Intersectional Feminist Insights into the Lived Experiences of Domestic Violence and Trauma in Marginalized Women

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Abstract

Violence against women continues to be a pervasive social issue worldwide, including in Canada, with women from marginalized social locations often facing compounded forms of violence, exclusion, and systemic neglect (Kaur & Garg, 2008; Singhal et al., 2021; Sokoloff & Dupont, 2005; World Health Organization, 2021). Domestic violence (DV) is a potentially traumatic experience for many women, often resulting in serious physical and psychological consequences, including post-traumatic stress disorder (PTSD) (Goodman & Epstein, 2008). However, the experiences and meanings that marginalized women attribute to trauma and PTSD remain underexplored (Baird, 2018). This thesis addresses this gap by critically examining how women who have experienced domestic violence and received a PTSD diagnosis understand and give meaning to trauma, and how they experience interventions provided by domestic violence and mental health services.

Guided by an intersectional feminist framework (Crenshaw,1991), the research views trauma and violence as socially and structurally situated phenomena shaped by power, inequality, and identity (Brown, 2017; Herman, 2015). Using a feminist phenomenological approach and interpretative phenomenological analysis (IPA), the study draws on in-depth, open-ended interviews with women from diverse marginalized backgrounds in Canada, including Indigenous women and those from rural, religious, disabled, and sexually diverse communities. The methodological focus on lived experience and meaning making allows women's voices to guide the interpretation of trauma beyond clinical or diagnostic frameworks.

The findings highlight that participants conceptualize trauma not solely as an individual psychological response but as an ongoing experience of social and structural harm embedded

within systems of inequality. Women described coercive control as a persistent form of domination that extends beyond physical violence and is shaped by race, class, disability, sexuality, and geography. Participants' interpretations of PTSD reveal tensions between clinical definitions and lived realities of trauma, often exposing gaps in service delivery and cultural understanding.

This research contributes to feminist scholarship on trauma and domestic violence by foregrounding the lived experience of marginalized women and challenging dominant, medicalized understandings of PTSD. It offers insights that can inform culturally responsive, intersectional, and trauma- and violence- informed practices within domestic violence and mental health systems.

Keywords: Domestic violence, Coercive Control, Trauma, Intersectionality

Résumé

La violence envers les femmes continue d'être un problème social omniprésent à l'échelle mondiale, y compris au Canada, où les femmes issues de milieux sociaux marginalisés font souvent face à des formes de violence, d'exclusion et de négligence systémique (Kaur & Garg, 2008; Singhal et al., 2021; Sokoloff & Dupont, 2005; World Health Organization, 2021). La violence conjugale (VC) est une expérience potentiellement traumatisante pour de nombreuses femmes et entraîne souvent des conséquences physiques et psychologiques graves, notamment un trouble de stress post-traumatique (TSPT) (Goodman & Epstein, 2008). Toutefois, les expériences et les significations que les femmes marginalisées attribuent au traumatisme et au TSPT demeurent peu explorées (Baird, 2018). Cette thèse comble cette lacune en examinant de façon critique comment les femmes ayant vécu de la violence conjugale et reçu un diagnostic de TSPT comprennent et donnent un sens au traumatisme, ainsi que la manière dont elles vivent les interventions offertes par les services de violence conjugale et de santé mentale.

Guidée par un cadre féministe intersectionnel (Crenshaw, 1991), la recherche conçoit le traumatisme et la violence comme des phénomènes socialement et structurellement situés, façonnés par le pouvoir, les inégalités et l'identité (Brown, 2017; Herman, 2015). En utilisant une approche phénoménologique féministe et l'analyse phénoménologique interprétative (IPA), l'étude s'appuie sur des entrevues approfondies et ouvertes avec des femmes issues de divers milieux marginalisés au Canada, incluant des femmes autochtones ainsi que des femmes vivant dans des communautés rurales, religieuses, en situation de handicap ou issues de la diversité sexuelle. L'accent méthodologique sur l'expérience vécue et la construction de sens permet aux voix des femmes de guider l'interprétation du traumatisme au-delà des cadres cliniques ou diagnostiques.

Les résultats démontrent que les participantes conceptualisent le traumatisme non seulement comme une réponse psychologique individuelle, mais aussi comme une expérience continue de préjudices sociaux et structurels ancrés dans des systèmes d'inégalités. Les femmes ont décrit le contrôle coercitif comme une forme persistante de domination qui dépasse la violence physique et qui est façonnée par la race, la classe, le handicap, la sexualité et la géographie. Les interprétations du TSPT par les participantes révèlent des tensions entre les définitions cliniques et les réalités vécues du traumatisme, mettant souvent en lumière des lacunes dans la prestation des services et la compréhension culturelle.

Cette recherche contribue aux travaux féministes sur le traumatisme et la violence conjugale en mettant de l'avant l'expérience vécue des femmes marginalisées et en remettant en question les conceptions dominantes et médicalisées du TSPT. Elle offre des réflexions pouvant éclairer des pratiques culturellement adaptées, intersectionnelles et ancrées dans des approches tenant compte des traumatismes et de la violence au sein des systèmes de violence conjugale et de santé mentale.

Mots-clés : violence conjugale, contrôle coercitif, traumatisme, intersectionnalité

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Introduction

Domestic violence remains one of the most pervasive forms of gender-based violence worldwide and in Canada (Howard et al., 2010; Semahegn & Mengistie, 2015). In Canada, marginalized women, including Indigenous, racialized, immigrant, disabled, rural, and sexual minority women, experience some of the highest rates of domestic violence (Cotter, 2021b; Government of Canada, 2025; Heidinger, 2021; Jaffray, 2021; Savage, 2021). Their heightened exposure reflects the ways systems of racism, colonialism, ableism, heterosexism, and poverty intersect to limit safety and access to support (Abraham & Tastsoglou, 2016; Sokoloff & Dupont, 2005). These intersecting structures not only increase vulnerability to violence but also shape how its consequences, particularly trauma, are experienced, expressed, and responded to within different social and institutional contexts (Brown, 2004, 2008, 2017).

In addition, domestic violence has profound consequences for women's mental health and overall well-being (Roberts et al., 1998; Singhal et al., 2021; Trevillion et al., 2012). Beyond immediate fear and physical injury, survivors often experience anxiety, sleep disturbances, depression, dissociation, and ongoing disruptions to their daily lives and relationships (DeJonghe et al., 2008; García-Moreno et al., 2013; Gorde et al., 2004; Iverson et al., 2009; Macy et al., 2009; Schumacher, 2009; Titchiner, 2017). In addition, trauma is one of the most widely recognized consequences of domestic violence and is frequently conceptualized through the clinical category of post-traumatic stress disorder (PTSD) (Campbell, 2002; Golding, 1999; Goodman & Epstein, 2008; Gorde et al., 2004; Humphreys & Joseph, 2004; Kamo, 2009; Vaddiparti & Varma, 2009).

This research focuses on trauma as a significant and enduring consequence of domestic violence, with particular attention to DV-related trauma as it is shaped by domestic violence and lived under conditions of structural inequality. Situated within this broader context, my engagement with this research has evolved through my professional work as a counsellor supporting women who have experienced domestic violence and trauma. In working with women across diverse social locations and social contexts, I witnessed how factors such as ethnicity, culture, socioeconomic background, disability, age, sexuality and other intersecting identities shape differing experiences of domestic violence. These encounters prompted me to question whether women living in different countries experience domestic violence in similar ways, or whether broader political, social, and cultural contexts produce distinct forms and meanings of domestic violence as patriarchal violence. This question also became central to how I began to conceptualise DV-related trauma within different social contexts and an intersectional framework.

Through both my lived experience as an immigrant and my professional practice in the UK and later in Canada, I observed that while the prevalence and social responses to domestic violence may differ across contexts, women continue to be profoundly affected, often experiencing long-term psychological and emotional consequences, including trauma. Although I occupied certain positions of relative privilege at different stages of my life, becoming an immigrant made me increasingly aware of how intersecting social locations such as gender, ethnicity, and immigration status influence whose experiences of domestic violence and trauma are recognized, heard, or made invisible. This reflexive awareness informs the ethical and analytical position from which this research is conducted.

Feminist frameworks that critically examine patriarchy as a root condition of gender-based violence (Dobash & Dobash, 1979; Pyles & Postmus, 2004) have profoundly shaped my

engagement with this research and resonate with my personal history and social location, through which I have both witnessed and lived how patriarchal systems structure women's lives across different social contexts.

Through my review of the literature on domestic violence and trauma, I observed increasing recognition of the link between domestic violence and trauma (Birkley et al., 2016; Gerber et al., 2021; Johnson & Benight, 2003; Joseph et al., 2015; Roberts et al., 1998;Warshaw et al., 2013), alongside a persistent tendency to conceptualize trauma in a narrow and medicalized way, primarily through a focus on PTSD symptoms and symptom-based treatment approaches when trauma is defined solely through PTSD or similar diagnostic categories (Griffing et al., 2006; Iverson et al., 2013; Jones et al., 2001; Krause et al., 2008). Additionally, I am influenced by scholars who warn that interpreting trauma solely through diagnostic models can obscure the wider structural oppression such as patriarchy, racism, ableism, class inequality, and colonialism that both produce and perpetuate violence (Brown, 2004, 2017; Burstow, 2003, 2005; Baird, 2018; Kulkarni, 2019; Quiros & Berger, 2015). This tension between clinical interpretation and structural understanding forms a key point of departure for this study.

Despite existing research, there remains a critical gap in understanding how women themselves understand, interpret, and construct meaning around their experiences of domestic violence and DV-related trauma, as well as how they perceive and experience the PTSD diagnosis as a label (Baird, 2018) . Given these concerns, it is essential to explore domestic violence and trauma from the perspectives of women situated within diverse social locations, including differences in race, ethnicity, class, sexuality, and disability. This gap is particularly pronounced for women whose voices are often marginalized within both clinical practice and academic research.

Research Aim

Building on the gaps identified within intersectional feminist and trauma scholarship, this study aims to explore how women with lived experiences of domestic violence and trauma understand and make meaning of DV-related trauma and the diagnosis of post-traumatic stress disorder (PTSD). The thesis is guided by an overarching research question: how do women from marginalized social locations, including those shaped by race, ethnicity, geographic location, disability, and intersecting forms of social exclusion, in Canada understand and give meaning to trauma in the context of domestic violence, and how do their social locations shape their experiences of PTSD diagnosis and intervention?

This research responds to these gaps by centring women's voices and lived experiences. Guided by an intersectional feminist framework (Crenshaw, 1991; Collins, 2000) , a feminist phenomenological approach, and informed by interpretative phenomenological analysis (IPA), the study examines how women from marginalized social locations in Canada understand trauma, negotiate the label of PTSD, and experience domestic violence and mental health services. By centering women's lived realities, this study contributes to more inclusive, contextually grounded, and socially just understandings of trauma, as well as women's active processes of resilience, resistance, and self-reclamation. Rather than treating trauma solely as a clinical outcome, this research positions DV-related trauma as a lived, social, and political experience shaped by intersecting structures of power.

Structure of the Thesis

This thesis is organized into eight chapters that build upon one another to explore how women from marginalized social locations in Canada understand and give meaning to trauma in the context of coercive control. Each chapter contributes to the overarching goal of developing an intersectional and feminist understanding of trauma grounded in women lived experiences.

Chapter One offers a critical review of the literature on domestic violence through the lens of coercive control. It examines how coercive control manifests in women's everyday lives, analyses the prevalence of domestic violence in Canada, and explores its impacts on women's mental health, well-being, autonomy, safety, and freedom.

Chapter Two examines key historical and theoretical understandings of trauma, including the emergence of post-traumatic stress disorder (PTSD) and feminist and intersectional critiques of its medicalised and individualised framing within diagnostic systems such as the DSM. It highlights how trauma has been contested and redefined as a socially and structurally situated experience shaped by power, gender, race, class, ability, and colonial histories. The chapter also discusses trauma-informed approaches in the context of domestic violence, emphasising the need to understand trauma beyond individual pathology.

Chapter Three outlines the intersectional feminist theoretical framework underpinning this study. It draws on the work of Collins & Bilge (2016) to explain the core principles of intersectional feminist and its relevance for understanding trauma, coercive control, and women lived experiences within structures of power and inequality. The chapter also critically reflects on the limitations of intersectional feminist theory and clarifies how it is applied within this research.

Chapter Four outlines the methodological design of this study. It begins by discussing the origins of phenomenology and feminist phenomenology, then moves to the epistemological positioning of the research, followed by its grounding in feminist phenomenology, coercive control, and trauma. The chapter then details the sampling and recruitment strategies, as well as the data collection procedures. It also addresses researcher positionality and reflexivity. The process of data analysis is explained using Interpretative Phenomenological Analysis (IPA), followed by a discussion of the study's credibility and trustworthiness. The chapter concludes with the ethical considerations guiding this research.

Chapter Five begins with an introduction to the research findings and a socio-demographic profile of the participants. As the findings are extensive, they are presented across two standalone chapters, Chapters Six and Seven.

Chapter Six discusses findings organised around women's understandings and experiences of coercive control and post-separation violence, including how they make sense of trauma as DV-related trauma and how their social locations intersect with their experiences of coercive control and trauma.

Chapter Seven focuses on women's experiences and understandings of PTSD diagnosis, including how PTSD is conceptualised and applied by professionals across different sectors, such as mental health services, domestic violence organisations, and legal systems (including family courts). It also explores how women resist coercive control within their daily lives and systems, how their social locations shape these encounters, and how their needs are addressed or overlooked during professional interventions.

Chapter Eight offers a critical discussion of the study's findings in relation to existing literature and the intersectional feminist framework, drawing on Collins and Bilge (2016) and Collins (2000). This chapter reflects how the six core concepts of intersectionality and the four domains of power intersect with marginalized women's experiences of coercive control, DV-related trauma, and their everyday practices of resistance. The chapter also outlines the study's limitations and discusses its implications for future research, policy, and practice.

Chapter 1. Domestic Violence through the Lens of Coercive Control

Introduction

This literature review is divided into two chapters. Chapter One explores the concept of domestic violence, beginning with a discussion of terminology and the feminist origins of the term. It then considers the implications of gender-neutral language. The chapter also presents critical perspectives on domestic violence by comparing narrow, incident-based definitions with broader frameworks that recognise a wider range of abusive behaviours. Building on this discussion, the concept of 'coercive control' is introduced as the primary lens through which domestic violence is understood in this thesis. The chapter further examines the prevalence of domestic violence in Canada, drawing on both self-reported and official data, including police reports, and engages with key debates on gender symmetry versus asymmetry. Finally, it explores the physical, financial, social, and mental health consequences of domestic violence for women, highlighting the deep impact of abuse across multiple areas of their lives. Together, these sections provide a comprehensive foundation for understanding domestic violence as a gendered and multidimensional form of abuse.

Chapter Two examines the concept of trauma and post-traumatic stress disorder (PTSD), focusing on the historical development of these diagnostic labels and their relevance to the experiences of women who have endured domestic violence. Together these chapters offer an integrated perspective on the relationship between domestic violence and trauma, which is central to the aims of this thesis.

1.1. Feminist Origins of the Term 'Domestic Violence'

For much of the past, violence against women in intimates setting was largely regarded as private matter (Dixon, 2014). Within a patriarchal context, the preservation of the family was prioritized, while little attention was given to recognizing violence against women or domestic violence as a problem, let alone as a crime (Dixon, 2014; Pleck, 1987). Before the term domestic violence gained prominence, the issue was referred to by narrower labels such as 'wife beating', 'wife abuse', 'wife battering', and 'woman beating', which reflected limited understandings of the problem and framed it as a private matter confined to marital relationships (Dobash & Dobash, 2014).

Before the 1970s, marriage was widely seen as a structure where men held authority over women. In some cases, husbands were permitted to discipline their wives physically, with such actions sometimes supported by prevailing legal and religious norms (Clark, 2011). In contrast, women who killed their husbands were punished severely, as this was seen as a violation of the natural order (Clark, 2011; Dixon, 2014; Gómez, 2024). Also, 'wife beating' was widely minimized by police, courts, and popular culture and it was not subject to legal jurisdiction. This dismissal was reinforced by psychiatric perspectives which pathologized domestic violence by portraying it as a problem of certain women or social classes and framing it as a mental illness. Within this view, female victims were often blamed for provoking violence through masochistic tendencies or labelled as 'aggressive' (Clark, 2011; Dobash & Dobash, 1979).

However, feminists later challenged the idea that female victims provoked violence through masochism or aggression, arguing that such claims placed responsibility on women rather than addressing the underlying power dynamics in abusive relationships. To build on this shift, Lenore Walker (2006) introduced the concept of battered women's syndrome, which sought to explain

women's responses to sustained abuse. However, the term 'syndrome' has been widely critiqued for its potential to pathologize survivors, even though Walker's work aimed to validate their reactions as understandable within the context of abusive relationships (Dixon, 2014).

As feminist movements gained momentum during the 1970s, terms such as 'wife beating' and 'spousal abuse' were reframed as domestic violence and understood as a social problem embedded in systems of gender inequality, needing attention from academics, criminal justice system and policymakers. This period also saw the emergence of the term domestic violence and a shift in how it was understood, moving from a private matter to a public crime (Dixon, 2014; Schechter,1982).

Thus, feminists' movement exposed domestic violence prevalence across all social groups, reframed it as part of systemic male dominance, redefined rape as an act of violence not sex, and advanced practical responses by establishing shelters where battered women could seek refuge and support, demand stronger police protection, and advocate for women in the courts and legal protections (Clark, 2011).

Feminist movement emphasizing that domestic violence is a social justice issue rooted in patriarchal culture and argue that violence against women is not merely a personal or psychological problem but a political issue stemming from societal structures that privilege male dominance and control over female autonomy (Schechter, 1982). Feminist perspectives focus on the unequal distribution of power in society, which perpetuates gender inequality and creates conditions for violence against women (Pyles & Postmus, 2004). Moreover, feminists began referring to 'battered women' as 'survivors' to emphasize their agency and resilience, rather than portraying them as passive victims (Clark, 2011).

Since violence against women gained wider attention in the 1970s, ongoing debates about how domestic violence should be defined have centred on questions of meaning and conceptualisation (Kelly & Westmarland, 2016). These discussions have raised issues about the extent of domestic violence across different contexts, the gender of perpetrators whether primarily men, women, or both (symmetry versus asymmetry), the scope of definitions from narrowly focused physical acts to broader forms such as emotional or financial abuse, and the most appropriate responses to address it (Dobash & Dobash, 2014).

The definitions outlined in this chapter demonstrated that they are dynamic, evolving over time in response to changing social awareness and recognition. There are often historical, theoretical, and political factors that influence the choice of terminology (Haaken & Yragui, 2003). Therefore, the terminology used to describe domestic violence has evolved over time, reflecting shifts in understanding, policy, and feminist critique (Walsh et al., 2015).

1.2. Gender-Neutral Terminology

Early family violence scholars such as Straus (1979) employed gender-neutral terms like ‘partner violence’ or ‘family conflict’ when discussing domestic violence, because they did not conceptualize domestic violence in intimate or familial setting as inherently gendered. This approach framed violence as a relational or situational problem emerging from interpersonal conflict, rather than one as manifestation of broader gender inequality.

More recently, gender-neutral terms such as ‘intimate partner violence’ (IPV) has also been defended for their inclusivity, enabling recognition of violence in diverse contexts, including same-sex and trans relationships (Donovan & Hester, 2015; Renzetti, 1992). However, while the gender-neutral terms such as ‘intimate partner violence’ or ‘partner violence’, expand the conceptual focus, they can also inadvertently depoliticize the issue.

Conceptualizing violence as a product of 'ordinary' interpersonal interactions implies symmetrical responsibility, suggesting that women are equally responsible for perpetrating violence. This framing obscuring the deeply gendered power dynamics and systemic inequalities that underpin domestic violence (DeKeseredy, 2011; DeKeseredy & Dragiewicz, 2009).

Feminist scholars including Dobash and Dobash (1979) and Johnson (2005) have argued that gender-neutral frameworks from the early 'family violence' or 'family conflict' to later inclusive uses of gender-neutral terminology such as IPV, can erase the disproportionate victimization of women in severe and coercive forms of abuse. By removing gender from the conceptualization, these approach risk rendering invisible the structural inequalities and patriarchal power relations at the core of domestic violence (Anderson, 2007; Dobash & Dobash, 2004). Mullender (1996) similarly stated that using gender-neutral language that encompasses all abusers and survivors irrespective of gender or the nature of their relationship may unintentionally create an illusion of neutrality conveying the misleading impression of "mutual conflict" (p.18).

Researchers who emphasize the gendered nature of abuse argue that violence should be examined within the broader context of ongoing abusive relationship rather than through incident-based approach which overlook the underlying power dynamics. This perspective shows that men's physical and sexual violence against women is often embedded in a broader "constellation of abuse" a continuum of intimidation, coercion, and control that cannot be reduced to isolated incidents (Dobash & Dobash, 2004, p.328).

1.2.1. Critique of Narrow Incident- Based Definitions of Domestic Violence

Building on critiques of gender-neutral terminology, feminist scholars have also questioned the conceptual adequacy of the term 'domestic violence' itself .While the term aimed to be inclusive, feminists argue that it fails to capture the structural, patterned, and often hidden dimensions of

coercion and control predominantly experienced by women in intimate relationships (Bagshaw, 2011; Johnson, 2005; Westmarland & Kelly, 2016). For example, the term 'violence', has been critiqued for failing to capture the full scope of abuse, focusing only on physical violence and overlooking forms of mistreatment such as psychological abuse, manipulation, economic abuse, sexual coercion which are often just as damaging as physical violence (Mullender, 1996).

As Mullender (1996) noted, critiques of the term 'violence' in the context of domestic violence reveal ongoing debates over its definitional boundaries. A narrow definition confines the concept to physical acts of abuse, whereas a broader definition extends it to include emotional, psychological, financial, and other non-physical forms of abuse (Dobash & Dobash, 2014). Narrow definitions, as DeKeseredy and Schwartz (2011) note, exclude many coercive tactics or non-physical tactics perpetrators use to maintain power and control like psychological abuse, thereby obscuring the full extent of abuse.

Kelly and Johnson (2008) point out this narrow definition can also have an adverse consequence for women. A narrow definition of abuse can prevent women form seeking help and support particularly if women may recognize their situation as abusive but struggle to identify it under the 'physical act', as a result, their abuse may go underreported and women's feelings and experiences may be minimized or dismissed (DeKeseredy, 2011; DeKeseredy & Schwartz, 2011). Moreover, behaviours often deemed 'non-violent' such as sustained emotional abuse or financial control are frequently trivialized or ignored in legal and policy contexts (Côté et al.,2025; Robinson et al., 2016)

A broader conceptualization, by contrast, recognizes domestic violence as an ongoing pattern of abuse rather than isolated incidents (Kelly & Westmarland, 2016). This broader perspective or

approach acknowledges that abuse may not leave visible injuries like bruises yet still instills fear, undermines autonomy, and erodes self-worth (Dobash & Dobash, 2004).

Building on the broader definition of domestic violence, women face the layers of oppression in their personal life which named "continuum of unsafety" (Stark, 2007, p. 86) that include violent acts which committed by "men, institutional violent and violence which is imposed by socio-structural" factors (Kelly, 1988, p.45). Kelly's (1988) concept of the 'sexual violence continuum' further illustrates how male violence functions as a socially constructed mechanism of power and domination, not confined to a single form such as physical assault. This continuum shows how such violence operates across a spectrum of behaviours from rape and sexual harassment to pornography, domestic violence, and other forms of violence directed at women all of which serve to reinforce gendered hierarchies. As Kelly and Radford (1998) argue, viewing violence through this continuum provides a more comprehensive framework for understanding how seemingly distinct acts interconnected forms of violence are strategically used to control, subordinate, and sustain women's inequality.

Defining domestic violence against women is therefore a complex and multifaceted issue that can not be fully captured by a narrow incident-based approach alone (Saltzman & Fingerhut, 2000). Because domestic violence fundamentally revolves around power and control (Stark, 2007), focusing solely on physical violence as one form of domestic violence neglects other forms of domestic violence such as, "isolation, economic control, verbal criticism, setting standards for childcare and housework" that structure women's daily lives and applied by abusive man (Kelly, 1988, p.131). Stark (2007) argues that these forms of control are central to understanding abuse, as they entrap women in relationships characterized by pervasive fear and subordination

Consequently, the narrow framing of domestic violence as isolated incidents overlooked the experiences of many women who report that their abusive partners engage in ongoing, 'everyday' behavior characterized by the 'micro-management' of their lives (Kelly & Westmarland, 2016; Stark, 2007). Scholars such as Stark (2007) advocate for a broader conceptualization of domestic violence, arguing that it should be understood as a pattern of 'coercive control'. This framework of coercive control more accurately reflects the realities of domestic violence, emphasizing the complex dynamics of power and control that underpin abusive relationships (Stark, 2007). In the next section, I will explore 'coercive control' as a broader lens for understanding domestic violence more deeply.

While acknowledging these critiques, this thesis intentionally retains the term domestic violence to remain grounded in its feminist origins and historical role in advocacy and scholarship (Dixon, 2014; Pyles & Postmus, 2004). Retaining the term affirms its political and historical significance within feminist movements that have long framed domestic violence as an issue of gendered power rather than private conflict. However, this thesis also extends the concept by integrating Stark's (2007) framework of coercive control, which reconceptualizes domestic violence as a sustained, patterned, and gendered abuse of power operating through intimidation, isolation, surveillance, and the erosion of autonomy. In doing so, domestic violence is redefined not merely as a series of discrete incidents but as an ongoing system of domination an entrenched manifestation of patriarchal power and social inequality (Hooks, 2015).

1.3. Understanding Domestic Violence Through the Lens of Coercive Control

1.3.1. Coercive Control Definitions

The concepts of power and control are pivotal in feminist research on domestic violence, which since the mid 1970, has framed this issue within the context of the systematic domination of men

over women, highlighting how these power dynamics contribute to the prevalence and perpetuation of domestic violence (Côté et al., 2025; Dobash & Dobash,1979). Building on feminist theory, American scholar Evan Stark, developed the coercive control framework to provide a deeper understanding of domestic violence through the lens of the deprivation of freedom and coercive control as he named it. In his 2007 book, *Coercive Control: The Entrapment of Women in Personal Life,* Evan Stark challenges the conventional understanding of domestic violence, which often frames it as a series of separate 'acts' or 'incidents'. As noted at the end of the previous section, Stark proposes a broader perspective, suggesting that domestic violence should be seen as a widespread issue rooted in the desire for control and the limitation of individual freedom and autonomy (Côté et al., 2025).

Stark (2007) argues that by concentrating only on physical violence, many tactics employed by abusers, which serve to entrap women and limit their freedom, are overlooked. Therefore, in his words, 'coercive control' as domestic violence in survivor's life would be considered as overlapping forms of abuse and inequality , coercive and controlling behaviours and "any act as violent that causes the victim to do something she does not want to do, prevents her from doing something she wants to do, or causes her to be afraid regardless of whether assault was involved" (Stark, 2007, p.201).

Coercive control is acknowledged as a gender-specific social issue (men control women) that stems from the existing male dominance and their advantageous positions over women and are not merely characterized by physical violence but are better understood a men's attempts to destroy women's autonomy and restore patriarchy in intimate relationship (Barlow & Walklate, 2022; Stark, 2007, 2009, 2010). In recent decades, as women have achieved greater independence and autonomy, male perpetrators have perceived that physical violence has become both less effective

as a means of maintaining control and less socially acceptable, carrying greater risk of sanctions. Consequently, men have adapted their strategies, merging overt acts of violence with more subtle and invisible methods of coercive control in order to sustain their dominance and preserve their social privilege (Gill & Aspinall, 2020).

1.3.2. The Manifestations of Coercive Control

Stark (2007) defines coercive control as a fundamental aspect of abusive behaviour. Coercive control involves a series of repetitive, cumulative and routine strategies rather than being incident specific and has cumulative effects. Coercive control operates through two concepts: coercion and control (Stark, 2006, 2007).

A number of authors also define coercive control not merely as the use of force or threats to compel a specific response, but as a sustained pattern of behaviors including intimidation, isolation, surveillance, and psychological manipulation through which an abuser seeks to dominate their partner and restrict their autonomy within the relationship (Cook & Goodman, 2006; Hamberger et al., 2017). It also includes degrading acts such as physical violence, insults, threats, and assaults, which can have long-term consequences, including physical, behavioural, or psychological effects (Côté et al., 2025; Tanha et al., 2010).

According to the model of coercive control, coercion is focused on the present and is used to compel a particular action from the victim, while control extends beyond a single moment in time, involving the ongoing deprivation and exploitation of the woman for the abuser's benefit (Barlow & Walklate, 2022; Stark, 2007; Walby & Towers, 2018).

Control refers to "structural forms of deprivation, exploitation, and command that compel obedience indirectly by monopolizing vital resources, dictating preferred choices, microregulating

a partner's behavior, limiting her options, and depriving her of supports needed to exercise independent judgment" (Stark, 2007, p.229). In fact, control operates through non-explicitly violent but terrorizing strategies that restrict the women daily life. Unlike coercion, control strategies are more difficult to identify or detect (Cook & Goodman, 2006; Côté et al., 2025). According to Stark (2007) and Stark and Hester (2019), it is impossible to understand coercive control through isolated incidents, as the obedience or dependence of the victim often results from a cumulative pattern of directs tactics, such as manipulation, isolation among others developing over time and gradually undermining the victims' autonomy.

When an abuser uses both coercion and control, he gains 'total authority' over his victim (Buzawa et al., 2015; Stark, 2007). Stark's 'cage analogy' is used to conceptualize and explain the nature of coercive control. This analogy emphasizes that domestic violence is a pattern of behaviour that creates an invisible 'cage' around the victim (Cowan, 2023; Myhill & Johnson, 2016; Stark, 2007). This cage is constructed through tactics such as micromanagement, emotional manipulation, humiliation, and aggression which deprived the freedom of victim. This framework reveals a systematic action aimed at systematically depriving the victim's autonomy and freedom, creating an environment of entrapment and subjugation (Barlow & Walklate, 2022; Côté et al., 2025; Stark, 2007). In addition, Katz (2022) compares living under coercive control in a domestic setting to existing under a dictatorship. In this context, the abuser acts as a dictator, appearing calm in public while exerting cruel control at home. Like oppressive regimes, conflict is suppressed, communication with outsiders is limited, and victims experience constant surveillance. Compliance is enforced through threats and punishment, creating a situation that resembles a mini tyranny (Katz, 2022).

From this point forward, this thesis adopts coercive control as outlined by Stark (2007) as the conceptual lens through which domestic violence against women is understood and analysed. Stark's (2007) concept of coercive control is firmly rooted in feminist theory and is explicitly gendered. It emphasises how men's domination and control over women operate through ongoing patterns of surveillance, isolation, and restriction. This concept functions as a framework for understanding how gendered power is enacted and maintained, situating coercive control within the broader socio-political context of patriarchy.

Although Stark's work has made a crucial contribution to understanding coercive control, its engagement with intersectional dimensions of abuse remains limited (Lapierre et al., 2025) . More broadly, despite increased attention to domestic violence though the lens of coercive control, important aspects of these experiences remain under-researched, creating ongoing blind spots within scholarship, law, policy, and professional practice. There is still limited research exploring how coercive control is experienced within certain communities, including Indigenous and immigrant women (Alsinai et al., 2023; Ogden & Tutty, 2023; Simic, 2025). These gaps point to the need for an intersectional feminist approach that recognises how multiple systems of oppression shape women lived experiences of violence (Tolmie et al., 2024). While coercive control is often conceptualised as a form of gendered violence and a manifestation of patriarchal oppression, it cannot be understood through a single or universal lens. Intersectional feminist, which has been central since Crenshaw's (1991) foundational work, foregrounds the importance of considering how different social locations and contexts including race, ethnicity, age, disability, social class, and sexuality shape women's experiences of coercive control (Donovan & Hester, 2015). Within patriarchal contexts, abusive behaviours are often dynamically and strategically

adapted around specific women through ongoing and evolving patterns of control (Donovan & Barnes, 2021).

1.4. Prevalence of Domestic Violence in Canada

Domestic violence is a widespread global issue affecting women across all regions and societal background and is widely recognized as a major public health concern (WHO, 2021). According to Cotter (2021a), data from the Survey of Safety in Public and Private Spaces (SSPPS) show that 44% of women and girls aged 15 and older in Canada (approximately 6.2 million individuals) who have ever been in an intimate partner relationship reported experiencing psychological, physical, or sexual abuse at some point in their lives. The survey included 45,893 respondents nationwide (43,296 in the provinces and 2,597 in the territories). Psychological abuse was the most commonly reported form of domestic violence, experienced by 43% of women with any history of intimate relationships. This was followed by physical violence (23%) and sexual violence (12%). Among those who experienced psychological abuse, a significant proportion also reported physical or sexual abuse. Additionally, women victims were more likely than their male counterparts to have experienced multiple forms of abuse, with nearly one in three reporting ten or more abusive behaviours in their lifetime.

