Practice Note

Domestic Violence Providers' Reflections on Identity, Lived Experience, and Trauma-Informed Practice

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Abstract

It is critical that domestic violence (DV) service providers are trained in providing trauma-informed (TI) supports to their clients. While some work has focused on how personal characteristics, such as self-efficacy and burnout, influence providers' provision of TI services, little research examines how service providers conceptualize the influence of dimensions of their own identity on their provision of TI care. This practice brief fills this gap, sharing qualitative insights from DV service providers regarding the influence of their identity in the context of TI trainings and service provision. Providers discussed aspects of identity, including lived experience with trauma, cultural/racial identity, parenthood, and physical characteristics, in the context of both strengths and limitations that shape their connection to TI training and care. Recommendations for social workers to inform future workforce development initiatives are discussed.

Keywords

professional development, culture, interpersonal violence, service providers

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Introduction

Current guidance emphasizes the critical importance of trauma-informed service delivery for organizations that provide services to intimate partner violence (IPV)-exposed children and families (Holmes et al., 2022) and highlights the need to support protective factors among children, families, and communities (Tonsing, 2025). J. M. Wilson and colleagues (2015) have identified six trauma-informed (TI) key principles within domestic violence (DV) programs by synthesizing themes from TI documents specific to DV programs: (1) establishing emotional safety, (2) restoring choice and control, (3) facilitating

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connection, (4) supporting coping, (5) responding to identity and context, and (6) building strengths. There is an evident need for TI training and support for DV service providers, including social workers in these roles, given that they are working directly with trauma-exposed adults and children (Stover & Lent, 2014). Research has shown that many DV service providers have histories of interpersonal violence themselves, upwards of half of providers in some samples (Voth Schrag et al., 2022). Furthermore, DV service providers are at high risk for stress and burnout due to the unique and emotionally challenging complexities of the job (Lundy & Crawford, 2024); thus, TI approaches may also help reduce the risk of developing their own stress and traumatization.

One factor that is often discussed in the context of TI supports for DV service providers is responding to client identity and context, notably ensuring that staff are considerate of and attentive to client intersecting identities and how those may influence their work with clients (J. M. Wilson et al., 2015). However, characteristics of a provider's own personal identity are often overlooked, although these factors may influence uptake and integration of TI training. This is concerning, given that factors related to identity, notably experience of race-related workplace microaggressions, have been linked to compassion fatigue among DV service providers (Voth Schrag et al., 2022). Exploration of how providers understand their own characteristics and identity, and how these factors influence their receipt of TI training, may shed important light on training recommendations that target aspects of identity and experiences, as well as promote the well-being of the DV workforce.

Current Study

This practice note draws on reflections from a broader study focused on perceptions of and experiences with TI training among DV service providers. In the initial study, DV service providers were asked how they integrate TI training into their setting, as well as barriers and opportunities for implementing TI care with individuals affected by IPV. During interviews, practitioners spontaneously reflected on how their own identity and lived experiences shaped how they digested TI training and delivered TI care as DV service providers. Although not a formal topic in the interview guide, this practice insight surfaced organically and consistently. This practice note summarizes practitioner reflections on how personal characteristics and experiences contribute as both strengths and barriers to their integration of TI training and provision of TI services within their respective roles. These reflections offer implications for how TI training development can target the unique needs and positionalities of DV service providers.

Method

Procedures

Participants were recruited from IPV-serving organizations whose staff participated in a TI training with a local early childhood mental health organization in 2023. Participants were given a link to an online consent document, and those who consented were asked to provide their contact information and availability for scheduling the focus group session. Three focus groups were conducted virtually to accommodate the varied schedules/shifts and geographic locations of the participating providers. Focus groups were composed of three to six participants, were 1 hour long, and took place virtually over Zoom. A total of 13 providers participated (see Table 1 for participant demographics). Focus groups were recorded and transcribed, with participant initials replaced by a pseudonym.

