

The Vouch and the Work of Collective Healing

Rise Up with Black Women Survivors of Domestic Violence in Newark

Dr. Jamila T. Davis

Abstract

Access to healing requires more than the availability of services. It also depends on whether survivors can approach those services without surrendering dignity, cultural belonging, or control over their own stories. This reflective practice essay examines Rise Up!, an eight-week healing circle developed at the Shani Baraka Women's Resource Center in Newark, New Jersey. Writing from the perspective of a credible messenger and co-creator, I consider how lived experience, collective reflection, and clinical partnership shaped the work. Particular attention is given to the vouch, a trusted community member's introduction of a clinician into an existing relationship of care. Drawing on Black feminist thought and healing-centered engagement, I argue that this invitation carries obligations of accountability rather than guaranteeing trust. The essay offers practice recommendations for shared leadership, survivor choice, safety, and community-led evaluation. It presents lessons from practice, not evidence of program effectiveness.

Keywords: Black women; domestic violence; credible messengers; collective healing; community and clinical partnership

Introduction: Entering the Circle

When I entered the Shani Baraka Women's Resource Center to help lead Rise Up!, I expected to teach. I had spent years creating curricula, teaching in prisons, and speaking about trauma, incarceration, and recovery. Yet sitting with other Black women survivors brought me back to parts of my own healing that remained unfinished. My experience could help me begin a conversation. It did not place me outside the work that conversation would require.

That recognition matters for how we understand credible messengers. In Rise Up!, credibility came from bringing lived experience into a relationship with other women, rather than presenting a completed story of survival for them to imitate. The work asked me to listen as well as speak. It challenged the distance that can develop between the person offering help and the person expected to receive it.

Rise Up! was developed in Newark, New Jersey, through my collaboration with Lakeesha Eure at the Shani Baraka Women's Resource Center. The eight-week circle addressed self-worth, boundaries, healthy and harmful relationships, coping with anxiety, and personal goals. Storytelling and shared reflection accompanied the educational material. Recruitment through the center and my social media networks created routes into a community space that did not require women to begin by identifying themselves as therapy clients. As the work developed, licensed clinician Jessica Rodriguez joined the team and offered additional therapeutic support.

This essay reflects on that experience from my position as a credible messenger and co-creator. Its central question is how community relationships can make care more approachable while preserving survivors' authority over their choices. I focus on what we called the vouch: the introduction of a clinical partner by someone whose credibility was already established in the circle. The lessons offered here are grounded in practice and interpreted through scholarship. They are not findings from a formal evaluation or a claim to represent every participant's experience.

Section 1: Black Women as Authorities in Their Own Healing

A social justice approach begins by asking who is allowed to define the problem. If a woman's hesitation about services is treated only as resistance, the institution escapes scrutiny. Crenshaw's (1991) analysis of violence against women of color shows why responses organized around gender alone can miss the effects of racism and economic exclusion. An intervention can acknowledge abuse while failing to address the conditions that constrain a survivor's options. For practitioners, this means examining the accessibility and conduct of services alongside the choices survivors make.

Recent research sharpens this concern. In qualitative interviews with 28 urban Black women who experienced intimate partner violence during the pandemic, Pirsch et al. (2026) identified racialized harm and institutional encounters as central to accounts of mistrust. Their Upper Midwest study reinforces a question for Newark: what must institutions do to earn trust? It does not establish outcomes for Rise Up!

Black feminist thought provides a second starting point. Collins (2000) places Black women's knowledge and self-definition at the center of an analysis of intersecting oppression. Applied to a healing circle, this perspective asks facilitators to take women's interpretations of their own lives seriously. The authority to describe harm, identify a need, or imagine a future should not depend on using clinical language. At the same time, shared racial identity does not erase differences in sexuality, disability, class, faith, or experience with institutions. Cultural responsiveness requires room for disagreement within the group.

Ginwright's (2018) practitioner essay on healing-centered engagement, developed in the context of work with young people, broadens attention from an individual's injury to collective well-being, culture, agency, and the conditions that produce harm. It offers a useful orientation for Rise Up!, where conversations about pain also made room for aspirations and relationships. This framework does not establish that any particular circle is effective. It helps specify the kind of practice we are trying to build: one that can recognize trauma without making trauma the entirety of a woman's identity.

