more effective in addressing

both the physical and emotional harm suffered by survivors.

In the Ethiopian context, a study by Gebreyesus and Fikadu (2020) evaluated the outcomes of shelter-based support for domestic violence survivors in Addis Ababa. They found that women receiving trauma-informed psychosocial support were more likely to rebuild social networks, gain employment, and demonstrate improved emotional resilience compared to those who only received emergency shelter.

Another local study by Mekonnen et al. (2021) investigated the implementation of trauma-informed care in counseling centers in urban Ethiopia. They reported several challenges, including limited training for professionals, cultural taboos around discussing trauma, and resource constraints. However, the study emphasized the potential of trauma-informed frameworks to transform survivor services if tailored to local realities and backed by policy support.

Collectively, these empirical studies underscore the transformative potential of trauma-informed care for survivors of domestic violence. They also highlight the importance of training, cultural sensitivity, systemic support, and survivor-centered practices. The literature supports the integration of trauma-informed care into shelters, counseling services, and healthcare settings as a holistic strategy for fostering long-term recovery among survivors.

2.11 Gaps in the Literature and Implications of the Review

A review of global, regional, and national literature on trauma-informed care (TIC) reveals important progress in recognizing the value of TIC as a holistic, client-centered approach to

supporting survivors of domestic violence. Numerous studies in high-income countries have shown that TIC can foster emotional safety, strengthen therapeutic alliances, reduce re-traumatization, and promote long-term recovery. Additionally, recent efforts in low- and middle-income contexts, including studies in South Africa, India, and Kenya, have begun to explore the cultural adaptation of trauma informed practices.

However, the review also reveals several important gaps that justify the current study. First, while trauma theory and TIC frameworks are well developed globally, there is limited research that explores how these principles are operationalized in Ethiopian domestic violence support settings. Most local studies on gender-based violence focus on prevalence, risk factors, or access to services but do not examine the quality or trauma sensitivity of service delivery. This leaves a gap in understanding how survivors' emotional needs are addressed within the recovery process.

Second, although trauma-informed care emphasizes the need for multi-level, culturally sensitive interventions, there is insufficient literature addressing how Ethiopian service providers perceive and implement these principles in practice. There is a lack of empirical research that examines how trauma-informed care is translated or not into the actual delivery of shelter services, counseling, and advocacy. Furthermore, there is little exploration of survivors' own lived experiences with trauma recovery services, making their voices underrepresented in the literature.

Third, while the existing literature highlights promising interventions, few studies critically evaluate the institutional and systemic barriers that may hinder the integration of TIC, such as

resource limitations, training gaps, or inter-agency fragmentation. These structural issues are particularly relevant in the Ethiopian context, where service delivery often occurs in challenging conditions.

The present study intends to address these gaps by exploring the implementation and experience of trauma-informed care in a women's shelter organization in Addis Ababa. It does so by gathering perspectives from both survivors and service providers. This dual lens allows the study to assess the alignment between TIC principles and actual service practices, and to identify cultural, institutional, and relational factors that shape trauma recovery support.

By bridging the gap between theoretical ideals and practical realities, this study aims to generate context-specific insights that can inform the development of trauma-informed models that are culturally grounded, survivor-centered, and practically feasible in Ethiopia. The review of related literature thus not only guided the research design but also revealed the need for empirical work that integrates theory, lived experience, and local context into a cohesive understanding of trauma-informed care.

Chapter Three

Methodology

3.1 Research Design

This study adopts a phenomenological design to explore how trauma-informed care (TIC) is experienced and understood by both survivors of domestic violence and the service providers who support them. Phenomenology is especially suitable for this research because it seeks to uncover the lived experiences of individuals and the meaning they attach to those experiences—rather than simply measuring external behaviors or outcomes.

In the context of trauma-informed care, survivors may internalize their encounters with support systems in deeply personal and emotional ways. Similarly, service providers bring their own interpretations and emotional responses to delivering TIC in a shelter setting. These subjective meanings cannot be fully captured through quantitative or generalized methods.

By using phenomenology, the study allows participants to describe their realities in their own words, revealing insights into how safety, empowerment, and trust are perceived in practice. This approach is especially important in Ethiopia, where little is known about how TIC is applied, and where cultural and institutional dynamics may influence how care is delivered and received.

Phenomenological inquiry thus aligns closely with the goals of trauma-informed practice itself—centered on listening, validating, and understanding individuals' experiences within their specific contexts.

3.2 Description of the Study Site

The study was conducted at the Women's Shelter and Development Association (WSDA), known locally as “yesetoch marefiya ena lematt maheber” which is located in Akaki Kaliti Sub-City, in the southern part of Addis Ababa, Ethiopia. The organization is situated near Derartu Secondary School, within a semi-urban residential area that is accessible by both public and private transportation.

3.3 Target Population

The target population for this study consisted of two groups: (1) adult female survivors of domestic violence residing in a selected women's shelter in Addis Ababa, and (2) service

providers working at the same shelter. The survivors included individuals who had accessed shelter-based support services such as counseling, legal aid, and skills training. The service providers included counselors, social workers, and staff members directly involved in delivering trauma-related support.

The population was purposively selected based on their direct engagement with trauma-informed care. Female survivors were considered eligible if they had resided at the shelter for at least one month and had received counseling or psychosocial support. Service providers were included if they had at least one year of professional experience in trauma-related care within the shelter context.