The focus groups were conducted by the second author and guided by semi-structured interview questions that included questions about the participants' use of TI concepts, successes and challenges of implementation, and the impact of TI training on their collaboration with other IPV service providers. The interview guide was developed in collaboration with the organization conducting the TI training and a local DV coalition, informed by

Table 1. Focus Group Participants (n = 13).

Participant Characteristics	*N* (%)
TI training	
CARE	7 (54%)
Other TI training	6 (46%)
Workplace Role	
Direct service	7 (54%)
Supervisor/manager	4 (31%)
Missing	2 (15%)
Race/ethnicity	
Caucasian	6 (46%)
NA/AI	1 (8%)
Hispanic	1 (8%)
Missing	6 (46%)
Gender	
Female	13 (100%)

their respective expertise. Questions included "Are there specific aspects of the trauma-informed care (TIC) trainings that you have incorporated into your engagement with children in your setting?" and "What barriers have you experienced in your setting to implementing trauma-informed care with individuals affected by IPV?" The study was reviewed and deemed exempt by the University of Utah Institutional Review Board.

Analysis

Focus groups were transcribed verbatim by the third author and uploaded into Dedoose software for analysis. Two coders (Author 1 and 3) then coded the transcripts using thematic coding to identify individual and group levels of thematic analysis (Hesse-Biber & Leavy, 2010). This approach to coding aligned with the intention of the focus group methodology, which aimed to understand shared reflections among providers. For the broader study, two coders independently coded one transcript and aligned to identify a list of broad themes and preliminary codes. A second transcript was then coded using the proposed codebook. Each transcript was double-coded, and the coding team met with Author 2 to reconcile any discrepancies.

Coders used memos during analysis to generate insights during coding; these memos helped the research team recognize that identity-related reflections surfaced across interviews and might hold practical implications, ultimately informing the focus of this practice note. Because identity was not a central focus of the interview guide, related reflections varied in depth. We include them here not as a full analytic theme but because of their relevance for understanding TI practice in DV settings.

Provider Insights and Implications for Practice

Participants highlighted several practice insights related to their personal characteristics and experiences, their understanding of TI care, and the implementation of TI skills, including lived experience with trauma, cultural/linguistic identity, identity as a parent, and physical characteristics. Quotes from the qualitative study are shared, and related practice implications follow below.

Lived Experience With Trauma

Several DV service providers shared how their own experiences of trauma, whether specific to IPV or other trauma, influenced how they approach or value TIC. One provider shared about the value of TI training around signs and red flags of IPV for community members, contextualized with their own trauma experience, sharing,

> "Hopefully, we teach people in our community. . .the signs and stuff like that so they don't continue these things or they prevent having these relationships. Cause I know that there were so many signs when I fell with my first husband. . .if they'd trained us on a lot of the stuff I would have seen those red flags and I'd have been running for the hills. (Participant 1)

Another participant discussed their experience with cultural trauma/discrimination, describing how their cultural trauma shapes

their work and interpersonal interactions with children in IPV settings, sharing:

> Knowing how I felt in a white community and not seeing other kids who look like me a lot everywhere. . . and then going back and forth to a different community, where all you see is you, the other Native Americans, but still feeling like an outsider in that world. . . . And so I guess like I always make sure my body language is there. My eye contact is there. Everything that they can see is showing them that I'm there. (Participant 2D)

Providers framed personal and professional trauma exposure primarily as a strength, which allowed them to have an informed response to clients. Indeed, shared experiences of trauma may support client disclosure and rapport (Kirkner et al., 2021). However, providers also discussed their lack of personal trauma exposure, or exposure to specific types of trauma, as a barrier to feeling effective in understanding, connecting with, or supporting some clients. For example, the same participant who discussed cultural trauma also highlighted how not having a personal history of sexual assault may make it difficult for them to relate to a client, sharing,

> "The other day I had a client kind of disclose her sexual assault when she was a child, and like that, felt like a barrier because I didn't experience that. And I don't know what that could, like, what she could need from me besides telling her, like, "I'm sorry that happened to you." I'm like, "I'm here," and just listening, listening to her. (Participant 2D)