Furthermore, in 2022, police services in Canada recorded 117,093 victims of intimate partner violence, with women accounting for 78% of all cases. The rate of intimate partner violence was almost seven times higher among women and girls aged 12-24 (776 per 100,000) compared to their male counterparts (114 per 100,000), and more than three times higher among women aged 25-64 (661 per 100,000) than among men in the same age group (203 per 100,000) (Statistics Canada, 2023). However, police-reported data has key limitations: many women who experience domestic violence do not report it often due to beliefs that the abuse is a private matter, fear of

stigma, concern over legal consequences, or mistrust in the justice system (Burczycka, 2016; Heidinger, 2022; Immigration, Refugee and Citizenship Canada, 2019). Additionally, several manifestations of coercive control are not criminalized and therefore do not appear in police statistics, further underrepresenting the full scope of abuse (Aspinall et al., 2024; Burczycka, 2019; Heidinger, 2022; IRCC, 2019; Public Health Agency of Canada, 2018).

Beyond gender, other socioeconomic characteristics intersect to impact the likelihood of experiencing domestic violence (Cotter, 2021b). According to Statistics Canada's 2018 Survey of Safety in Public and Private Spaces (SSPPS), which surveyed 45,893 Canadians aged 15 and older living in private households, Indigenous women reported disproportionately high rates of domestic violence compared with non-Indigenous women. Overall, 61% of Indigenous women reported experiencing some form of domestic violence since age 15, compared with 44% of non-Indigenous women, with Indigenous women also more likely to report severe forms of abuse and repeated victimization. When focusing specifically on physical or sexual violence, 44% of Indigenous women reported such experiences compared with 25% of non-Indigenous women, with prevalence rates particularly high among Métis women (48%), First Nations women (43%), and Inuit women (35%) (Heidinger, 2021, 2022).

Moreover, using data from the 2018 Survey of Safety in Public and Private Spaces (SSPPS), this study analyzed self-reported experiences of domestic violence among Canadians aged 15 and older, covering both lifetime and past-year experiences. The survey sample included 43,296 respondents from the provinces and 2,597 from the territories and provided a comprehensive national dataset that captured a wide range of domestic violence types including psychological, physical, and sexual violence and applied an inclusive definition of intimate partners, encompassing current or former spouses, common-law partners, dating relationships, and other

intimate connections among women. For the purposes of this analysis, women were identified based on self-reported gender, and sexual minority women were defined as those who did not identify as heterosexual, including lesbian, bisexual, and other non-heterosexual identities. Results revealed that 67% of sexual minority women reported experiencing domestic violence, with bisexual women facing the highest rates significantly more than their heterosexual counterparts. This includes lesbian, bisexual, and other women who identify with a sexual orientation outside of heterosexuality (Jaffray, 2021).

Furthermore, women with disabilities may be more vulnerable to domestic violence due to factors such as increased isolation or dependence on a partner (Savage, 2021). The 2018 Survey of Safety in Public and Private Spaces (SSPPS) highlights a significant difference in the prevalence of domestic violence between women with and without disabilities Savage (2021) reports that among women with a history of intimate relationships, 55% of women with disabilities experienced at least one form of domestic violence from the age of 15 onward, compared with 37% of women without disabilities. The most frequently reported type of domestic violence among women with disabilities was psychological abuse (53%), followed by physical assault (32%) and sexual assault (18%). These figures were notably higher than those for women without disabilities, where psychological abuse, physical assault, and sexual assault were reported at 36%, 17%, and 7%, respectively (Savage, 2021)

Self-reported data from the SSPPS in 2018 show that in Canada, physical or sexual violence committed by an intimate partner was more common for women in remote areas (4%) compared to those in accessible areas (3%) (Burczycka, 2022). Furthermore, police-reported rates of

domestic violence experienced by rural[1] women in Canada are significantly higher than those reported by urban women (Conroy, 2021). Specifically, rural women experience domestic violence at a rate[2] 75% higher than urban women (Conroy et al., 2019). However, it is important to note that women in remote communities may face specific challenges, such as isolation, that can impact their experience of domestic violence (Annan, 2008; Mantler et al., 2021).

While the data above reveal the widespread and gendered nature of domestic violence in Canada, scholars differ in how they interpret these patterns. Central to this debate is the question of whether domestic violence is symmetrical occurring at similar rates among men and women or asymmetrical, with women disproportionately experiencing severe and coercive abuse.

1.4.1. Symmetry versus Asymmetry in Patterns of Domestic Violence

A central scholarly debate surrounding domestic violence prevalence concerns whether violence is perpetrated equally by men and women (symmetrical), or whether it is primarily perpetrated by men against women (asymmetrical) (Dobash & Dobash, 2014; DeKeseredy & Schwartz, 2011; Kelly & Johnson, 2008).

Advocates of the symmetrical perspective, such as Straus (1993) argue that women are equally as violent as men in intimate relationships. According to this view, domestic violence is not necessarily rooted in power and control but often arises from escalating conflicts or dysfunctional family dynamics. Instruments like the Conflict Tactics Scale (CTS) have been central to this approach, documenting violent acts by both partners. Yet, this Conflict Tactics Scale (CTS) has

[1] These statistics define "rural" as "all areas outside of census metropolitan areas (populations of at least 100,000, of which 50,000 or more live in the urban core) and census agglomerations (core population of at least 10,000)" (Conroy, 2021).
[2] Domestic violence rates (per 100,000) are 789 for rural women

been widely critiqued (DeKeseredy & Schwartz, 1998; DeKeseredy,1988) for focused on counting discrete violent acts, regardless of context or motive so ignoring the broader context and gendered dynamics of abuse, and for minimizing the coercive control that often characterizes male-perpetrated violence.

However, Intimate terrorism (IT) and situational couple violence (SCV) represent two distinct forms of domestic violence that help clarify the debates on gender symmetry and asymmetry (Johnson, 2005, 2017). Intimate terrorism involves systematic coercive control, where violence is used alongside tactics such as economic abuse, isolation, and intimidation to dominate a partner. It is frequent, severe, and highly gendered, with men as the primary perpetrators in heterosexual relationships, reflecting the asymmetrical nature of domestic violence. In contrast, situational couple violence arises from conflicts that escalate into violence without a broader pattern of control. It is less severe, less likely to escalate, and generally symmetrical, with both men and women perpetrating violence at similar rates (Johnson, 2017). While IT is most visible in agency settings due to its severity, SCV is more often captured in population surveys, highlighting how different forms of domestic violence underpin the apparent tension between findings of gender symmetry and evidence of asymmetry. The failure to distinguish between these types of domestic violence has fuelled confusion in the gender symmetrical and asymmetrical debate and obscured the structural and gendered dynamics of domestic violence (Johnson, 2017).

The apparent contradictions in research on domestic violence stem largely from differences in sampling methods, context, and definitions. Agency-based data sourced from shelters, courts, or hospitals tend to capture cases of coercive controlling violence that are severe, asymmetric, and predominantly male-perpetrated. In contrast, large-scale population surveys like the ones relying on Conflict Tactics Scale (CTS) tool are more likely to identify situational couple violence, which

is typically less severe, more common, and appears gender symmetrical. These definitional and theoretical divergences where feminist researchers emphasize male-perpetrated coercive control and family sociologists highlight symmetrical violence help explain the differing conclusions across studies. Together, they underscore the importance of distinguishing between types of domestic violence to account for both its symmetrical and asymmetrical dimensions (Kelly & Johnson, 2008).

1.5. Consequences of Domestic Violence

Domestic violence has considerable negative impacts on women's physical health, women's mental health and women's well-being and safety (Campbell, 2002; Goodman & Epstein, 2008; Semahegn & Mengistie, 2015; WHO, 2021). Coercive control operates through ongoing patterns of intimidation, isolation, surveillance, and micro-regulation of everyday life, which erode women's sense of dignity, autonomy, and safety (Stark, 2007). The cumulative impact is often described as entrapment and state of terror such as women live in constant fear, with restricted freedom of movement, limited social connections, and diminished access to financial resources (Lohmann et al., 2024b). The consequences of coercive control therefore extend far beyond discrete acts of violence, embedding themselves in women's everyday lives and undermining their fundamental rights to equality, safety, and self-determination (Pitman, 2017). As Stark (2007) defines coercive control as a crime against liberty, highlighting how it systematically strips women of autonomy in personal, economic, and political life. By isolating victims, controlling their resources, and violating their privacy, abusive partners restrict fundamental rights such as safety, mobility, and self-determination. Stark (2007) argues that this form of abuse disproportionately targets women due to enduring gender inequalities, ultimately undermining not only individual freedom but also broader social progress.

1.5.1. Impact of Domestic Violence on Women's Physical and Sexual Health

Emerging research highlights that domestic violence has lasting adverse effects on survivor's health, persisting even after the abuse has ended (Campbell et al., 2002). The relationship between violence and physical health is complex, with effects that range from immediate and visible injuries, such as bruises, burns, and bites, to more severe, long-term conditions, including disabilities and, in some cases, fatal outcomes (Campbell, 2002; Karamali, 2021; Plichta, 2004; Spencer et al., 2025). Even after the violence has ended, its harmful effects on women's physical health can persist, highlighting the lasting consequences of abuse (Dillon et al., 2013; Plichta, 2004; WHO, 2013).

Campbell and Lewandowski (1997) indicate that physical violence is a significant risk factor for a wide range of physical health issues commonly treated in outpatient and emergency settings. These issues include direct injuries, such as broken bones, facial trauma, and tendon or ligament damage, as well as potential neurological sequelae, evidenced by chronic headaches, and undiagnosed hearing, vision, and concentration problems, which may stem from untreated loss of consciousness and other abuse-related injuries.

In addition, the physical health consequences for women can be sever, including chronic pain, physical disabilities, neurologic disorders, migraine headaches and reproductive health issues (sexually transmitted diseases, unintended pregnancies, pelvic inflammatory disease), additionally, domestic violence is associated with sleep difficulties and gastrointestinal issues, further impacting overall well-being (Tan et al., 2018; Vashisht, 2019).

In a case-control study conducted by Campbell et al. (2002), which included 201 women who had experienced domestic violence and 240 women with no history of abuse as control group, findings revealed that abused women reported significantly higher rates of various health issues. These

issues include headaches, back pain, sexually transmitted infections, and gastrointestinal problems, alongside a 50% to 70% increased likelihood of developing gynecological, chronic stress-related, and central nervous system disorders. Notably, those who experienced both physical and sexual abuse exhibited the highest prevalence of these health issues. Extending this argument, sexual assault can lead to various gynecological issues, including but not limited to vaginal infections, abnormal vaginal bleeding, chronic pelvic pain, and persistent urinary tract infections (Golding, 1996).This study underscores the substantial long-term health consequences of domestic violence and highlights the importance of universal screening and comprehensive assessments for women presenting with frequent gynecological, stress-related, or neurological symptoms to better identify and support survivors (Golding, 1996).

Furthermore, a scoping review conducted by Dillon et al. (2013) examined 75 studies published between 2006 and 2013 from both Western and developing countries, which included both quantitative and qualitative research. The findings indicate that domestic violence is consistently associated with adverse physical health outcomes. These outcomes include chronic pain, somatic disorders, chronic illnesses, gynecological problems, and an increased risk of sexually transmitted infections (STIs) and HIV, particularly when linked to sexual abuse and violence. This research also aligns with findings from the World Health Organization (2013), which indicate that women in abusive relationships experience significantly higher rates of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), compared to those who have not experienced abuse. Additionally, they report greater incidences of unintended pregnancies, recurrent abortions, and various gynecological health issues.

Thus, coercive control has severe and enduring consequences for women's physical health. Its impact extends beyond immediate injuries to include chronic pain, fatigue, disrupted sleep, and

long-term problems with metabolic and hormonal regulation. Many survivors also report persistent fatigue and joint pain linked to the cumulative toll of trauma and complex post-traumatic stress, illustrating how coercive control undermines women's health long after specific acts of violence have ceased (Coker et al., 2000; Lohmann et al., 2024a).

1.5.2. Impact of Domestic Violence on Women's Financial and Social Life

In the context of domestic violence, coercive control tactics often isolate women from their friends and family while also hindering their employment and education (Goodman & Epstein, 2008). The financial impact of coercive control is profound, as economic abuse through tactics such as financial control, economic deprivation and economic dependency serves as a key mechanism for limiting women's autonomy and reinforcing their disempowerment (Pitman, 2017). Abusive partners create numerous barriers that prevent victim-survivors from securing or maintaining jobs (Swanberg & Logan, 2005). These barriers can include destroying educational materials, withholding financial or childcare support, inflicting visible injuries, and harassing or threatening them at work. Such tactics contribute to joblessness, missed workdays, and overall economic instability, further trapping victims in abusive situations (Goodman & Epstein, 2008; Rayner-Thomas et al., 2016).

According to Even (2011) abused women often face intentional barriers that prevent them from maintaining employment, serving as a method of isolation and financial manipulation that heightens their reliance on their abuser. Even when they manage to keep a job, domestic violence creates serious challenges to career growth. Abusive partners may also prevent them from networking, limiting their professional connections. Furthermore, restricted access to career development opportunities reduces their chances for job advancement and financial independence (Even, 2011). In addition, Even (2011) highlights that beyond the absence of sufficient income for

self-sufficiency, the isolating nature of domestic violence limits opportunities for survivors to develop job skills, gain work experience, or explore different career paths to identify a suitable industry fit.

There is a significant link between domestic violence, job instability, and financial reliance on abusive partners, as abusers often disrupt their victims' employment (Lantrip et al., 2015; Showalter, 2016). A systematic review by Showalter in 2016 highlighted that workplace disruptions can manifest as harassment on the job, leading to decreased productivity and performance. Additionally, lost work time was identified as a critical factor contributing to job instability, with many studies noting reductions in work hours and many women reported job loss or unemployment as a direct consequence of domestic violence.

One of key tactics of coercive control is the micromanagement of the victim-survivor's activities, which undermines their personal freedom and significantly impacts their social life, including their relationships with family and friends (Gill & Aspinall, 2020). For example, perpetrators frequently enforce isolation by rigorously overseeing the victim's social interactions and imposing limitations on their ability to communicate with others. This sustained control progressively weakens the victim's connections with family and friends, resulting in heightened social isolation and the erosion of their support network (Conroy & Crowley, 2022; Walklate & Fitz-Gibbon, 2019).

In addition, coercive control also frequently extends to the economic domain in victim-survivor life (Nevala, 2017). This includes restricting transportation, limiting access to household utilities, controlling food consumption, forcing the victim to beg for money, disabling communication devices, and interfering with employment or education (Sharp-Jeffs, 2017). Furthermore, coercive control impacts nearly every facet of a victims-survivors' life, affecting daily routines, personal

well-being, financial independence, legal status, and parental rights (Dutton & Goodman, 2005; Hamberger et al., 2017).

While domestic violence leads to a range of consequences, including physical, sexual, financial, and social effects, many women express that the psychological and mental health impacts of domestic violence are especially profound and have the most significant influence on their overall well-being (Heward-Belle et al., 2024). These effects will be addressed in the next section.

1.5.3. Impacts of Domestic Violence on Women's Mental Health

The relationship between domestic violence and mental health has become more identified and documented during the last two decades of the 20th century, and women who experience domestic violence may face long-term emotional distress and psychological injuries (Goodman & Epstein, 2008). Women who experience domestic violence are at an increased risk of suffering from various mental health issues, including anxiety, depression, psychosis, mood disorders, post-traumatic stress disorder (PTSD), substance abuse, sleep disturbances, stress-related headaches, eating disorder, shame, guilt and social dysfunction, suicidal ideation, and diminished self-esteem (DeJonghe et al., 2008; García-Moreno et al., 2013; Gorde et al., 2004; Heward-Belle et al., 2024; Iverson et al., 2009; Kamo, 2009; Macy et al., 2009; Schumacher, 2009; Titchiner, 2017). Coercive control intensifies these outcomes by restricting women's independence and decision-making power, which erodes self-confidence and further contributes to negative impact on women's mental health (Hamberger et al., 2017).

A study by Pico-Alfonso et al. (2006) compared three groups of women: those who were not abused, those subjected to both physical and psychological abuse, and those experiencing psychological abuse alone. The findings revealed that all women who experienced physical violence also endured psychological abuse, with many additionally facing sexual violence. Both

abused groups (physically/psychologically and psychologically abused) exhibited higher levels of depressive and anxiety symptoms, PTSD, and suicidal thoughts compared to the non-abused group, with no significant differences between the two abused groups. Sexual violence was particularly associated with more severe depression and a greater likelihood of suicide attempts, whether or not PTSD was present. Furthermore, in this study women who experience domestic violence and suffer from depression or comorbid conditions report higher levels of anxiety and suicidal ideation. The findings from Pico-Alfonso et al. (2006), supported by other studies (Coker et al., 2002; Jones et al., 2001; Romito et al., 2005), suggest that psychological abuse can be just as detrimental to mental health as physical violence. In some cases, psychological abuse may have an even stronger and more distinct impact (Taft et al., 2005). Research indicates that women who encounter multiple forms of abuse may face a heightened risk of developing mental disorders and experiencing co-morbid conditions (Dutton et al., 1999; Jones et al., 2001).

According to Campbell (2002) and Oram et al. (2017), domestic violence significantly heightens the risk of depression in women who do not have a prior history of depressive symptoms. Depression can influence a woman's everyday functioning, including her capacity to form and sustain relationships, which can lead to social isolation and reduced access to support networks. Similar findings indicate that approximately 47.6% of women subjected to domestic violence experience depression, while other studies report that 63.8% of victims develop post-traumatic stress disorder (PTSD) (Golding, 1999; Kamo, 2009). Furthermore, depression can hinder an abused woman's ability to care for her children, carry out daily tasks, achieve objectives in her career and education, and make future plans (Helfrich et al., 2008).

Additionally, research suggests a strong link between sexual violence and mental health issues, however, it often does not distinguish between partner and non-partner violence (Sardinha et al., 2022; Sardinha et al., 2024; Temple et al., 2007). Furthermore, sexual violence is associated with drug and alcohol dependence (Oram et al., 2017).

Substance use frequently emerges as a coping mechanism among victim-survivors of domestic violence, highlighting its deep interconnection with mental health consequences (Saunders, 2017). Numerous women in abusive relationships resort to substances as a coping strategy, especially to deal with PTSD related to assaults or other mental health issues (Kilpatrick et al., 1997). Furthermore, using substances can act as a way to escape the emotional turmoil tied to domestic violence, including feelings of fear, anger, and humiliation, or to tolerate the abusive situation (O'Brien et al., 2016). Additionally, certain women may turn to drugs or alcohol as a means to temporarily flee their reality (Campbell, 2002). Although not every woman facing domestic violence engages in substance use, for some, it offers a momentary redemption from the psychological and emotional burden of abuse. Following this explanation, research shows that women who encounter domestic violence are at a twofold increased risk of experiencing depression and are nearly twice as likely to develop alcohol use disorders (Kumar et al., 2013).

According to Karamali (2021), feelings of shame, low self-esteem, and inadequacy can lead women in abusive relationships to undermine their self-worth. They often experience confusion and numbness, resulting in a loss of identity and trust. This diminished sense of self may lead them to view themselves as unworthy of love and isolated from others. Stark and Flitcraft (1991) conducted vital research on the links between suicide and domestic violence. They observed significantly high rates (29.5%) of suicidal attempts among women subjected to domestic violence

which recorded at an A&E (Accident and Emergency) service, also the suicide rate was substantially higher for black women (48.8%) than white women in their research.

Research indicates that there is a connection between domestic violence and mental health, with women's experiences of depression, post-traumatic stress disorder (PTSD), and self-harm being interpreted as 'symptoms' or consequences of enduring violence and abuse (Humphreys & Thiara, 2003). Nixon et al. (2004) studied a sample of women who experienced domestic violence through agencies and shelters, they observed that the group with comorbid PTSD/major depressive disorder (MDD) had experienced physical abuse in the six months before the study and were more likely to have undergone an adult rape outside the abusive relationship. Stein and Kennedy (2001) through their investigation announced 43% comorbidity between MDD and domestic violence-related PTSD.

Therefore, coercive control has profound and lasting effects on women's mental health. Survivors often live in constant fear and hypervigilance, with their fight-or-flight system permanently activated, leading to anxiety, panic, exhaustion, and other stress-related symptoms. Many experiences loss of self-esteem, and erosion of identity, compounded by sleep disturbances, dissociation, concentration problems, and persistent feelings of shame and self-blame. Collectively, these impacts often align with complex post-traumatic stress disorder, marked by 'emotional dysregulation', a negative self-concept, and long-term difficulties in relationships (Carman & Kay-Lambkin, 2022).

The effects of domestic violence are believed to have psychological similarities to the trauma experienced by hostages who endure torture (Dutton, 1993; Herman, 2015). Furthermore, trauma represents a significant psychological impact of domestic violence, which raises considerable concern. Women who have undergone various forms of domestic violence, including physical and

sexual violence, as well as stalking throughout their lifetimes, also report symptoms consistent with post-traumatic stress disorder (PTSD) (Bennice et al., 2003; Smith et al., 2017; Taft et al., 2007). PTSD, as one of the significant psychological aftermaths of domestic violence has led to pains such as impulsive rage, flashbacks (reliving the trauma), intrusive memories of traumatic events, and overwhelming negative thoughts or images that remind them of abuse/violence (Jones et al., 2001; Sharhabani-Arzy et al., 2003). The victims-survivors of domestic violence evade situations that remind them of violence, hence receiving support from mental health or criminal justice systems is undesirable for them because they have to retell their stories frequently and in detail (Goodman & Epstein, 2008). Severity and continuation of violence is linked with pervasiveness and intensity of PTSD and depression (Jones et al., 2001). In addition, victim-survivors of domestic violence might use drugs or alcohol to cope with the psychological pain of violence and PTSD (Lemon et al., 2002; Najavits et al., 2004).

There is a clear link between domestic violence and trauma, as explained in the literature above. Therefore, the next chapter will first address trauma history and then explore the deeper connection between domestic violence and trauma.

Chapter 2. Trauma, Post Traumatic Stress Disorder (PTSD), and Domestic Violence

Introduction

This chapter begins by delving into the historical evolution of trauma, mapping its conceptual development and the shifting understandings throughout history. It then explores the emergence of post-traumatic stress disorder (PTSD) as a formal diagnosis, illustrating the debates surrounding its classification and recognition in the mental health field. The discussion progresses to the intersection of domestic violence and trauma, highlighting how the experiences of domestic violence fit within broader trauma frameworks. Following this, the chapter critically evaluates the main trauma models, questioning their limitations and applicability. Finally, the chapter introduces the trauma-informed approach, outlining its core principles and critically considering both its potential and its shortcomings when applied in the context of domestic violence.

2.1. Historical Definition of Trauma

The idea that exposure to overwhelming fear can cause long-lasting psychological effects is not new. From the time of Homer to the present, people have recognized that extreme experiences can lead to troubling memories, emotional numbness, and states of heightened alert (van der Kolk et al., 1996). Thus, since the earliest psychiatric interventions, the controversial argument has been about trauma's etiology. Is it related to human's origin or psychological? "Is trauma the event itself or its subjective interpretation? Does the trauma itself cause the disorder, or do pre-existing vulnerabilities cause it? Are the patients pretend to be ill and suffer from moral weakness, or do they suffer from an unintentional dissociation of the capacity to take charge of their lives?" (van der Kolk et al., 1996, p.47). Therefore, the causes and nature of trauma whether rooted in external events, internal vulnerabilities, or subjective interpretation have long been debated.

Railways, particularly ‘railway accidents’ hold an important place in psychological trauma history since 1860s through the investigations of two scientists, John Eric Erichsen and his fellow surgeon Page. They had concentrated on “railroad spines” and “railway injuries”, respectively (Figley et al., 2017; Steffens, 2018; van der Kolk et al., 1996, pp.47-48). The term ‘railway spine’ was practiced for the survivors of railway accidents who had no visible physical injuries, though they experienced somatic complaints, sleeplessness, and emotional difficulties for whiles after the accidents. John Eric Erichsen believed these symptoms came from physical damage to the spinal cord, while Page argued that terror itself was a major factor (Figley et al., 2017; Steffens, 2018; van der Kolk et al., 1996).

Initially regarded as a physical condition, trauma was debated as either organic or functional. In the absence of evidence, many suspected malingering (Figley et al., 2017). However, understanding trauma evolved further through war. During the American Civil War, many soldiers exhibited ‘soldier’s heart’ marked by chest pain and breathlessness (Figley et al., 2017). In 1889, neurologist Herman Oppenheim coined the term ‘traumatic neurosis’, suggesting trauma caused nervous system changes and should not be morally condemned (van der Kolk et al., 1996).

By World War I, psychological trauma had become widely visible. Soldiers exposed to prolonged horror developed what was called ‘shell shock’, a term introduced by Charles Myers in 1915. Initially believed to result from physical blasts, it soon became clear that emotional stress alone could produce paralysis, memory loss, or shatter mental stability. Many were mischaracterized as cowards or hysterical (Herman, 2015; van der Kolk et al., 1996).

After World War I, interest in trauma weakened but resurfaced in World War II. Abram Kardiner’s (1941) work described how trauma disrupted identity, leaving survivors trapped in the past and vulnerable to panic and aggression and described how trauma reshapes a person’s relationship with

themselves and the world (van der Kolk et al., 1996). Later, Tichener (1986) termed this phenomenon ‘post-traumatic decline’, noting that trauma could lead to dissociative, flashbacks and panic triggered by ordinary stimuli (as cited in van der Kolk et al., 1996).

In addition, the Holocaust gave rise to ‘concentration camp syndrome’, where survivors experienced long-term physical, psychological, and social consequences. Many came to interpret emotions only as somatic states (van der Kolk et al., 1996). Meanwhile, analysis of historical military records confirmed that psychological explanations often outweighed physical injury (Follette & Ruzek, 2006).

Alongside growing interest in trauma from physical events like war and railway accidents, the study of hysteria emerged as a crucial early effort to understand psychological suffering particularly among women. Historically tied to the Greek word for womb, ‘hysteria’ was often used vaguely to describe a broad range of physical and emotional symptoms such as paralysis, fainting, or erratic behaviour (Lasiuk & Hegadoren, 2006). These symptoms were frequently interpreted through a gendered lens, reinforcing harmful assumptions about female emotional fragility (Lasiuk & Hegadoren, 2006).

Notably, similarities between symptoms of hysteria and those observed in railway accident survivors (diagnosed with ‘railway spine’) began to blur the boundary between physical injury and psychological distress. French neurologist Jean-Martin Charcot was instrumental in shifting medical views, demonstrating that hysterical symptoms could be induced or alleviated through hypnosis. This pointed to psychological, rather than physiological, origins of the disorder. Building on this, Pierre Janet introduced the concept of ‘dissociation’, arguing that overwhelming memories, when not fully processed, could become fragmented and manifest as involuntary physical or emotional reactions (Gasquoine, 2020; North, 2015; van der Kolk et al., 1989)

Moreover, Freud initially proposed that hysteria stemmed from childhood sexual trauma, but later withdrew this theory, suggesting instead that such memories were imagined. This reversal contributed to the long-standing dismissal of abuse survivors' accounts (Herman, 2015). It was not until feminist writers in the 1970s called out this neglect that women's real experiences of trauma especially related to domestic and sexual violence were re-centred in clinical and scholarly discourse (Figley et al., 2017; Herman, 2015).

Freud (1920) also later described trauma as agitation that surpasses the individual's capacity to cope and articulated that "traumatic stress is a consequence of breaking the junction between the inner and outer world in the survivor's mind" (as cited in Dalenberg et al., 2017, pp.15-16). In addition, Ferenczi, who was a follower of Freud and focused on the traumatized analytic case, revealed two moments in terms of trauma definition: the primary experience of the event, and the rejection or denial of child or youth reactions by individuals on whom he or she depends. The Ferenczi tradition's truth has been shown in the later research confirming that children and adults with powerful social support showed a lower PTSD rate (Dalenberg et al., 2017)

Balint (1959) added to this understanding by emphasizing that trauma could not have happened for an individual in an isolated environment, it is an output of two-person psychology (Dalenberg et al., 2017). In line with this, Leys (2000) traced the modern concept of trauma back to 19th-century studies on 'physiology of shock', which gradually evolved into an understanding of trauma as a 'wounding of the mind' caused by sudden, overwhelming emotional shock (as cited in Figley et al., 2017, p.2).

In this study, trauma is understood as an experience that is profoundly distressing. What differentiates trauma from ordinary stress is the sense of being physically or psychologically overwhelmed (Wilkin & Hillock, 2014). Such experiences may lead to intrusive symptoms,

including nightmares or flashbacks, and can impair a person's ability to function effectively in certain contexts (Baird, 2018; Humphreys & Thiara, 2003). Trauma may arise from events such as violence, bereavement, or systemic forms of oppression. Its consequences can be emotional, psychological, or physical, with effects that may be either short-lived or enduring. Beyond this clinical framing, this thesis also engages with broader political perspectives on trauma, which emphasize its embeddedness in social structures and inequalities (Brown, 2024).

Building on this history of trauma, the next section turns to the emergence of post-traumatic stress disorder (PTSD). Whereas trauma refers broadly to overwhelming experiences and their impacts, PTSD represents the medical system's attempt to classify and standardize these experiences within psychiatric frameworks.

2.2. Defining PTSD Diagnosis

The development of PTSD as a formal diagnosis has been shaped by war, activism, and evolving understandings of trauma. During World War II, the U.S. military and Veterans Administration described combat stress responses in soldiers 'transient situational syndromes' as acute stress responses in individuals without preexisting psychopathology (Brett, 1996), paving the way for language later used in DSM-I.

Building on this perspective, the American Psychological Association (APA) introduced the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the first time in 1952. In DSM-I (1952), Gross Stress Reaction was introduced based on World War II symptomatology, acknowledging trauma as a reaction to external events rather than inherent pathology, but it was removed in DSM-II (1968), prompting criticism from Vietnam veterans and clinicians who sought validation for war-related psychological harm (Brett, 1996; Figley et al., 2017).

The political and therapeutic advocacy of the 1970s particularly through the efforts of Vietnam Veterans Against the War (VVAW), who organized therapeutic 'rap sessions', and antiwar psychiatrist Chaim Shatan played a pivotal role in securing the inclusion of PTSD in DSM-III (1980) (Alford, 2016). Shatan identified what he termed post-Vietnam syndrome, characterized by 'delayed massive trauma' that manifested as guilt, rage, emotional numbness, and alienation. He referred to this condition as 'impacted grief', capturing the deeply buried psychological pain many veterans endured (Alford, 2016).

DSM-III (1980) and its revision DSM-III-R (1987) framed PTSD as resulting from 'events outside the range of normal human experience'. The diagnostic focus emphasized 'non-ordinary events' and a presumed 'universal emotional reaction' (Dalenberg et al., 2017, p.18; Humphreys & Joseph, 2004, p.561). However, this conceptualization was later criticized, leading to revisions in DSM-IV (1994), which removed the requirement that trauma be 'outside the range of normal human experience' and expanded its scope to include events such as criminal violence and sexual assault (Alford, 2016). Two distinct components in DSM-IV introduced Criterion A1 (event type) and Criterion A2 (emotional response), acknowledging that trauma is defined both by the nature of the events and the individual's psychological reaction as fear, helplessness, or horror (Dalenberg et al., 2017, Figley et al., 2017).

In DSM-5 (2013), the subjective emotional response (Criterion A2) from the definition of trauma was removed, narrowing the definition to objective exposure only. In contrast to DSM-IV, which required an individual to experience "fear, helplessness, or horror" under the Criterion A2 during the event, DSM-5 now focuses solely on the objective nature of the traumatic exposure and narrowing the definition of trauma (Pai et al., 2017). This change in DSM-5 was intended to increase diagnostic clarity and reliability by standardizing what constitutes a qualifying traumatic

event (Friedman, 2013). While this revision promotes clearer diagnostic criteria, by removing the subjective emotional response form trauma definition, this revision tightens the criteria, potentially the real and painful experiences of survivors, even when their trauma doesn't involve visible violence or life-threatening events (Pai et al., 2017), such as emotional abuse or coercive control. Researchers emphasize that trauma must also be understood through the lens of individual perception, especially in contexts like domestic violence, structural oppression, and racialized harm, where psychological impacts are profound (Brown, 2008, 2017; Herman, 2015) despite not meeting DSM-5 thresholds. Although the DSM-5 offers a clearer and more standardized definition of PTSD than previous editions especially in specifying symptom clusters and trauma exposure criteria the role of subjectivity in trauma remains a contested issue. While the DSM-5 eliminated the requirement for an immediate emotional response to trauma (e.g., fear, helplessness, horror), critics argue that understanding how individuals subjectively process traumatic events is still essential to comprehending the diverse ways PTSD manifests.

The DSM-5 defines Post-Traumatic Stress Disorder (PTSD) through a specific set of diagnostic criteria, beginning with exposure to a traumatic event. This event must involve actual or threatened death, serious injury, or sexual violence, and may occur through direct experience, witnessing it happens to others, learning that it occurred to close relations, or repeated exposure to distressing details in professional contexts (Friedman, 2013). To meet the diagnostic threshold, individuals must exhibit symptoms across four domains: intrusive memories, avoidance behaviors, negative changes in thoughts or emotions, and heightened arousal or reactivity (American Psychiatric Association, 2013; Friedman, 2013). These symptoms must persist for more than one month and result in significant functional impairment (American Psychiatric Association, 2013; Friedman, 2013).