This population was chosen to ensure that participants had sufficient exposure to trauma-informed practices to meaningfully reflect on their experiences. Their perspectives were essential for understanding the real-world application and challenges of trauma-informed care in a low-resource, shelter-based setting.

3.4 Samples and Sampling Techniques

This study employed a purposive sampling technique, a method commonly used in qualitative research to select participants who can provide rich, relevant and diverse information about the phenomenon under investigation. The selection was guided by the participants' experience with trauma informed care, either as recipients (survivors of domestic violence) or providers (counselors, social workers or administrative staff) within the women's shelter and development association in Addis Ababa.

3.4.2 Inclusion criteria

Survivors must have accessed trauma informed care service (e.g. shelter, counseling) at the study site within the past two years.

Service providers must have at least one year of experience delivering support to survivors of domestic violence in the selected organization.

Participants must be willing and able to provide informed consent and engage in interviews or group discussions.

By using purposive sampling and applying clear inclusion criteria, the study ensured that the selected participants were well positioned to offer meaningful insights into how trauma informed care is understood, experienced and delivered in an Ethiopian context.

3.4.3 Exclusion Criteria

The following participants were excluded from the study:

1. Male survivors of domestic violence – This study focused exclusively on adult female survivors residing in the selected women’s shelter to maintain gender and contextual consistency.
2. Survivors who had not received counseling or psychosocial support – Participants needed to have experienced trauma-informed services to provide meaningful insights aligned with the research objectives.
3. Shelter residents who had stayed less than one month – A minimum stay duration was required to ensure sufficient exposure to services for reflection.
4. Service providers with less than one year of experience – To ensure credibility and depth of

insight, only experienced professionals were included.

5. Minors and individuals with significant communication barriers – Participants needed the ability to provide informed consent and express their experiences clearly during interviews or focus groups.

These exclusion criteria ensured that the study remained focused on those with relevant, in-depth experiences of trauma-informed care in the context of shelter-based services.

3.5 Instruments of Data Collection

To gather in depth and context rich information, this study utilized semi-structured interview guides and a focus group discussion (FGD) protocol as the primary data collection instruments.

These tools were designed in alignment with the study's objectives and were informed by the trauma-informed care framework and relevant literature.

3.5.1 Language and Recording:

The instruments were administered in Amharic, the participants' preferred language, to ensure clarity and comfort. All interviews and discussions were audio-recorded with consent and later transcribed and translated into English for analysis.

These instruments were critical in capturing nuanced, first-hand accounts of how trauma-informed care is practiced and experienced in the Ethiopian context.

3.6 Procedure of Data Collection

The data collection process was conducted in a systematic, ethical, and culturally sensitive manner to ensure the credibility of the study and the comfort of participants. The procedures followed several key steps:

1. Preparation and Ethical Clearance:

Before beginning data collection, ethical clearance was obtained from the relevant academic department, and permission was secured from the Women's Shelter and Development Association in Akaki Kaliti Sub-City, Addis Ababa. Formal letters of cooperation were sent to the organization, explaining the purpose and procedures of the research.

2. Recruitment and Informed Consent:

Participants were selected based on purposive sampling. Survivors and service providers who met the inclusion criteria were approached with the assistance of shelter staff. The researcher explained the purpose of the study, assured confidentiality, and emphasized voluntary participation. Written informed consent was obtained from all participants.

3. Conducting the Interviews:

In-depth, semi-structured interviews were conducted with six survivors and four professional service providers. Each interview lasted between 45 and 60 minutes and took place in a private room at the organization's premises to ensure comfort and confidentiality. The interviews were conducted in Amharic, audio-recorded (with permission), and supplemented with field notes.

4. Focus Group Discussion:

One focus group discussion was conducted with selected service providers to supplement the individual interviews. The discussion lasted approximately 90 minutes and followed a pretested guide designed to stimulate conversation on trauma-informed care practices and institutional challenges. The session was also conducted in Amharic and audio recorded.

5. Data Transcription and Translation:

Following data collection, all audio recordings were transcribed verbatim in Amharic and subsequently translated into English by the researcher. Care was taken to maintain the original meaning and emotional tone of participant responses. Transcriptions were reviewed for accuracy and completeness.

6. Confidentiality and Data Management:

All personal identifiers were removed from transcripts to protect participant privacy. Audio files and transcripts were stored securely in password-protected files accessible only to the researcher. Pseudonyms were used during analysis and reporting.

This procedure ensured that the data collection was respectful, trauma-sensitive, and aligned with the study's aim of understanding the lived experiences and perspectives surrounding trauma-informed care.

3.7 Procedure of Data Analysis

The data collected through in-depth interviews and focus group discussion were analyzed using thematic analysis, following the six-phase approach proposed by Braun and Clarke (2006). This

method was selected for its flexibility and suitability in identifying, analyzing, and reporting patterns (themes) within qualitative data.

Step 1: Familiarization with the Data

The researcher began the analysis process by listening to audio recordings and reading through the Amharic transcripts multiple times to gain an overall understanding. This step also involved reviewing field notes taken during interviews and the FGD to contextualize verbal responses.