Rise Up! also belongs in conversation with the tradition of sister circles. Neal-Barnett et al. (2011) describe the cultural relevance of these gatherings in relation to anxiety among African American women. Their work offers a rationale for taking familiar forms of collective support seriously; it does not establish outcomes for Newark survivors of domestic violence. In our circle, the practical importance of gathering was that women could encounter recognition from one another. My responsibility was to support that exchange without deciding in advance what another woman's healing should look like.

More directly relevant to domestic violence, Waller et al. (2024) reviewed eight intervention studies addressing depression and posttraumatic stress disorder among Black women experiencing intimate partner violence in the United States. Their synthesis highlights community settings, culturally responsive delivery, lived experience, and practical support as design considerations. Methodological limitations prevent treating these as independently proven ingredients or evidence that Rise Up!'s particular approach is effective.

Section 2: The Vouch as an Accountable Invitation

My relationship with the women mattered when Jessica entered the circle. I could introduce her as someone I trusted and make space for a different kind of support. The vouch gave that introduction a relational foundation. A professional credential could explain her qualifications; my endorsement offered a reason to consider getting to know her. The distinction helped me understand that the availability of counseling and a survivor's willingness to explore it are different questions.

Richardson's (2022) discussion of the co-sign in gun violence research provides a related point of reference for credible messengers' role in connecting communities and institutions. The settings and purposes differ. In Rise Up!, I use the vouch to describe a practitioner's relational introduction, not a validated treatment mechanism. Its significance lies in how an existing relationship may create an opening for another one.

Domestic-violence scholarship offers a closer parallel. Drawing on interviews with 30 African American survivors, Waller et al. (2023) recommend warm handoffs rather than relying only on referral lists. This supports understanding an introduction as relational rather than administrative. Their qualitative study develops a theory of help-seeking; it does not test whether a vouch improves engagement or safety.

An opening, however, is not an entitlement. My trust in a clinician cannot stand in for another woman's consent. A participant must remain free to listen, ask questions, seek a different provider, or decline counseling. If she feels that refusing the referral would disappoint me or threaten her place in the circle, the vouch risks reproducing the pressure we want the space to resist. This is the ethical tension at the center of credible messenger practice: the same influence that makes an invitation meaningful can make it difficult to refuse.

For that reason, the vouch should make the professional more accountable to the community. The clinician still has to explain the work, respect boundaries, and earn trust through conduct. The messenger needs a way to hear concerns and reconsider an endorsement. A program should not depend on personal loyalty to shield a provider from criticism. Survivors need a route to raise concerns that does not require confronting the very person whose reputation brought them into care.

This understanding also changes what institutions ask of credible messengers. We should have a voice in decisions about the space, referrals, and participant support, rather than being used mainly to recruit people into a service designed elsewhere. Our relationships are not an inexpensive substitute for institutional trustworthiness. When a program benefits from community credibility, it assumes a responsibility to sustain the conditions under which that credibility can be offered honestly.

Section 3: Clinical Partnership Without Taking Over the Circle

The work also taught me to recognize limits in what the circle could hold. There were needs that could not be met responsibly through encouragement, shared experience, or an educational curriculum alone. Recognizing those limits required us to reconsider the support around the group. A commitment to sisterhood did not remove our obligation to protect participants and make appropriate care available.

Jessica's involvement brought additional clinical support into a space where relationships already existed. The challenge was to make that support accessible without implying that the community work had been merely preliminary or inadequate. Credible messengers and clinicians brought different forms of knowledge. The partnership made it possible to consider those forms together while recognizing that lived experience does not authorize someone to practice beyond their training.

A lesson I draw from this experience is that clinical support should be planned with the community from the outset, rather than introduced only after a crisis. Shared leadership does not require interchangeable roles. A credible messenger may help shape the language, relationships, and rhythm of the circle. A licensed clinician remains responsible for work within their professional scope. Both need clarity about when to pause a session, offer individual support, or connect someone with a more appropriate service.

Self-disclosure requires similar care. My willingness to speak about my own life was part of how I entered the work, but another person's need must determine how much space my story occupies. Henretty and Levitt's (2010) review describes varied findings on therapist self-disclosure and emphasizes the importance of its circumstances. Disclosure should therefore be purposeful rather than treated as inherently therapeutic. Neither a clinician nor a credible messenger should expect participants to care for the facilitator's unresolved pain. Support and reflective supervision for the people leading the circle belong in the program's design.