While this diagnostic framework offers standardized framework, it also reflects a narrowly constructed view of trauma, it centers on specific types of traumatic events and 'symptom' expressions, leaving out broader lived experiences that can be traumatic. Trauma is not solely defined by the external event, but by how individuals subjectively experience, interpret, and integrate these events into their lives, trauma is often more about its psychological and emotional impact than the event itself (Brown, 2017; Burstow, 2003, 2005; Linklater, 2014; Thomas-Skaf & Jenney, 2021) . Consequently, what we culturally and clinically understand as 'trauma' often extends beyond what is narrowly captured in a PTSD diagnosis. In section 2.3.1. I will further explore feminist critiques that challenge the limitations of PTSD diagnosis.

2.3. Connection between Domestic Violence, Trauma and PTSD

Humans react to danger through a complex interaction of physiological and psychological responses including heightened alertness, sharpened attention, and intensified emotional states all of which prepare the body for the fight flight freeze response (Herman, 2015). However, when individuals are unable to escape or present an effective defense or respond to the threat, the overwhelming nature of the threat may exceed their capacity to cope, resulting in trauma. Trauma, in this context, refers to a psychological and emotional wound that disrupts one's fundamental sense of safety, control, and integration. Such experiences can lead to lasting alterations in arousal, cognition, memory, and emotional regulation (Herman, 2015). Individual responses to trauma vary widely, from short-term distress to persistent impairments. Empirical evidence indicates that trauma exposure significantly elevates the risk for a range of mental health conditions, including depression, anxiety, dissociation, eating disorders, substance use disorders, and trauma-specific diagnoses such as posttraumatic stress disorder (PTSD) (Herman, 2015).

The relationship between Posttraumatic Stress Disorder (PTSD) and gender-based violence, especially concerning domestic violence, has a complex history and has been extensively studied (Herman, 2015; Humphreys & Joseph, 2004; Stark, 2007; Walker, 2006). Scholars on PTSD demonstrated that a significant rate of domestic violence victim-survivors experienced symptoms of PTSD, flashbacks or nightmares, numbing of emotions, physiological arousal, avoidance of stimuli, and inability to concentrate, which is linked with traumatic events (Campbell, 2002; Gorde et al., 2004; Humphreys & Joseph, 2004). A meta-analysis by Golding (1999) found that the weighted mean prevalence of PTSD among women who have experienced domestic violence was 63.8%, with prevalence estimates across the 11 reviewed studies ranging from 31% to 84%. Notably, even the lowest of these estimates exceeds three times the lifetime prevalence of PTSD among women in the general population, reported at 9.7% (Kessler et al., 2005). Research further indicates that PTSD among women with histories of domestic violence is associated with a range of adverse outcomes, including psychological difficulties (e.g., depression), behavioural concerns (e.g., substance use and risky sexual behaviour), and physical health problems (e.g., neuromuscular symptoms, stress-related conditions, sleep disruption, and gynaecological health issues) (Cavanaugh et al., 2010; Dutton, 2009; Sullivan & Holt, 2008; Woods et al., 2008).

Vaddiparti and Varma (2009) noted that women facing systematic oppression, abuse, and domestic violence are more likely to experience of developing depression and other negative mental health outcomes, such as PTSD, compared to men. Domestic violence is correlated with negative consequences such as depression, anxiety, psychosexual dysfunction, substance abuse, and PTSD (Gorde et al., 2004; Schumacher, 2009). As Humphreys and Thiara (2003), who reviewed through literature, explained that PTSD might be a significant pattern in women who have experienced domestic violence; hence, considering PTSD as a negative psychological and emotional

consequence amongst survivors of domestic violence has been significant. According to the National Intimate Partner and Sexual Violence Survey conducted in the United States, more than 50% of women who have experienced different types of intimate partner violence, such as physical violence, sexual violence, or stalking during their lifetime, also report showing symptoms of posttraumatic stress disorder (PTSD) (Smith et al., 2017).

Walker (1979) introduced the cycle of violence model and the concept of Battered Woman Syndrome (BWS), describing it as aligned of PTSD. She outlined how survivors develop cognitive, emotional, and behavioral coping mechanisms in response to sustained and unpredictable violence, which often leaves them feeling trapped and disempowered (Walker 2006; Walker, 2016). Building on this foundation, Herman (2015) examines how survivors of domestic violence experience feelings of captivity similar to political prisoners, resulting in lasting trauma and PTSD. She critiques the psychiatric mislabeling of such survivors particularly women as having borderline personality disorder, arguing that this pathologizes their trauma rather than acknowledging its origins. Stark (2007) further expands on this concept through his theory of coercive control, emphasizing how abusers utilize tactics of coercive control to establish circumstances that lead to the restriction of survivors' autonomy and undermine their sense of self, creating conditions that both sustain the abuse and contribute to trauma-related symptoms and PTSD.

In addition, Herman (2015) and Stark (2007) note that perpetrators of coercive control instill constant fear and dependency in their victims to establish dominance. This ongoing systematic control and coercion erodes the survivors' autonomy and sense of self, leading to trauma. As a consequence of prolonged and repeated trauma, survivors may develop a severe form of post-traumatic stress disorder (PTSD), which can infiltrate and erode their personality (Herman, 2015).

Trauma is a well-known notion that is frequently used casually in everyday conversations. Responses to trauma are found on a spectrum rather than as a single disorder, varying from short-term stress reactions that clear up without professional help to traditional PTSD, and in instances of ongoing and repeated trauma, complex PTSD (CPTSD) (Feriante & Sharma, 2023; Herman, 2015).

Herman (2015) introduced a separate diagnosis known as Complex Post-Traumatic Stress Disorder (CPTSD). This was established to address the shortcomings of the current understanding of post-traumatic stress disorder, which does not sufficiently encompass the variety of symptoms stemming from prolonged and repeated trauma, along with the significant alterations in personality that can arise in situations of captivity. This notion is especially pertinent for women facing domestic violence. She mentioned that CPTSD manifests through several 'symptoms', including dissociation, flashbacks, a deep sense of shame, and feelings of isolation. Victim-survivors who have experienced repetitive and inescapable violence in intimate relationships frequently show more complex symptoms than those who undergo trauma from a single event (Sanderson, 2013).

Furthermore, Platt et al. (2009) refers domestic violence as one of the most destructive kinds of betrayal a person can undergo. Because the victim-survivor's trust, safety and respect erode gradually by someone whom she perceived as her most intimate ally which called the consequences of these devastating behaviours as betrayal trauma in which happened in an abusive relationship. Violence in intimate relationships may ruins the victim's worldview and trust in herself and the world. Survivors also experience this betrayal trauma through seeking help from communities or institutions when victims' experiences and feelings do not validate (Platt et al., 2009). Sanderson (2013) also outlines that survivors of domestic violence who suffer from CPTSD often struggle with trusting that the world is safe. This distrust, when connected to the previously

mentioned feelings of guilt and shame, can result in a difficulty in reaching out for assistance beyond the abusive relationship.

Moreover, Freedman (2006) described the negative impacts of trauma on domestic violence victims- survivors' inner and outer worlds. The victims of domestic violence face an unstable emotional condition as a trace of a traumatic event which is called "shattered self". However, the other consequence of trauma on the survivors' belief is named "shattered worldview". The "shattered self" and the "shattered worldview" are responses to traumatic events. Consequently, after a traumatic event, a victim of domestic violence, who may also be "a survivor", is faced with the state of having contradictory thoughts and beliefs, especially as relating to behavioural determination and attitude change. For example, "she asks herself: am I not capable of protecting myself against serious harm? Is the world not a safe place, or was I somehow incautious? Am I somehow responsible for the attack?". This fragmented worldview imposes the thought to domestic violence survivors that "the world is an unsafe place because they are women" (Freedman 2006, p.105), while the victim experiences a variety of aftermaths such as helplessness and fear. As Herman (2015) points out; "When neither resistance nor escape is possible, the human system of self-defence becomes overwhelmed and disorganized" (p.34).

Recent research has increasingly examined the links between trauma and domestic violence (Birkley et al.,2016; Dutton, 2009; Joseph et al., 2015; Pill et al., 2017; Trevillion et al., 2012). Psychiatric diagnoses such as PTSD (Post-Traumatic Stress Disorder) and CPTSD (Complex Post-Traumatic Stress Disorder) are acknowledged for their role in validating individuals' suffering and facilitating access to essential mental health services and support systems (Tseris, 2019b). However, these diagnoses have also faced criticism from feminist scholars (Berg, 2002; Tseris, 2013, 2018, 2019a, 2019b).

2.3.1. Critique on Medicalization of Trauma and PTSD Diagnostic Label in Domestic Violence Context

Burstow (2018) explains that even well-intentioned ideas in mental health often place blame on the person receiving help, rather than addressing wider social or systemic causes. These discussions are based on the idea that emotional distress comes from personal problems and can be managed through professional help and self-directed coping strategies (Tseris, 2019a, 2019b). The inclusion of PTSD in the DSM-III (American Psychiatric Association, 1980) sparked an ongoing debate within feminist psychology and clinical social work (Berg, 2002; Tseris, 2018). PTSD as a diagnosis used it to address women's mental health issues by feminist therapists, however, feminists criticized the PTSD diagnosis in DSM.

The study of psychological trauma has historically centered on male experiences, particularly those related to war, while overlooking the trauma endured by women and children within their lived realities (Brown, 1991). In addition, in DSM-III definition, which framed PTSD as resulting from extraordinary events, arguing that gender-based violence is a widespread and common experience for many women and girls (Brown, 1991). Herman (2015) argued that mainstream psychiatry has historically neglected to fully acknowledge the profound impact that abuse and violence have on survivors, particularly women and overlooking how such experiences shape survivors' lives long after the events themselves. To address this issue, she introduced the concept of Complex PTSD (CPTSD) to represent the effects of prolonged interpersonal trauma more accurately. Herman contended that traditional PTSD does not adequately address the complexities associated with repeated violations, such as domestic violence (Herman, 2015). Despite advocacy, Complex PTSD was not added to the DSM-5 but is recognized in the ICD-11[3] alongside PTSD. Researchers

[3] *International Statistical Classification of Diseases and Related Health Problems*, 11th Edition (ICD-11).

criticize the DSM's exclusion of complex and developmental trauma, arguing that PTSD fails to capture the impact of prolonged interpersonal violence like rape and abuse (Ford, 2017; Herman, 2015).

Brown (1991) and Burstow (2003) also argued that PTSD diagnosis relies too heavily on pathologizing survivors without considering the social context in marginalized groups including women. Mainstream mental health focuses on the biomedical model, simplifying trauma to individual pathology while overlooking socio-political factors. This narrow view reinforces systemic power imbalances, limiting opportunities for meaningful healing and contributing to the ongoing marginalization and gendered violence experienced by survivors (Tseris, 2019b). Unlike other psychiatric labels, PTSD and Complex PTSD highlight the external sources of distress, however their focus on individual symptoms limits analysis of power dynamics and structural inequalities in violence (Tseris, 2019b).

Further critic claimed by Humphreys and Joseph (2004) that "the DSM framework is not a neutral tool, as defining and categorization of human experience by a group of professionals who legitimate particular patterns of behaviour related to specific norms take the process of naming out of the hands of those who experience the behaviour in this case, domestic violence survivors" (p.562). Linklater (2014) also critiques trauma discourse for its Western origins and its focus on individual rather than State responsibility, limiting its effectiveness in achieving social justice. Despite efforts to broaden the concept, trauma discussions remain centered on DSM diagnoses like PTSD. Therefore, medicalizing, pathologizing and individualizing trauma reactions based on psychic trauma discourses, lead to victim-blaming and labelling of personality issues (Webster & Dunn, 2005; Wilkin & Hillock, 2014).

Moreover, several feminist scholars (Brown, 2004, 2017; Burstow, 2003, 2005; Herman, 2015; Thompson, 2021; Tseris, 2013, 2018) criticized diagnoses of PTSD as contextless symptoms without admitting the sociopolitical context in trauma discourse. As claimed by feminists scholars, it is inadequate to tying trauma to a physically threatening incident or events in and of itself (Threat to life or physical integrity), especially in the case of women who have experienced domestic violence and other oppressed groups who experience daily violence within sexist, racist, classist, homophobic, and ableist societies, these everyday experiences of violence are described as "secret trauma" and "insidious trauma" which should be considered in the types of trauma discourse (Brown, 2017; Burstow, 2003; Dixon, 2014; Root,1992; Russell, 1986). Feminists also argue that PTSD diagnosis neutralizes male violence by equating sexual abuse and domestic violence with non-gendered traumas like combat or natural disasters. They contend that this de-gendering of trauma overlooks the specific sociopolitical dynamics of male violence against women, grouping diverse experiences under one diagnosis without acknowledging their distinct structural causes (Berg, 2002).

Feminist movements have played a crucial role in bringing attention to interpersonal violence within trauma psychology. They challenge the idea that the world is fair or that victims are responsible for their suffering, instead exposing systemic inequalities and advocating for trauma survivors (Brown, 2017). Another critic on psychological trauma raised that "trauma is not a disorder, trauma is a series of reaction/responds to actual" and interconnected situations which should be seen within context (Burstow, 2003). Trauma is commonly understood as the psychological impact of life-threatening events. However, Tseris (2018, 2019a, 2019b) critiques the narrow framing of trauma as only stemming from life-threatening incidents, arguing that it should also include harms linked to systemic oppression, such as racism and domestic violence.

She warns that blurring the line between traumatic events and their psychological consequences can depoliticise violence, replacing precise terms like “violence” with “trauma” in ways that obscure its social and structural roots.

Feminist perspectives call for an intersectional understanding of trauma that prioritizes survivor agency, structural change, and collective healing beyond clinical models (Brown, 1991; Burstow, 2003; Tseris, 2013, 2015). Traditional trauma frameworks, shaped by psychiatric discourses and DSM classifications, often universalize trauma while overlooking women’s diverse social locations and the broader systemic conditions that sustain violence and oppression (Tseris, 2013). Trauma does not exist in isolation, it operates in layers, with each layer shaped by intersecting identities, oppressions, and social structures (Burstow, 2003). Women’s experiences of domestic violence, for example, are profoundly influenced by race, class, immigration status, disability, and sexuality, which affect both their exposure to violence and their access to support. Marginalized women often experience compounded trauma, not only from interpersonal abuse but also from systemic inequities, such as institutional racism, economic precarity, and legal discrimination (Brown, 2017). These sociopolitical complexities must be acknowledged to develop more effective interventions that move beyond individual pathology and address the structural roots of trauma (Quiros & Berger, 2015).

By recognizing trauma as a layered phenomenon, rather than a universal psychological response, it becomes clear that traditional psychiatric models alone are insufficient. A more nuanced approach requires understanding how women’s diverse social locations intersect with their experiences of violence, shaping their responses and recovery. Neglecting these complexities risks further marginalizing survivors and reinforcing the very structures that contribute to their

victimization (Fleck-Henderson, 2017; Fugate et al., 2005; Kelly, 2011; Kulkarni, 2019; Sokoloff & Dupont, 2005; Sokoloff & Pratt, 2005).

2.4. Trauma- Informed Approach in the Context of Domestic Violence

The Trauma-informed approach has quickly evolved from a grassroots activist concept to a widely accepted framework in mental health services (Tseris, 2013, 2019b, 2024). Trauma- informed approach was proposed as a means of reducing re-traumatization through universal trauma screening and greater sensitivity within service settings. Since then, trauma-informed approach has become an overarching framework rather than a treatment model, emphasizing the pervasive impact of trauma and guiding systems of care to respond appropriately to survivors' needs. In contrast to trauma-specific interventions, which target the symptoms of trauma, trauma-informed approach recognizes that traumatic experiences particularly those stemming from violence fundamentally shape how individuals experience and interpret the world (Scott & Jenney, 2023). When trauma is viewed only at the level of individual experience, there is a risk of overlooking the broader social and structural contexts that shape and sustain it (Thomas-Skaf & Jenney, 2021). In the case of domestic violence, a trauma-informed approach requires acknowledging how systemic inequalities contribute to and compound survivors' experiences of violence. A central principle of trauma-informed approach is the recognition that trauma is widespread and affects individuals in diverse ways (Thomas-Skaf & Jenney, 2021).

Once seen as a marginal idea, trauma-informed approach has now become a fundamental aspect of mental health policy and service delivery (Tseris, 2019b, 2024). Trauma-informed approaches differ from traditional mental health services by emphasizing the social context and root causes of distress rather than solely focusing on symptom management (Tseris, 2019b, 2024)

Feminist scholars, such as Burstow (2003) and Herman (2015) argue that mainstream psychiatric approaches individualize trauma focusing on symptoms and diagnosis rather than the systematic cause of gender-based violence. Given these limitations, there is growing recognition of the need for trauma-inform approach which offers holistic, survivor-centred approach that prioritizes safety, empowerment and structural awareness in service delivery (Wathen & Mantler, 2022). Trauma-informed approach is particularly relevant in domestic violence services as survivors often experience re-traumatization within legal, medical and mental health services that fail to account for power imbalance and intersectional inequalities (Sullivan et al., 2018). Therefore, moving beyond clinical trauma models to a trauma-informed approach ensures that services support rather than further harm survivors.

Trauma-informed approach is an approach for delivering services that recognizes the pervasive impact of trauma, and it aims to provide environment that is sensitive to the unique needs of individuals who have experienced traumatic events, such as physical or sexual abuse. Rather than being a specific treatment technique, it represents an organizational and systemic strategy that can be utilized across various sectors, including mental health services, legal systems, domestic violence shelters, and community advocacy initiatives (Reeves, 2015). Trauma-informed approach is grounded in six key principles that prioritize survivors' dignity, safety, and healing. First, creating emotional and physical safety is essential. This involves cultivating welcoming spaces, consistent staff behavior, and clear communication to reduce the fear and unpredictability that survivors often face. Second, restoring a sense of choice and control helps counteract the coercion experienced in abusive relationships. Survivors are supported in sharing their stories on their own terms and in shaping the services they receive. Third, building meaningful connections with staff, peers, family, and the wider community is central to healing the relational harm caused by

violence. Fourth, helping survivors understand and strengthen their coping strategies while validating their emotional responses supports holistic recovery, including attention to physical well-being and spiritual needs. Fifth, services must affirm each person's unique identity and be responsive to cultural, social, and systemic factors. This includes actively addressing barriers related to race, class, sexuality, and immigration status. Sixth, recognizing and building on survivors' strengths encourages leadership, resilience, and long-term empowerment (Goodman et al., 2016; Tseris, 2024). These principles collectively shift the focus from asking "What's wrong with you?" to understanding "What happened to you?" and "Who are you?", fostering a more inclusive and compassionate response to trauma (Goodman et al., 2016; Reeves, 2015; Tseris, 2024; Wilson et al., 2015). These principles distinguish trauma-informed approach from traditional mental health models, which often emphasize diagnosing and treating disorders, rather than understanding trauma within the context of gendered violence and oppression (Tseris, 2018).

Trauma-informed approach initially aligned with feminist principles by validating women's experiences, challenging biomedical models, and acknowledging social contexts of distress. However, critiques highlight its integration into mainstream mental health systems without disrupting underlying power structures (Tseris, 2024). Despite claims of de-pathologization, trauma-informed approach often mirrors conventional psychiatric approaches by focusing on symptom identification and treatment. Additionally, when combined with resilience discourses, it may shift responsibility onto individuals to navigate systemic inequalities rather than addressing structural causes (Tseris, 2019a, 2019b). While trauma-informed approach enhances service delivery, it falls short in tackling fundamental issues such as patriarchy, racism, and economic injustice (Burstow, 2003; Tseris, 2019b).

Building on this, integrating trauma-informed principles within the multiple sectors that interact with survivors of domestic violence is essential for effective and survivor-centered care. Survivors frequently engage with health care, mental health services, domestic violence shelters, community support programs and legal institutions each of which must be equipped to recognize and respond to DV-related trauma. In healthcare settings, trauma-informed approach has been shown to enhance patient engagement, reduce re-traumatization, and improve outcomes through safe, respectful, and collaborative care models (Panzer & Smit-Dillard, 2017). Mental health services, however, often fall short in implementing trauma-informed principles, risking superficial or surface-level applications unless these approaches are grounded in survivor-defined outcomes and systemic accountability (Sweeney & Taggart, 2018). Community-based domestic violence programs and shelters play a particularly vital role, and studies have shown that when these services adopt trauma-informed approaches emphasizing emotional safety, choice, and cultural responsiveness survivors report more positive emotional and relational outcomes (Nemeth et al., 2023; Warwick-Booth & Coan, 2024).

In addition, trauma-informed approach within the judicial system, particularly in cases involving domestic violence is essential. Heward-Belle et al. (2024) highlight how judicial officers often lack sufficient understanding of the mental health consequences of domestic violence such as DV-related trauma, which can lead to misinterpretations of survivors' behaviors such as perceived inconsistency, withdrawal, or emotional reactivity as indicators of unreliability or instability. This misunderstanding risks re-traumatizing victims and undermining their credibility in court. The authors argue that trauma-informed judicial training is essential to ensure decisions account for the psychological impact of prolonged abuse and to reduce secondary victimization within legal processes (Bradshaw et al., 2024). Randall and Haskell (2013) highlights how survivors of gender-

based violence can be re-traumatized by legal systems that prioritize standardized procedures over emotional safety.

Together, these findings support a shift toward trauma-informed systems that prioritize healing, contextual understanding, and structural change over pathologizing or punitive models. They also align with broader feminist critiques, such as those presented by Tseris (2019b), who warns that mainstream mental health and justice frameworks often neglect the social roots of trauma and inadvertently perpetuate systemic inequities. However, research by Wilson et al. (2015) suggests that trauma-informed approach is unevenly understood and inconsistently applied in many domestic violence organizations, highlighting the need for cross-sector training and shared definitions. The development of the Trauma-Informed Practice (TIP) scales by Goodman et al. (2016) further provides an evidence-based framework to assess these principles across organizations, reinforcing the importance of integrating trust, empowerment, cultural humility, and parenting support into all survivor-facing systems. Trauma-informed approaches which apply in different sectors like mental health often focus narrowly on individual experiences while overlooking the broader structural conditions such as systemic oppression, racism, and gender-based violence that shape and compound those experiences (Tseris, 2019b; Tseris et al., 2024). In doing so, trauma-informed frameworks risk depoliticizing trauma, reducing it to a personal psychological issue rather than situating it within contexts of marginalization and power inequality (Baird, 2018; Tseris, 2019b, 2024).

As Reeves (2015) argues, trauma-informed approach must be understood as a shared, multi-sectoral responsibility, not confined to any one domain. Without this broad integration, survivors risk experiencing fragmented care, re-traumatization, or exclusion from the very systems designed to protect and support them.

2.5. Research Questions

Guided by an intersectional feminist framework and a feminist phenomenological approach, this research seeks to illuminate how women from marginalized social locations understand domestic violence, DV-related trauma, and the diagnosis of post-traumatic stress disorder (PTSD), as well as how they experience professional interventions across sectors such as domestic violence services and mental health care.

To achieve this aim, the study is guided by the following research questions:

1.How do women understand trauma in light of their experiences of domestic violence?

2.How do women make sense of their PTSD diagnosis and the process that led to this diagnosis?

3.How have women's experiences of domestic violence, trauma, and PTSD diagnosis been addressed by professionals, and to what extent have these interventions contributed to their healing , safety and freedom?

4.How have women's experiences and understandings of domestic violence and trauma been shaped by their identities and social locations?

These questions are grounded in feminist commitments to centering women's voices, acknowledging lived experience as a source of knowledge, and examining how intersecting systems of power shape the meanings and consequences of trauma.

Chapter 3. Theoretical Framework

Introduction

This chapter presents the theoretical framework guiding the study: feminist intersectionality. Drawing on this perspective, the chapter examines how social locations such as gender, race/ethnicity, class, sexuality, disability, and geography intersect with systems of power and oppression including patriarchy, racism, and classism to shape lived experiences (Crenshaw, 1991). It positions marginalization as a structural condition rather than an individual circumstance, showing how institutional, cultural, and policy contexts sustain inequality (Crenshaw, 1991). Through this lens, the chapter explores how domestic violence and trauma are not merely personal experiences but are deeply embedded in social structures (Baird et al.,2021) that produce vulnerability while also shaping women's strategies of resistance and survival.

The discussion unfolds in several parts. It begins by introducing intersectional feminist and tracing its origins in Black feminist thought, which challenged single-axis analyses of oppression. It then defines social location as a foundational concept, highlighting how identity and position are shaped relationally through social, cultural, and structural forces. The chapter next outlines the six key concepts of intersectionality social inequality, power, relationality, social context, complexity, and social justice and demonstrates how these ideas together provide a comprehensive analytic framework. Building on this foundation, the chapter applies an intersectional lens to domestic violence through the concept of coercive control and then examines trauma as both an individual and structural phenomenon. It then engages with key critiques and limitations of intersectionality to clarify its scope and methodological relevance. Finally, the chapter concludes by outlining the role of intersectional feminist in this study, explaining how it shapes the research design, analysis, and interpretation of findings.

3.1. Intersectional Feminist Perspective

Intersectional feminist provides a critical analytical lens for examining how systems of power operate in interconnected ways to shape lived experience. Rooted in Black feminist scholarship, intersectionality challenges single-axis analyses of oppression by showing that social locations shaped by gender, race, class, sexuality, and migration status do not function independently but intersect to produce distinctive forms of privilege and disadvantage (Crenshaw, 1991; Cho et al., 2013; Collins & Bilge, 2016). In this study, this farmwork serves as the central theoretical framework, guiding the research design, shaping data analysis, and informing the interpretation of findings. It allows for a nuanced understanding of how domestic violence and trauma are experienced differently across intersecting social locations. By connecting the micro-level of lived experience how women understand, feel, and respond to violence in daily life with the macro-level of policy, law, cultural expectation, and institutional practice, intersectionality reveals how systems such as patriarchy, racism, and classism shape both women's vulnerabilities and the strategies they use to resist and survive (Collins & Bilge, 2016; Collins, 2000).

3.1.1. Origins of Intersectional Feminist

African American women activists in the 1960s and 1970s faced exclusion from movements that claimed to advance equality. Feminism, civil-rights activism, and labour organising each centred a single axis of inequality gender within feminism, race within the civil-rights movement, and class within labour struggles while overlooking how these dimensions overlapped in the lives of Black women (Collins & Bilge, 2016). Early intersectional thought emerged as a response to this marginalization, insisting that systems of power interact and that social identities and structures together shape lived experience, particularly for African American women (Harper & Kurtzman,

2014). Building on these insights, intersectionality has become one of the most influential contributions of feminist scholarship (McCall, 2005).

Kimberlé Crenshaw (1991), a pioneer of Critical Race Theory, expanded this tradition by critiquing the single-axis framework that dominated legal scholarship and anti-discrimination policy. She argued that women of colour experience interlocking forms of oppression that cannot be reduced to race or gender alone. Collins and Bilge (2016) likewise contend that single-focus analyses of inequality fail to capture the realities of Black women, who are marginalized simultaneously as women, as Black individuals, and as workers. Because none of the dominant social movements addressed these overlapping oppressions, Black women developed intersectionality as a conceptual tool to name and challenge the multiple dimensions of discrimination shaping their lives (Crenshaw, 1991; McCall, 2005).

This framework also critiques mainstream feminist theory for emerging largely from white, middle-class experiences and for overlooking the interconnected oppressions many women face (Baird, 2012). As Chan & Erby (2018) observes, a feminist movement cannot truly represent all women if some groups remain excluded from its voice and visibility. Black feminists often positioned as outsiders within urged mainstream feminism to recognise how gendered oppression intersects with racism and other hierarchies of power (Haegele et al., 2018).

Over time, intersectionality has evolved into a multidisciplinary framework used to analyse how social identities, structural positions, and political struggles interact to shape experience and to guide social-justice strategies (Cho et al., 2013; Chan & Erby, 2018). A key premise is that identities and social locations are relational rather than isolated (Crenshaw, 2011; Moodley & Graham, 2015). Categories such as race, gender, class, ethnicity, sexuality, disability, nationality, age, and religion are not neutral descriptors, they derive meaning through power relations such as

sexism, racism, class inequality, and heterosexism (Collins, 2017). As an analytical tool, intersectionality explores how these relations are interconnected, mutually shaping, and continually evolving (Collins & Bilge, 2016).

3.1.2. Social Location as a Foundational Concept

Before addressing the six key themes of intersectional analysis outlined by Collins and Bilge (2016), it is important to clarify a foundational concept that underpins this framework: social location. In this study, social location refers to the dynamic positions individuals hold within social hierarchies, shaped by intersecting factors such as gender, race/ethnicity, sexual orientation, disability, religion, and geographic or cultural context for example, rurality or living in socially conservative environments (Yuval-Davis, 2015). These positions are neither neutral nor self-determined, they are produced by historical and ongoing systems of power and oppression that influence access to resources and opportunities, create conditions of vulnerability, and shape how people experience and respond to domestic violence and trauma (Collins, 2012; Shields, 2012; Waweru, 2018).

Social location is not a fixed attribute or an individual characteristic, but a relational position continually shaped by political, cultural, and structural forces (Anthias, 2002; Collins & Bilge, 2016). This view highlights that people's lives are deeply embedded in broader social systems and cannot be understood apart from the contexts that shape them. For example, a woman's experience of coercive control may differ substantially depending on whether she is racialized, disabled, marginalized because of her sexual orientation, or living in a rural and socially conservative community (Cramer & Plummer, 2009; Nelson & Lund, 2017; Zoe Hilton et al., 2024). These intersecting conditions influence both her vulnerability to abuse and her access to support and strategies for resistance (Crenshaw, 1991; Crenshaw, 2011).

Recognising social location is therefore essential for linking individual narratives to broader structures of inequality. It demonstrates that identities are not merely personal markers but socially constructed positions with political and material consequences (Cho et al., 2013). As Haraway (1988) argues, knowledge itself is "situated," meaning that people's perspectives and interpretations are shaped by where they stand within power relations. Examining social location thus provides a critical foundation for intersectional feminist analysis, allowing researchers to trace how systemic forces shape lived realities and how those realities, in turn, expose the workings of power, privilege, and oppression (Carastathis, 2014; Kobayashi, 2009; Walby et al., 2012).

Understanding social location as a core element of this analytical perspective is an essential first step, but it forms only part of the broader analytical framework. Building on this foundation, Collins and Bilge (2016) outline six central concepts (social inequality, power, relationality, social context, complexity, and social justice), which enhance our ability to analyze how interlocking systems of oppression shape women's experiences of domestic violence and trauma.

3.1.3. Main Concepts of Intersectionality

3.1.3.1. Inequality

Intersectionality offers a powerful framework for understanding how social inequality is produced, sustained, and experienced through the interaction of multiple social locations such as gender, race/ethnicity, class, sexuality, migration status, age, disability, religion, and geographic or cultural context within broader systems of oppression and power (Crenshaw, 1991; Collins & Bilge, 2016). Rather than viewing these dimensions separately, intersectional analysis shows how they shape and reinforce one another, generating complex and distinctive patterns of privilege and disadvantage (Collins & Bilge, 2016).

From this perspective, inequality does not stem from a single form of discrimination but arises from the overlapping and mutually reinforcing effects of structures such as patriarchy, racism, colonialism, and classism. These interconnected systems determine people's opportunities, access to resources, and life chances in ways that cannot be explained through one axis of inequality alone (Collins, 2017).

By shifting the focus from individual factors to broader historical, political, and institutional forces, intersectionality exposes the depth and complexity of inequality. It encourages a more nuanced understanding of how disadvantage is structured and maintained, and how it varies across contexts and over time (Collins & Bilge, 2016).

3.1.3.2. Power

Power is central to intersectional analysis. Rather than being viewed as a single or static influence, intersectionality conceptualises power as dynamic, relational, and embedded within interconnected systems that shape people's social positions and life chances (Collins, 2000; Collins & Bilge, 2016). Structures such as patriarchy, racism, capitalism, and heteronormativity do not act independently, they interact and reinforce one another, influencing how inequality is produced, maintained, and experienced across different social contexts (Collins, 2017). Collins describes the domains of power as a conceptual tool for examining how power operates in different contexts (Collins, 2000, 2017). The interpersonal domain concerns the everyday interactions through which power is lived and felt (Collins, 2000). It encompasses the emotional, psychological, and physical tactics used in intimate relationships, as well as the subtle ways that dominance, fear, or dismissal are communicated in daily life. For women located at the margins whether because of race and ethnicity, disability, sexual orientation, religion, or rurality, these interactions shape not only how coercive control is enacted but also how safe, visible, or valued they feel in their immediate

environments. Power in this domain is often expressed through moment-to-moment behaviours that influence women's autonomy, confidence, and sense of self.

The cultural or hegemonic domain operates through the meanings society attaches to different identities and social groups (Collins, 2017). Media representations, community narratives, religious norms, and everyday language all contribute to ideas about what is "normal," acceptable, or expected of women. Stereotypes related to gender, race, disability, sexuality, or religion can become so widespread that they appear natural, even when they marginalise or misrepresent certain groups (Collins, 2000). For example, cultural expectations in socially conservative or rural communities may pressure women to maintain family unity or silence experiences of abuse, shaping how violence is recognized and how survivors view themselves. These dominant cultural messages influence how women understand their own experiences and how they are perceived by others.

The disciplinary domain refers to the institutional practices, routines, and professional norms that regulate behaviour and shape how people are categorised, evaluated, and responded to (Collins, 2000). In settings such as healthcare, mental health services, policing, and family courts, decisions about who is believed, who receives support, and whose behaviour is closely examined often reflect unspoken biases. These practices, though they may appear neutral, can lead to unequal outcomes. For instance, racialized women may be less likely to be believed, disabled women's concerns may be overshadowed by assumptions about capacity or vulnerability, and lesbian or bisexual women may encounter heteronormative assumptions within services. In this domain, power operates through assessment tools, documentation practices, and risk frameworks that constrain women's choices and shape their interactions with institutions (Collins, 2000).