Step 2: Generating Initial Codes

after familiarization, the translated English transcripts were coded manually. Initial codes were generated by highlighting meaningful statements, repeated patterns, and significant phrases that related to trauma-informed care principles and survivor experiences. Both semantic (explicit) and latent (underlying) meanings were considered.

Step 3: Searching for Themes

the generated codes were then grouped into broader categories or potential themes. Codes that shared similar meanings or patterns were organized together. For instance, codes relating to “emotional support,” “feeling heard,” and “safe space” were clustered under a potential theme of “psychological safety.”

Step 4: Reviewing Themes

Themes were reviewed and refined to ensure they accurately reflected the data. At this stage, some themes were merged, split, or discarded depending on their relevance and internal

consistency. Each theme was checked against both the coded data and the full dataset for coherence.

Step 5: Defining and Naming Themes

once the final themes were confirmed, the researcher defined what each theme represented in the context of the research objectives. Sub-themes were also identified to capture deeper layers within the main themes. Clear and concise names were assigned to each theme to represent their essence.

Step 6: Producing the Report

The final step involved weaving the themes into a coherent narrative. Verbatim quotes from participants were integrated to support the interpretation and provide authenticity to the findings. The analysis aimed to reflect both the personal experiences of survivors and the institutional perspectives of service providers.

Throughout the process, the researcher maintained reflexivity and kept analytical memos to document evolving interpretations and to enhance the transparency and trustworthiness of the analysis.

Chapter four

Result and Discussion

4.1.1Result

4.1.1introduction

This chapter presents the findings of the study based on qualitative data collected through semi-structured interviews with six survivors of domestic violence and four professional service providers, as well as a focus group discussion (FGD) with selected staff members. The analysis is guided by the five research questions and is structured using thematic analysis, which involves identifying patterns and themes across participants' narratives. Data were coded manually, and themes were developed inductively from the transcripts.

The findings are organized as follows: first, a summary of key findings is presented. Next, each research question is addressed through major themes supported by verbatim quotes from participants. Individual survivor cases are highlighted to provide depth and context. Finally, cross-cutting themes are presented to illustrate patterns observed across all survivors. This structure ensures that the findings remain grounded in participant voices while directly responding to the study's research objectives.

4.1.2 Summary of Key Findings

This section summarizes the primary findings that emerged from the analysis of in-depth interviews and a focus group discussion. The insights are organized around the five core research questions, each addressing a different aspect of trauma-informed care (TIC) in domestic violence services within the Ethiopian context.

Partial Implementation of TIC:

Trauma-informed care is being implemented in a limited and sometimes inconsistent manner. Professionals reported that key TIC elements—such as emotional safety, respect, and confidentiality—are commonly applied, especially in counseling. However, principles like

empowerment, collaboration, and choice are less consistently practiced across departments.

Positive Survivor Experiences with Limitations:

Survivors expressed that they felt safe, respected, and emotionally supported, particularly during counseling. Many emphasized how being listened to without judgment helped their emotional healing. Still, several survivors noted that support ended once they left the shelter, and they struggled with reintegration.

Barriers in Service Delivery:

Professionals identified numerous barriers to implementing TIC effectively. These include limited staff training, emotional burnout, lack of supervision, and absence of trauma-specific policy guidance. Some professionals also highlighted the emotional toll of working without adequate support.

Influence of Social and Institutional Factors:

Cultural stigma, gender norms, and economic limitations were significant challenges. Survivors often faced blame or rejection from their communities. Service providers also noted the lack of collaboration between sectors such as health, justice, and social services.

4.1.3 Description of Participants and Cases

This section provides a brief overview of selected participants in the study to contextualize the findings. A total of ten participants were involved, including six survivors of domestic violence and four professional service providers. Survivors were purposively selected from a women's shelter in Akaki Kality Sub-City, Addis Ababa, while professionals were drawn from the same institution and related services.

Trauma Survivor informants

Participant 1: A 28-year-old woman who stayed in the shelter for three months after escaping physical abuse from her husband. She received both shelter and individual counseling services.

“Staff always asked for permission and respected my choices.”

“The intake process was respectful and nonjudgmental, which made me feel safe.”

“Counseling helped me address nightmares and panic attacks.”

Participant 2: A 34-year-old mother of two who was referred by the police. She participated in group therapy and appreciated the emotional support provided. “The staff at the gate shouted at me once. I didn't feel safe after that.”

“There has to be community education; survivors still feel ashamed when they go home.”

“I participated in group therapy and appreciated the emotional support.”

Participant 4: A young adult survivor of marital rape. She highlighted the importance of being heard and not judged. Her case worker allowed her to decide the pace of her healing process. “I felt like a human being again, not a victim.”

“In some areas like administration, I don’t think they understand trauma at all.”

“I was allowed to decide the pace of my healing process.”

“I continued to face stigma in my neighborhood after I left.”

Participant 6: A woman in her late 20s who felt safe within the shelter but struggled due to the lack of follow-up services after discharge. “They should help us find jobs or give us some training after leaving.”

“I felt safe during my stay but forgotten after discharge.”

Participant 8: A survivor of extended domestic and economic abuse. She valued the trauma-informed approach but noted the absence of community-based support. “My community blames women for the violence. They say we are the cause.”

“I liked the counseling, but there was no support when I left the shelter.”