Although rates of trauma are high among mental health providers broadly, trauma histories among DV service providers may more closely mirror the experiences of the survivors they support (Voth Schrag et al., 2022). This advocate–survivorship role can lead to a sense of resonance with TI training, and, when working with clients whose experiences feel similar, that can be magnified when there is also a shared intersectional trauma experience (Sutton et al., 2021). It may be that providers drawn to this specific field (compared to more general human service providers) have a sense that a shared identity as a survivor is linked to their effectiveness at providing TI supports. However, DV service providers may rely on this resonance in trauma history more so than other mental health providers, which can create a barrier when there are no shared trauma experiences.

Future TI training for DV service providers may build off the strengths, or hidden capacities (Ellis et al., 2020), that providers may associate with a shared trauma history, while also exploring the myths or assumptions providers may make based on their own life experiences (e.g., our experience is the same; I can't help if I don't share the experience). TI trainings for DV service providers may focus on highlighting the constellation of traumatic experiences related to IPV and helping build capacity in recognizing and supporting clients with non-IPV-related trauma as well. In doing so, TI trainings can support DV service providers who have a personal trauma history expand their knowledge and understanding of trauma impacts across an array of trauma experiences, supporting the extension of their lived experience knowledge to the individuals they serve who may have different trauma exposures. In addition, while attention to secondary traumatic stress is often a part of TI trainings, it may be especially important for DV service providers given the strong links between personal histories of trauma and secondary traumatic stress and vicarious trauma (Leung et al., 2023).

Cultural/Linguistic Identity

When asked to discuss their TI practices in their role, providers reflected how their own cultural or linguistic identity influenced their approach to TIC, such as the quote from the provider above (Participant 2D) who described how their lived experience navigating insider/outsider status as a Native American influenced their communication with children in IPV settings. Another provider described their awareness of how people from another culture may respond to their style of verbal and nonverbal communication, sharing,

> I'm Puerto Rican. It's just understanding that that sometimes doesn't resonate or I'm a very direct and to the point person. So just kind of like dialing it back a bit and recognizing, like my reactions, my facial awareness. If I'm doing this [gestures crossing arms] to a client, like certain things that are normal to me. I talk with my hands and things like that, like, just kind of like being very much aware of that, as [to] how that may be received or perceived by a client based on their culture. (Participant 6A)

Providers also discussed their unfamiliarity or lack of connection to a culture as a potential barrier to providing TIC, noting the importance of cultural humility and understanding the cultural context of families they serve. When discussing working with an immigrant mother who encountered language barriers along with a fear of deportation, one provider noted:

> There were things that I didn't understand culturally. . .fears that I don't have. . . .And I thought, wow, you know, that's not my culture. That's not my experience. . . . those aren't my fears. I have a lot of other fears, those aren't my fears, and it really helped me to see where maybe we need to be a little bit better when we are helping those families with those cultural challenges. (Participant 2B)

In the study, providers were aware of what cultural values/identity they brought to their work and how this may support or hinder their support of survivors. Indeed, understanding the cultural context of survivors is important for serving culturally diverse communities (Taylor et al., 2024), even if it does not arise through a shared cultural identity. Interestingly, while providers framed the lack of shared culture as a barrier to services, they did not highlight strategies to overcome these barriers in their discussion of TI supports, nor ways in which their TI trainings were attentive to culture. This may reflect a common critique of TI trainings as under-emphasizing or ignoring the intersections of culture and trauma and reinforcing the need for culturally responsive TI supports (Kulkarni, 2019; Palma et al., 2024).