Finally, the structural domain reflects the broader social arrangements that organise access to resources, opportunities, and protections. Laws, public policies, economic structures, and the distribution of services all determine the conditions under which women seek safety and support (Collins, 2000). Women living in rural or underserved regions may face limited access to domestic violence shelters, mental health support, or responsive policing. Structural inequality shapes how gender, race, sexuality, disability, religion, and geographic location are positioned within society, influencing women's exposure to harm and their ability to seek protection. These structural conditions often operate in ways that seem invisible or inevitable, yet they play a powerful role in shaping life possibilities and risks (Collins, 2000; Ramsay, 2014).

Taken together, these four domains of power (Collins, 2000, 2017) illustrate that power is multidimensional. It is expressed in personal relationships, cultural expectations, institutional practices, and the wider structures that organise social life (Collins, 2000). Intersectionality helps illuminate how women experience these domains differently depending on their social locations, gender, race/ethnicity, sexual orientation, disability, religion, and geographic or cultural context. Importantly, power is not only restrictive. Women also resist, challenge, and navigate these forces in creative and courageous ways, demonstrating that power relations are dynamic and subject to change (Collins, 2015).

3.1.3.3. Relationality

Relationality highlights that social categories and systems of power are interconnected and mutually shaping rather than separate or independent (Collins & Bilge, 2016). Instead of treating gender, race, class, sexuality, or disability as isolated variables, relational thinking examines how they interact within broader structures of inequality to shape people's social locations and lived experiences (Collins & Bilge, 2016). This approach moves beyond additive models that simply

combine different oppressions and instead explores how they interact to produce complex, distinctive outcomes (Collins & Bilge, 2016; Ramsay, 2014).

For instance, sexism is experienced differently depending on race and class, just as racism and classism are shaped by gendered expectations. These intersections create patterns of inequality that cannot be understood in isolation. Relationality also underscores how systems of power influence and transforms one another across contexts, shaping people's access to resources, decision-making, and meaning making. By focusing on the relationships among systems of oppression (Rodriguez et al., 2016), rather than viewing them as separate forces, intersectionality offers a more nuanced and realistic understanding of how inequality is lived and reproduced (Collins & Bilge, 2016).

3.1.3.4. Social Context

Social context is essential for understanding how social locations and power relations develop, operate, and change over time. Intersectional theory argues that categories such as gender, race, class, sexuality, religion, and disability are not fixed or universal, rather, their meanings shift across historical, political, cultural, and economic contexts, shaping how inequality is organised, justified, and sustained (Collins & Bilge, 2016). The significance of these categories and the value attached to them varies across societies and changes over time, influencing how inequality is organised and sustained.

By focusing on context, intersectional analysis reveals that oppression is rooted in structural forces rather than merely in individual bias (Collins, 2012). Systems of inequality derive power and legitimacy from institutions, policies, cultural narratives, and ideologies that normalise their operation (Hamilton-Mason et al., 2018). Situating social locations and power relations within their specific contexts allows researchers to trace how they evolve, intersect, and are resisted. This

approach ensures that understandings of inequality remain grounded, context-sensitive, and attentive to diversity, avoiding universal explanations (Collins, 2012, 2017).

3.1.3.5. Complexity

Complexity is a defining feature of intersectional analysis. It reflects a commitment to understanding the multi-layered and interdependent nature of social life. People's experiences are shaped by numerous aspects of social location gender, race, class, sexuality, disability, religion, and migration status that interact across different levels of society to produce outcomes that cannot be explained by a single factor (Collins & Bilge, 2016). These factors do not simply accumulate but combine dynamically, sometimes in unexpected ways, creating new forms of privilege and disadvantage (Collins, 2000).

Recognising complexity means moving beyond linear or oversimplified explanations of inequality. It invites researchers to examine how multiple institutions, structures, and historical forces converge to shape experience. It also calls for reflexivity awareness that our categories and analyses are shaped by context and an understanding that no single theory can fully capture the diversity of human realities (Walby et al., 2012). Embracing complexity thus leads to a richer, more precise understanding of how inequality operates and how individuals navigate their social worlds (Collins & Bilge, 2016).

3.1.3.6. Social Justice

Social justice is a foundational principle of intersectional feminist. It reflects the framework's dual commitment to analysing inequality and transforming the systems that sustain it (Collins & Bilge, 2016). Intersectionality does not merely describe how power operates, it exposes these dynamics to support collective action for change (Collins, 2000).

This principle recognises that formal equality on its own does not always result in fair outcomes (Collins & Bilge, 2016). Even when rights are legally secured, intersecting forms of discrimination and structural barriers continue to prevent marginalized groups from realising those rights fully. Social justice goes beyond the fair sharing of resources (Collins & Bilge, 2016). It also requires recognition, participation, and empowerment. Central to this is giving greater voice to those most affected by inequality in research, policymaking, and social institutions (Anderson, 2019; Collins, 2017) .

By placing social justice at its core, intersectionality becomes not only an analytical framework but also a guide for envisioning and creating more equitable societies. It seeks to dismantle systemic hierarchies and foster inclusion, ensuring that inequality is not only understood but actively challenged (Rodrigues, 2025).

Together, these six interrelated concepts (social inequality, power, relationality, social context, complexity, and social justice) form the foundation of this analytical approach. They offer the tools needed to understand how multiple systems of oppression shape people's lives and provide a critical framework for exploring issues such as domestic violence and trauma, where individual experiences are deeply intertwined with broader social and structural forces.

3.2. Intersectional Feminist and Domestic Violence through the Lens of Coercive Control

Feminist scholarship has long recognized domestic violence as a manifestation of patriarchal power, in which men use violence and abuse to assert control and dominance over women (Anderson, 2007; Bagshaw, 2011; Dobash & Dobash, 1979; Hunnicutt, 2009). Stark (2007) conceptualises coercive control as a gendered form of domination sustained by historical and ongoing inequalities between men and women. He argues that coercive control is not an individual

pathology, but a social practice rooted in structural gender inequality what he terms “sexual inequality” (Stark, 2007, p.5). Men’s ability to control women is reinforced by cultural norms and social institutions that legitimise male authority. Consequently, coercive control operates both interpersonally through men’s surveillance and restriction of women’s autonomy and structurally through social and institutional arrangements that normalise women’s subordination (Stark, 2012).

Societal expectations often associate masculinity with power and dominance, granting men social authority to monitor and regulate women’s behaviour. Abusers exploit these norms to erode women’s sense of agency and reinforce their subordinate status within patriarchal systems (Anderson, 2007; Dobash & Dobash, 2004; Stark, 2007). Coercive control can manifest through both visible and subtle tactics, from overt intimidation and isolation to covert manipulation that becomes normalised through everyday gender expectations (Stark, 2012). This combination of overt and insidious practices often prevents women from recognising coercive control as abuse especially when these behaviours are sanctioned by cultural norms that legitimise male dominance. Contemporary gender norms continue to sustain these hierarchies of control and inequality (Anderson, 2007; Bates et al., 2019). These norms are reinforced through socialisation processes that define men as dominant and women as subordinate, legitimising unequal power within intimate relationships (Anderson, 2009). While existing scholarship highlights the importance of an intersectional feminist framework for understanding how gender interacts with other dimensions of inequality such as race/ethnicity, class, sexuality, disability, and cultural context in shaping experiences of domestic violence (Collins & Bilge, 2016), there remains limited empirical work examining these dynamics within this specific context. This study contributes to this gap by applying an intersectional feminist lens to explore how these overlapping structures of power influence both the lived experiences and meanings of coercive control.

Viewed through Collins and Bilge's (2016) key concepts of intersectionality, coercive control reflects how power, social inequality, relationality, complexity, and social context intersect to shape women's vulnerability and resistance, while also highlighting the importance of social justice in challenging these systems. Furthermore, coercive control operates across Collins's four domains of power structural, disciplinary, hegemonic, and interpersonal (2000) demonstrating how control is embedded within the broader matrix of domination rather than confined to individual relationships.

Contemporary feminist scholarship argues that women's experiences of domestic violence cannot be understood through gender alone, they are also shaped by the intersections of race, class, sexuality, disability, and other structural oppression (Crenshaw, 2011). Focusing solely on gender potentially obscures how intersecting systems of inequality combine to produce distinct vulnerabilities and barriers to safety, freedom and recovery (Fairbairn, 2022; Mackey et al., 2025; McCall, 2005).

Crenshaw (1991) developed intersectionality to capture the experiences of women facing domestic violence alongside overlapping oppressions such as racism and sexism. She demonstrated that women of colour, positioned at the intersection of race and gender, cannot be fully understood through theories that address only one axis of oppression (Krane et al., 2000). Sokoloff (2008) similarly argues that gender inequality represents only one dimension of women's marginalization. Unlike earlier feminist approaches, intersectional analysis challenges explanations that locate victimisation solely in gendered power relations (Sokoloff & Dupont, 2005). Instead, it emphasises how multiple forms of oppression racism, classism, ableism, and others operate together within the home to shape both women's exposure to abuse and their possibilities for resistance (Sokoloff, 2008). Intersectionality has become central to feminist theory for conceptualising how systems of

oppression, including class, race, sexuality, ethnicity, disability, and gender, interact to shape survivors lived experiences. Domestic violence is therefore not a uniform phenomenon; it is deeply contextual, mediated by overlapping structures of inequality (Carastathis, 2014; Crenshaw, 1991; Sokoloff, 2008). Crenshaw's (1991) concept of structural intersectionality illustrates how systemic barriers such as limited access to services in rural areas, stigma within religious or conservative communities, and institutional bias against Indigenous women or women with disabilities compound experiences of abuse. She notes that "intersectional subordination" occurs when one form of disadvantage amplifies existing vulnerabilities, deepening women's disempowerment (p. 1249). Similarly, Voolma (2018) observes that women experience and respond to violence in diverse ways shaped by their intersecting identities, while Bograd (1999) stresses the importance of recognising this complexity in both theory and intervention.

Historically, this intersectional analytical approach has been guided by three interconnected principles that make it especially relevant for examining domestic violence among marginalized women: centring lived experience by foregrounding the voices of those most affected by multiple and overlapping systems of oppression; revealing structural and cultural dimensions of inequality by analysing how power operates across intersecting social hierarchies; and advancing social justice by linking knowledge production to efforts for social transformation (Collins & Bilge, 2016; Dill & Zambrana, 2019). Building on these principles, intersectionality challenges the assumption that women's experiences of violence are universal or homogeneous, rejecting simplified notions of 'sisterhood' and instead recognising the importance of difference, context, and positionality (Collins, 2000). In this study, these principles are reflected through a focus on domestic violence experienced by women, for example, in rural and socially conservative communities, as well as by Indigenous women and women with disabilities, whose lived realities

are often marginalized or overlooked within dominant discourses. This framework therefore centres their voices, illuminates how structural and cultural power relations shape their experiences, and supports the development of more socially just and inclusive understandings of domestic violence (Cardenas, 2023; Harper & Kurtzman, 2014).

As Sokoloff (2008) explains, "intersectionality colours the meaning and nature of domestic violence how it is experienced by self and responded to by others; how personal and social consequences are reproduced, and how and whether escape and safety can be obtained" (p. 155). This framework seeks to make the specific experiences and vulnerabilities of marginalized women visible (Sokoloff & Dupont, 2005). Crenshaw (1991) similarly highlights that domestic violence manifests differently across social identities and cultural contexts, with intersecting identities shaping women's experiences of both abuse and victimhood. Day and Gill (2020) add that women situated at the crossroads of multiple systemic injustices face compounded risks that heighten exposure to violence.

This concept underscores that domestic violence cannot be understood solely at the interpersonal level, it is embedded in broader social and institutional systems that perpetuate inequality (Collins, 2000). Bograd (1999) further observes that domestic violence frequently coexists with other forms of oppression, noting that the trauma of abuse may be intensified by external victimisation through racism, heterosexism, classism, or ableism compounding its psychological and social impact.

Extending on this foundation, the next section explores how intersectionality provides a critical framework for understanding trauma. Rather than viewing trauma purely as an individual psychological response, an intersectional approach reveals how it is shaped by overlapping systems of oppression. Through this perspective, trauma is understood as both a social and structural phenomenon rooted in the intersections of gender, race, class, disability, religion, and

other social locations that shape how violence and trauma are perpetuated within marginalized communities (Linklater, 2014; Quiros & Berger, 2015; Romero, 2023).

3.3. Intersectional Feminist and Trauma

Research directly linking intersectional feminist and trauma remains limited, yet intersectionality offers a crucial framework for understanding how social structures and systems shape the health and well-being of marginalized groups across multiple sociopolitical levels (Alegría & Cheng, 2023). Much of the existing trauma and health literature focuses on single forms of inequality such as gender or racism treating them as separate categories rather than interconnected forces (Bowleg, 2012). In lived reality, these systems do not operate in isolation, they overlap, reinforce each other, and intensify the effects of marginalization, exclusion, and chronic stress, creating conditions under which trauma is more likely to emerge and more difficult to heal (Brown, 2017).

This perspective aligns closely with Collins and Bilge's (2016) key concepts of intersectionality. Concepts such as social inequality, power, relationality, and complexity help explain why DV-related trauma rarely stems from a single event or identity marker. Instead, trauma is shaped through the interaction of multiple social locations such as race/ethnicity, disability, sexual orientation, religion, and rurality which influence how violence is enacted, how it is interpreted by others, and what forms of support are accessible. For example, a woman living in a rural or socially conservative community may face geographical isolation and community scrutiny, while a racialized or disabled woman may encounter disbelief or inadequate responses when seeking help. These layered experiences show that trauma arises not only from interpersonal harm but also from the broader inequalities that surround it (Tseris, 2015, 2019a).

Trauma is examined in relation to disciplinary practices within legal, health, and mental-health systems that may misrecognise or pathologize women's distress, alongside structural arrangements that limit access to safety, resources, and justice (Bowleg, 2017; Collins, 2000). Each domain shapes the conditions under which trauma develops and is responded to, demonstrating that trauma is not simply a psychological response, but a social and political experience shaped by unequal power relations (Bowleg, 2012, 2017).

Collins and Bilge's (2016) emphasis on relationality and complexity is particularly relevant to understanding DV-related trauma. These concepts remind us that individuals are embedded in families, communities, institutions, and histories that influence their well-being. Trauma becomes more intense when multiple challenges such as discrimination, economic precarity, or lack of services accumulate simultaneously. At the same time, relationality highlights that survivors draw on meaningful relationships, cultural strengths, and community support as sources of resilience (Collins, 2000, 2015).

Developed by Crenshaw (1991), intersectionality offers a lens through which to understand how social identities such as gender, race, sexual orientation, and disability interact within broader structures of power and domination (Buchanan & Wiklund, 2021). However, even where intersectionality is invoked in mental-health studies, key principles particularly attention to power and systemic oppression are often neglected (Buchanan & Wiklund, 2021).

Evidence consistently shows that marginalized populations, including racialized groups, economically disadvantaged communities, and incarcerated individuals, are disproportionately exposed to adversity and trauma (Ford, 2024 ; Ison et al., 2025; Mountz et al., 2024; Sabri & Granger, 2018). These groups face chronic stressors stemming from structural discrimination and inequality (Quiros & Berger, 2015; Seng et al., 2012). From an intersectional feminist standpoint,

trauma cannot be separated from the sociocultural contexts in which it occurs. Recognising how race, class, gender, and other axes of oppression intersect expands the concept of trauma to reflect the lived realities of women in vulnerable communities (Quiros & Berger, 2015). Trauma is not a personal failing, but a response shaped by social, emotional, and political contexts marked by bias and inequality: "The problem is not situated in the character of the suffering person" (Brown, 2004, p. 465).

Institutionalised discrimination through racism, sexism, or heterosexism produces trauma at both micro and macro levels. For instance, "when a husband beats his wife, when a man rapes a woman, when a person of colour is harassed out of a job by coworkers, [or] when the majority of soldiers exposed to combat come from the poor and working classes," trauma becomes a consequence of oppression, bias, and inequality (Brown, 2004, p. 465). Variation in trauma experiences among marginalized individuals arises from intersecting factors such as race, gender, socioeconomic status, and sexuality. Those subjected to domestic violence, for example, may face additional risks tied to racial or sexual identity that intensify trauma and complicate recovery (Vlajnic, 2023).

Intersectionality illuminates this complexity by revealing how social inequalities interlock to create distinctive disadvantages (Funer, 2023). It also challenges the root causes of inequity, promoting social justice by centring the voices of marginalized populations including immigrants and refugees in trauma scholarship (Critelli & Yalim, 2020; Romero, 2023). Incorporating intersectionality into trauma interventions enables approaches that are culturally competent, contextually responsive, and attuned to the needs of diverse groups (Bryant-Davis, 2019).

Marginalized groups are disproportionately exposed to trauma because their lives are shaped by intersecting systems of inequality and structural violence rather than by individual vulnerability (Muldoon et al., 2021). Social locations such as gender, race, class, disability, religion, sexuality,

and rurality influence how violence is enacted, experienced, and understood. For instance, women in rural or socially conservative settings may experience isolation and limited access to services, while racialized and disabled women often encounter institutional bias, disbelief, or exclusion when seeking support (Muldoon et al., 2021). These overlapping oppressions deepen exposure to trauma and restrict access to safety and care (Seng et al., 2012). In this context, trauma is not only psychological but also social and political, emerging from broader conditions that shape women's choices, opportunities, and sense of agency and safety (Burstow, 2003). This perspective aligns closely with Collins and Bilge's (2016) key concepts of intersectionality, which help explain why trauma occurs unevenly across different social locations. Social inequality highlights how unequal access to resources, protection, and support creates environments where trauma accumulates (Kapoor, 2024). Relationality emphasises that trauma affects not only individuals but also families, communities, and social networks, influencing how people respond to harm and where they can turn for care. Complexity reflects the layered nature of trauma, showing that multiple social locations shape both the impact of violence and the accessibility of support, a woman is never only her gender or only her race, but someone whose experiences are shaped through the intersections of these identities (Collins & Bilge, 2016). Social justice speaks to the need for healing approaches that address root causes rather than symptoms, recognising that meaningful recovery requires changes in policies, institutions, and community environments (Tseris, 2019b). From an intersectional feminist perspective, trauma must therefore be understood as both personal and systemic, arising from unequal power relations that affect women across multiple dimensions of their lives. Recognising these connections allows for a more compassionate and realistic understanding of trauma one that values women's strength and agency while acknowledging the need for wider social and structural change (Collins, 2000). Current PTSD treatment guidelines

further highlight the importance of an intersectional approach. Dominated by individualistic assumptions that overlook sociocultural factors, these approaches fail to account for how systemic oppression, discrimination, and historical trauma shape survivors' experiences (Funer, 2023). Their emphasis on universal trauma responses and standardised treatments disregards the diverse cultural expressions of trauma and the compounded vulnerabilities of women experiencing domestic violence at the intersections of race, class, gender, sexuality, and immigration status. An intersectional feminist lens directly challenges these omissions by situating trauma within broader structures of power and inequality, showing that recovery must address not only psychological symptoms but also the sociocultural and political realities of women's lives (Bryant-Davis, 2019).

Quiros and Berger (2015) note that many marginalized people experience trauma related to class, sexuality, or race/ethnicity, and interpersonal violence such as domestic violence is often intensified by broader sociocultural conditions. Such suffering, shaped by restrictive institutions, is common among women from marginalized backgrounds. Despite significant research gaps, a systematic approach is needed to understand trauma across its social, political, and emotional dimensions both interpersonal and structural. Moreover, recovery from trauma cannot occur without addressing the wider social and environmental contexts that sustain it (Brown, 2017). The notion that all women share identical trauma experiences is challenged by feminist intersectionality, which provides a more nuanced understanding of women's diverse identities and lives (Kelly, 2011).

Intersectional feminist provides an essential conceptual framework because gender inequality alone cannot explain domestic violence and trauma. Other forms of oppression often occurring outside the abusive relationship intersect to shape women lived experiences (Lockhart & Mitchell, 2010). Intersectionality therefore serves as an analytical tool for examining how identity, power

relations, and gender inequality operate together to produce complex forms of harm (Cole, 2009; Crenshaw, 1991). From this perspective, trauma and domestic violence are deeply intertwined, particularly for women in marginalized communities. Survivors with intersecting identities such as race, gender, class, immigration status, sexuality, or disability face compounded oppression that heightens vulnerability and shapes their pathways to recovery. Structural barriers such as racism, poverty, and limited access to culturally responsive services intensify harm and restrict opportunities for healing. At the same time, stigma and internalised oppression deepen shame and isolation, while cultural resources such as spirituality, community, and collective resistance can foster resilience. Understanding domestic violence and trauma through an intersectional feminist lens thus requires situating women's experiences within the broader social and political systems that both create harm and shape recovery (Bryant-Davis, 2019).

3.4. Critiques and Limitations of Intersectional Feminist

While intersectional feminist offers a powerful framework for analysing domestic violence and trauma, it has also attracted significant scholarly debate. One persistent challenge concerns its conceptual and methodological complexity. Because intersectionality seeks to capture the interlocking nature of power, privilege, and oppression, researchers sometimes struggle to apply it coherently in empirical studies (McCall, 2005). Some risk reducing intersectionality to a checklist of social categories, oversimplifying its purpose, while others apply it so broadly that its analytical focus becomes diffuse (Davis, 2008; Cho et al., 2013). These tensions reflect ongoing attempts within feminist scholarship to maintain the framework's political depth while ensuring it remains practical for research.

Another concern relates to the potential fragmentation of feminist theory. By emphasising difference and specificity, intersectional approaches can make it harder to identify shared

structures of oppression or to foster collective resistance (Carastathis, 2014). This tension between recognising diversity and sustaining solidarity has long been discussed within feminist debates. Moreover, as intersectionality has entered institutional, policy, and global development discourses, scholars have warned that it risks being depoliticised or diluted, used as a descriptive 'diversity tool' rather than as a critical challenge to power (Dhawan & Varela, 2016; Kapoor, 2024; Lahiri-Dutt, 2025).

A further critique concerns the uneven application of intersectionality across disciplines and contexts. Although the concept is rooted in Black feminist thought and activism, some uses of it neglect these origins or reproduce Western-centric perspectives that overlook non-Western feminisms (Bilge, 2013; Hancock, 2016). Such tendencies can obscure the political and historical roots of intersectionality and risk re-centring privileged academic voices. These critiques highlight the need for reflexive application remaining attentive to context, positionality, and the politics of knowledge production.

Despite these challenges, this framework remains a vital and evolving framework for analysing coercive control and trauma as products of intersecting systems of power. Its enduring strength lies in its capacity to reveal how overlapping structures such as gender, race, class, and cultural context shape women lived experiences and access to safety, justice, and recovery. When used critically and contextually, intersectionality continues to provide one of the most comprehensive lenses for understanding and transforming the social conditions that sustain violence and marginalization.

3.5. The Role of Intersectional Feminist in This Study

Intersectional feminist provides the overarching theoretical lens that informs every stage of this study from framing the research questions to analysing and interpreting the findings. By focusing

on the interaction of social locations such as gender, race/ethnicity, class, sexuality, disability, religion, and geographic or cultural context, intersectionality offers a framework for understanding how domestic violence and trauma are shaped by overlapping systems of power and oppression (Crenshaw, 1991; Collins & Bilge, 2016).

This study builds on intersectionality's understanding of power as structural and relational rather than individual (Collins, 2000, 2017). Situating women's experiences of domestic violence and trauma within broader social, political, and institutional systems moves the analysis beyond explanations that attribute abuse solely to personal relationships or individual pathology. Viewed through the lens of coercive control, intersectionality reveals how violence functions simultaneously as a deeply personal experience and a structural expression of power rooted in gendered hierarchies, economic dependency, social isolation, and cultural norms that legitimise control and silence resistance (Stark, 2007; Sokoloff & Dupont, 2005).

Applying this lens to trauma also underscores that women's experiences cannot be separated from the social contexts in which violence occurs. Oppression, discrimination, and exclusion intersect to shape not only the nature of trauma but also access to safety, justice, and recovery. For example, factors such as race/ethnicity, disability, or rural isolation interact with gendered power to compound vulnerability and restrict access to support. Intersectional analysis therefore shifts attention from the individual to the structural, examining how systemic inequalities produce trauma and constrain the possibilities for healing, safety and freedom (Collins, 2000; Brown, 2008; Burstow, 2003).

In response to critiques that intersectionality can be conceptually broad or challenging to apply, this study adopts a context-specific and reflexive approach. Rather than treating intersectionality as a checklist of identity categories, it is used here as a critical and relational tool to trace how

social locations shape lived experience and how structural power operates across different dimensions of women's lives (Collins, 2000; Collins & Blige, 2016).

Ultimately, this framework provides both the conceptual and ethical foundation of this research. It ensures that women's experiences of domestic violence and trauma are not treated as isolated or universal but as complex, contextually situated realities shaped by power relations. By centring the voices of marginalized women and connecting their narratives to broader social structures, this framework promotes a nuanced and justice-oriented understanding of domestic violence and trauma, one that acknowledges both the depth of harm and the potential for resistance and social change.

Chapter 4. Methodology

Introduction

This chapter outlines the methodological framework for examining the lived experiences of women, particularly marginalized women, who have faced domestic violence and trauma. It begins by situating the study within phenomenological traditions, highlighting the philosophical origins of phenomenology and the development of feminist phenomenology. This is followed by a discussion of the study's epistemological position, before considering the relevance of feminist phenomenology for researching domestic violence and trauma. The chapter then explains the sampling and recruitment strategies, followed by a detailed account of the data collection procedures. Reflexivity and positionality are discussed as central to the research process, before turning to the analytic approach and procedures used to interpret the data. Finally, issues of credibility, trustworthiness, and ethical considerations are addressed.

4.1. Phenomenology

Phenomenology is a qualitative approach that seeks to understand how people experience and make meaning of their everyday lives. It focuses on the lived experience how individuals perceive, feel, and interpret the situations they encounter. Rather than measuring or categorising, phenomenology invites deep engagement with participants' stories to grasp the essence of what it means to live through particular experiences (van Manen, 2016). This approach aligns well with human-centred research that values voice, emotion, and meaning in social inquiry.

I chose a qualitative approach because it is the most appropriate methodology for constructing comprehensive understanding regarding domestic violence and trauma as phenomena under investigation, allowing for detailed description (Connolly, 2018). A combination of

phenomenology and feminist methodological approaches was adopted, as phenomenology enables me to investigate the profound lived experiences of women who have lived through domestic violence and trauma, while the feminist approach gives voice and agency to women in exploring how domestic violence and trauma are understood (Baird, 2012). In the following sections, I will outline the main types of phenomenology to clarify how this study is positioned within that broader tradition.

4.1.1. Husserl's Phenomenology as Origins of Phenomenology

Before World War I, phenomenology had emerged as a philosophy in Germany (Dowling, 2007). Husserl is credited as the German philosopher who introduced the concept of phenomenology in the early twentieth century. Then, phenomenology has evolved into a reliable approach for investigating the foundation of science, consciousness, human sciences, and nursing to explore everyday experiences in individual lives (Matua & Van Der Wal, 2015).

Husserl's phenomenology was an approach attempted to complete pure phenomenology (Dowling, 2007). Positivism, with considering "objective observations as external reality" refused by Husserl's phenomenology, and rather Husserl's phenomenology claimed that "phenomena as perceived by the individual's consciousness should be the object of scientific study" (Neubauer et al., 2019, p.92). Thus, doing this inquiry needs researchers put aside all preconceptions, believes, attitudes, and any scientific theory about the phenomenon to provide unbiased and rigorous study (Flood, 2010).

Husserl considered 'experience' and human 'consciousness' as the original source of knowledge (Dowling, 2007). Therefore, the phenomenological 'reduction', 'epoche/bracketing' invented by Husserl to expel the essential component of the lived experiences of individuals (Flood, 2010).

Husserl's phenomenological view attempts to understand "the essential features of a phenomenon as free as possible from cultural context" and has been reflected on the descriptions of experience (Dowling, 2007, p.132). Therefore, phenomenology as an approach aims to represent the essence of phenomena by investigating the viewpoint of individuals who have lived through the phenomena (Dowling, 2007). In fact, the purpose "of phenomenology is to give the meaning to the experience" by two questions: "what was experienced and how it was experienced" (Neubauer et al., 2019, p.91).

Phenomenology was illustrated as "the study of phenomena as they manifest in our experience, of the way we perceive and understand phenomena, and of the meaning phenomena have in our subjective experience. More simply stated, phenomenology is the study of an individual's lived experience of the world; by examining an experience as it is subjectively lived, new meanings and appreciations can be developed to inform, or even re-orient, how we understand that experience" (Neubauer et al., 2019, p.92). From phenomenologists' point of view, "people, actively create and construct the meaning of the world they interpret as they engage with it and phenomenology can be used as a tool to explore the basic human truths that can only be accessed via inner subjectivity" (Flood, 2010, p. 27).

4.1.2. Heidegger's Hermeneutic (Interpretive) Phenomenology

Hermeneutic phenomenology approach is "interested in human beings as actors in the world and so focuses on the relationship between an individual and his/her lifeworld. Hermeneutic phenomenology's term 'lifeworld' referred to the idea that individuals' realities are invariably influenced by the world in which they live, in contrast Husserl phenomenological focus on acts of attending, perceiving, recalling and thinking about the world and on human beings as knowers of phenomenon" (Neubauer et al., 2019, p.94).

Hermeneutic phenomenology investigates the "meanings of an individual's being in the world, as their experience is interpreted through his/her 'lifeworld', and how these meanings and interpretations influence the choices that the individual makes" (Neubauer et al., 2019, p.94). Simply stated, hermeneutic phenomenology focuses on what people experience instead of what people consciously know, and the individual's reality is constantly affected by the world in which they live (Flood, 2010). Husserl aimed to understand specific 'beings' or phenomena, while Heidegger concentrated on 'Dasein', a term that translates to "the human mode of being" or "the way humans find meaning within their world" (Laverty, 2003, p.24). This approach emphasizes how human existence is situated and meaningful within a broader context, shifting the focus from isolated phenomena to the experiential reality of being human (Laverty, 2003).

Hermeneutic phenomenology declared that "people always interpret and find meanings in events in their lives, including how these events affect the context in which these individuals operate" (Matua & Van Der Wal, 2015, p.24). Moreover, Flood (2010) asserted that in hermeneutic phenomenology subjective experiences are connected with social, political, and cultural context and individuals' everyday choices restricted by a situation of their everyday lives.

4.1.3. Similarities and Differences

Both of Husserl's phenomenology and Heidegger's Hermeneutic phenomenology approaches attempted to reveal the human lived experience and life world. Also, they endeavoured to regain what they realized had been failed by empirical scientific research in the human field (Laverty, 2003; Matua & Van Der Wal , 2015). However, the researcher position, the data analysis process, and issues of rigour or credibility might present distinctions between these two methodologies (Laverty, 2003). For instance, while Husserl's phenomenology claimed that researcher should bracket all pre-assumptions during data collection and analysis, Hermeneutic phenomenologists

assert that making sense of the participant's world by interpretation and pre-existing knowledge is part of the data collection and analysis (Flood, 2010; Laverty, 2003; Matua & Van Der Wal, 2015).

In conclusion, both Husserl and hermeneutic phenomenology provide important insights into the study of lived experience, particularly regarding consciousness, meaning, and interpretation. However, after comparing the differences and similarities between Husserl's phenomenology, which serves as the foundation of phenomenology, and Hermeneutic phenomenology, I have determined that Hermeneutic phenomenology aligns more closely with intersectional feminist as a theoretical framework for this research. This alignment provides a deeper understanding of complex social situations and the ways in which layered identities intersect in individuals' lives. (Laverty, 2003). As Hermeneutic phenomenology emphasises "a person's history or background, includes what a culture gives a person from birth and is handed down, presenting ways of understanding the world and people's background cannot be made completely explicit. Through this understanding, one determines what is real" (Laverty, 2003, p.24).

4.2. Feminist Phenomenology

Feminist phenomenology, as an umbrella term, was developed at the intersection of phenomenology and feminist approaches. At the heart of this approach, it considers lived experiences on behalf of phenomenology and combines it with gender studies as the main character of feminist theories, which would ultimately mean applying phenomenological theory to feminist issues (Fielding & Olkowski, 2017).

Feminist phenomenology is, by definition, a critical phenomenology (Simms & Stawarska, 2013). Critical phenomenology examines how various factors such as ideology, politics, language, and power structures shape and limit people lived experiences and consciousness (Simms & Stawarska,

2013). Feminist phenomenologists aim to accurately represent and analyze gendered experiences, creating a space for recognizing women's voices. This approach requires a careful balance between critically examining existing discourse structures and acknowledging the complexities of individual, contextualized, gendered life experiences. By achieving this balance, feminist phenomenology seeks to establish a foundation for ethical, non-patriarchal political action that benefits women, men, and children alike (Simms & Stawarska, 2013).