Participant 10: Reported substantial emotional recovery due to consistent counseling. However, she faced financial instability after leaving the shelter. “Counseling helped me sleep and eat again after so many restless nights.”

“I felt mentally stronger, but still worried about money after leaving.”

“I was turned away once due to lack of space before I finally got in.”

Professional informants

- Participant 3: A case worker with five years of experience in domestic violence services. She expressed concern about limited institutional training and burnout.
- Participant 5: A mental health counselor who highlighted the use of emotional validation and empowerment in her sessions.
- Participant 7: A shelter coordinator involved in intake and referrals. She noted a lack of supervision and emotional support for staff.
- Participant 9: A social worker who discussed the need to integrate community and cultural resources into trauma-informed care.

4.1.4 Major Themes Based on the Research Questions

This section presents an in-depth thematic analysis of the data collected through interviews and focus group discussions. The analysis identifies five core themes aligned with the study's research objectives. Each theme begins with a detailed finding, followed by direct participant quotes, interpretation of the evidence, and a discussion of how the theme addresses the relevant

research question.

Implementation of Trauma-Informed Care in Services

Finding: The implementation of trauma-informed care (TIC) in domestic violence services was found to be partial and inconsistent. While survivors reported feeling emotionally safe and respected within counseling sessions, they noted that other service areas did not reflect the same approach. Professionals acknowledged TIC principles but highlighted a lack of formal structures for consistent delivery.

Supporting Quotes

“Staff always asked for permission and respected my choices.” Participant 1, Survivor

“Our counseling sessions always begin with letting the client decide where to start.” Participant 5, Professional

“In some areas like administration, I don’t think they understand trauma at all.” Participant 4, Survivor

Interpretation

These quotes show that TIC is most visible in therapeutic interactions, where empathy and choice are prioritized. However, the inconsistency in its application across departments suggests an organizational gap. Survivors' trust varied depending on the role of the staff they encountered, indicating that institutional-wide training and policies are needed.

Connection to Research Question

This theme answers the research question on TIC implementation by highlighting both its presence and its limitations. TIC is embraced in theory but requires structural support for uniform practice.

Survivors' Experiences with Trauma-Informed Support

Finding: Survivors consistently described their experiences as emotionally transformative when TIC was applied. The sense of being heard, validated, and not judged contributed significantly to their emotional recovery. Still, some reported inconsistent attitudes from non-counseling staff, which diminished the sense of safety.

Supporting Quotes

“I felt like a human being again, not a victim.” Participant 4, Survivor

“Counseling helped me sleep and eat again after so many restless nights.” Participant 10, Survivor

“The staff at the gate shouted at me once. I didn't feel safe after that.” Participant 2, Survivor

Interpretation

The emotional relief expressed by survivors reinforces the importance of trust, empathy, and choice. However, breaches in trauma-informed behavior—even from a single staff member—undermine the survivor's sense of safety. Survivors need consistency in TIC from all staff, not just therapists.

Connection to Research Question

This theme addresses how survivors experience TIC. Their stories reveal both the power of trauma-informed care and the harm caused when it is applied inconsistently.

Barriers to Providing Trauma-Informed Care

Finding: Professionals reported multiple structural and emotional barriers to providing consistent trauma-informed care. These included staff burnout, limited institutional support, inadequate training, and a lack of emotional support systems for caregivers.

Supporting Quotes

“We have no emotional support ourselves; it's draining.” Participant 7, Professional

“Some staff still don't understand trauma well; they just focus on immediate needs.” Participant 5, Professional

“I often feel overwhelmed because there is no time to rest or reflect.” Participant 3, Professional

Interpretation

These quotes indicate that while TIC is valued, its implementation is hindered by unaddressed staff needs. Emotional exhaustion and insufficient training affect service quality. Institutional care for caregivers is necessary to sustainably deliver trauma-informed services.

Connection to Research Question

This theme directly responds to the research question on challenges in delivering TIC. It shows that without supporting the well-being of providers, trauma-informed principles cannot be fully practiced.

Social and Institutional Factors Affecting TIC Delivery

Finding: Survivors and professionals both cited cultural stigma, social blame, and institutional fragmentation as critical barriers to effective trauma-informed care. Survivors especially faced reintegration difficulties due to community perceptions and lack of coordinated external support.

Supporting Quotes

“My community blames women for the violence. They say we are the cause.” Participant 8,
Survivor

“Religion and culture can block survivor access to services.” Participant 9, Professional

“There’s no strong link between our center and health or police services.” Participant 7,
Professional

Interpretation

TIC cannot be implemented in isolation. Survivors returning to unsupportive environments are at risk of re-traumatization. Also, weak institutional partnerships hinder timely and holistic care, showing the need for cross-sectoral collaboration.

Connection to Research Question

This theme addresses the influence of contextual and institutional factors on TIC delivery, showing how culture and coordination challenges must be addressed.

Suggestions for Enhancing Trauma-Informed Care

Finding: Participants provided several recommendations to improve trauma-informed services. These included structured staff training, consistent follow-up care after discharge, peer-based survivor support, and broader community sensitization programs.

Supporting Quotes

“They should help us find jobs or give us some training after leaving.” Participant 6, Survivor

“We need refresher courses and a proper follow-up system for discharged survivors.” Participant 3, Professional

“There has to be community education; survivors still feel ashamed when they go home.”