A scoping review of IPV interventions developed specifically for immigrant communities highlighted the need to integrate cultural nuances, values, and systemic stressors unique to immigrant families who have experienced IPV (Rai et al., 2023). These recommendations should also be considered when developing culturally responsive TI trainings for DV service providers, given the limitations of TI trainings highlighted by these providers. In addition, TI training should promote self-reflective practice that equips DV service providers to consider their own cultural values, as well as increased exploration of how culture, cultural values, and culturally related experiences (e.g., fears of safety associated with immigration status) may influence help-seeking among DV survivors. Simulation-based training, for example where a provider has a chance to interact with an IPV survivor in a work-based scenario, has recently been positioned as a training approach that can support service providers in recognizing intersecting identities within TIC, in addition to supporting reflection on the influence of their own personal identities (Tarshis et al., 2024), and is a promising area of future training/practice.

Identity as Parent

Providers also spontaneously discussed parenthood as an identity characteristic that informs their integration and delivery of TI supports to clients within their organizations, primarily around key interpersonal skills delivered in TI trainings (e.g., active listening). For example, one provider referenced their familiarity with content from a specific TI training, noting,

> But I do work with youth, and I am a mom. And so. . .I've like heard some of this stuff in different contexts, so like the praise and pointing out, I've heard called sportscasting in the past. And so it's kind of something I'd already done with my kids. (Participant 2A)

Providers discussed their training, or lack of training, as a parent and how that intersects with key skills being amplified in TI trainings

and, in some cases, even discussed how they used TI skills with their own children.

Providers also spoke to a potential bias that providers and clients may hold toward other providers who are not parents themselves, which may result in undermining skills or potential contributions among providers. Another provider shared a similar perception about parenting as enhancing the delivery of TI supports, noting the value of "[the provider] having their own children. They've actually worked, used some of these kind of skills, which I think has helped." The provider goes on to share that

> [providers] that don't have kids, they're kind of clueless [about how to respond to children when] they've been in shelter. They're just like [gesturing confused face, shoulders shrugging, and palms up] and they'll call. . .and get information from staff, who actually have some kind of knowledge [about children]. So they're learning. (Participant 1A)

This quote highlights a perspective that basic parenting information is a key part of TI supports among DV service providers; it reiterates prior perspectives that shared experiences—whether it be trauma histories, cultural experiences, or parenting status—are as important to the competencies of DV service providers. Another provider shared how this bias may also be perceived by clients or children in a DV shelter, noting,

> I'm like certainly a younger person that works with them. I'm not a parent. Kids definitely know that. And I see the kind of. . . .It's not that there's a lack of respect, but maybe like a lack of listening, because, like, yeah, [they think] we're here to have fun. (Participant 2C)

Parenting experiences (or lack of experiences) may be an unspoken lens through which DV service providers are interpreting TI training, implementing TI skills, or evaluating the TI supports of their colleagues. While unexamined in the broader TI training literature, this insight may be readily integrated when developing TI training for DV service providers. For parents, this may include an examination of how existing parenting skills, and/or skills related to co-regulation, relationship building, and modeling, can be built upon for the development of TI skills and how existing parenting knowledge and experiences may get in the way of integrating new TI skills. Organizational biases regarding the parenting status of providers may also need to be examined and addressed to promote supportive workplace dynamics.

Physical Characteristics

Finally, providers shared how they attend to their physical characteristics, including mannerisms, physicality, and size, when considering providing TI care to clients. Providers noted being aware of how their size, physicality when talking, and body language impacted their provision of TI services, such as the provider above who was aware of how a client's cultural background may influence how they interpret the provider's physical mannerisms, including facial expressions and tendency to talk with their hands. Another provider discussed their physicality in the context of their TI work as a domestic violence service provider (DVSP), saying:

> I'm quite tall, like I'm 5'10. . .I don't wear heels; like cowboy boots are about the most I can do. I'm not a petite person at all, so like I have to be aware of, like my, just my body position to people, because a lot of my clients are literally half my size and so I don't want just my build to be scary. I mean, it's kind of happened before, just because they couldn't help it, and I can't change how big I am. So it's just something I became very aware of pretty early in my advocacy years. (Participant 6B)

These practitioner insights align with a study of how DV service providers build trust with clients, where providers similarly discussed using physical mannerisms (e.g., talking with their hands) and shared language to build trust with a Spanish-speaking client (Taylor et al., 2024). Programs seeking to develop TI trainings for DV service providers could integrate insights from this practice note in addressing physicality in TI trainings,

providing learning materials that prompt providers to reflect on how their size, physicality, tone of voice, eye contact, and other physical factors may influence their rapport building with survivors and subsequent provision of TI care.