Before feminist perspectives and phenomenology merged to form feminist phenomenology, feminists critiqued phenomenology for its limitations. Even though they were skeptical about abandoning phenomenology entirely, because it was the methodology that provided a comprehensive explanation of embodied lived experience (Fielding & Olkowski, 2017; Fisher, 2000). In her paper *Feminist Phenomenology*, Fisher (2000) presents feminist critiques of traditional phenomenology, arguing that the work of some phenomenologists contains essentialist and masculinist assumptions. She further notes that analyses of lived experience grounded in classical phenomenology often remained generic and gender-neutral, which led feminist scholars to view phenomenology as male-biased or masculinist in both its structure and orientation (Fisher, 2000). Furthermore, feminists argued that sex and gender, as crucial categories in describing lived experience, were largely overlooked in traditional phenomenology (Fisher, 2000). Besides, the structure of subjectivity was considered as universal regardless of individual specifications such as gender inequality or sexual differences, therefore, phenomenology neglected the unique specificities of women's experiences (Fisher, 2000). Some critics believe that leaving out gender isn't just a small mistake that can be easily fixed; instead, it shows a deeper bias that favors a male perspective, which is then presented as the standard human experience for everyone (Stawarska,

2018). In addition, poststructuralist feminists critique the phenomenology for its focus on experience, arguing that it lacks political, historical, and social context (Stawarska, 2018).

Feminism can engage with phenomenology not only to critically analyze gendered experiences but also to transform the field itself by incorporating feminist understandings of social and power relations into phenomenological approaches. Without a feminist perspective, phenomenology risks unintentionally supporting existing power structures, particularly by accepting, without critique, the self-doubt and self-criticism commonly felt by women who are socialized to view themselves as less capable compared to male, white, or able-bodied individuals (Stawarska, 2018).

Despite these criticisms, Fisher (2000) declared that phenomenology and feminism could be compatible. Using feminist approaches such as investigating gender inequality at many levels of society (Lauve-Moon et al., 2020), legitimating women's voices as a reliable source of information (Campbell & Wasco, 2000), and giving agency to women by applying phenomenology, helps to investigate lived experiences and attain more profound perception and knowledge. Therefore, this compound has created novel disciplinary as feminist phenomenology (Fisher, 2010; Fielding, 2017). Regarding compatibility of feminist and phenomenology, Simms and Stawarska (2013) stated "phenomenology is feminist as long as it includes questions related to gendered experience and sexual difference within its field of study" (p. 6). Thus, feminist phenomenology plays a crucial role in revealing an entire realm of experience that traditional phenomenology has neglected, largely because it ignored sexual difference and treated male experience as if it were universal (Oksala, 2004).

Building upon all that has been mentioned feminist phenomenology acknowledges that there are multiple approaches to know about living experiences, which is not to "imply relativism that is, the belief that all approaches or ways of understanding the world are equally true or equally

adequate" (Fielding, 2017, p.vii). According to Fisher (2010), by shifting phenomenology further on gender, social and political issues through a feminist approach, feminist phenomenology furnished significantly to the feminist and phenomenological discourses.

The compatibility between feminism and phenomenology has been highlighted by scholars such as Baird and Mitchell (2014), who note that both approaches share a concern with giving voice to lived experience. While phenomenology centres on how individuals experience and interpret their world (Dukas & Kruger, 2016), feminist scholarship extends this by situating those experiences within relations of power, language, culture, and social context. Hermeneutic phenomenology adds that understanding is always interpretive and historically situated, so meanings emerge through our backgrounds and horizons (Holroyd, 2007). Taken together, these commitments align with an intersectional lens, which shows how gender intersects with race, class, sexuality, disability, and migration status to shape exposure to, and interpretations of violence and trauma (Crenshaw, 1991).

4.2.1. Epistemological Position

The epistemological foundation of this study in feminist ways of knowing, which challenge positivist assumptions that truth can be discovered through detached, value-free observation (Sprague & Kobrynowicz, 2006). Feminist epistemology asserts that all knowledge is situated, relational, and shaped by power, and that who we are our bodies, histories, and social locations profoundly influences what and how we know (Harding, 1991; Sprague & Kobrynowicz, 2006). Within this framework, women are recognized as authoritative knowers of their own lives, and their experiences are valued as legitimate and essential sources of understanding social structures and inequalities (Code, 1991; Sprague & Kobrynowicz, 2006).

Building on this foundation, the study draws on intersectional feminist epistemology, which recognizes that knowledge is shaped by the intersecting systems of power that structure women's lives. Intersectionality reveals that gendered experience is inseparable from race, class, sexuality, ability, and place, producing diverse and situated ways of knowing (Collins, 2000; Goel, 2015).

This study also draws on feminist phenomenology, which views lived and embodied experience as a vital source of knowledge. The body is understood as a site of knowing, where emotion, perception, and memory reveal the social and political dimensions of life (Alcoff, 2000; Fisher & Embree, 2000; Young, 2005). Within this framework, women's experiences of domestic violence, trauma, resistance, and everyday survival are seen as embodied insights into how gendered power is lived and felt (Young, 2005).

Together, these perspectives establish an epistemological stance that treats women lived realities as authoritative and situated (Haraway, 1988). Knowledge is understood as co-constructed through dialogue and reflexivity, grounded in empathy and a commitment to amplifying women's voices as a means of challenging dominant structures of power (Hesse-Biber et al., 2007).

4.2.2. Feminist Phenomenology, Domestic Violence and Trauma

The research questions should guide methodology choices (Kross & Giust, 2019). The primary research inquiry of this study focused on exploring the lived experiences of marginalized women who have experienced domestic violence, trauma and have been diagnosed with PTSD. Specifically, it aimed to understand participants' meaning-making of trauma in relation to their experiences of domestic violence, how women make sense of their PTSD diagnosis and how they experience interventions by professionals in regard to their experiences of domestic violence,

trauma, and PTSD diagnosis, and finally how have women's experiences and understanding of domestic violence and trauma been shaped by their identities and social locations.

Therefore, this study utilized an intersectional and feminist approach through hermeneutic/interpretive phenomenology to explore the experiences of women who have faced domestic violence and trauma. This combination of theoretical and methodological perspectives aligns well with the research questions and reflects my perspective as a researcher.

As previously mentioned, to improve the theoretical basis and endeavour to get a more profound knowledge of the experience of living with domestic violence and trauma, phenomenology and feminism can be united (Fisher, 2000). Because phenomenology desires to understand how the individuals' perception is connected to the social world, alongside feminist ideology considered women as an expert in terms of their experience of violence and abuse (Campbell & Wasco, 2000). The synthesis of feminism and phenomenology to reach a more profound perception of women lived experiences of domestic violence would be beneficial for this research (Baird & Mitchell, 2014; Baird, 2012). Feminist phenomenology provides the setting to understand women's voices and conceptualizes women as individuals, while male world experiences are recognized as the norm (Simms & Stawarska, 2013).

By applying a feminist phenomenological approach, participants are considered as experts of their own experiences. This approach offers a "precious insight into how a woman understands herself and how others understand her in multiple contexts" (Benoit et al., 2016, p. 59), which aligns with the objectives of this research to develop a deep understanding of women's experiences of domestic violence and DV-related trauma in contexts of marginalization. Furthermore, this study draws on the integration of intersectionality and feminist phenomenology (Mason, 2018; Shabot & Landry, 2018; Chamarette, 2018) to examine how women's multiple social locations structure

their lived experiences of DV-related trauma. Thus, by combining intersectional feminist with feminist phenomenology, the researcher realizes the complex social situations to understand different experiences of women and "extract the core attributes elaborated and exposed within the textural-structural descriptions of lived experience" simultaneously (Richardson & Loubier, 2008, p.149).

I chose to utilize a feminist phenomenology perspective within hermeneutic/interpretive phenomenology because these methodological approaches provided the flexibility to incorporate an intersectional feminist framework into my research. This allowed me to frame my phenomenological research questions in a way that specifically addressed how gender, social class, disability, religious, sexual orientation and ethnicity intersect in experiences of domestic violence and trauma. An intersectional feminist hermeneutic/interpretive phenomenological approach enabled me to examine trauma and domestic violence by centering women's experiences and situating them within multiple intersecting systems of oppression, including but not limited to gender. Additionally, this approach facilitated the use of hermeneutic/interpretive phenomenology's reflexive data analysis techniques (Smith & Osborne, 2008). As a result, these approaches help me understand how women's subjective experiences as first-hand experience in domestic violence and trauma with various social identities result to make sense of their lived experiences.

4.3. Sampling and Recruitment

4.3.1. Sampling Strategy

In qualitative inquiry, purposive sampling is commonly employed to ensure that participants are selected for their capacity to shed light on the research question. As Padgett (2017) explains, this

approach involves deliberately recruiting individuals who can contribute meaningful insights, and Palinkas et al. (2015) similarly highlight the value of engaging those with significant experience or expertise related to the phenomenon under investigation. Furthermore, as sampling through social media platforms such as X, Instagram, and Facebook is increasingly recognized as a credible method in social research (Connolly, 2018), this approach allowed access to participants who might otherwise remain unreachable through traditional gatekeepers. Many women do not engage with counselling centres, shelters, or related services due to factors such as their social identities, prior negative experiences, or a general distrust of institutional support systems (Bagwell-Gray et al., 2025). In order to reduce this barrier and reach women with more diverse social locations and experiences, I used social media platforms as an additional recruitment strategy to broaden the sample and enhance the inclusivity of the study.

Additionally, I considered snowball sampling, as this method is commonly used when researching minority or marginalized populations. It refers to a recruitment process in which existing participants directly identify and connect potential participants with the researcher (Connolly, 2018). Recruiting participants solely through services settings automatically excludes non-service users. Therefore, I employed a combination of purposive, social media, and snowball sampling strategies to recruit participants, which I explain in more detail in Section 4.3.2.

With regard to the inclusion criteria, this research focused on individuals who identified as women (cisgender or transgender), have experienced domestic violence, and have received a PTSD diagnosis related to their experience of domestic violence by health or mental health professionals. Participants must have been separated from their abusive partner (no time limit), lived in Canada, and spoken English. Additionally, they should identify as marginalized women, including racialized women, Indigenous women, women with disabilities (mental or physical), LGBTQ+ as

well as those from various religious, nationalities and various geographic locations across Canada. The desired age range for participants was 18 and above (Appendix III. Recruitment Flyer). It is worth noting that the initial recruitment strategy was limited to Ontario. However, after receiving emails from women across different provinces, I expanded the inclusion criteria to allow participation from across Canada. I therefore paused recruitment, underwent an additional ethics review, and received approval to broaden the study's eligibility criteria accordingly. In addition, proficiency in English was an inclusion criterion. However, participants whose first language is a minority language for example, Francophone participants were considered eligible as long as they could communicate effectively in English.

4.3.2. Recruitment Strategy and Procedures

For purposive sampling, I began by considering domestic violence shelters and community organizations as initial points of contact. To implement this approach and recruit participants, I first consulted the Shelter Safe Canada website as resources to identify shelters across Canada. Then, I directly contacted by email executive director of various domestic violence shelters and community organizations which focused on gender-based violence or violence against women and gender diverse people fields across Canada to provide a more diverse sample (Kirchherr & Charles, 2018). I inquired whether they agreed to the dissemination of the recruitment flyer. Upon their agreement, the recruitment script (see Appendix II) was shared, outlining the purpose of the research project and providing an introduction with information about me as the researcher and about the study. Also, upon request, a copy of the ethics approval granted by the University of Ottawa was also provided. Consistent with my intersectional feminist framework, I also specifically reached out to organizations serving Black communities, immigrant communities, and the LGBTQ+ community. I used the same approach as with shelters and women's organizations.

If the directors agreed, I sent them the recruitment flyer for dissemination, and potential participants could then contact me directly if they wished to participate.

Furthermore, in recognition of potential structural barriers faced by survivors with regard to accessing services, I did not limit recruitment to shelters and community organisations. A recruitment flyer outlining the project inclusion criteria and my contact information was disseminated through the social media accounts (X, Instagram, Facebook) of organizations, such as the Feminist Anti-Violence Research Collective (FemAnVi). Potential participants could therefore contact me directly. This approach enabled me to reach out to participants who do not engage with formal services and to include women from a wider range of social locations.

In addition, snowball sampling was employed. When potential participants contacted me and agreed to take part in the study, I asked whether they would be comfortable sharing the recruitment flyer within their support systems and advocacy networks, so that other survivors might also learn about the study.

After disseminating the recruitment flyer and making efforts to include women from diverse social locations, eleven potential participants who learned about the study through women's organizations, social media, or other potential participants contacted me directly by email. Six women immediately expressed interest in participating. In addition, five other potential participants initially contacted me with questions about the study, leading to several email exchanges and, in some cases, further conversations. Their outcomes are described below:

Four potential participants did not proceed to the interview stage. Of these, two did not meet the inclusion criteria: one did not meet the English-language requirement, and another described circumstance related to her child's disability that fell outside the study's inclusion criteria. A third

potential participant chose not to take part because no financial incentive was offered for participation in the study. A fourth potential participant, who learned about the study through snowball sampling, initially expressed willingness to participate, however, she later decided not to take part because she was in the midst of court proceedings and the post-separation process, which she described as a particularly difficult time.

A fifth potential participant, who identified as a Black woman, expressed interest in taking part. I conducted a pre-interview with her via Zoom, and she initially agreed to participate in the study. However, she later withdrew before the first interview due to concerns that recalling past experiences might be re-traumatizing. Finally, I conducted pre-interviews with six participants who immediately expressed interest in taking part in the study. These pre-interview sessions were used to explain the research process, including the number and duration of interviews, and to discuss participants' preferences. They also provided an opportunity for participants to raise any concerns or ask questions about the interview process. No participants declined or withdrew during the data collection process.

4.3.3. Sample Size and Rationale

Given the intersectional feminist theoretical framework, recruitment aimed to include women from diverse social locations and identities. Although the study sought to include Black and racialized women as an important area of inclusion, none were represented in the final sample. At the same time, the study did not approach women's social locations as fixed identity categories, rather, it focused on each participant's unique lived experiences and examined marginalization in relation to power and positionality (Collins, 2017). While the sample did not reflect the full diversity originally sought, participants nevertheless represented varied social locations and experiences

that enabled an exploration of how domestic violence and trauma are shaped through unequal social relations and structures of power (Collins & Bilge, 2016).

Finally, six women who met the inclusion criteria and provided informed consent participated in this research project. This sample size is consistent with the orientation of feminist phenomenology, which values depth and relational engagement with participants (Connolly, 2018), as well as broader phenomenological guidelines that typically recommend small, information-rich samples of 6 to 10 participants (Creswell, 2014; Padgett, 2017). The decision to work with this number of participants reflects the principle that, in phenomenological inquiry, the richness and depth of the data are prioritised over sample size. Across the study, 31 in-depth interviews were conducted, allowing for sustained engagement with participants' narratives while providing the detailed and nuanced accounts necessary to illuminate lived experiences of domestic violence and trauma (Padgett, 2017).

4.3.4. Description of the Sample

The study included six women aged between their 20s and 50s (mean age = 42.3 years; median age = 46 years). All participants had experienced domestic violence and trauma and had been diagnosed with PTSD related to these experiences by health or mental health professionals, such as psychiatrists. Each participant had separated from her abusive partner. All participants spoke English. The sample reflected diverse backgrounds across Canada and included women with varied social locations and identities, including: One participant lived with a physical disability in a rural setting; one identified as pansexual and queer; one was an Indigenous woman; another identified as part of a religious minority (Wicca) while living in a rural community; one was a Catholic, Francophone woman residing in a rural area; and one was a Christian woman with a physical disability and living in rural and conservative area. As this research is grounded in

feminist phenomenology and Interpretative Phenomenological Analysis (IPA), participant profiles were presented in a more narrative format. Further details regarding the participants' social profiles, including each woman's social locations, will be described in Chapter 5. In line with ethical considerations, all participants were assigned pseudonyms.

4.4. Data Collection Procedures

Since this study focuses on women's subjective accounts of their experiences of domestic violence and trauma, multiple in-depth interviews were conducted with each participant. This was the most appropriate method of data collection within a feminist phenomenological approach (Fisher, 2000). Feminist methodology emphasizes the importance of women's voices and perspectives, allowing stories to be told as participants themselves understand them, while offering both freedom and flexibility in the research process (Connolly, 2018). To achieve the depth required in phenomenological research, each participant took part in four to six online interviews, with each session lasting between 60 and 90 minutes. A single interview was not sufficient to capture the complexity of women's experiences of domestic violence and trauma, and multiple interviews enabled a more nuanced and in-depth understanding (Padgett, 2017). In total, I conducted 31 online interviews with participants, all of which were audio recorded. The number of interviews conducted with each participant is described alongside their social profiles in Chapter 5. In addition, given the wide geographic area (across Canada), the individual interviews were conducted by Zoom between April 2023 and September 2023.

From a feminist perspective, it is essential to create communicative space for women to express their lived experiences and clarify their emotions and thoughts (Castillo, 2015). In the interviews, I used broad, open-ended questions to explore women lived experiences. For example, I began with prompts such as "Can you walk me through your experience of domestic violence?" and

followed up with probes like “How…?” or “Could you explain further…?” to elicit richer detail. Drawing on my counselling background, I chose this format to encourage participants to expand on their experiences in various contexts. This approach aligns with feminist phenomenological methodology, which emphasizes fluid, participant-led interviews that allow individuals to describe their experiences in their own terms (Flood, 2010). Using this method, participants in this study were able to share their lived experiences, including interactions with institutions such as family courts, criminal courts, police, and child services.

Interviews were conducted in English. The interview questions were guided by an intersectional feminist lens, addressing the main themes of domestic violence, trauma and PTSD, the role of professional interventions, and experiences with mental health and domestic violence services in relation to participants’ social locations. As multiple interviews were conducted, each participant took part in four to six sessions, which were initially scheduled on a weekly basis, however, flexibility remained central throughout the interview process, with scheduling adapted to participants’ needs, availability, comfort, and safety. Each theme could be explored in a separate session, but flexibility was prioritised throughout, with participants’ circumstances on the day of the interview taking precedence. For example, the first interview was typically devoted to participants’ experiences of domestic violence, while subsequent themes were covered depending on time and the flow of the conversation. I aimed to keep each interview session to approximately 60 minutes in order to respect participants’ time and energy and to avoid undue fatigue, given the sensitive nature of the topic. The full interview guide is provided in Appendix IV.

4.5. Reflexivity and Positionality

As a feminist researcher applying an intersectional lens and drawing on feminist phenomenology, I view reflexivity as central to this study. Reflexivity involves recognizing how personal, cultural, and social contexts shape the ways we interpret and connect with the world (Baird, 2012). It is not a discrete step but an ongoing practice that reminds me that my own history, professional background, and beliefs inevitably influence the choices I make in research from identifying a gap in the literature to engaging with participants and interpreting their narratives.

In phenomenological traditions, reflexivity has sometimes been linked to the idea of "bracketing out" one's assumptions to fully enter into the experiences of participants (Laverty, 2003). Yet I view this as both unrealistic and undesirable. From a feminist and hermeneutic phenomenological perspective, presuppositions cannot be completely set aside, rather, they must be acknowledged as part of the meaning-making process. As Laverty (2003) argues, meaning is always co-constructed, shaped by both our histories and the contexts in which we live. Similarly, feminist research highlights that knowledge is situated and influenced by the researcher's standpoint (Connolly, 2018). For studies of domestic violence and trauma in particular, experiences cannot be understood apart from broader social, cultural, and political contexts that frame women's lives (Baird, 2012).

My professional background as a counsellor, including several years of working with survivors of domestic violence and women living within broader structures of oppression, has significantly informed and shaped my approach to this research. In this role, I have witnessed firsthand the challenges they face in the aftermath of abuse, particularly the long-lasting effects of trauma. Before beginning my PhD, I had already been exploring the link between domestic violence and trauma. During my doctoral studies, I deepened this exploration by spending months engaging

with literature on domestic violence, trauma as a consequence, and the ways these experiences intersect with women's diverse social locations.

As an immigrant woman, I have lived with the reality that patriarchy shapes women's lives everywhere, but migration brought with it another layer of inequality. As an immigrant, I gradually became aware of the subtle ways systemic inequalities operated across personal and institutional contexts, shaped by the intersections of ethnicity, gender, and immigrant status. These experiences revealed how power relations quietly shape inclusion, recognition, and the visibility of certain voices. Although these reflections on systemic inequality differ from the domestic violence and trauma experienced by the participants, they deepened my understanding of how social locations and power relations shape lived experience. Women's experiences domestic violence and experiences of trauma more broadly cannot be understood solely at the individual level but must be situated within the wider social and political structures that shape vulnerability and resilience. For this reason, to claim neutrality would not only be impossible but also inconsistent with the feminist phenomenological framework that underpins this research.

At the same time, I am reflexive about the limits of my position. Domestic violence is not part of my own personal lived experience, and I am conscious that I cannot fully place myself within the stories that participants shared. Yet my counselling and research experience, my shared gender identity, and my commitment to empathetic listening became bridges that helped me to connect with participants while respecting their autonomy. Throughout this research I have grappled with questions of insider and outsider status: Where do I place myself in relation to women whose identities and histories differ from mine? In what ways am I privileged, for example, as a heteronormative woman compared to women who identify as LGBTQ2+? How do I balance my role as a researcher with my commitment as a feminist advocate for marginalized women?

These questions have no final resolution but holding them has been part of my reflexive practice. I remain aware that my thoughts, opinions, and emotions about domestic violence and trauma shape not only how I hear participants' stories but also how I analyse and write about them. Rather than erasing this influence, I acknowledge it as part of the co-construction of knowledge in this study, consistent with feminist phenomenology and intersectional feminist frameworks.

Furthermore, in the analysis process, I engaged in ongoing reflexivity through journaling and self-reflection whenever needed, recording my own emotional responses and assumptions. I also discussed my interpretations with my supervisor several times, which helped me remain attentive to how my perspectives could shape meaning.

In this study, I saw myself as a listener and collaborator, walking alongside participants rather than standing outside their experiences. I drew on my counselling skills to create space, allowing moments of silence and using empathy to support participants as they shared their stories. I regarded them as the true experts of their own lives, and many also spoke as advocates, articulating their rights and resilience. They narrated their experiences in their own words and sometimes through metaphors, offering me ways to understand what they had lived. My role was to hold this space with openness and respect, enabling participants to feel heard. Several women expressed that participation felt cathartic and that the questions themselves helped them reflect on how different aspects of their identities such as disability or living in rural areas intersected with their experiences of domestic violence and trauma.

Data collection was shaped by intersectional feminist and trauma- and violence-informed approach that prioritized flexibility, safety, and respect. I scheduled interviews around participants' needs, including evenings and weekends, often when children were not at home, so they could speak freely. For those who requested it, I sent interview questions in advance to help manage

dissociation or anxiety, and I allowed space for silence and emotional pauses. I also remained open to topics that participants introduced beyond my original interview questions, such as their experiences with family courts or their own perspectives on justice. I treated these contributions as part of their lived narratives, affirming their role as collaborators in shaping the study.

At times during the interviews, participants experienced re-traumatization, with feelings of shame, blame, or emotional distress emerging as they shared their stories. In these moments, I drew on my counselling skills and paid close attention to trauma-related language, silences, body language, and emotional expressions such as tears, recognising these as meaningful elements of their narratives. Throughout this process, I listened with empathy and offered support while reflexively balancing my dual position as both a researcher and a feminist counsellor. This boundary was not always easy, yet my feminist stance guided me to acknowledge that violence and trauma are deeply connected and must be validated when voiced. These practices encouraged participants to open up more fully, and several described the process as cathartic, affirming that their voices were heard and valued.

I regarded participants as co-constructors of meaning and therefore sought to stay close to their own words and metaphors, even when they drew on psychological language from previous therapy experiences. As a novice feminist phenomenological researcher using Interpretative Phenomenological Analysis (IPA), I chose to include long unedited quotes to honour participants' voices and preserve the richness of their lived experiences. Repetitions and certain speech patterns were intentionally retained in participants' quotations in order to preserve the ways they expressed and narrated their experiences. This approach reflects feminist epistemology, which values authenticity and resists reducing women's narratives to abstracted themes (Tapia, 2025). Within IPA's double hermeneutic process, where the researcher interprets participants' own interpretations

of their experiences, the use of extended quotations provides transparency in how meaning is constructed while maintaining fidelity to participants' voices and perspectives (Farr & Nizza, 2019). They also convey emotion, tone, and the temporal flow of experience, bridging the experiential and analytical dimensions of the research while upholding respect for participants' voices (Larkin et al., 2006). Preserving these expressions was essential to honouring participants' agency and standpoint, while I simultaneously acknowledged my interpretive role as a researcher balancing respect for their language with the responsibility of synthesizing themes that reflected both individual voices and shared experiences.

4.6. Data Analysis

4.6.1. Interpretative Phenomenological Analysis

Interpretive Phenomenology Analysis (IPA) will be the appropriate data analysis method for this research as I drained insight from the field of feminist phenomenology (Haegele et al., 2018; Murawski, 2020). For analysis of how people comprehend their significant life experiences in different contexts, Interpretive Phenomenology Analysis (IPA), as a process, will identify the hidden meanings of human experience through the narrative produced by participants (Tyler et al., 2019). This approach includes three essential elements: "phenomenological (i.e., focus on lived experience), hermeneutic (i.e., interpretation by the researcher as a way to gain insight into participant experiences), and idiographical (i.e., focus on in-depth analysis of each participant) roots" (Haegele et al., 2018, p.300).

The first element is phenomenological, grounded in phenomenology as a philosophical discipline concerned with exploring and interpreting human experiences as they are lived and perceived. Although phenomenologists may have different areas of focus and interests, they generally share

the common goal of exploring what it means to be human in its various dimensions. This exploration often revolves around significant matters that shape our lived environment. Additionally, many phenomenologists are committed to uncovering how we can gain insights into our experiences of the world (Smith et al., 2021).

The second key theoretical foundation of Interpretative Phenomenological Analysis (IPA) stems from hermeneutics, which emphasizes that understanding is always mediated by interpretation. Hermeneutics developed as a distinct and older line of thought from phenomenology, though these approaches intersect, particularly in the works of hermeneutic phenomenologists like Heidegger (Smith et al., 2021). While experiences may present themselves with obvious meanings, they also hold deeper layers that require careful exploration. In IPA, this perspective underpins the researcher's role, which is to interpret how participants themselves attempt to make sense of their experiences and to bring those meanings into awareness (Smith et al., 2021). Hermeneutics holds a significant place in intellectual history and provides essential theoretical insights for IPA, an interpretative phenomenological approach focused on examining how a phenomenon presents itself, with the analyst actively involved in interpreting this appearance. Detailed descriptions of the relationship between prior understanding and the new phenomenon being examined enrich our comprehension of the research process (Smith et al., 2021).

The third key influence on IPA is idiography, which emphasizes a focus on the particular. Also, the essence of IPA is the idiographic aspect which helps the researcher to disclose in detail what experiences for each individual are like and what perception each individual is creating of what has happened in their lived experience (Haegele et al., 2018).

Unlike most psychology, which typically aims to identify general laws at the population level, Interpretative Phenomenological Analysis (IPA) focuses on in-depth, detailed analysis at the

individual level (Smith et al., 2021). This approach manifests in two main ways: first, by conducting thorough and systematic analyses, and second, by understanding specific experiences from the perspective of particular individuals within their specific contexts (Smith et al., 2021). Consequently, IPA utilizes small, purposefully selected samples and often effectively employs single-case analyses. This idiographic approach allows for careful generalization by grounding insights in detailed, contextualized experiences (Larkin et al., 2006). Importantly, the focus on the particular goes beyond studying individuals alone, as IPA understands experiences as both uniquely situated and relational. Through this lens, each person provides a distinct perspective on their engagement with phenomena, rather than presenting a static view of an isolated 'individual' (Smith et al., 2021).

Thus, this IPA be compatible with intersectional feminist as both consider the reality of the individual as influenced by their everyday experiences and the historical cultural, political background and these backgrounds is not removable when you want to understand the experience of individuals, how the intersection of these backgrounds make meaning of individuals experiences (Lopez & Willis, 2004). Following the goals of phenomenological research, which seeks to reveal common elements in shared experiences, I concentrated on the similarities among various social identities. This method is beneficial in intersectional research as it helps researchers avoid generalizing findings to a single identity (Cole, 2009). This means paying attention to the subtle differences among individuals and groups is crucial.

In addition, social location is a concept that helps researchers better understand people's experiences. It involves examining both social institutions and individual actions to gain deeper insights into the inequalities faced by marginalized groups, such as diverse women who have experienced domestic violence and trauma (Cole, 2009). Therefore, I can analyze data at both

individual and systemic levels, looking at the similarities in participants' social identities and contexts. Additionally, I will consider how the intersections of their social identities and backgrounds influence the participants experiences and outcomes in the studied context.

4.6.2. Process of Data Analysis

Following data collection, all audio recordings were transcribed verbatim to ensure accuracy and preserve participants' original expressions (Haegele et al., 2018). The data analysis was conducted manually, one case at a time, with no software used, allowing for a detailed and idiographic engagement with each participant's account, as recommended in Interpretative Phenomenological Analysis (Smith et al., 2021; Smith & Nizza, 2022).

The specific steps for data analysis were based on Smith et al. (2021) and followed seven recommended steps (Table 1). The first step, commencing with the initial case, was the process of reading and re-reading, which required thorough engagement with the data to become immersed in the participant's account (Smith et al., 2021). This stage involved repeatedly reading each transcript and revisiting the corresponding audio recordings. Throughout this process, the researcher documented observations, reflections, and preliminary insights that appeared potentially significant for later stages of analysis (Smith et al., 2021).

In the second step, I began to identify the specific ways in which each participant discussed, understood, and reflected on domestic violence and the trauma associated with it. This stage, referred to as Exploratory Noting by Smith et al. (2021), involved detailed engagement with the data. As a novice researcher, my aim was to stay closely aligned with participants' explicit meanings by exploring what mattered to them and examining the significance of these elements. I sought to understand the meanings embedded in their experiences how they made sense of abuse,

the actions of abusers, significant life events, and their perceptions of their social location in the context of abusive behaviour. Attention was also given to the language participants used to describe their experiences and the contexts in which they expressed them. This approach facilitated deeper interpretive and reflective engagement with the data.

The third step was to include the "constructing experiential statement" as "the statements are experiential because they should relate directly to the participant's experiences or to the experience of making sense of the events that happened to them" (Smith et al., 202, p.86). The primary goal of transforming exploratory notes (step 2) into experiential statements (step3) is to craft a concise summary that captures key themes, reducing detail while preserving depth and complexity.

After completing the third stage of identifying experiential statements or themes, I moved to the fourth step, which involved examining the connections among these statements and mapping how they related to one another. At this stage, I drew upon the analysis from the previous steps to organize, cluster, and structure the themes, highlighting the most meaningful and significant aspects of participants lived experiences, as recommended by Smith et al. (2021).

In stage five, I created Personal Experiential Themes (PETs) by clustering experiential statements for each participant, assigning titles that capture their essence. PETs represent significant aspects of participant lived experience. In addition, in this stage sub-themes also emerged. Sub-themes are derived from the main themes (or Personal Experiential Themes, PETs) by breaking down the broader concepts into more specific, nuanced categories that reflect particular aspects of the main theme.

The next step, referred to as Step Six, involved moving to the next participant's transcript and repeating Steps One through Five. This process involved an initial close reading of the transcript,

the development of exploratory notes, the creation of experiential statements, the organisation of these statements into clusters, and the generation of personal experiential themes (PETs) and, where relevant, associated sub-themes for the next case.

The seventh step involved identifying patterns of similarity and difference among the Personal Experiential Themes (PETs) generated in the previous stage, leading to the development of Group Experiential Themes (GETs). In Interpretative Phenomenological Analysis, Group Experiential Themes (GETs) are higher-level themes developed through identifying shared patterns of meaning across participants' individual experiential accounts, while remaining grounded in participants lived experiences. GETs allow the researcher to move from idiographic analysis toward a group-level understanding without losing the depth of individual accounts.

In Interpretative Phenomenological Analysis (IPA), the aim is not to establish a 'group norm' or an 'average' experience but to illuminate both the shared and distinctive aspects of participants' lived experiences. This cross-case analysis therefore focuses on exploring points of convergence and divergence across the individual cases.

4.7. Credibility and Trustworthiness

This study adhered to four quality principles outlined by Yardley (2000, 2008). The first principle, sensitivity to context, was addressed by being attentive to participants' perspectives and social contexts. Drawing from my own experiences as a counselor and researcher in domestic violence and trauma, I remained attuned to the participants' conditions throughout the research process. Additionally, I maintained sensitivity to participants' viewpoints by asking open-ended questions, allowing them to opt-out if they felt uncomfortable, and adjusting interview timings to accommodate their readiness to discuss sensitive topics. Furthermore, I ensured sensitivity to the

data by remaining open to alternative interpretations. For instance, I didn't expect that a PTSD diagnosis would be seen as a dual feeling, illustrating the complexity of participants' experiences.

Yardley's (2000, 2008) second principle is commitment and rigour, which I upheld through detailed engagement with the topic during data collection and analysis. I utilized my non-judgmental and active listening skills to encourage participants to share their stories from various perspectives. For instance, while discussing institutional responses like court or child services wasn't part of the initial research questions, I adapted to the flow of the participants' willingness to explore these topics. This approach enriched the data collection process, aligning with feminist phenomenology by providing participants the voice and space to be heard. Furthermore, I engaged in multiple discussions with my supervisors to evaluate and improve my methodological competence and skills.