Participant 2, Survivor

Interpretation

These recommendations reflect a shared understanding of service gaps and practical solutions.

Both groups want a more sustained, empowering approach that supports recovery even beyond the shelter.

Connection to Research Question

This theme provides direct answers to the research question about future improvement, indicating that survivor and staff perspectives align on the need for holistic and long-term interventions.

4.1.5 Individual Survivor Cases

This section presents detailed narrative summaries of five survivor cases to illustrate the diverse experiences and responses to trauma-informed care within the service setting. These narratives highlight how trauma-informed practices were perceived and experienced by the survivors, emphasizing emotional recovery, service gaps, and the ongoing challenges faced during and after institutional support.

Participant 1

A 28-year-old woman who stayed in the shelter for three months after escaping physical abuse by her husband. She described the intake process as respectful and nonjudgmental, which made her feel safe from the beginning. Counseling helped her address nightmares and panic attacks. However, she noted a lack of job readiness support, which left her anxious about life after discharge.

Participant 2

A 34-year-old mother of two, referred by the police after years of physical and emotional abuse. She stayed in the shelter for two months and attended group therapy and individual counseling. She reported feeling emotionally validated and empowered to begin rebuilding her self-worth. However, she expressed concern over the lack of support after discharge, particularly in terms of financial independence and reintegration.

Participant 4

A young woman who survived marital rape and was referred by a health extension worker. She initially found it difficult to trust staff but gradually opened up through repeated, trauma-sensitive interactions. She valued being given control over how and when to talk about her experience. Her main concern was the cultural stigma she continued to face in her neighborhood after reintegration.

Participant 6

A woman in her late 20s who sought shelter after escaping from an economically and verbally abusive household. She appreciated the safety and the listening attitude of counselors but felt

abandoned after her shelter stay ended. She highlighted the absence of structured follow-up and employment assistance as a barrier to her full recovery.

Participant 10

A survivor of prolonged marital violence who had previously attempted to seek help but was turned away due to lack of space. Upon admission, she was supported through regular counseling and skills training. She reported improved mental stability and the ability to manage her emotions. However, she emphasized the need for more long-term community support, especially after leaving the institution.

4.2 Discussion of Findings

(Objective-Based)

This section discusses the findings of the study in relation to its specific objectives and in light of updated international, African, and Ethiopian literature.

Objective 1: To examine how trauma-informed care principles are understood and applied by professionals working with survivors of domestic violence.

Findings showed that professionals generally understood the importance of trauma-informed care (TIC) principles such as safety, emotional support, and client choice. However, their application was often limited to counseling sessions. As Participant 5 noted, “Our counseling sessions always begin with letting the client decide where to start.” This reflects an awareness of empowerment and collaboration. Yet, other areas of the institution, including administrative and intake procedures, lacked consistency in TIC practices. This supports global literature that emphasizes whole-organization integration of TIC, not just its application by therapeutic staff (SAMHSA, 2014; Levenson, 2017). In Ethiopia, similar gaps in provider training and institutional consistency were highlighted by Gebreyesus & Fikadu (2023).

Objective 2: To explore the lived experiences of survivors in receiving trauma-informed care services from the selected organization.

Survivors shared both positive and challenging experiences. Emotional support, respectful communication, and a sense of safety were highly valued. Participant 1 shared, “Staff always asked for permission and respected my choices,” which aligns with the principle of choice and empowerment. However, others noted experiences that made them feel unsafe or unsupported after discharge, which diminished the perceived continuity of care. This supports African literature from Artz et al. (2020), which indicates a lack of survivor-centered systems in transitional care.

Objective 3: To identify the institutional, cultural, and contextual factors that facilitate or hinder

the effective delivery of trauma-informed care.

Findings revealed structural and emotional barriers for both survivors and providers. Providers reported burnout, inadequate training, and lack of supervision, while survivors cited stigma and blame from their communities. Participant 8 noted, “My community blames women for the violence.” These social factors align with Sharma et al. (2020), who advocate for culturally grounded TIC, especially in collectivist societies. The weak coordination between shelters and external sectors such as police and health was also a major institutional challenge, echoing regional findings from South Africa and Kenya (Musyoka et al., 2019).

Objective 4: To assess the perceived outcomes of trauma-informed services from both the perspectives of survivors and service providers.

Survivors described emotional relief, improved coping, and a renewed sense of identity. For example, Participant 4 stated, “I felt like a human being again, not a victim.” Service providers similarly noted progress in clients’ emotional states. However, both groups expressed concern over the absence of follow-up support after shelter discharge. This suggests that while short-term outcomes were positive, long-term recovery support remains insufficient.

Objective 5: To provide recommendations for enhancing trauma-informed care practices in gender-based violence response programs in Ethiopia.

Participants recommended formal staff training, policy frameworks, and structured reintegration

programs. Participant 6 emphasized, “They should help us find jobs or give us some training after leaving.” Updated research supports these suggestions: according to Levenson (2020), sustainable TIC requires continuous staff development and survivor-centered reintegration pathways. Ethiopian studies call for policy-level integration of trauma-informed practices across all relevant sectors.

Overall, the findings align with international and regional literature, reinforcing that TIC must go beyond counseling sessions and be embedded in every aspect of service delivery to achieve transformative outcomes for survivors.