Section 4: Building Conditions for Collective Healing

West's (2024) domestic-violence practice guidance, developed in consultation with Doris O'Neal, calls for care grounded in survivors' goals, cultural identities, and strengths. This advocacy guidance helps make the following responsibilities concrete.

For practitioners and funders interested in this approach, the first task is to share decision-making. Invite Black women survivors and local credible messengers to help determine the circle's purpose, participation expectations, and standards of care. Compensate that work. A consultation after the program has already been designed offers less power than a role in deciding what the program will do. Community partners also need a voice in how the work is described publicly and whose knowledge receives credit.

Second, protect choice within the group. Attendance should not create an obligation to tell a painful story, accept a referral, or demonstrate progress through public vulnerability. A woman who listens quietly may be exercising judgment about her own safety. Spiritual language and practices, when welcomed by participants, can have a place without becoming conditions of belonging. A culturally grounded circle must remain open to women whose beliefs and ways of participating differ from those of its facilitators.

Third, develop an explicit safety plan with qualified partners. Before sessions begin, establish group agreements, explain confidentiality and its limits, and identify who will respond if conflict or acute distress arises. Privacy cannot be guaranteed simply because participants share a room or an identity. Plans should address how a session may be interrupted, how immediate needs will be assessed, and how participants can obtain support afterward. These are recommendations for responsible design, not claims that a single protocol fits every setting.

Fourth, distinguish community support from clinical care without making the transition cold or confusing. A personal introduction can help, but the participant should know what is being offered, what information will be recorded, and whether any information would be shared. Accepting counseling should not require permission for unrelated publicity or research. Clear explanations protect the relationships that make the introduction possible.

Fifth, resource the practical conditions of participation. A circle cannot resolve an unsafe housing situation or replace access to legal advocacy, income, and other material supports. Programs should build referral relationships and budget for locally identified access needs, such as transportation, child care, or accessible meeting space. Remote participation may expand access for some women while creating privacy risks for others. Decisions about format should be made with participants, rather than assuming that digital access is automatically safer or more convenient.

Finally, avoid treating the end of an eight-week curriculum as the end of responsibility. Consider continued circles, voluntary peer connections, and leadership opportunities according to participants' interests and available resources. Do not turn a survivor's progress into an expectation that she will immediately become a messenger for others. The opportunity to lead should include preparation, compensation, and the freedom to step back. Long-term support also requires realistic staffing and boundaries so that commitment does not become permanent, unpaid availability.

Section 5: What Practice Reflection Can and Cannot Establish

I can describe what the work asked of me and the reasoning that developed through it. This account cannot establish how much participants benefited, whether counseling engagement increased, or whether the vouch caused a change. It contains no systematically analyzed outcome data, comparison group, or independently gathered participant accounts. My role in creating the program also shapes what I notice and how I interpret it. A commitment to Rise Up! makes critical inquiry more necessary, not less.

The next stage should be a community-shaped evaluation that asks participants what meaningful support looks like to them. Questions could include whether women feel respected, can disagree safely, understand their options, and can access services they choose. Evaluation should also examine adverse experiences and reasons for leaving, rather than relying only on the accounts of those who remain. Participation in an evaluation must be separate from access to support, with appropriate consent, privacy protections, and ethics review where required.

The vouch itself deserves careful study. It would be useful to learn when an endorsement helps, when it creates pressure, and how trust changes after the initial introduction. These questions can guide adaptation without assuming that a relationship developed in Newark can be reproduced simply by exporting a curriculum. Local leadership and the ability to respond to criticism are part of the work, not optional additions to a program model.

Conclusion

Rise Up! brought me into a circle where my experience could be useful and my own healing could remain unfinished. That combination changed how I understood leadership. Credibility carried a responsibility to listen, recognize limits, and make room for support I could not provide alone.

For social justice practitioners, the larger lesson is to build services that deserve the trust communities are asked to place in them. The vouch can create an opening. What happens after that opening depends on survivor choice, the conduct of professionals, and the resources available to sustain care. Black women's knowledge should shape those conditions from the beginning.

The aim is a space where a woman can be heard without being reduced to her trauma, receive support without surrendering her authority, and belong without having to perform recovery. That is the work of collective healing to which Rise Up! calls us.

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