Yardley's third quality principle (2000, 2008) emphasizes the importance of transparency and coherence, which I achieved by providing a thorough overview of the data collection and analysis processes. I clearly detailed the criteria for selecting participants, outlined the method used for conducting interviews, and explained the analysis techniques employed. Additionally, I included quotes from the transcripts in the findings section to allow readers to assess the validity of my interpretations (Yardley, 2008). Moreover, I practiced reflexivity by reflecting on my counselling background and my knowledge of domestic violence and trauma. I maintained awareness of my thoughts during the research process and held regular meetings with my supervisor to discuss these reflections. This practice allowed me to critically examine how my background might influence the research outcomes.

Yardley (2000, 2008) emphasized that the quality of research is partly determined by the significance of its findings and their potential impact on knowledge, policy, and interventions for

survivors of domestic violence. This study aims to inform readers particularly mental health professionals, shelter workers, and those involved in courts, police, and child services about the dynamics of trauma and domestic violence and how these experiences intersect with different social locations. Most importantly, this research has created a platform for women who have experienced domestic violence to share their lived experiences, empowering them to have their voices heard.

In addition to the aforementioned criteria, I conducted an "independent audit" by sending the data analysis of the first participant to my supervisor. This included the annotated transcript of the initial interview, which contained my initial explorations, experiential statements, clusters, and Personal Experiential Themes (PETs). This process aimed to add an additional layer of credibility and trustworthiness to my research project (Smith et al., 2021). Given the sensitive nature of trauma and the possibility that revisiting past experiences could cause distress or re-traumatization, I decided not to involve participants in member-checking, a process that involves sending transcripts to participants and asking them to review and comment on them (McKim, 2023). During the interviews, I observed that speaking about their experiences was difficult for many participants. In line with a trauma- and violence-informed approach, I prioritised participant safety and wellbeing and therefore chose not to re-contact them for this purpose. However, as noted earlier, I maintained rigour in the research process through ongoing reflexive and analytical checks. This included reviewing the first audit trail and engaging in several iterative discussions with my supervisor throughout the analysis process, moving back and forth between the data and emerging interpretations to strengthen the trustworthiness of the findings.

4.8. Ethical Considerations

4.8.1. Ethics Approval

The research project received approval from the University of Ottawa's Office of Research, Ethics, and Integrity (Appendix VI).

4.8.2. Informed Consent and Voluntary Participation

Participation was entirely voluntary, the consent form clearly indicates the themes that addressed during the interviews, so that the participants could make an informed decision. Further, participants had the right to withdraw from the study at any time and could choose not to answer any questions without facing negative consequences. It was crucial to ensure that participants provided their informed consent freely (Appendix I).

A copy of the consent form was emailed to the participants before the first interview. Participants were also invited to contact me via email if they had any questions or wanted additional information. During the first interview, the participants and I read the consent form together before obtaining their consent. The participants then provided oral consent, which was recorded. Prior to their initial interview, participants received a study description and an informed consent form, including information regarding confidentiality, all of which they reviewed.

4.8.3. Confidentiality

A key ethical concern in this study was ensuring the privacy and safety of participants (Creswell & Poth, 2018). To protect their identities, all participants were assigned pseudonyms, and any identifying details were carefully removed or disguised in transcripts and subsequent writing. Given the sensitive nature of domestic violence, I was especially attentive to the possibility that women could be identifiable through contextual markers such as location or family circumstances,

and I took care to anonymize such information while preserving the integrity of their stories. All original recordings and participant information were stored securely on my encrypted, password-protected computer, and data will be retained for five years following the completion of the study in line with university policy. Interviews conducted online were carried out using the encrypted University of Ottawa Zoom account, which provided additional safeguards for digital confidentiality. Beyond these procedural measures, I approached confidentiality as a feminist ethical commitment, recognizing it as integral to protecting participants' dignity and agency throughout the research process. Alongside protecting participants' privacy, I also recognized the potential for emotional distress or re-traumatization during interviews, which required additional ethical attention.

4.8.4. Sensitivity to Trauma

Given that participants were invited to share deeply traumatic experiences, there was a clear potential for emotional distress during interviews. To minimise this risk, I ensured that participants retained full agency throughout the process. They could skip questions, pause, or discontinue the interview at any point without consequence. I remained attentive to verbal and non-verbal cues, suggesting breaks, rescheduling, or ending an interview if participants showed signs of discomfort. In keeping with trauma-informed practice, participants who requested it were given the interview guide in advance, allowing them to prepare emotionally and cognitively. This was especially important for women who experienced trauma-related dissociation, as recalling past violence could make it difficult to remain present. For instance, one participant asked me to gently restate the question when she lost focus, which I did to support her reorientation. Silence was also respected as an important part of meaning-making, and participants were not pressured to continue until they felt ready. To further safeguard their wellbeing, I provided each participant with a list of

specialized domestic violence resources, available free of charge and 24/7 (Appendix V). These measures were intended not only to reduce harm, but also to create a safe and respectful environment where women could share their stories on their own terms. In this sense, ethical practice was closely tied to a feminist commitment to care, dignity, and the validation of participants lived experiences.

Chapter 5. Introduction to the Findings and Participants Sociodemographic Profile

Introduction

This chapter presents the findings from the Interpretative Phenomenological Analysis (IPA) conducted on the experiences of six women who endured domestic violence, trauma, and received a Post-Traumatic Stress Disorder (PTSD) diagnosis as a result of domestic violence experiences. The purpose of the analysis was to explore how participants made sense of their lived experiences and to understand the meanings they attached to domestic violence, trauma, and PTSD. As discussed in the methodological chapter, the findings are organised into ten Group Experiential Themes (GETs) (see Table 2) developed through the IPA process and presented consecutively, in numerical order, across two findings chapters. The GETs reflect patterns of both shared and individual experiences among participants, capturing points of convergence and divergence across their accounts.

Given the depth and complexity of the data, the findings are presented across three chapters. This first chapter introduces the participants and provides contextual information regarding their sociodemographic characteristics and social locations in order to situate the analysis that follows. The second and third chapters present the substantive findings in detail.

The second findings chapter, titled "Trauma and Coercive Control: Insights from Lived Experiences," focuses on participants' experiences of domestic violence, including the continuation of coercive control after separation. It also explores how participants made sense of trauma within the context of domestic violence, including how they experienced and understood trauma in relation to their lived experiences. Finally, the chapter considers the intersection between domestic violence, trauma, and participants' social locations, highlighting how factors such as

ethnicity, sexual orientation, religious, disability, cultural background, or geography shaped their experiences and understandings.

The third findings chapter, "Surviving the System: PTSD, Justice, and the Search for Safety," examines participants' perceptions of the PTSD diagnosis as a label and their experiences with interventions while seeking help and support. It also reflects on participants lived experiences of applying survival strategies and how their PTSD diagnosis was represented within judiciary system such as family court. Furthermore, this chapter considers how social locations, along with experiences of domestic violence and trauma, intersect through an intersectional lens to illuminate the diverse and complex realities of participants' lives.

5.1. Introducing the Participants

Before delving into the individual narratives of the six women I interviewed, it is important to acknowledge that each participant experienced coercive control, post-separation violence and DV-related trauma. They were all diagnosed with PTSD, directly related to the trauma endured from these abusive experiences. These participants lived in four different provinces across Canada, highlighting the diverse regional and social contexts that shaped their experiences of domestic violence and trauma. In consideration of confidentiality, the name of the province will not be disclosed.

In addition, I included participants' religious identities in their descriptions only when they self-identified as religious, named a religion, or described religious practice, otherwise, I did not mention religion in their profiles. All participants were also Canadian citizens and non-racialized women. It is important to note that the terms partner, abusive partner and abuser are used interchangeably in this chapter when referring to participants' descriptions of their abuser.

To further understand the lived experience of participants in domestic violence and trauma, it is crucial first to introduce the social profiles of the participants. Each woman's unique social location, including factors such as age, ethnicity, geographical setting, religion, sexual orientation, and ability/disability, played a significant role in shaping how they experienced coercive control, trauma, and the interventions they sought.

Additionally, when I had a conversation as a pre-interview with participants and later during the interviews, they pointed out several times that they considered PTSD to be a disability. For them, this was not only a diagnostic label but also a recognition of how PTSD shaped their daily lives like interrupting work, relationships, and social participation. They described how 'symptoms' such as hypervigilance, nightmares, or difficulty concentrating often restricted their capacity to 'live normally' , and how this sense of restriction mirrored the ways disability is defined in broader policy frameworks. This perspective aligns with the Government of Canada (2025) and Ontario Human Rights Commission (2025) definition of disability as a condition that significantly limits a person's ability to participate fully in society. Below is a brief overview of each participant's social profile, providing context for the themes that will emerge in the analysis:

MAE

MAE is a white female in her early 50s which has been living in a rural area during the abusive relationship and continued to live there after the separation. She identified herself as a woman with a physical disability related to Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). She endured various forms of coercive control, including emotional abuse, the use of children by the abuser as a means of control, financial control, isolation, the regulation of everyday life such as dictating routines and meals, and stalking, although she did not report physical violence. After leaving the abusive relationship, she was diagnosed with PTSD while seeking help to heal from

the emotional pain she experienced. She was unemployed due to disability that she experienced. MAE participated in six interviews throughout the study.

Elizabeth. M

Elizabeth. M is a white female in her 20s. She identifies as pansexual and queer. She experienced emotional and psychological abuse, sexual control and violence, gaslighting, isolation, restriction of her autonomy like making the Elizabeth. M doubt about her queer identity, and silent treatment while she was in an abusive relationship. After leaving the abusive partner, she was diagnosed with PTSD due to the emotional and psychological pain she experienced. Additionally, she identifies as having ADHD which she considered as disability. Elizabeth. M participated in six interviews throughout the study.

Rose

Rose is a white, Catholic, Francophone woman in her 40s. She has been living in a rural area while she was in and out of the abusive relationship. She experienced sexual and emotional violence, witnessing violence directed towards her children and dictating discipline and routines towards her and children. Furthermore, she faced an additional layer of violence and marginalization stemming from her partner's status as a police officer as she explained "*so be a cop comes with a status at the end of the day like you're not like everybody else and not being a cop made me unequal*". She was unemployed due to a PTSD-related disability resulting from domestic violence: "*I guess with the PTSD that would be the disability of being triggered when I don't know when I'll be triggered, so I haven't been able to keep a job, so that's been a disability*". Rose contributed to six interview sessions across the duration of the study.

Katie

Katie is in her 30s and identifies as a white Christian woman living in what she describes as a rural, conservative area. She experienced coercive control, emotional, psychological, and sexual violence, as well as stalking and gaslighting, which caused her to question and doubt the abusive nature of his actions and to fear his threats. Katie has been dealing with mental and physical disabilities. During her experience of domestic violence, she was diagnosed with PTSD, which is classified as a mental disability. Additionally, she has dealt with a stroke, patent foramen ovale (PFO) and ADHD. She was unemployed due to disability that she experienced. Katie participated in five interview sessions throughout the study.

Sasha

Sasha is a white woman in her late 40s living in a rural area. She experienced coercive control and financial abuse and, as a result, was diagnosed with PTSD, which she considered a mental disability. She also referred to Complex Post-Traumatic Stress Disorder (C-PTSD) in describing her lived experiences. Additionally, she has a physical disability due to an autoimmune disorder of her liver and a thyroid condition. Sasha explained that she practised Wicca, a minority religion, although she described her practice as limited. Because she practices Wicca and has lived in a rural area, she is considered marginalized "*I'm Caucasian, but and I am marginalized because of the wicca, and because of the rural, and because of all that"*. In her experience, the abuser used Wicca practice to impose psychological and emotional abuse on her. Sasha contributed to four interview sessions across the duration of the study.

Willow

Willow identified as an Indigenous woman of Métis descent in her late 40s. She has been experiencing coercive control, financial control and ongoing post-separation violence directed

toward her, particularly related to child custody issues. She described experiencing ADHD and having received a PTSD diagnosis as a result of domestic violence, both of which she considered disabilities. Willow participated in four interview sessions throughout the study.

In addition, it should be noted in the participant's profile that **MAE**, **Sasha**, **Rose**, **Katie**, and **Willow** each have children from their partner, which underscoring the complexities of co-parenting in the context of coercive control and post-separation violence. The number of children has not been disclosed in order to protect participants' anonymity and confidentiality.

Chapter 6. Trauma and Coercive Control: Insights from Lived Experiences

Introduction

The first findings chapter focuses on participants' experiences of domestic violence and trauma. Drawing on a feminist phenomenological and interpretative lens, this chapter presents Group Experiential Themes (GETs) that capture how participants made sense of coercive control and trauma. In this chapter, the Group Experiential Themes (GETs) range from GET.1 to GET.4, with some themes including subthemes to capture additional nuances within participants' experiences. These should not be read as rigid categories, but as overlapping meaning structures that emerged from participants' accounts.

In presenting the findings, I move between participants' voices, my interpretative reflections, and the intersectional feminist framework through which meaning is made of participants' narratives. This chapter should be read as the foundation of the findings, as it highlights the meanings of coercive control and trauma, as well as the intersections between social location, coercive control, and trauma within participants lived experiences. It aims to show how participants embodied and lived experiences reveal the complex and situated nature of coercive control and trauma.

6.1. Unseen Scars of Coercive Control (GET.1)

The first group experiential theme (GET.1) captures participants' accounts of coercive control as a pervasive feature of their relationships. Participants described restrictions on movement, surveillance of communications, and constant monitoring of daily life. This theme captures the enduring presence of control in participants' lives and the ways it shaped their sense of autonomy and freedom. The accompanying subthemes: It was a hidden bruise, Emotional wounds of control,

and Sexual violence as an unseen and unspoken layer of coercive control further deepen understanding of how participants made meaning of these experiences within their narratives.

6.1.1. It Was Hidden Bruise

Participants pointed out that in today's world, domestic violence is often narrowly associated with physical harm, making it difficult for others in society to recognize abuse when there are no visible signs, such as bruises. They emphasized that control and coercion played the central role in how power was imposed on them by their abusive partners. Coercive control was hidden and insidious, lacking the obvious markers that others might expect, yet deeply harmful in shaping their everyday lives.

Here **Elizabeth. M** described her experience of domestic violence as "*It was not a strictly physically abusive relationship. It was more sexually and emotionally abusive and it wasn't like physical violence to the simple definition of that, it was much more like emotional verbal violence*"

MAE likewise shared her experience of domestic violence as "*I wasn't hit but he used his violence against me to intimidate and to frighten... incredibly controlling and coercive and manipulative, and really on all levels like emotionally..., psychologically, sexually, financially, very much so and he was very careful, and I never did get a punch"*

Katie and **Rose** recount experiencing coercive control, including threats and the fear of consequences for disobeying their abusive partners:

> "*He would threaten me with his gun and tell me if I didn't behave, I was goanna get it... meaning he was going to shoot me*" ***(Katie)***

> "*There was a lot of punishment for talking... there's always consequences... so it was like this is the way I am and that's it, you have to toggled on or there's consequences or there's consequences and you have no right to be afraid of me*" ***(Rose)***.

Therefore, in the experiences of **Elizabeth. M, MAE, Katie** and **Rose** domestic violence was not easily recognizable, both for the women themselves and for the public, as it involved a pattern of acts like threatening by gun, intimidation, threating by sever consequences and forcing them to be silent which are of hidden.

I also found that participants were experiencing isolation, silent treatment, financial control, as described by the participants. **MAE, Katie and Sasha** shared that they experience isolation as a result of the surveillance of their abusive partner. They explained that their abusive partners have had control and power over different aspects of their relationship and social life. Here **MAE** explained that it was hard socialize as her abusive partner was everywhere, like jumping into conversations. This was actually part of belittling and humiliating her and he did not want her to have any dignity "*It's hard to do social things, he would come in and interfere, or intervene, or take over, dominate that*" or as **Katie** described that she directly banned to visit her friends "*I wasn't allowed to see friends*" which highlighting the isolation and deprivation of liberty like connection with friends by her abusive partner.

Sasha's abusive partner exerted surveillance and controlling her daily life, leading to her social isolation "*I had to let him know where I was going and what I was doing, and how long approximately it would be if he wasn't with me as well as he limited my time with my best friends, he limited my time with my family*"

In addition, **Sasha, MAE, and Rose** described coercive control in various ways, including the use of silent treatment which refers to a tactic where one partner purposely withholds conversation,

attention, or emotional connection in order to discipline, assert authority, or manipulate the other person, being chaotic and imposing discipline, reflecting their individual experiences. As **Sasha** described, her abusive partner imposed control and coercion even through seemingly small details, such as the kind of music they could listen to when they were together. If she and their children obeyed his preferences, the situation remained calm, but if she or children attempted to show their own agency by choosing music or offering an opinion, there were consequences. One of the most common was the silent treatment, a form of punishment that left **Sasha** feeling isolated and diminished:

> "*We all [she and her children] walked on angels, it wasn't just me we all did, they all knew they saw the anger they saw, we'd get into a vehicle, and we had to listen to the type of music he liked or there was hell to pay like we heard about it, or we'd get the silent treatment... his favorite thing to do to me, while we were together, was, give me the silent treatment all power and control*"

A similar scenario happened to **MAE**. Any act of disobedience or attempt to assert her own will against the abuser's preferences was met with punishment, often in the form of the silent treatment "*if he didn't like what I was saying, or he would give us all the silent treatment*". **MAE** shared that her abuser imposed control by making everything dependent on his chaotic behavior. For example, he deliberately removed the door handle from the bathroom, so that even the small moments of privacy and liberation that the bathroom might normally provide were denied. In this way, control extended into the most intimate spaces of daily life*:* "*Our whole world was wrapped up in his created chaos... he just kept things chaotic...we didn't have door handles in our house, no door handle in the bathroom, so you could never be alone in the bathroom*"

Rose explained that her abuser enforced a strict routine that she and the children were required to follow. The abuser deprived them of flexibility, spontaneity, and even the smallest expressions of personal choice. In this way, routine became a tool of coercive control a hidden but powerful form of domination that maintained fear and compliance:

> "*One time I had a friend come to visit us on a Saturday and I couldn't see her we had to go see my in-laws, so she travel all this distance to see me, and I hadn't seen her forever and we were leaving to see my in-laws and so the routine for him was like so important so we weren't allowed to change the routine*"

Also, **Elizabeth. M's** partner imposed silent treatment as a sexual control weapon when she did not agree to have sex with him. It seems that it was the consequence as result of not satisfying his sexual desire: "*I didn't want to it he was like completely stonewalling, not even speaking to me... if I shot that down in his eyes [she meant sexual request by her partner] he would just kind of leave me to deal with my like, neglect me and my emotions*"

Financial abuse and control also played a concealed role with a significant impact on participants' lives. As **MAE** explained that she had not been allowed to have personal bank account "*what I received through like child tax benefit went into like the family bank account, I didn't have my own bank account*". Further, **Katie** described that her abuser controlled her social life by imposing financial control "*then he was very controlling with finances. I wasn't allowed to go anywhere. I was only allowed to tank a gas a week. I wasn't allowed to leave the house more than once a day*"

For **MAE** and **Katie,** the financial micromanagement by their abusers functioned as a form of deprivation, stripping away autonomy and reinforcing isolation. By controlling access to economic

resources, the abuser not only maintained dominance but also created barriers that made it harder for participants to leave the relationship or imagine life beyond it.

Furthermore, **Sasha** described how her abusive partner established a financial tie to manipulate her life. This memory moved her to tears:

> "*He controlled… I didn't have access to anything financial like…there was no joint bank account, I didn't have access to money , even food, like groceries he would not give me money to buy groceries he had to be there with us to buy it... we were married I had no access for the first 3 years of 2 and a half, 3 years of our marriage to funds so when I had the babies of course you know you have menstrual or heavy bleeding after, right, I had to ask him for money to buy pads or he came with me to buy groceries he was always with me to buy groceries when I had access to it, I had to give him receipts if I lost a receipt I was questioned, or I had the silent treatment after*"

Sasha described how financial abuse was woven into her everyday life. Her abusive partner kept all financial resources under his control, and there was no joint bank account or shared access to money. Even basic necessities such as groceries were withheld unless he chose to provide funds. She recalled that after childbirth, when she experienced heavy bleeding, she had to ask him for money to buy menstrual pads. These moments illustrate how financial control operated as a tool of coercive power by denying her access to the most basic resources for herself and her children, the abuser created dependence, humiliation, and constant reminders of his dominance. This form of deprivation stripped her of dignity and autonomy, forcing her to negotiate for even the most private and essential needs.

In another instance of financial abuse, **Willow** explained how her partner financially exploited her while everything was under her name. **Willow** shared how financial abuse unfolded after she moved to Canada with her abusive partner. Because he was not a Canadian citizen, all financial accounts and credit cards had to be registered under her name. However, rather than this giving her any autonomy, her abusive partner took advantage of the situation by using all the resources without consulting her or involving her in financial decisions. He accumulated debt and spent freely, leaving her responsible for the consequences. In this way, financial control operated not only through deprivation but also through exploitation her name and resources were used against her, binding her to his choices while stripping her of agency. These dynamic reveals how coercive control can manifest through financial dependency in reverse, where the abuser manipulates structural circumstances to maintain dominance:

> "*I was too financially dependent on him but everything was in my name, because I was a Canadian citizen and I found out, you know, he hadn't paid the rent where we lived, he destroyed my credit rating. I'd never had a credit rating problem here, he left me a thousand dollars tickets, he bought trucks in my name…he had ruined me financially, and I had no money… he had taken my money*"

6.1.2. Emotional Wounds of Control

Participants spoke about the emotional toll of coercive control in ways that showed just how deeply it cut into their sense of self. They described how the ongoing, ever-shifting patterns of control appearing at different moments and in different forms left them feeling pushed aside, unseen, and gradually stripped of hope. What they shared makes it clear that coercive control is not only about limiting what someone can do, it reaches into a person's emotional life and leaves marks that are

often invisible to others. These emotional wounds, though hidden, stay with them, shaping how they feel, how they trust, and how they move through the world long after the relationship ends.

As **MAE** expressed that she felt unwanted as result of emotional abuse and neglect by abusive partner toward her health issue and disability "*And he was very much he was very dismissive of my health issues but that's the reality*". For **Katie** recalled feeling hopeless and unworthy as a result of the constant and layered nature of coercive control. She explained that it was not the punches or physical bruises that marked her, but the embodied feeling inside her, a pain with no visible bruise "*Domestic violence can be… it can be anything it's not just you know the physical bruises or the punches…so many different levels to it that can leave you feeling helpless and helpless and hopeless and just worthless at the same*"

Rose also described how her abuser showed no sense of responsibility toward her, often leaving the house without any explanation, news, or answer about where he was. He dismissed her feelings and ignored her worries, leaving her in a state of uncertainty and fear. For **Rose**, this repeated disregard created a deep sense of abandonment an emotional wound that emerged directly from the pattern of control and coercion in the relationship:

> "*I think the worst was the abandonment… it sounds it's just he would either go to work and not come home…he would not pick up his phone.. I had no idea if he was fine…I mean the abandonment was like he would not call home…he would just disappear and then when he'd come home the next day...it was like what was my problem why did I have a problem with this? and it went on it went on for so many years*"

Similarly, **Willow** described feeling abandoned during her pregnancy, a time when she most needed support from her partner. Although they lived in the same home, her partner was emotionally absent leaving her to cope largely on her won. She recalled her story as:

> "*He wasn't around, he was not around he wasn't around when I was pregnant he was not around…we lived together, but he wasn't around…like just absent I don't know… during my pregnancy during my pregnancy I was mostly left alone…after I had my baby it was just very aggressive, like very cruel with his words like I would beg him to come see her…I begged him to be in [her daughter's name] life, my daughter he wasn't interested at all…*"

This deliberate withdrawal off care and refusal to engage, both during her pregnancy and after that, highlighted a form of emotional control leaving **Willow** feeling abandoned, isolated and forced to bear responsibility alone: "*going through a difficult pregnancy you know, I don't have memories of him during my pregnancy...I don't actually have memories of him during my pregnancy, except for he was absent and I guess lying*" . Through the lens of coercive control, his absence was not simply neglect but a patterned strategy of abandonment and intentional deprivation, used as a weapon to impose control. For **Willow**, the only memory she carried from her pregnancy was his absence the absence not only of a partner but also of the father of her daughter.

6.1.3. Sexual Violence as Unseen and Unspoken Layer of Coercive Control

Participants described how sexual violence was not an isolated act, but part of a broader pattern of coercive control. Within their relationships, sex was used as a tool of domination, where consent was undermined and intimacy became another site of power and fear. Through the lens of coercive control, sexual violence is understood not only as physical violation but also as the systematic

erosion of autonomy, functioning as a way of asserting ownership over women's bodies and reinforcing dependence.

In **Katie's** word, she was forced to have sex by her abusive partner in different situations. Sex played as coercion tools in her intimate relationship:

> "*There was a lot of sexual abuse...he sexually abused myself, he would put his dick on my shoulder when we were eating at the supper table…I would try and be doing dishes or anything like that, and he'd come on he'd be like, oh, come on, just touch it, just touch it, or he try and put it in my mouth. I'd be sleeping with him, and he would try and slip his penis in my butt, or anything like it*"

Katie explained that her abuser subjected her to sexual violations in different situations without her consent. She emphasized the depth of this harm by saying that "*nowhere was ever safe*", highlighting how sexual violence functioned as a pervasive form of coercive control that invaded every space of her life "*was just so invasive nowhere was ever safe*"

Elizabeth. M recalled being threatened by her partner with statements such as, "*if you don't do this, then you don't love me*" This placed an obligation on her to comply, turning sex into a duty tied to her role as a woman and partner:"*In general, I definitely experienced it more as like a you need to be doing this active service for me, and if you don't do this, then you don't love me…you don't care about me despite me feeling, you know upset uncomfortable*"

Within the lens of coercive control, such manipulation shows how gendered expectations and love in intimate relationship were weaponized. By framing refusal as rejection, the abuser transformed intimacy into a tool of domination, eroding her autonomy and reinforcing his power.

In various instances, **Elizabeth. M** was a target of sexual violence in which she clearly expressed her lack of consent to her partner. Despite her saying "*I don't want to do this anymore*", he chose to disregard her words and feelings: "*There was on several occasions where we're actually having sex and midway through the sex, I would say, I don't want to do this anymore, can you get off of me, or like we need to not do this anymore and he would say no like, let me finish, and him being a lot stronger than me, I like couldn't even push him off…I couldn't even do anything that way and he wouldn't stop. So, there was a lot of that kind of sexual violence that I was experiencing pretty regularly*". This deliberate neglect of her refusal demonstrates how sexual violation was used as a form of coercive control, stripping her of autonomy and treating her boundaries as irrelevant.

Rose noted that sexual violence began during the dating stage of her relationship and continued even after they have been separated. During the dating stage, he sexually violated her by ignoring her lack of consent, even when another person was present in the room. When she spoke with her friends, they noticed that she was not doing well. After she explained the situation to them, they identified the experience as rape. His disregard for her refusal illustrates how sexual violence was used from the outset as a way to impose power and establish control:

> "*So there was his friend in the room, passed out on the bed and he wanted to have sex with me and I said, no because there's someone else in the room but no was not an answer so I ended up having sex with him to have him, I spoke with my friend over the phone and he picked up that something was off with me, I said well something happened and then I explain what happened and my friend said so you got raped*"

Also, **Rose** mentioned that she was unaware that sex could be used as an abusive tool. Instead, she thought it was a regular part of marriage and felt obligated to do what was expected as wife*:*

> "*So I was questioned and people would ask me, well, was he violent with you and I never said yes, because I didn't see him being physically violent with me at the exception of when we were sleeping together….I just kind of downplayed saying, well, he's just hitting me, because I guess sex didn't matter, that he was hitting me while we were having sex I don't know…sexual behavior he was hitting me*"

Under this expectation, she did not realize that what was happening was in fact coercion and violation. She described how her abusive partner was often physically violent during sex, using these moments to impose power and control.

In the following passage **Rose** expressed her loss of dignity and respect when targeted of sexual violence by her partner "*It was awful awful awful feeling...it was even more degrading in the aspect of like who am I going to talk about this with?*". **Rose** revealed that rape persisted throughout their relationship, occurring in various situations "*He ended up forcing me to have sex in the basement while my dad and my kids were upstairs in the house*". Through the lens of coercive control, her account reveals how cultural and relational norms around marital obligation were exploited by the abuser, turning intimacy into a weapon of domination while silencing her ability to refuse.

As earlier **Sasha** explained the silent treatment by partner, she brought another layer of coercive control where she was coerced into having sex with her abusive partner to break the silent treatment and survive while she was in abusive relationship. She recalled felt trapped and devalued by her abuser:

> "*When he told me I had to start paying for things, I gave him sex in order to pay and I ended up getting pregnant with our youngest child [she was crying and be silent]… there was there was sexual assault because you'd have sex to quit stop the silent treatment, you'd [she meant herself] have sex to stop the anger to appease so I mean this I was raped but I never had the physical bruises*"

This phrase by **Sasha**, "*So I mean this I was raped but I never had the physical bruises*" emphasized of the hidden nature of coercive control where coercion or sexual violence have used to intimidate, control and violate her sexual autonomy without necessarily causing visible injuries. At the same time, her narrative shows a form of resistance. By recognising and naming the absence of bruises, she challenged narrow, physical definitions of domestic violence and highlighted how harmful coercive forms of abuse can be.

Willow discussed her experience of sexual violence, though she chose not to delve into the detail, suggesting the severity of what she had endured. She shared that she has never been able to forget what happened recalling in particular the day she became pregnant, which she associated directly with this act of sexual violation:

> "*I know the day I got pregnant because it wasn't nice I don't think it was rape, but it wasn't nice it's burned into my memory…I don't think it was rape, I mean, I consented to having sex, but I didn't consent to having degrading sex left me crying...I had sex with him when I got pregnant it was [date], he was very aggressive, and I was crying and then he walked away and said, I thought you were into that rapey thing you know, I don't know what he would call it*"

Through the lens of coercive control, this account illustrates how sexual violence was used to dominate and dehumanize her, with lasting emotional and bodily consequences that extended far beyond the moment itself "*It was very aggressive, and I was crying, and I was face down like I consented to sex, but not to the way had happened, and I was left crying I'll never forget it*"

Although she technically gave consent, describing it as degrading and aggressive reveals that the experience was deeply harmful and left her feeling violated. This suggests a coercive dynamic, where power and aggression are used in intimate contexts. The fact that it left **Willow** crying and feeling degraded points to a profound emotional disconnection between what was agreed to and what was experienced. While she may not have verbally refused, the experience left her feeling violated and diminished, particularly in the context of power and coercion.

Following the participants' narratives on coercive control, they emphasized that the control never truly ends, instead, it shifts from one form to another after separation. This leads to the second Group experiential theme as Post-separation coercive control.

6.2. Post-Separation Coercive Control (GET. 2)

A key theme that was highlighted consistently across interviews for me as a researcher was the notion of ongoing abuse and control, particularly in their post-separation lives. Given the continued nature of this abuse, I have chosen not to confine their domestic violence experiences to a specific time frame, as it reflects the participants' realities of abuse persisting beyond the initial separation. All the six participants who experienced post-separation coercive control after leaving an abusive partner explained that abuse does not stop when they left the abuser. Contrary to societal assumptions breaking abuse chains by leaving abuser is a myth. Additionally, five participants have been in contact to the abuser because of their children and child custody.

Threats, harassment, stalking, and other forms of control and coercion were significant aspects of the abusive actions that continued after leaving the abuser. Following quotes captures the ongoing nature of post-separation coercive control, highlighting how it extends beyond the relationship and into the survivor's attempt to move forward. Participants' accounts revealed that post-separation contact often became another arena for manipulation, intimidation, and surveillance, illustrating the enduring reach of coercive control in their lives.

Rose recalled that after separation, she still experiencing sexual violence as she has forced to have sex with him like a reward or pay to him to keep him under control. **Rose** said that healing from domestic violence is not possible as experiencing ongoing coercion and control like forced sex by the abuser "*the sexual violence got a lot worse… there's still healing that needs to happen and so that's why sometimes it's difficult because it's the past but it's not we're still living with this man [children are connection between them]*". By reflecting on "*we're still living with this man*" they have remained in contact with their abuser because of children, **Rose** highlighted the pattern of domination continued beyond separation, showing that coercion and control can persist even without cohabitation.

Notably, **Rose** expressed that abusive partner physically marked her to show the power and control on her "*The last time I had sex with their dad [she meant abusive partner] he had like marked me like he put his teeth, he like he made sure there was markings because he's like your mine. I own you it's like I was his property, and I needed to be like marked* ". The act of **Rose**'s abuser marking her after their separation was as a deliberate assertion of dominance, symbolizing his perceived ownership and control over her. This behavior served as a physical reminder of his authority over **Rose**. It was an attempt to diminish her autonomy and identity, reinforcing that she remained under his control both physically and emotionally.

Elizabeth. M experienced stalking via social media. She felt threatened and she wanted to do legal action as she had this experience in one of their breakups:

> "*Legally speaking, I definitely thought about getting a restraining order just in terms of like, I didn't think he was necessarily goanna come back into my life, but I've had previous experiences where he had felt so desperate that he started social media stalking me and started trying to contact me through all*"

Katie was frustrated by the continuous stalking by her abuser. She explained that even with a protection order, there was still a threat from the abuser. She stated that the law did not hold the abuser accountable for his abusive behaviour, and she felt unprotected "*the stalking, the stalking still continues to this day I have a protection order on him, and he still drives by our house at least once a week... nobody will hold him accountable, and so he just keeps stalking us*". In **Katie**'s narrative the unpredictability of being followed, watched, or contacted to sustains fear and anxiety over her and reminding her and her children that autonomy is still restricted and they are not free even after separation.