5.3 Future Directions and Recommendations

Future Directions

Future studies should explore the long-term impact of trauma-informed care (TIC) on survivors’ psychological well-being and reintegration outcomes. While this study provided insight into immediate experiences, it is important to understand how TIC affects survivors’ resilience, relationships, and socioeconomic reintegration over time. Longitudinal or mixed-method research could capture the evolution of recovery trajectories in various cultural and institutional contexts.

Further, future research should broaden the scope of populations studied. This includes male survivors, children, and persons with disabilities, who may also benefit from TIC yet remain underrepresented in current research. Developing and testing localized, culturally responsive TIC

models in collaboration with service users, community leaders, and policymakers could improve relevance and sustainability in the Ethiopian context.

Recommendations

Shelters and support organizations should embed trauma-informed principles across all levels of service, not just within counseling. This includes administrative processes, intake procedures, reintegration planning, and daily interactions. Mandatory staff training, regular supervision, and inter-agency collaboration should be implemented to ensure consistency in the application of TIC. Policymakers should develop clear guidelines to standardize trauma-informed practices in gender-based violence response programs.

In addition, post-shelter support systems must be strengthened to promote sustainable recovery. Survivors emphasized the need for skills training, job placement assistance, and community reintegration support. Government institutions and NGOs should invest in structured aftercare services that extend TIC beyond the shelter setting. These efforts will enhance survivors' autonomy and resilience, and reduce the risk of re-traumatization or return to abusive environments.

CHAPTER FIVE

Summary and Conclusion

5.1 Summary of the Study

This study was conducted to explore the implementation and effectiveness of trauma-informed care (TIC) for survivors of domestic violence in a shelter and counseling setting in Addis Ababa, Ethiopia. The research was grounded in the increasing recognition of TIC as a globally endorsed framework for supporting trauma survivors. Despite its relevance, little was known about how this model functions in low-resource, culturally complex environments like Ethiopia.

The primary purpose of the study was to examine how trauma-informed care is understood, applied, and experienced by both survivors and service providers. It aimed to assess the strengths and limitations of existing services and identify strategies for improving the delivery of TIC in domestic violence response systems.

To answer research questions, a qualitative research design was used. Data were collected through in-depth interviews with six survivors and four service providers, along with one focus group discussion. The data were manually transcribed and analyzed using thematic analysis to identify patterns and meanings relevant to the research questions.

The study revealed five key findings:

- (1) trauma-informed care is partially and inconsistently implemented across services;
- (2) Survivors value emotional safety, empathy, and being treated with dignity;

- (3) There are significant gaps in post-shelter reintegration support;
- (4) Professionals face emotional exhaustion, training gaps, and institutional barriers;
- (5) Both groups suggest the need for systemic reforms, including staff training, follow-up care, and community education.

Overall, the study contributes practical and theoretical insights for improving trauma-informed service delivery in Ethiopia and similar contexts.

5.2 Conclusion

This study aimed to explore the understanding, implementation, and lived experiences of trauma-informed care (TIC) among female survivors of domestic violence and service providers in a shelter setting in Addis Ababa. Based on the research questions and objectives, the following conclusions are drawn:

First, trauma-informed care principles such as emotional safety, respect, and empowerment are recognized and partially practiced by service providers, particularly in counseling sessions.

However, their implementation is inconsistent across departments, revealing a need for organization-wide integration of TIC principles.

Second, survivors described both positive and negative experiences with shelter services. While many felt emotionally supported and respected during their stay, gaps in reintegration support and follow-up care highlight the limitations of current service models in sustaining long-term

healing. These findings support the objective of exploring lived survivor experiences and evaluating perceived outcomes.

Third, institutional challenges such as limited training, emotional fatigue, and lack of structured policies hinder effective TIC delivery. Cultural stigma and insufficient collaboration with external sectors also emerged as barriers, aligning with the objective to identify contextual and systemic obstacles.

Fourth, both survivors and service providers emphasized the importance of strengthening trauma-informed practices through staff training, follow-up services, and survivor-centered reintegration programs. These practical insights support the study's final objective of generating actionable recommendations to improve gender-based violence response services in Ethiopia.

In conclusion, while the shelter demonstrates intuitive efforts toward trauma-informed care, a more structured, consistent, and culturally responsive implementation is essential for achieving sustainable recovery and empowerment for survivors.

Reference

- Abebe, A., & Tsegaye, D. (2022). Survivor-centered services in Ethiopian shelters: Challenges and opportunities. *Ethiopian Journal of Psychology*, 18(2), 33–49.
- Alemu, A., & Tadesse, B. (2019). Community perceptions and mental health stigma in Ethiopia. *African Journal of Social Sciences*, 11(1), 20–31.
- Artz, L., Meer, T., & Müller, A. (2017). The effectiveness of shelter services for abused women in South Africa. *Journal of Interpersonal Violence*, 32(17), 2652–2672. <https://doi.org/10.1177/0886260515592614>
- Bloom, S. L. (2013). *Creating sanctuary: Toward the evolution of sane societies* (2nd Ed.). Routledge.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Courtois, C. A., & Ford, J. D. (2013). *Treating complex traumatic stress disorders in adults*. Guilford Press.
- Elliott, D. E., Bjelajac, P., FalLOT, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461–477.
- FalLOT, R. D., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. *Community Connections*.
- Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.
- Gebreyesus, H., & Fikadu, T. (2020). Addressing gender-based violence in Ethiopia: Service gaps and opportunities. *Ethiopian Journal of Social Work*, 14(1), 25–42.
- Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. Basic Books.
- Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, 62(2), 105–113. <https://doi.org/10.1093/sw/swx001>
- Levenson, J. (2020). Implementing trauma-informed principles in social service settings. *Trauma, Violence, & Abuse*, 21(2), 1–13. <https://doi.org/10.1177/1524838019847923>
- Mekonnen, G. B., Alemu, T. G., & Bifftu, B. B. (2021). Intimate partner violence and associated factors among women in Ethiopia: A systematic review. *PLOS ONE*, 16(6), e0252200.
- MoWSA. (2021). *National Strategy on Harmful Traditional Practices against Women and Children in Ethiopia*. Ministry of Women and Social Affairs.