Discussion

While some studies focus on how personal characteristics, such as self-efficacy and burnout, influence providers' provision of TI services (Najmabadi et al., 2024), very few examine how DV service providers conceptualize the influence of dimensions of identity on their provision of TI care. This practice note fills this gap by sharing qualitative practice insights from DV service providers on their identity in the context of TI trainings and service provision. Providers discussed aspects of identity, namely lived experience with trauma, cultural/racial identity, parenthood status, and physical characteristics, in the context of how they shape their connection to TI training and care, sharing both strengths and limitations that they attribute to their identity.

Social workers make up a large proportion of professionals involved in DV service provision (Mersky et al., 2019), and providing effective, culturally responsive TI supports is a key part of social work competencies (M. H. Wilson & Webb, 2018). Social workers are thus uniquely positioned to ensure that the intersectional identities of DV service providers and the ways in which they integrate those identities into their training and work are intentionally integrated into TI trainings within DV-focused organizations. Furthermore, social work training can be informed by the findings of this practice note regarding identity characteristics that may influence the receipt and integration of TI training. In one sample, almost three fourths of social work graduate students had personal exposure to or experience with IPV, and 43% had personally experienced IPV in their relationships, rates substantially higher than nursing or medical students (Connor et al., 2012). Furthermore, social work students are often taught to consider their positionality in terms of identity and lived experience as related to their social work practice, including biases and case conceptualizations. Linking this critical self-reflection to coursework related to TI practices may also be of value, both for students who do and do not go into DV-specific practice.

Despite the novel and practice-relevant findings outlined in this practice note, there are some notable limitations that should be considered. The discussion of identity characteristics arose spontaneously across the focus groups and was not specifically asked about in the semi-structured interview guide. This means that providers were not specifically probed about identity characteristics, and some characteristics (e.g., gender) were not discussed. Future research could specifically ask providers about how their personal identity may promote or hinder their receipt of TI training or provision of TI services, examine a wider array of identity dimensions, or use stratified quota sampling to recruit providers across a wide array of identity characteristics.

Conclusion

This practice note identifies aspects of identity that DV service providers discussed in the context of their receipt of TI training and provision of TI services, notably lived experience with trauma, cultural/racial identity, parenthood status, and physical characteristics. Providers' own identity is rarely integrated into TI trainings or considerations of TI service delivery; future TI trainings may take into account the extent to which DV service providers are considering their identity as relevant, and either a support or a hindrance, to the TI supports they provide.

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References

Connor, P. D., Nouer, S. S., Mackey, S. N., Banet, M. S., & Tipton, N. G. (2012). Overcoming barriers in intimate partner violence education and training of graduate social work students. *Journal of Teaching in Social Work*, *32*(1), 29–45.

Ellis, B. J., Abrams, L. S., Masten, A. S., Sternberg, R. J., Tottenham, N., & Frankenhuis, W. E. (2020). Hidden talents in harsh environments. *Development and Psychopathology*. https://doi.org/10.1017/S0954579420000887

Hesse-Biber, S. N., & Leavy, P. L. (2010). *The practice of qualitative research*. Sage.