Willow described her situation as being trapped in her abuser's grip. He has been using stalking as a coercion tactic for 10 years:

> "*We're being stalked we have a stalker...what he does is he comes and parks outside our house when my daughter is here, he doesn't do it when I'm alone, only when my daughter is with me but he will park outside for hours and hours, and threaten and writing [send text message]...he would walk around my place, walk around all the doors and windows, and knock on the doors and windows...so, I started to live with all my curtains covered in, my*

doors locked…so he will sit outside my place in his car for hours and send text that say stop hiding"

The abuser's stalking eroded **Willow**'s sense of safety by invading spaces that should have been secure, such as their homes. This intrusion demonstrates how coercive control collapses the boundaries between private and public life, leaving survivors with no place of refuge.

Willow also felt trapped in the wheel of coercive control which created by her abuser and has not any choice to flee. **Willow** described post-separation coercive control through the theft of her dog. By taking her pet, the abuser not only inflicted emotional pain but also reinforced his ability to intrude into her life even after the relationship ended. This act illustrates how post-separation violence operates symbolically as well as practically using cherished relationships and possessions to maintain power, cause distress, and undermine the survivor's sense of stability and safety:

"*He builds so much power over my life, you know it's a form of entrapment I can't make any choices I can't do anything there's no where I can call for help we literally have a stalker who attacks the door…he even tried to steal my dog and the police help me get my dog back, but not my daughter*"

Furthermore, **Katie's** abusive partner utilized ongoing financial control as another tactic of abuse. She describes how the abuser manipulated child support payments as a means of exerting power, using financial dependency to maintain control over her and the children even after separation. In this way, what should have been a source of support and stability became another mechanism of coercion, reinforcing his dominance and prolonging her vulnerability "*He keeps pounding us, and he doesn't make an effort to see the kids anymore…he's very narcissistic and it's just it's like control...even the financial abuse he's not paying child support*"

Like **Katie**, **Sasha** is also experiencing ongoing control after separation. In her lived experience, children have also been used as tools to control and abuse her. He denied the children's health issues, not out of ignorance but as a way of asserting that his authority must prevail over her concerns as a mother. This demonstrates how post-separation coercive control extends into parenting, where decisions about children's wellbeing become another arena for domination, forcing women to navigate conflict and undermining their autonomy in caring for their children:

> "*He still the coercive control...he refused medical treatment for the kids he refused right like all medical treatments for most of the kids like, if he just refused to allow them to have surgeries, he refused to allow to have dental procedures done so the abuse continues with it when you leave*" ***(Sasha)***.

In addition, **MAE** experienced post-separation violence in multiple forms, similar to other participants. Stalking and harassment were among the coercive tactics she endured after the separation, Even when faced with charges for stalking and harassment, the abuser continued to use coercive tactics to assert and impose his power and control:

> "*That's a story that's a long yeah, but he he was charged in [year], and with stalking and harassment online and that's also been a shit show, and you know, he's driven by the like he's driven by the house here a lot and I'm very close to him, still physically we're in the same community that's really hard I know sometimes like he'll not supposed to but not supposed to be near but…*"

Alongside this **MAE** described that her ex-partner used coercion and exerted control over her and their children by navigating the judicial system and by abuser's lawyer:

> "*Knowing what I know now, through that process, women are really uninformed going into it and it is a mess it is a… it is a system that is not made to protect abused women and children at all and yeah, that abuse continued through the system with a lawyer helping him right*".

Therefore, **MAE** believes that coercion and dominance by the abuser never truly ends only the form of control changed "*As they never let you go, they never let you…they never want to release that control, so anything they can do to keep bringing you back in they will do*"

The next group experiential theme (GET.3) that emerged was based on how participants perceived their experiences of domestic violence as trauma. Rather than focusing on clinical 'symptoms' or formal trauma discourses, their narratives revealed the everyday ways they made sense of trauma through simple examples, personal reflections, and the feelings they articulated in their own words.

6.3. From Experience to Understanding: Seeing Domestic Violence as Trauma (GET.3)

This theme reveals how participants made sense of their domestic violence experiences as traumatic, with a profound impact on every aspect of their lives. From this point onward, I will use the term 'DV-related trauma' to describe the trauma that participants experienced directly as a result of domestic violence, as conveyed through their own narratives. This phrasing reflects how they themselves interpreted and gave meaning to their lived experiences, framing domestic violence not only as abuse but as a source of enduring psychological, emotional, and embodied trauma.

MAE explained the DV-related trauma as facing day to day coercive control like a "*form of torture*" for her: "*I mean, without doubt, absolutely, of course, it's incredibly traumatic…it's a form of torture*". She described the trauma as stemming from the constant daily manipulation and control she endured in the relationship: "*it's every single day being minimize the manipulate, it lied to every single day*"

MAE explained that the trauma had become so infused in her daily life that she was no longer fully aware of its presence, reflecting the pervasive and insidious nature of abuse and trauma "*you know the trauma built in you until you just don't even know really that it's there*". She perceived her life as a daily battle while in the abusive relationship, constantly living under the weight of control, fear, and trauma: "*I would get up in the morning, and I would go through a mental exercise…there's no escape from it from that and that's traumatic over [number of years] years*". She highlighted there's no escape as core manifestation of coercive control which deprive the liberty of **MAE**.

Rose also believed domestic violence was "torture" as she felt forced into the role of her abusive partner's mistress to protect her children, despite it being against her will. She described the enduring trauma of sexual abuse within the intimate relationship, which left her feeling terrified and powerless: "*I'm the mistress...I shouldn't even be the mistress…I was dying…I was dying. I was tortured. I was terrified I was terrified to be alive...I was terrified for my kids*". Living in constant fear and enduring what she described as torture was overwhelming, terrifying, and deeply traumatic for **Rose**.

Rose wanted to speak more about her experiences of sexual violence, yet each time she tried, she struggled to recall and articulate them because of the trauma involved. Her body language during

the interview revealed this difficulty she would fall silent, appear distracted which suggested how painful and challenging it was for her to open up about such experiences:

> "*Like I can't explain but he would come at night when the kids were sleeping and then it doesn't make sense, but I think we talked about the notion he need to train me yeah and so yeah and as much as I want to remember right now I don't… to be honest…. it would happen whenever and but he never want to get caught and so it was like I would have to like to turn on the house lights and then he knew that it was safe*"

Her narrative highlighted how sexual violence can be a traumatic and overwhelming experience, and how articulating that trauma is often difficult. While she wants remain present in the moment and communicate with others, those around her may have no understanding of the trauma she carry: "*And so even I'm trying to explain to you right now, and I don't have words, but because we need to be in contact with other people but so if you're hurt in such a cruel way how do you go about taming I guess your own fear or your own hurt*"

In the subsequent quote, **Rose** explained that the sexual violence was not only an act of force but also a form of training, where the abuser conditioned her responses over time. She later interpreted these experiences as rape, recognizing how her consent was systematically stripped away. What stands out is how this trauma became embodied: even when the abuser physically was not present, she described feeling his presence through a phone call, a reminder that the violation lingered in her body and mind:

> "*We would get into this scenario that he was training me so I would know how to handle rape and so he was my trainer knowing that now we were not going to be together forever, and so to prepare me for the real world, because I was so naive and innocent...I had to*

train to handle rape? so I would be raped in different circumstances, so I would know how to handle it…I would get phone calls at the house because he wanted to talk to the kids and the question would be, so what's your what's the color of your underwear? and then it'd be like when your underwear is touching your skin I'm touching you"

Here **Rose** expressed healing from traumatic experience like sexual violence is difficult as she struggled to articulate her experience due to the trauma it caused her with the counsellor. Each attempt to discuss it felt like a triggering event, snapping her memory back to the distressing moments, reinforcing a cycle of trauma that made it difficult for her to express the severity of what she had endured:

"*Healing sexual violence is a whole other problem yeah so, I don't think I even talk about it with counselor... that's very challenging… but yeah, that that topic is very yeah, it's challenging but it needs like the key cause it's triggering obviously but you need to address it at 1 point and how do you address by not speaking about it I don't have a solution*"

Verbalizing her experiences was compounded by feelings of shame associated with her trauma, creating a barrier to processing and healing.

Sasha described the financial abuse and silent treatment as leaving an "*everlasting deep scar*", highlighting how profoundly the emotional abuse and distress affected her: "*on all of it…there was financial, of course the financial… the silent treatment that has left an everlasting deep scar that I can't explain what that did. I don't know if there are words…glares it's really difficult*". She struggled to find the words to describe the long-lasting impact of the abuse. It suggesting that the trauma was so overwhelming that it was beyond words. Her struggle to put her feelings into words

shows how complicated her emotional pain is and the deep, often unspoken scars that the abuse has caused.

Sasha recalled the DV-related trauma in a situation when she was delivering her baby. She reflected on her memory as she did not have joy when she had baby: "*My life wasn't you know I don't even think I had true joy when I had my babies*". She continues with her partner was there physically but there were no sign of support and compassion during significant life events such as childbirth: "*like my the nurses in the delivery room told my ex to hang up his phone or leave because he was he was in the delivery room he wasn't he was on his phone talking to people while I'm going through labour and they just said, like, either shut that off or get out, how do you enjoy?...*", she felt abandoned when she needed love and care from her partner.

The absence of her partner's support during childbirth left **Sasha** with deep emotional wound , highlighting how this neglect not only undermined her well-being but also deprived her of vital emotional connection at one of the most critical moments in her life: "*that's painful to say for me, because they're my babies but that was my life so, yeah, that it causes trauma...that all causes trauma*", **Sasha** emphasized that although she did not experience physical violence, the emotional and psychological abuse she endured was even more damaging and wore her down:" *He never laid his hands on me, but he sure did beat me down emotionally and mentally as well as financially. right?*"

Katie described her abuse as both traumatic and overwhelming, noting that it triggered physical reactions in her body throughout the relationship. Her account illustrates how emotional distress translated into bodily symptoms, underscoring the profound impact that psychological trauma from domestic violence can have on a survivor's overall health and well-being: "*I had so much stress of being with him that half my hair fell out, I lost so much weight*"

Katie explained that trauma does not appear all at once but builds gradually, layer by layer, through the ongoing experiences of coercive control:

> "*There was lots of sexual abuse there was lots of financial abuse there was a lot so controlling there was physical abuse in there was a lot of mental and emotional abuse as well there was lots of cheating as a consequence as well and yeah, just the entirety of it was very traumatising…there was lots of gaslighting and so the trauma built up over time*"

Katie believed that experiencing domestic violence was traumatic experience as each incident, no matter how subtle, added to the weight she carried, leaving her with a cumulative sense of trauma that was difficult to escape:

> "*So to experience trauma as a result of domestic violence it could be it could be anything it doesn't have to be physical it could be being dragged down the hall to being raped and thrown in the bedroom and it could be cornered while you're doing laundry you know it could be when you're trying to eat supper, and he's trying to make sexual advances on you…it could be him going after the children it could be him controlling the finances and not allowing you to go anywhere it could be him going after your family and isolating you, so you don't have a support system anymore [crying]*"

This DV-related trauma led her to turn to alcohol as a way to cope, survive, and endure the abuse: "*I was experiencing trauma the whole time I just wasn't able to label it and then that's why I would turn back to drinking because I didn't know how to cope*"

To provide greater analytical clarity and to emphasise how participants made sense of trauma through their narratives, I also developed the following subthemes: Living on the edge, Detachment and loss, and Abuser as the root of the wound.

6.3.1. Living on the Edge

As I delved deeper into the interviews on the traumatic nature of participants' coercive control experiences, a recurring pattern of ongoing fear and hypervigilance became evident. This insight informed the development of a subtheme within the broader understanding of DV-related trauma as Living on the Edge. Participants drew on powerful metaphors to express their heightened state of alertness, anxiety, and emotional overwhelm, revealing the lasting imprint of trauma on their everyday lives and the enduring consequences of living within an abusive environment.

Elizabeth. M described her experience of living in constant fear and uncertainty while she was in relationship as traumatic. She emphasized that it significantly contributed to her distress during the abusive relationship. She vividly illustrated the distress and constant instability by stating: "*I was walking on eggshells for a good part of that relationship*", emphasizing the overwhelming nature of her daily existence under such circumstances.

During her relationship, regardless of the situation, she was constantly expecting that something would explode: "*No matter what we were talking about, there would be sometimes where he would just explode*", in her words, her body seemed to anticipate danger before it arrived everyday conversations carried the tension of an impending explosion, leaving her constantly braced for harm: "*and I just started physically anticipating these blow ups like every time ... I instantly get very, very fearful that something was gonna happen...so yeah, it definitely felt like I was walking on eggshells for a good part of that relationship*". Living in constant fear and unpredictability felt like "*walking on eggshells*", stripping away any sense of safety or comfort while she was in the relationship: "*And what he was doing was a huge stress so, everything honestly like I was just stressed out the whole relationship like there wasn't really a point where I was fully there was never a point where I was comfortable*".

Similarly, **Sasha** explained that living in a constant state of stress, always anticipating potential harm, created trauma for both her and her children. She reflected on how she had to remain hyperaware of even the smallest physical signals in her abuser's body to predict what might happen next. Every gesture, every behavior whether directed at her, the children, or not at all took on meaning as a possible sign of danger so they had to "*tiptoe*" constantly: "*We had to start watching like I had to watch how he held himself when he drove into the yard like how he was driving, how his shoulders and jaw were because then I could tell when he was angry…so you just kind of tiptoed".* Therefore, **Sasha** believed that not only she herself but also her child was subjected to trauma from being constantly watched by the abuser. She emphasized that they both lived as if "*walked on a edge*," always alert and preparing to protect themselves from the next episode of abuse*:* "*All kids are traumatised so when you are, and I'm trying to make my home a nonviolent situation but yes, it wasn't physically violent but when you all walk we all walked on a edge 24/7*"

As **MAE** directly stated, she was in a constant state of hypervigilance:"*Basically, I was hypervigilant every day...anything that would create stress or trigger him and his behaviours*". **MAE** explained that due to the ongoing pattern of coercion and control by her abuser, she had to learn how to anticipate what his next abusive behavior might be, also her reflections illustrating how domestic violence embeds trauma not only in the mind but also shaping how she moved, thought, and reacted to her surroundings:

> "*I learned over the years to see ahead...what was coming and what was going to make things worse so, for example, trying to figure out how to get the garbage out of there before he would go through it and escalate around garbage...things like finances, I learned and took me a while, but I learned"*

Rose employed the "*pins and needles*" metaphor to explain her experience of residing in a state of endless anxiety within an unpredictable and distressing environment: "*like he...everything was just like the pins and needles in the house, and it was just so bad* ". **Rose** articulated that the DV-related trauma continued even after separation, as the threat and terror remained constantly present. Every moment carried fear whether thinking about finding a job or caring for her children because of the possibility that the abuser might retaliate. For her, separation did not end the violence, the ongoing presence of post-separation abuse meant that the element of terror never disappeared:

> "*Just because of the fear element and the terror element…the time like goes on for so long that it's like even today, like looking for a job like, I'm still questioning when is the next attack? so people trying to say, well, we understand your past, but it's over but I was like do you really know it's over?*"

Rose describes her experience of living with domestic violence inflicted by her abusive partner, who was also a police officer, showed how this intersection extended into her trauma, shaping the way she carried and understood it. She emphasized the ongoing trauma and abuse resulting from the unpredictability of the judicial system in conjunction with the power dynamics associated with her partner's professional status. She highlighted that her abusive partner continues to exert coercion and control over her, leveraging his power to escape compliance with established rules and regulations:

> "*I want to say the trauma continue because nothing seems to be following any rules even if like as we went through the legal system it was still not following rules there was like what you call it exceptions it's always it was always an exception or oh things should have gone this way, but it went that way and I would learn about it after the fact*"

Rose emphasised that that's why her domestic violence experience has been traumatic: "*I believe it's traumatic because what was traumatic is everything that happened was it against everything I believed in*"

Katie outlined the hypervigilance as "*I'm always on edge*", she emphasized that her response was not confined to the past, but an ongoing reaction to the continuing violence that persisted even after This underscores the lasting effects of DV-related trauma, which stripped away her freedom as well as her children's, leaving them to grow up in an environment marked by fear and constant unpredictability:

> "*It is so unnerving, and I'm always on edge I'm always hypervigilant I'm always looking over my shoulder, wondering what's goanna happen I can't let my kids go play freely outside because I'm scared if he's around, or if he's lurking, you know there's not that freedom*"

Katie described feeling trapped by the abuser and experiencing DV-related trauma in an unsafe environment. She felt there was no escape, as he stalked and followed her and their children. This sense of entrapment and isolation both of which **Katie** identified as elements of coercive control made her experience deeply traumatic:

> "*Being trapped in his house, being isolated and there's still that element of coercive control, because he's still following us around even though he's not physically a part of our life but there's just no escaping there's no escaping and I don't know what to do, because I'm trying to keep my kids safe*"

Another aspect of feeling unsafe became apparent to **Katie** as she endured the trauma of sexual violence. The lasting effects left her in a constant state of terror and created a pervasive sense of

vulnerability in her daily life. She identified her abuser as a sex addict, which, in her view, made the environment even more unsafe and intensified her trauma: "*And yeah, the sex addict, the dominance and yeah, just nowhere was safe...I was just I was so stressed out living with him and being raped all the time like serially raped all the time*".

In her account, **Willow** echoes the pervasive sense of threat, fear and her DV-related trauma as, being on "*just to constantly be on high alert to anticipate the next thing*" She also pointed out that DV-related trauma affected her physical health, and that being judged or pathologized because of her domestic violence experiences only deepened the trauma. For her, domestic violence was not only a traumatic experience in itself but one that continued to shape how others perceived and treated her: "*to have my physical health suffer to be judged by people to be pathologized for being the victim of abuse*"

Willow's narrative sheds light on the multifaceted trauma experienced as a result of ongoing threats from the abuser and the challenges encountered within the institutional response:

> "*I didn't want to...I didn't want to live through it what I just wanted to break from it it was an onslaught who threats at every angle every direction.…I'm one person. I'm just one person like the horror of being threatened with your child repeatedly, and then victim services, police and child welfare are all going after you, too, the whole government, it was a lot…a lot*"

Willow primarily experienced post-separation violence as her partner's persistent stalking and harassment. Prior to her abusive relationship, she felt more at liberty and less fearful. However, after experiencing domestic violence, she is constantly uncertain and afraid of being watched by her abuser. This indicates that she has had to redefine her safe spaces as a result of DV-related

trauma: "*I was too naive to be afraid...very too naive …now absolutely terrified now look every time we've talked, I'm in my bedroom it's because it's a safe it's like a crutch for me it's a hiding thing*"

In the following narratives on how participants explained DV-related trauma, many emphasized that enduring such trauma left them with a profound sense of detachment and a loss of identity, which will be further illustrated through the narratives of **Elizabeth. M**, **Sasha,** and **MAE** in the upcoming quotes.

6.3.2. Detachment and Loss

When asked how they experienced coercive control as a form of trauma, participants often spoke about a growing sense of detachment from themselves. They described feeling separated from their authentic identities, as though parts of who they were had been pushed aside or silenced. This subtheme of detachment captures how coercive control gradually pulls individuals away from their true selves, leaving them emotionally adrift.

In her account, **Elizabeth. M** reflected on how, during the abusive relationship, she felt disconnected from her authentic self because of the abuser's persistent coercion, control, and constant questioning and she coped with living under constant stress in an unpredictable environment created by her partner:

> "*I found myself to be completely distracted and detached from all of my other relationships with other people…my school studies, like my eating, my sleeping...all of this, like it very much was discounted to the side which I mean I think I just replaced with stress in my life, and I just I became obsessive in a lot of senses over that, just because again, I was like*

stressed out all the time that basically a big bomb was going to drop and that's something that was going to happen, and it was going to be upsetting and terrible"

She explained, in a metaphorical way, what it meant for her to come out of that relationship, capturing the depth of disconnection and the struggle of reclaiming herself: "*So coming out of that relationship it was kind of like hitting rock bottom and rediscovering who I actually was, because I was so dissociated from who I was*"

Elizabeth. M recalled that her responses to DV-related trauma included addiction and suicidal thoughts, describing the experience as feeling unlike herself as though she had become somebody else entirely:

"*I didn't even recognize myself coming out of that relationship like I never thought I was going to be somebody that, for example, dealt with addiction, or I never thought I was going to be somebody that really, like whatever act on suicidal ideation…I know I had self-harmed in the past, but I never really thought that that was going to become like such integral parts of who I was, and it really felt like that was who I was leaving*"

Following her separation from her abuser, she began on a journey of rediscovery and exploration of her true self to rebuild her life on her own terms: "*So it's been a lot of like rediscovering myself and rediscovering the trust in myself that I did not have at all*"

Sasha felt a profound loss of self-identity as she expressed her desire to regain her pre-abuse persona and her pervasive feeling of detachment from her true self, which was a result of enduring DV-related trauma to survive while she was in abusive relationship: "*I wasn't who I wanted to be... I wasn't who I needed myself to be.. I just survived and that is the only description I did* "…. She

recalled seeing herself at that time as "*gray mush*", capturing the sense of numbness and loss of clarity she experienced "*it was gray mush!*"

Likewise, **MAE** reflected on this detachment as a loss of trust in herself, explaining that he had 'snowed' her at the beginning of their relationship. She expressed that this loss of trust extended beyond herself, shaping how she saw the world around her: "*who's to say that couldn't happen again?*"....The ongoing manipulation eroded her identity and fractured her understanding of the world around her: "*Trust in myself to see it, because he snowed me at the beginning...and who's to say that couldn't happen again?...he's really good at it…he is a really masterful manipulator* "

DV-related trauma contains the experience of loss for **MAE**: "*Trauma is a loss of...lot of my support friends…there's no trust, is really hard I guess that's what I'm trying to say…trust is really hard. because ha! how do you trust* ", also includes the loss of self-belief stemming from her decision to remain in an abusive relationship in order to protect herself and her children. This trauma may manifest in feelings of blame and guilt and loss of trust: "*How do you trust yourself after … so you know [number of years] years of my life with this tied up with this man, and I chosen...I know that blaming myself is not constructive but they're still part of my brain...but I also subjected [number of kids] kids to him*"

In addition, **MAE** highlighted that her self-worth was diminished by the abuser, who made himself the center of the relationship. She felt she had to satisfy his desires and diminish herself to survive: "*I think your self worth is gone, you don't have any sense of your own…the all of space or and everything's hijacked all the time...everything's about him...you don't matter in the in the big picture*"

Further, under the central From Experience to Understanding: Seeing Domestic Violence as Trauma (GET.3) , participants identified the abuser as the source of their trauma showed a clear understanding of the direct connection between their domestic violence experience and the psychological, emotional, and physical suffering they experienced. In my discussions with participants about DV-related trauma, I noticed that they consistently identified the abuser as the source and trigger of their trauma manifestations when narrating their stories. From this, the following subtheme emerged.

6.3.3. Abuser as the Root of the Wound

By recognizing the abuser as the cause of their trauma, participants emphasized that the coercive control they endured were not isolated incidents but consistent patterns that significantly impacted their lives and led to lasting DV- related trauma. This highlights that, for these participants, DV-related trauma was not just an internal struggle but an externally imposed trauma, underscoring the abuser's role in damaging their emotional, psychological and physical well-being.

Here **Elizabeth. M** described experiencing a sense of relief upon exiting the relationship and gaining awareness of the abuser's role in her trauma: "*It's almost like I was in this intimate relationship, and once I got out of it, it was a huge relief off my shoulders*". Thus, in order to keep her relief, she had to cut off all connection with her partner: "*Like he and I have completely detached…I'm like I'm no longer even friends...I had to basically like cut off all of the connections that I had with him*"

It appears that her partner has been the primary cause of her distress and traumatic reaction such as panic attack and suicidal thoughts: "*Because anything anything that reminded me of him triggered panic attacks, triggered flashbacks, and triggered suicidal ideation for me…. so I really*

had to kind of cut all of that off and having done that is definitely helped me in terms of the panic attacks have been like a lot less frequent…I don't feel like I don't feel suicidal anymore"

In the following quote, **Elizabeth. M** described how seeing his picture re-traumatized her and led her to use coping strategies such as dissociation or using drugs to distance herself from the source of pain and trauma triggers*:*

> "*It's not something that I struggle with continuously but I know that if I were to see him, if I were to get reminded of him, even looking at a picture of him to be honest, like, I know that I would go right back into a cycle there's been times where I've been accidentally updated about his, what he's doing in his life from friends like they've just mentioned him in passing for whatever reason and it causes me to spiral for about a week like that's kind of all I can think about.. still like quite obsessive, not to the point of it like really completely destabilizing my life, and completely like making my life dysfunctional. But it like like definitely dissociating like crazy and those were the times that I would find that I would go back to marijuana in terms of like just trying to numb something out like just any updates of him like it's mostly not like me thinking about the situation anymore that puts me into that state but it's like getting updates about what he's doing in life that really really make me spiral out of control*"

Katie defined her abusive partner as unpredictable, which left her uncertain about how to proceed in the relationship. She experienced emotional turmoil as she was confronted with his inconsistent behaviour, finding it difficult to anticipate his actions or the consequences of his abuse*:*

> "*He was always really moody, and I wondered if he was bipolar or something…it was really hard to keep up with them, because one day he'd just be up and then down... so it was a lot of emotions and a lot of a lot of like up and down*"

She articulated that she consistently found herself in a state necessary for survival, while dealing with the abusive dynamics of her relationship. **Katie** explained that her partner was like a "*ticking time bomb*", symbolizing uncertainty and unpredictability. Eventually, the abusive partner's explosion caused high emotional and psychological costs for her, like being constantly on edge and worrying about the next step for herself and her abuser "*He's a ticking time bomb*".

Also, **Katie** added that due to constant gaslighting by abuser which is a form of psychological manipulation where her abuser makes her doubt her own memories, feeling and perceptions she called him a "*mental terrorist*", which resulted in her recording his texts and other interactions as a survival strategy for her safety and well-being:

> "*I can't understand this guy like he's like a mental terrorist like he's in my head all the time, and I can never figure out like I'm saving all these screenshots, because he says one thing and then I catch him in a lie*"

Katie continued with: "*We're tied for a long, long time, unless, like a until somebody dies unfortunately like, that's this order of existence until we're gone…*". In her explanation, she seemed visibly frustrated, as she trapped by an abuser with no evident means of escape until one person dies within this traumatic dynamic.

Sasha recognized that her abusive partner persistent presence in her life and the sustained abuse, referred to as post-separation violence, notably exacerbated her Post-Traumatic Stress Disorder (PTSD) and resulted in re-traumatization. Sasha considered this to be a complex issue because of

the ongoing DV-related trauma, which is why has been referred to it as complex post-traumatic stress disorder (CPTSD: "*it's called complex part…complex PTSD*"…In reflection by **Sasha** coercive control 'is never done' and it continues even after separation "*it's a continuation like it's never.. intimate partner violence is never done*"

Because of the children, **Sasha** was required to remain in contact with her abuser and see him when interaction was necessary. She explained that these interactions involved subtle yet intimidating behaviours, including threatening looks and the deliberate use of silence and disregard as forms of control: :

> "*For example, I drop my boys off with their father out now, right? now it's interactions between us… I had to give them the kids report cards, and I have passport application forms that I need them to fill out and bring that to me , I opened up my door to my car, as soon as I opened up the door to my car he put his window up, so I stood out there and had to go, excuse me excuse me, and he just, and the look he gave me, and I took three steps back because it's just the look like that's all it is*"

During the divorce proceedings, **MAE** was faced directly with her abuser in court, an experience that led her to believe that she was confronting the source of her trauma. She articulated that as a result of the re-traumatization associated with domestic violence, she experienced functional impairment and showed symptoms signifying post-traumatic stress disorder (PTSD), such as panic attacks:

> "*So more panic because I'm terrified of.. I have to face him now physically...I have to go to court, and I have to sit in a courtroom with him over there, and I was just terrified, like just nonfunctional, terrified that the fear just escalated and ran away*"

During the research interview and discussions on the legal proceedings, **MAE** revisited court documents and evidence. She notably referenced the term "*kick-me*", which indicates a re-traumatization as she engaged with the papers and recalled the "*brutal*" incidents: "*I pulled those out after our conversation last week, and I read them, and they're just kick me. It's they're brutal like they're incredibly articulate and brutal to read* "

Willow expressed that having the abuser still present in her life continues to experience ongoing trauma as she is nearby and in the same city as the abuser, who was a persistent stalker and abuser: "*a safe environment for me, personally, it's distance from him*"

Rose has reflected on the abuser as the source of her trauma. Despite being separated, they are in contact because of their children. **Rose** has previously articulated that one of the main abusive behaviours by her partner has been toward their children. The children are still in contact with their father and feel they have no option to disobey if they don't want to see him. This connection makes **Rose** re-traumatized, as she remembers all the abusive incidents towards the children. She believes that abusive partner (children's father) imposes coercion, control, and emotional abuse towards the children, as evidenced by specific examples she provided during her interview:

> "*They visit their father and I'm trauma...I want to say it's triggering even though it's been a long time I'm still not at peace and so I think that has to do with the trauma never finding peace... I think it's traumatic that when there's an incident where the kids are the visiting him and he doesn't bother spending time with them and that's triggering for me… you don't see them for two weeks you expect them to go visit you but you're not there so they're visiting your empty apartment and my kids are old now and you would people say well they don't have to go see their dad but how? they were never allowed to have another opinion and so even though they're [age of children], they still visit him*"

Therefore, **Rose** has been experiencing ongoing emotional distress and feelings of insecurity due to the abuse towards children exerted by the abuser specifically when children are with their father:

> "*It could just be feeling unsafe and so if they are sick who's gonna look after them so that's triggering because their well being is not looked after and so when their well-being is put into question then that's a trigger because of how their well-being was not a priority in the past*"

Rose believed that the abuser did not care about the children's best interests, the only thing that mattered to him was maintaining power and control over her and the children: "*every time he would take action I take another decision it would be triggering for me to know that he's still using his power not in the kids best interest, but just to be in power*"

Following my initial conversation with participants regarding the DV-related trauma and how they understood their domestic violence as traumatic experience, I then asked how they personally perceived trauma by this question "What does the word trauma mean to you? Or How do you understand trauma".

For participants, DV-related trauma extended deeply into both mind and body. They described psychological wounds, physical illness, and embodied injuries as manifestations of this trauma, emphasizing that it was not something they could easily overcome, but rather an experience with lasting impact. While in the midst of abuse, many struggled to articulate their pain perhaps because they lacked the language to fully express their lived realities, or because the trauma itself was so overwhelming. Over time, in looking back, they found ways to give voice to their trauma by articulating it as embodied reactions. In doing so, participants made sense of their trauma in deeply personal and powerful ways, framing their survival not only as endurance but also as testimony.

When I asked about what trauma means in the context of domestic violence, **Rose** responded: "*I don't really know what's wrong with me just know something's wrong*". This response encapsulates a profound sense of confusion and internal turmoil. **Rose** is wrestling with a hidden but pervasive sense of distress, highlighting the often inaccessible nature of trauma: "*I don't really know what's wrong with me I just know something is wrong I didn't understand why I was so sick and eventually I would get a diagnosis of depression*"

Furthermore, **Rose** shared: "*I want to say, an empty shell I was just dead but there was still a body I couldn't do like just everything was tremendously demanding*" and "*I sometimes just felt dead*". The phrase "*empty shell*" captures a feeling of emptiness and detachment from oneself. **Rose** describes feeling "*dead, but there was still a body*", indicating a severe dissociation between her physical presence and her emotional or psychological state.

The definition of **Rose** illustrates the complexity of understanding trauma as she wrestles with hidden distress: "*it's traumatic because even after he's gone I still can't function and that's what's traumatic because I should just be able to live and let the past in the past*"

Further explaining her experience, **Rose** compared trauma to poison. The metaphor of poison illustrates how keeping traumatic experiences bottled up exacerbates their detrimental effects, likening it to poison that intensifies when left untreated. This metaphor captures the sense of internal toxicity and the urgent need to expel these destructive emotions:

> "*I can't I can't there's too much to bury anyways and it's poison that's why we call it just poison…this discussion it just remind me of back when I started going to see a therapist, I would feel so awful, so awful I I compared to like throwing up.. because I had silence for*

so long that when I was speaking oh, I was nauseous I was not at what was coming out. oh, it was reminded, and so I was like, but after you throw up you feel better"

In **Rose's** perspective trauma can manifest physically as sickness, and these bodily reactions highlight the profound impact of trauma on her body. For her, the strength of this response showed up in the body itself, as if it was pushing her to get out:

"*Trauma was very like the concept best way I could like physically explain it when I started getting help when I would see someone and they were asking me question it was like I was gonna throw up I was like physically not well…my stomach was not good I was shaking everywhere… it's like it becomes physical that's how I explain a trauma sometime there's a delay but it's so strong that it's not just in your head it's like you're physically sick to what's going*"

Rose's repeated confusion about "*what's wrong with me*" highlights the pervasive obscurity and complexity of trauma: "*You don't know how to explain this to doctors I'm like what's wrong with me there's something wrong with me I don't understand* ". Here again, **Rose** spoke about how the trauma surfaced in her body through the physical sensations and reactions she carried and how she explained it to the doctor: "*And I said like my taste and the food I ate was bitter like my my taste was had changed…is it such a trauma that my body is reacting to all the food I'm putting in my mouth*".