Musyoka, M. M., Mbwayo, A. W., & Mathai, M. (2019). Barriers and facilitators to accessing mental health services in Kenya. *African Journal of Primary Health Care & Family Medicine*, 11(1), 1–7.

Nnadi, I. (2012). An insight into violence against women as human rights violation in Nigeria: A critique. *Journal of Politics and Law*, 5(3), 48–56.

SAMHSA. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. U.S. Department of Health and Human Services.

https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Sharma, A., Kaur, R., & Bansal, V. (2020). Cultural adaptation of trauma-informed care in India: A community-based approach. *International Journal of Social Psychiatry*, 66(6), 540–549.

Tiruneh, F. N., Chuang, K. Y., Ntenda, P. A., & Chuang, Y. C. (2017). Factors associated with intimate partner violence against women in Ethiopia: A multilevel analysis. *PLOS ONE*, 12(10), e0186325.

Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). A systematic review of trauma-focused interventions for domestic violence survivors. National Center on Domestic Violence, Trauma & Mental Health.

World Health Organization. (2021). Violence against women prevalence estimates, 2018. <https://www.who.int/publications/i/item/9789240022256>

Appendix A: Participants' Responses by Research Question

Note: The following are summarized, translated, and anonymized responses from Participants 1 to 5, categorized by role (Survivor or Professional).

Participant 1 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

Staff applies principles of safety and confidentiality, though some aspects like empowerment are still developing.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I felt respected and supported, especially during counseling sessions.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Lack of training and limited resources is major issues.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Cultural stigma and lack of awareness in the justice system affect delivery.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Provide more long-term follow-up support and training for staff.

Participant 2 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

Implementation exists in counseling but is inconsistent in shelter practices.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I appreciated being listened to without judgment.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Heavy caseloads and emotional burnout are common among staff.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Gender norms and underfunded services weaken delivery.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Increase shelter capacity and involve survivors in service planning.

Participant 3 (Professional)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

We try to uphold TIC principles, but there are gaps in inter-agency coordination.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

They made me feel safe and understood my emotional needs.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Limited intersectoral support and lack of funding.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Lack of policy support and public awareness.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Stronger collaboration between shelters, health centers, and police.

Participant 4 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

It's a core part of our approach, especially in the counseling department.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I was empowered to make my own decisions.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Time constraints and staff turnover create inconsistency.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Societal stigma discourages some survivors from seeking help.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

More trauma-specific training and supervision for staff.

Participant 5 (Professional)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

We consistently apply TIC in intake and case management.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I regained my confidence and felt emotionally safe.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Language barriers and cultural misunderstanding affect services.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Traditional beliefs about gender roles limit community support.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Create community awareness campaigns and survivor peer networks.

Participant 6 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

The organization uses a trauma-informed approach in counseling, but more consistency is needed in other services.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I appreciated the privacy and how the staff gave me time to tell my story.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Limited staff availability affected how quickly I received services.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Social shame and lack of family support made it difficult to speak out.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Ensure continued psychological support after shelter exit.

Participant 7 (Professional)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

We train new staff in trauma-informed principles, though follow-up is often lacking.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I notice that women open up more when we apply these methods.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

There is no regular supervision or support for staff experiencing secondary trauma.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Overcrowding and underfunding in facilities slow down service delivery.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Create a referral system that ensures survivors are supported after discharge.

Participant 8 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

They respected me and never pressured me to talk before I was ready.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

I trusted the counselor more than anyone else at that time.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

Some staff was helpful, but a few did not seem trained or empathetic.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

My community still blames women for abuse, which makes recovery hard.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Offer job training and legal help to help us move on.

Participant 9 (Professional)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

Our focus is on safety and empowerment, though some team members need more training.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

When we create a calm and respectful space, survivors engage better.

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

We lack culturally relevant tools and approaches.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Religion and traditional roles sometimes clash with our work.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

Develop survivor-led peer support programs in the community.

Participant 10 (Survivor)

1. How are trauma-informed care principles currently being implemented in domestic violence support services in Addis Ababa?

They used calm voices and never judged me, which helped me trust them.

2. How do survivors of domestic violence perceive and experience the support they receive through trauma-informed care services?

The counseling helped me sleep again and eat better after many months.