Holmes, M. R., Berg, K. A., Bender, A. E., Evans, K. E., O'Donnell, K., & Miller, E. K. (2022). Nearly 50 years of child exposure to intimate partner violence empirical research: Evidence mapping, overarching themes, and future directions. *Journal of Family Violence*, *37*(8), 1207–1219. https://doi.org/10.1007/s10896-021-00349-3

Kirkner, A., Lorenz, K., & Ullman, S. E. (2021). Recommendations for responding to survivors of sexual assault: A qualitative study of survivors and support providers. *Journal of Interpersonal Violence*, *36*(3–4), 1005–1028. https://doi.org/10.1177/0886260517739285

Kulkarni, S. (2019). Intersectional trauma-informed intimate partner violence (IPV) services: Narrowing the gap between IPV service delivery and survivor needs. *Journal of Family Violence*, *34*(1), 55–64.

Leung, T., Schmidt, F., & Mushquash, C. (2023). A personal history of trauma and experience of secondary traumatic stress, vicarious trauma, and burnout in mental health workers: A systematic literature review. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*(S2), S213.

Lundy, T., & Crawford, J. (2024). Health and wellness outcomes of intimate partner violence support workers: A narrative review. *Trauma, Violence, and Abuse*, *25*(4), 2942–2956. https://doi.org/10.1177/15248380241231604/

Mersky, J. P., Topitzes, J., & Britz, L. (2019). Promoting evidence-based, trauma-informed social work practice. *Journal of Social Work Education*, *55*(4), 645–657.

Najmabadi, L., Agénor, M., & Tendulkar, S. (2024). "Pouring from an empty cup": Manifestations, drivers, and protective factors of occupational stress among healthcare providers of trauma-informed care. *Journal of Interpersonal Violence*, *39*(9–10), 2041–2075. https://doi.org/10.1177/08862605231215028

Palma, C., Abdou, A. S., Danforth, S., & Griffiths, A. J. (2024). Are deficit perspectives thriving in trauma-informed schools? A historical and anti-racist reflection. *Equity & Excellence in Education*, *57*(1), 76–92.

Rai, A., Ravi, K., Shrestha, N., & Alvarez-Hernandez, L. R. (2023). Culturally responsive domestic violence interventions for immigrant communities in the United States: A scoping review. *Journal of Social Work in the Global Community*, *7*(1), 1.

Stover, C. S., & Lent, K. (2014). Training and certification for domestic violence service providers: The need for a national standard curriculum and training approach. *Psychology of Violence*, *4*(2), 117–127. https://doi.org/10.1037/a0036022

Sutton, A., Beech, H., Ozturk, B., & Nelson-Gardell, D. (2021). Preparing mental health professionals to work with survivors of intimate partner violence: A comprehensive systematic review of the literature. *Affilia*, *36*(3), 426–440.

Tarshis, S., McQuaid, J. H., Diallo, M., Baird, S. L., & Asakura, K. (2024). Using simulation to train service providers in responding to intimate partner violence (IPV) and Trauma. *Families in Society*, *105*(3), 442–456. https://doi.org/10.1177/10443894241246570

Taylor, S., Stallings, A., Greenstein, S., Ochoa, A., Said, A., Salinas, N., Becerril, N., Guevara, W., & Phan, M. (2024). Serving IPV survivors in culturally diverse communities: Perspectives from

current service providers. *Violence Against Women*, *30*(8), 1866–1882. https://doi.org/10.1177/10778012241239938

Tonsing, J. (2025). A qualitative study of children's exposure to domestic violence and factors that facilitate children's ability to cope. *Child Abuse Review*, *34*(3), e70034. https://doi.org/10.1002/CAR.70034

Voth Schrag, R. J., Wood, L. G., Wachter, K., & Kulkarni, S. (2022). Compassion fatigue among the intimate partner violence and sexual assault workforce: Enhancing organizational practice. *Violence Against Women*, *28*(1), 277–297. https://doi.org/10.1177/1077801220988351/FORMAT/EPUB

Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry*, *85*(6), 586–599. https://doi.org/10.1037/ORT0000098

Wilson, M. H., & Webb, R. (2018). *Social Work's role in responding to intimate partner violence (Social Justice Brief)*. National Association of Social Workers. https://www.socialworkers.org/LinkClick.aspx?fileticket=WTrDbQ6CHxI%3D