**Appendix B: Semi-
Structured Interview Guide**

Title: Trauma-Informed Care for Survivors of Domestic Violence

Target Groups: Domestic Violence Survivors and Professional Service Providers

Section A: Background Information

1. Age:

2. Gender:

3. Role: (Survivor / Service Provider)

4. Duration of involvement with the organization:

5. Type of services received or provided:

3. What challenges and barriers do service providers encounter in applying trauma-informed care approaches?

I felt the support was helpful, but limited to only when I stayed there.

4. What contextual and institutional factors influence the delivery of trauma-informed care in the Ethiopian setting?

Lack of follow-up and housing affected me after I left.

5. How can trauma-informed care services be improved to better meet the recovery, safety, and empowerment needs of survivors of domestic violence?

They should extend help beyond the shelter period, like giving skills and follow-ups.

Section B: Interview Questions for Survivors

6. 1. Can you describe the type of support you received from this organization?
7. 2. How did the services make you feel emotionally, physically, and psychologically?
8. 3. Did you feel safe and respected by the staff during your stay? In what ways?
9. 4. Were you involved in making decisions about your care or support?
10. 5. What problems or difficulties did you face while receiving services?
11. 6. What changes or improvements would you suggest for the services?

Section C: Interview Questions for Professional Service Providers

12. 1. How do you and your organization apply trauma-informed care in supporting survivors?
13. 2. What specific trauma-informed strategies or principles do you use when working with survivors?
14. 3. What training or resources have you received related to trauma-informed care?
15. 4. What challenges do you face when implementing trauma-informed approaches?
16. 5. In your view, how do institutional, cultural, or community factors affect trauma-informed service delivery?
17. 6. What would you recommend to improve trauma-informed care services?

**Appendix C: Sample
Focus Group Discussion
(FGD) Transcript Excerpt**

Date: March 18, 2025

Location: Safe House Shelter Counseling Room

Number of Participants: 5 (Survivors of Domestic Violence)

Duration: Approximately 60 minutes

Moderator: Researcher

Note Taker: Assistant

Opening Question: How did you feel when you first came to the shelter?

Participant 1: “At first, I was scared. I didn’t know anyone here. But the counselor welcomed me very kindly. She didn’t force me to talk. That helped me feel safe slowly.”

Participant 2: “For me, the staff listened without judgment. They gave me space, and that made me trust them. I was crying so much the first day, and they didn’t push me.”

Participant 3: “I had bad experiences with police before, so I thought it would be the same. But here, they respected me. They called me by my name. That gave me hope.”

Follow-Up: What support helped you the most during your time here?

Participant 4: “Counseling helped a lot. They asked about my feelings and gave me advice. Also, the group sessions helped. I saw I’m not the only one.”

Participant 5: “They showed me how to manage my panic. Breathing exercises, journaling. That helped more than I expected.”

Participant 2: “I liked that they didn’t blame me. In my community, people say it’s the woman’s fault. Here, I didn’t feel ashamed anymore.”

Probing Question: What could be improved in the support provided?

Participant 3: “When I left the shelter, I didn’t know where to go. They should help us more after leaving. I was worried about food, rent, everything.”

Participant 5: “There is only one counselor for many women. Sometimes we wait days for a session. They should hire more staff.”

Participant 1: “Yes, and we need job training. Counseling is not enough if we return to the same problems.”

Closing Reflections: What message would you give to others in your situation?

Participant 4: “Don’t stay silent. Seek help. There is life after abuse.”

Participant 2: “You are not alone. The pain can heal when someone listens.”

**Appendix D: Research
Questions (English and
Amharic Versions)**

1. How are trauma-informed care principles currently being implemented in domestic violence support services?

1. በአሁኑ ጊዜ የአሰቃቂ ሁኔታን ያገናዘበ እንክብካቤ መርሆዎች የቤት ውስጥ ጥቃት ድጋፍ አገልግሎቶች ውስጥ እንዴት እየተተገበሩ ነው?

2. What are the lived experiences of domestic violence survivors in accessing trauma-informed care?

2. ከቤት ውስጥ ጥቃት ተርፈው ያመለጡ ሰዎች የአሰቃቂ ሁኔታን ያገናዘበ እንክብካቤን በሚያገኙበት ጊዜ ምን ዓይነት የሕይወት ተሞክሮዎች አሏቸው?

3. What challenges and barriers exist in the implementation of trauma-informed care within the shelter or service center?

3. በማረፊያ ወይም በአገልግሎት ማዕከል ውስጥ የአሰቃቂ ሁኔታን ያገናዘበ እንክብካቤ በሚተገበርበት ጊዜ ምን ዓይነት እንደሚገኙ ችግሮችና እንቅስቃሴዎች አሉ?

4. How do service providers perceive and apply trauma-informed principles in their work with survivors?

4. አገልግሎት አቅራቢዎች የአሰቃቂ ሁኔታን ያገናዘበ መርሆዎችን በስራቸው ላይ እንዴት እንደሚመለከቱ እና እንዴት እንደሚተገበሩ ያስባሉ?

5. What strategies or improvements do survivors and professionals suggest for enhancing trauma-informed support?

5. ከቤት ውስጥ ጥቃት ተርፈው ያመለጡ ሰዎችና ባለሙያዎች የአሰቃቂ እንክብካቤን አገልግሎት ለማሻሻል ምን ዓይነት ዘዴዎች ወይም ማቀናበሪያዎችን አስቀምጠዋል?