However, without validation from the doctor, she doubted herself and feared she might be losing her mind: "*But if the doctor or not confirming, then I just well, I'm crazy I must be crazy…I'm really losing it*" However, she made sense of trauma in her own terms, explaining it through the physical sensations and reactions she experienced in her body: "*But I want to say all this is because*

trauma I guess makes you get out of your body". **Rose** started keeping a record of the domestic violence she and her children had gone through. Writing about it helped her understand the full extent of what she'd been through. However, seeing it all written down made her feel intense *anger* and *rage*. In just one week, she had suffered a lot of abuse. The anger and rage she felt started to show up as physical symptoms, which she connected to the DV-related trauma she had experienced. She considered trauma as something foreign that she needed to throw u*p* to feel better metaphorically:

> "*I write and then the second is like, oh, my God! Like how is this even like I was just outrage that I have to put this on a paper and there was like several incident in one week and it was like for me to admit this it was like outrageous and that I was still not able to make and stop,…after I felt better, so it was like I compared to throwing up so when you throwing up you feel awful…but after you're done throwing up, it's out of your system and you feel better...so that was my idea of like...cause I mean it was such a foreign concept and so that how that's how it played out physically for me*"

Rose highlighted that she noticed "*something wrong*" in herself. However, she did not have any label for her emotional turmoil. She blamed herself for experiencing these feelings and circumstances:

> "*Something was really wrong with me and think it was what the isolation only made it worse there was something really wrong with me…I want to say I fought as hard as I could to figure what's wrong with me, so my kids could be better my family could be better…I didn't see it myself I didn't understand it myself I really was angry that I was sick at myself like I didn't put the blame on others*"

During her relationship, **Rose** sought the assistance of a therapist to address her emotional and psychological distress. The therapist recognized her 'symptoms' as depression "*the first therapist she met me once, and she said, well it's like postpartum depression but since your baby is a little over a year it's just a full-on depression*", while they could also be interpreted as manifestation of trauma resulting from the domestic violence she endured.

Also, **Sasha** explained how the trauma caused by domestic violence leaves an enduring mark not only on the mind but also on the body. This imprinting manifests in various ways, as **Sasha** describes "*You can't you gotta learn how to cope because it sits in your body...it does like I can feel it when I talk about it my body does things it's not just in your head, so you can't just get over it and get through it and get beyond it* "

Sasha's statement highlights how deeply trauma can become embedded in the physical self**,** creating a constant, tangible reminder of past abuses. The chronic stress and trauma from domestic violence often have severe repercussions on physical health:

> "*So that stresses I don't know how to express it's it's a very internal thing I fully believe why I have my liver issues I fully believe that's why I'm being tested for my autoimmune disorders I've had a diaphragmacurnia that needed to be repaired I've had my gallbladder I would have had digestive issues like those are I fully believe living in that constant feeling like you are so tightly wound… the the stress of that does damage to your body so there's the… there's that physical stress as well* "

The correlation between psychological trauma and various health issues, such as liver problems and digestive complications, vividly illustrates how DV-related trauma affects physical health. **Sasha** has been reflecting on the various ways trauma has manifested physically in her. She

experiences chronic sleep deprivation, which has led to health issues. The trauma she experienced due to domestic violence continues to deeply impact her ability to sleep, eat, and maintain her overall health:

> "*I wasn't sleeping. I was maybe getting an hour of night wasn't sleeping… it was it was a crash like I crashed…I couldn't eat because it hurt you know like and I'm still like I still have my flare ups not of that now it's my liver that would be like so, the auto immune disorders your body really does tell you like when I think back, your body does tell you you've had enough you need to look at it right I really do believe that* "

In this quote, **Sasha** emphasizes how trauma can lead to significant memory issues and physical reactions, such as shaking, highlighting the ongoing struggle to manage daily life amidst the ongoing effects of trauma:

> "*So part of it is I don't remember a lot of stuff like my mind my memory has been … it's almost like somebody put something icy up my spine, and I literally shake from the inside out, and I can't calm down*"

MAE is another survivor who provides a mournful reflection on the nature of trauma experienced through domestic violence. She articulated that "*something is happening to you that you can't control… you can't stop it*" and reflected that in her view, DV- related trauma is different due to the trapped and inescapable nature of DV-related trauma. The inability to control or articulate the trauma, combined with the pervasive feelings of pain, isolation, illness, and fear, illustrates the profound and lasting impact on **MAE**'s life:

> " *I mean when I first heard it…I first began to talk about it in reference to both myself and the kids...to be honest, I just encompass all of those things like you're being something is*

happening to you that you can't control. you can't stop it you can attempt to navigate your way through it but it's also not like there's something deep in in this, like, I think, in the psychology of trauma with domestic violence…you can't get rid of it…you can't quite articulated like it for a long time I couldn't even speak it and so it's something that you carry you can't escape it it's a lot of pain, and it's a lot of isolation and a lot of illness, a lot of a lot of fear tied in with that word, and you know panic… panic attacks and dreams nightmares"

MAE compared the trauma she experienced as a result of domestic violence with the trauma caused by a school shooting. While both were devastating, she explained that trauma from coercive control was unseen and not visible to others. This invisibility made it far more difficult to articulate, seek recognition, or access support, especially when compared to trauma resulting from an event like a shooting, which is publicly acknowledged and validated:

"*Because let's say you know let's say you're part of a school shooting, and you live in the States, and my God, or even in Canada…there is a definable there is the moment, and there is an act that has happened to everybody sees, too and you can get support for this kind of trauma feels like that to me*"

This analogy by **MAE** stresses how trauma, regardless of its specific nature, profoundly influences daily life. However, **MAE** emphasizes that the trauma of domestic violence becomes a tangled part of one's existence, requiring ongoing effort and work to address and manage.

MAE reflected on the intrusive nature of DV-related trauma, noting that even after leaving the abusive relationship she could still be triggered and drawn back into traumatic memories. She emphasized the difference between this and other types of traumatic experiences, explaining that

DV-related trauma is embodied in everyday life, just as coercive control becomes embedded in the daily existence of those who endure it:

> "*And I think that the trauma is different because it encompasses almost every act of your day, and it is astonishing, especially at the beginning, coming out of the relationship how you can't get it out of your head…we didn't have a gathering… where we didn't talk about him and his family for some years...it's like they're in there you can't get them out and when you talk to other people they look at you like could you let it go? you're not with them anymore and it's not like that it's inside you*"

MAE elaborates on how this DV-related trauma marks every aspect of her life. The following quote captures how trauma casts a long shadow over everyday life and family interactions. Despite moments of relief, the trauma remains a constant, underlying presence that impacts all aspects of family dynamics and personal well-being:

> "*We could be sitting having a family meal and one of us will bring something up that it will trigger a memory of something that happened, or something that happened regularly or once in a while...that's every aspect of life for me, especially you know, having children, so that encompasses not only my life, but their lives in our lives when we're together so it takes all the family stuff, and you know, puts this shadow over it, and there's liberation from not having that shadow in the room with you, but it's still in the room with you*"

MAE described her deep inner scar of trauma as feeling "*dead inside*". Feeling "*broken*" or "*dead inside*" indicates emotional numbness or despair, potentially arising from DV-related trauma "*it was just I felt at that point like I'm goanna die here like I just felt so that inside I felt dead inside and I'm broken so broken*". She employed the metaphor of the "*frog in the frying pan*" to clarify

the dynamics of her experience with domestic violence and the development of DV-related trauma during her exposure to abuse and coercion:

> "*You know this analogy the Frog in the Frying Pan and that trauma just it grows, and it builds, and it builds until you don't even know where it begins...you are that frog in the frying pen...I was so completely broken and numb at the end just I didn't really care what happened to me…I was so numbed out I was so just completely broken, and then to come out of it* "

In **MAE** statement, she emphasized that she did not understand the internal turmoil she was experiencing, attributing it to the lack of a specific label. Only after leaving the abusive relationship did she recognize that her distress was caused by her abusive ex-partner behaviours and DV-related trauma which helped her to identify and understand her shattered and numbness state:

> "*It's like a wave of everything hits you that you suddenly start to name everything and realize in a different way what you've been living…so definitely feeling that PTSD within the relationship and the trauma that's happening*"

Elizabeth. M also offers valuable insights into how trauma manifests in her life. **Elizabeth. M's** narrative concerning the trauma related to domestic violence started when she became aware of an internal irritation for which she lacked a precise label:

> "*After a while I started to see a counsellor, just because I just thought that I was just having major anxiety…I didn't really know how to characterize anything that I was going through and basically it was like, well, I don't know why I'm so stressed out* "

Elizabeth. M's reflection highlights her initial confusion and uncertainty about the nature of her distress. She sought help because she recognized that something was wrong, but it was through therapy that she began to understand the deeper issues rooted in her trauma.

Elizabeth. M describes the trauma from domestic violence as a profound imprint that deeply affects her inner self. She explains that trauma feels like a deep, enduring injury that remains a part of her, regardless of time and attempts to move on. She reflects on this profound imprint as the nature of trauma, which influences her emotional responses, interactions, and overall sense of self:

> "*I think I started to recognize that okay trauma can show up in a lot of different ways, and I think that was like a big...big way of coming to realize that that it was like affecting me really deeply which is kind of how I would define trauma is like something that I really couldn't just get over, so to speak, and like that was something that I was ruminating on and had like a profound impact on how I was like interacting with other people*"

For **Elizabeth. M**, trauma represents a profound erosion of self-trust "*I think is a trauma just having no trust in yourself, I think is a huge part that I experience*". The experience of betrayal, manipulation, and gaslighting by former partner resulted in pervasive self-doubt that extended beyond the immediate trauma, impacting her confidence and shaking the very foundation of her self-belief.

Elizabeth. M understood trauma as a profound drain on her energy and sense of self: "*think after being through trauma the world just feels like you're kind of being swallowed into it rather than being able to lead your own life*". In her view, trauma has a way of overshadowing every aspect of life, making it difficult to regain control or a sense of stability. This narrative illustrates how trauma can lead to a profound sense of exhaustion and helplessness, where the survivor feels as though

their life is being overtaken by the effects of past abuse rather than being able to lead it on their own terms.

Elizabeth. M continues by describing trauma as "*loneliness, self-deprecation, anxiety and stress*" "*I think experiencing trauma a lot of it has to do with loneliness, a lot of that has to do with again self-deprecation, a lot of its anxiety and stress, but I think the anxiety and stress are only like surface level of motions*" alongside these emotions in her view which she explained as surface for her trauma meant "*where I think a lot of what trauma was for me was a pattern of needs not being met, and chronically not being met so much to the point*" realizes that her trauma largely stemmed from unaddressed needs, leading to feelings of self-deprecation and diminished self-worth.

This ongoing neglect by the abuser not only reinforced **Elizabeth. M's** belief that she deserved mistreatment but also heightened her anxiety and isolation, highlighting the lasting emotional trauma caused by the abusive relationship:

> "*Where I was then starting to and like explain that in my own head as me deserving that and me being terrible so again, like I said, lots of self-deprecation because of chronic of needs chronically being unmet like, and then that can be like emotional needs, sexual needs, whatever intimacy needs, it especially in this in the case of domestic violence, I think those are definitely*"

Elizabeth. M directly pointed out that trauma means self-trust "*I have no trust in myself like self-deprecating that, like again, I was kind of looking to any exterior, external like any external validation*", DV-related trauma has resulted in self-blame and obsession with responsibility, causing **Elizabeth. M** to believe she is at fault for her ex-partner's abusive behaviour:

"*A lot of thoughts of you know you made a mistake you should be...you should have never broken up with him that was stupid that was crazy he was the best thing that was ever going to happen to you you're always going to be alone nobody's going to love you as much as he did so a lot of those thoughts are still stuff that I really have to deal with on a regular basis and yeah like still, how I'm experiencing PTSD even to this day* "

Willow's narrative delves into how trauma as result of domestic violence is perceived as an injury**,** both mentally and physically, and highlights the severe impact of ongoing abuse. **Willow** provides a striking metaphor for understanding trauma, describing it as a profound injury that affects both the mind and body:

"*Trauma is an injury right I know people seem to use trauma as a buzzword now you know, like but I think if you think of trauma, I don't know for me it's the medical model is so crazy to me to separate your mental health and your physical health because I think they're I think they're like they feed each other they're all the same, I mean your health is your health, but so to sustain an injury* "

From **Willow's** perspective, trauma was understood not as a vague or overused concept but as a real and embodied injury. She rejected the separation of mental and physical health, instead seeing them as inseparable and mutually reinforcing. In her account, traumatic incidents were experienced as "*injuries*" that affected her psyche, wellbeing, finances, and environment. She emphasized that the wounds of trauma are not isolated but pervasive, with symptoms that linger and prevent healing:

"So for me these like sort of isolated incidents that are so shocking that it is an injury to my psyche or my well being, or financially or environmentally, these like these incidents,

are like injurious to and I've experienced them in so many ways, and then it creates I mean I guess it's like the symptoms of the wound which are pervasive for my traumatic experiences does that make sense to you? I guess the trauma is the injury, and it's the symptoms of the injury which sort of hold you so that wounds don't have time to heal…injury or wound so I've trauma to my leg because I broke it...I have trauma to my mind because I'm being terrorized…yeah, it's a it's a injury"

Willow's description emphasizes the inseparable connection between mental and physical health, arguing that trauma should be understood as a comprehensive injury affecting both realms. Through this lens, trauma is not simply an event but an ongoing wound one that continues to shape daily life long after the abusive incident has passed.

Willow further elaborates on the nature of trauma, describing it as continuous suffering within an environment of fear:

"*The trauma for me is like the ongoing hurts in this environment of terror I don't know how I survived it all I don't know how my heart didn't stop at some point like I've been shocked over and over by you know acts of violence yeah that are so you know inhumane I guess I'm not sure if I'm explaining it but that's the best I can explain with the question I mean, I don't know how to answer it* "

This statement underscores the relentless and pervasive nature of trauma in abusive environments. **Willow** highlights how the fear and terror imposed by the abuser create a toxic atmosphere, perpetuating the injury and preventing any real chance of recovery or healing.

Willow reflects on the deep-seated effects of DV-related trauma, expressing a profound sense of fear and threat by abuser where she pointed out to the metaphor if she could take a pill to erase or

dull memories traumatic memories "*we don't play by his rules the consequences are so severe that's not a healthy environment for anyone*". She highlighted that because of her daughter and the shared custody arrangement, she could not leave her behind and therefore had to remain in the same city as the abuser "*if I could take an amnesia pill I would, if I could forget about my daughter I would if I could…*"

Here, **Willow** reflected on the deprivation of liberty and autonomy in her life, questioning her basic human right to make choices for herself a right that had been taken away by the abuser. She described these layers of entrapment as deeply traumatic experiences:

> "*This is a lot this has been going on for [number of years] years I hate my life, my ability to think choices has been taken away from me 100% and that's a that's the foundation of being a human right like if you are a human you want to have the ability to make choices for yourself I don't I don't have any choices in this world like none*"

Willow's profound reflection illustrates the intense effect of trauma on her identity and independence. The desire to break free and the sensation of losing fundamental human rights highlight the deep sense of loss and powerlessness resulting from enduring abuse.

Trauma resulting from domestic violence manifests in deeply complex and multifaceted ways of coercive control in different layers of her life while she was in abusive relationship as **Katie** describes "*to experience trauma as a result of domestic violence I think is it can definitely be instances and the compounded relationship*". Then **Katie** that the abuser's coercive and controlling behaviors were not separate from the trauma but part of it, explaining how these actions became the very source of her suffering:

> "*It could be it could be anything it doesn't have to be physical it could be being dragged down the hall to being raped and thrown in the bedroom and it could be cornered while you're doing laundry you know it could be when you're trying to eat supper and he's trying to make sexual advances on you… it could be him going after the children it could be him controlling the finances and not allowing you to go anywhere it could be him going after your family and isolating you so, you don't have a support system anymore [crying]*"

She explained that although she was living through trauma during the relationship, she lacked the language to name or make sense of her distress "*I was experiencing trauma the whole time I just wasn't able to label it*" and she referred here the manifesto of her DV-related trauma by explaining her survival strategies "*and then that's why I would turn back to drinking because I didn't know how to cope and so to experience trauma as a result of domestic violence*"

Initially, **Katie's** understanding of trauma was limited to physical injuries, akin to those treated in a trauma center "*The word trauma is taken a few different meanings over time like when I first did hear the word trauma I would think like a trauma center like someone had a bad accident, and they're being airlifted to a trauma center because they've suffered some sort of physical trauma*"

Then, **Katie** articulated that DV-related trauma is not solely about the visible bruises or physical harm but encompasses a broader spectrum of psychological and emotional wounds:

> "*It can be anything it's not just you know the physical bruises or the punches…so many different levels to it that can leave you feeling helpless and helpless and hopeless and just worthless at the same time that's what that's what it means to me experiencing trauma it can it can happen in so many different ways you know just one incident it could be, or it could be a combination of years of incidents that are just building on each other*"

Her perspective evolved through therapy, where she learned that trauma also includes psychological and emotional suffering. This realization came from discussions with counselors, who helped her to find a word and label for her experiences:

> "*That's what I assume trauma was until I started going to counselors and talking about my experience and having them put words on it that I was able to realize what was going on like I knew in my soul it wasn't right but I never knew that…so it wasn't until I started talking to therapists, and they told me like that's trauma so I grew to realize that now trauma can mean an event that you had gone through like a traumatic experience. So, it could be a car accident it could be it could be something like it like the emotional distress that I went through. you know it could be something so emotionally distressing that it's traumatic meaning that it leaves the lasting impression on your brain and your body, and you can have different memory sensations because trauma can get trapped inside you like like your body keeps score*"

For **Katie** trauma was not only psychological but deeply embodied and she explained that the body retains the memory of traumatic events, which can be triggered by similar situations *"trauma can get trapped inside you like your body keeps score"*, with the body acting as a warning system when danger felt near:

> "*So even if we might not realize it or be able to put words to it, our body will remember those things and there will be certain triggers that take off when those similar situations are happening to try and give our bodies warning that you know something doesn't feel good about this and we should be careful or you know try and be safe or get out of it so that's how I view trauma I feel like it's an experience that happens to us…that is just so beyond our comprehension that our body remembers it and our brains remember it,*

because at the time it's just so much to comprehend and then that's why our bodies get triggered the way that they do with certain things and when I think of a traumatic event"

Katie used the striking metaphor of an asteroid hitting a planet to convey how traumatic experiences leave lasting craters in both mind and body, impossible to erase. Reflecting on her own experience, she recalled:

"*I definitely go back to that morning laying in my bed when [abusive partner] had message me…saying he wanted to go to [city name], and just how it went from being so elated to just being so distressing immediately after and it just it left such an impact like almost like when an asteroid hits a planet kind of thing, it leads creators like it's left an impact that memory is driven so deep into your body that your body remembers it because it's left such an impact on you and then it's something that we never really do away you know, there's lots of work and for me, anyway, like I I still remember that morning like it was yesterday*"

She connected this to what she called "*mental terrorism*" explaining that the accumulated impact of trauma had already contributed to a stroke, complex PTSD, and other serious health effects. Through this perspective, trauma emerges as a profoundly embodied wound, where the psychological and physical cannot be separated, and where the legacy of coercive control continues to reverberate in the body long after the events themselves "*And all of this mental terrorism it's affecting my health, you know I've already had a stroke I've already got C. PTSD you know I've all these things manifesting in different health outcomes as it is and it terrifies me*"

Despite engaging in various forms of therapy, including talk therapy, Cognitive Behavioral Therapy (CBT), and Dialectical Behavior Therapy (DBT), **Katie** shared that trauma's effects

continue to influence her life significantly. She noted that trauma does not simply disappear; it persists, impacting her health and emotional well-being long after the initial events have passed:

> "*Even in saying that I've gone to therapy and done lots of talk therapy and stuff like that, and CBT and DBT, and I still like it still bothers me a lot and for me I guess that's what trauma is because trauma is something that sticks with you it's not something that just goes away or passes [crying] it's something that's left such an impact on you that you still feel it no matter what you seem to do it's still it's still there, because it's left such a dead* "

Katie also perceived that there was an issue with her, as her family and support system did not believe that she truly needed help and was feeling suffering as a result of domestic violence: "*But my family and anyone that I would talk to would just be like oh well suck it up everybody has their story and you know just really minimize what I was going through and so it was kind of shocking when I got it…the next part I felt like I kind of felt like a stigma like well here's what's wrong with me so this has been it like this is what's wrong with me*"

The theme From Experience to Understanding: Seeing Domestic Violence as Trauma (GET. 3) was further developed through the identification of additional subthemes to provide greater clarity and analytical depth. These subthemes include the following: Shame came before trauma was named, and Finding words for the inner experience.

6.3.4. Shame Came Before Trauma Was Named

This subtheme captures how participants experienced shame as an immediate and powerful emotion that emerged even before they could recognise or name their experiences as trauma. They explained shame as one of the manifestations of DV-related trauma which considered here as a protective response to DV-related trauma. This early and pervasive feeling of shame often silenced

their voices, leading them to internalise the abuse and blame themselves for their partners' violent behaviours. It also made it more difficult for them to seek help or to situate their experiences within a broader understanding of domestic violence and its psychological impact.

As **MAE** stayed silent about the domestic violence because of the shame she carried, having internalized the abuse and come to believe it was her fault "*I didn't share a lot because…it's too hard when you're in it to tell people just there's too much shame involved with that [Silence and thinking gesture]*"

She faced isolation and did not seek help or support, as in her view, reaching out for support meant admitting she was experiencing domestic violence and that, to others, would mean she was 'stupid' for tolerating the abuse instead of leaving. This internalized victim-blaming entrapped her further, preventing her from fleeing:

> "*But you don't ask for help because asking for help means submitting that you're living with an abuser...what an idiot you are for doing that! and I know that in a brain level but here I can't go…I think this this shame is again almost like in your like hind brain while it's happening…but I'm choosing to stay…that's where the shame comes in if I say this is all the shit we're living…and then I have to tell someone that…I couldn't I admit that and own it…because you feel like you should have been smarter and I am an emotionally aware person*"

She reflected on how women's voices were often taken away by a society that perceived coercive control as something minor. This societal minimization enforced silence and further entrapped women in abusive relationships, as they were not believed. For her, this disbelief and isolation were deeply traumatic experiences "*the ability to have a voice is taken from you, because if you*

try to have a speak up and have a voice about something as minor as the garbage or you're pummeled and emotionally your know there's fear"

Rose also experienced shame manifestation of DV-related trauma. She expressed the same reasons as **MAE**; due to social stigma and victim-blaming by society. **Rose** sarcastically remarked that one never discloses domestic violence when seeing someone in a store because it is an unknown concept and awkward:

> "*There's a lot even if people talk about it there's still a lot of secrecy and the shame so it's very lonely because you won't meet somebody at the store say I haven't seen you a long time...oh, yeah, you know there's domestic violence going on at the house I'm fine now you you never talk about it*"

As discussed before, when **Rose** noticed her emotional turmoil, she reached out to a therapist who gave her the diagnosis of depression. Now, she stated that the shame related to domestic violence and trauma was causing her to experience depression "*that's why it's even worse because there's this shame and the secrecy and it's also in tangle with mental health so yeah I was diagnosed with depression*"

As we discussed earlier, **Rose** endured sexual violence. During our conversation about the trauma, she mentioned that she felt a sense of shame as result of rape, which was started since she was dating her partner. She explained that he was drunk and did not care about what was happening and seemed unaware or disconnected form the situation "*As I was having sex with him, he lost consciousness and I was left with such shame I was aware what's going on he's not, there's somebody else in the room…it was so a lot of shame I want to say it was making the behavior was only making me more a shame*"

In the given text, **Rose** expresses her reluctance to degrade her abusive partner's image in the eyes of their children by revealing the violence she endured. This has caused her to struggle with feelings of guilt. The trauma she experienced manifests as an internal conflict, wherein she is torn between the desire to speak out her truth and the need to keep it concealed in order to shield her children from harm "*I'm also guilty of not sharing my story with my children, because I still want to keep a good image of their dad which is very distorted but yeah so I'm guilty of talking*"

Sasha articulated the concept of shame as manifestation of trauma in relation to the suffering her children experienced domestic violence and trauma . She expressed feelings of shame and guilt, believing that she was unable to shield her children from an abusive environment, a responsibility she internalized as a consequence of the abusive situation:

> "*You can see your kids struggling, and you can't help them so now you've then you've got that guilt and shame on top of it and it becomes really difficult to look pass that...I hold a lot of guilt for what my children lived in and saw because I didn't protect them from them, and they're making choices in their adult life that I see follow in my footsteps, and the guilt of that is really substantial* "

Due to constant manipulation and gaslighting, **Elizabeth**. **M** internalized all narratives of abuse:

> "*You are actually stupid, you're ugly you're weird, like you're too emotional you're too much for other people so, I have a lot of self-shame that was dealing with already in terms of like I just felt like literally if I couldn't make this relationship work, then all of the things that I had believed in myself, or continued to believe in myself were true and so I really really tried desperately to make the relationship work as a result of not trying to feel a lot of the*

self-shame that I was feeling at the time, and I think that honestly really I think it was really pro like I think that really really influenced a lot of the trauma that I was feeling"

Therefore, the internalization of her experiences led to self-shame, causing her to view herself as the central fault within her abusive relationship. This internal shame led to DV-related trauma.

Another layer of shame that **Elizabeth M.** stated was related to the expectation of others for her to leave her relationship, while she stayed in abusive relationship due to DV-related trauma that she experienced. This expectation revealed a lack of awareness within her support network about the link between trauma and domestic violence. Such misunderstanding not only invalidated her experiences but also reinforced the shame that kept her in the abusive relationship:

"*So even with therapists like I stopped going to therapist at some point, because they just kept telling me you know you need to get out of this situation…it was a lot of shame like that was basically the only way I was able to survive...I think I just wasn't ready to hear a lot of that and so a lot of what I was coping with was just shame trying to talk to friends, trying to talk to family kind of feeling shot down by family and friends because they would just say, well leave him then, if you're so miserable, and that didn't seem like an option at the time for me.. you should just be able to leave him*"

The shame resulting from DV-related trauma and victim blaming caused **Elizabeth. M** to stay silent, leading to her isolation and leaving her only exposed to the narrative of her abuser. This narrative further intensified her feelings of shame, causing her to believe that she deserved the mistreatment and internalize the belief that she was a "bad person" in their relationship:

"*I started not wanting to talk to my friends about anything that was going on in the relationship…or even just my ex partners what he was telling me to do it was like, oh, I'm*

a terrible person I'm a bad person, and like again I'm only deserving of the shame and the suit of suicidal thoughts, and the depression that's overwhelming for me but that's all I deserved "

In addition, **Elizabeth. M** highlighted her ongoing struggle with feelings of shame and guilt stemming from the manipulation by the abuser, which has contributed to her experience of post-traumatic stress disorder (PTSD) and trauma:

"*So it's definitely still a really complicated relationship for me in terms of being able to recognize trauma and PTSD, because still like I wake up from nightmares, or I wake up from daydreams or what not, about my ex-boyfriend, and like I will get into these spirals of being like I made a mistake I should never have left him like my life was so much better with him*"

Katie similarly experienced victim blaming on her shoulder as a result of pressure from society regarding staying in an abusive relationship. She perceived that if she stayed in the relationship, at some point, she could protect her children from the abuse. However, she knew that leaving was the right choice. This conversation illustrates her struggle between the decision to flee and the shame and guilt because of DV-related trauma imposed by the abuser and society's attitude toward survivors, so here staying in abusive relationship is survival strategy for her and her children:

"*It really bothered me that I wrestle with this a lot, because like, especially with the kids, you know, they always tell women oh, if you're in an abusive relationship, you know, leave but at least, if I was with him, he never gone after the kids when I was with him you know I was that buffer at leas*"

She explained that shame and guilt continued to surface whenever she revisited those memories and emotions. Even after deciding to leave, she still questioned whether it was the right choice, revealing how deeply DV-related trauma continued to shape her thoughts and emotions:

> *"When I left I wasn't able to protect my kids, and then he went after them. So that's the part that kind of kicks me every once in a while still is that, you know, should I could have what I know what you know I still feel like I did the right thing and leaving but I regret the fact that I wasn't there to protect my kids and that he went after them not parts hard because I'm supposed to protect them right? so that part's hard [she cries] you leave and you think you're doing everything right but then things get 200 times worse…that was our experience that's why he turned on the kids and you know, sometimes I sometimes I often blame myself. no, had I not left would he have gone after the kids…had I not left at least I would have been a buffer for the kids, and you know I still would have been abused but at least he wouldn't have been able to go after my kids, I was still able to protect them, at that point* "

6.3.5. Finding Words for the Inner Experience

In the quotes that follow, I focus on how the women themselves recognized and articulated their trauma responses, highlighting the agency they showed in trying to understand what they had lived through. All six participants actively worked to make sense of their emotional and psychological states, often drawing on psychotherapy and seeking knowledge as part of reclaiming their narratives after abuse. Although some women used clinical terms such as fight, flight, or freeze during the interviews, my analysis centres on the personal meanings and the language they used to articulate their responses to DV-related trauma within their lived experiences, rather than on clinical definitions.

Rose, MAE, Sasha, Elziabeth. M and Willow described their own emotional responses to coercive control as numbing or freezing, showing how they understood and articulated their experiences. In one situation, **Rose** booked a couple's massage therapy appointment when she was pregnant. She expected her partner accompanied her in this situation. Her abusive partner was dismissive of her needs, and she explained her response to his behavior as "*we have a booked scheduled massage to go and he doesn't want to go he refused to go…I wasn't even feeling bad it was just I guess I was numb I was really numb*". **Rose** stated that numbness became a way to protect herself from the overwhelming emotions caused by the lack of support when her need for help was dismissed, shutting down felt like the only way to survive.

Also, **Rose** expressed that because she wanted to keep herself numb to tolerate trauma and emotional turmoil inside her, she kept herself sleepless to be numb:

> "*I want to say that not having rest for a long time was actually a way I survive actually, I'm just doing a full circle right now because the one thing that I struggle the most is going to bed now so there's no situation but I still struggle to go to bed… I came to conclusion that to keep myself in a lack of sleep state keeps me in a zombie state, so some people might take drugs, or they might drink alcohol or do all kinds of things to be numb but my numbing came by having not enough sleep*"

Being numb by **Rose** was not just about absence of feeling, it was a shield from the chaos by abuser to kept her in survival space.

MAE characterized herself as a "*big freezer*", reflecting on how emotional numbing became a survival strategy that allowed her to cope with and endure the ongoing abuse. As I discussed earlier, she stated that facing the reality of abuse and being in an abusive relationship brought shame, so

one adaptive strategy was to numb, blind, and freeze yourself to disconnect from the reality of abuse:

> "*I'm a big freezer most of all time...I was pretty you know I'm sure this is the case for a lot of women when you're in it there's lots of things you don't see there's lots of things you don't realize and you numb yourself to it, right? because you can't and if you would admit the depth of what you're living every day and you're admitting that you're putting up with it, and that's awful and there's a lot of shame in that, and there's a lot of guilt in that, especially with kids…including the numbing out that was in there as well, because then, when it became too much to cope with that was the only kind of way to give myself a break, you know, to disconnect from it and try to breathe*"

For **MAE**, "*walking through life like a ghost*", reflects a sense of disconnection from herself and her surroundings. Despite this, she demonstrated agency by centring her children and using singing as a grounding practice, which was an act of resistance and care in the face of DV-related trauma:

> "*I didn't have any joy I'd been like walking through my life like a ghost in a way like just focused on my kids and that was it so, I tried to do things like sing along to music which you know those were like a little moments where I had where I realized I hadn't done it in years like I just had been everything became so much about survival that I've forgotten how to live it* "

Sasha similarly explained that domestic violence led her to the freeze response. She recognized the need to plan her escape, however due to overwhelming nature of the domestic violence situation made her freeze, leaving her feeling stuck and unable to act which is necessary response to survive under the unsafe environment:

"*So in a lot of ways, it kind of made me freeze it took me a really long time to well, it took me about two years after I did that course to really get it into my head that I needed to get out and make the plan to go because it overwhelmed me*"

Elizabeth. M explained freeze response as surviving in stillness "*when he was yelling at me, I would have a tendency to freeze…there'd be times where he'd be screaming, yelling, and I definitely didn't know what to do or say, and would kind of just stay stunned in situations*"

Willow further explained that due to the overwhelming dynamics of domestic violence, influenced not only by abuse but also by the system, she had to fight to survive. However, due to constant abuse and trauma, she feels overwhelmed and frustrated. Then she stopped and shut down, as an adaptive strategy to survive unpredictable and overwhelming situation:

"*I just kept trying to go at something it's like you're on autopilot trying to get it to stop. And then it was after a while I just shut down I lost the will to fight like I used to have a lot of fight and mean to not fight back I mean, like, fight for our rights and I just got broken down yeah, I couldn't do it anymore I couldn't communicate with a lawyer anymore I was frozen, I felt like a ghost, couldn't do it, that's the only I have, even after I was destroyed, like torn apart by the police victim services, I still kept trying until I couldn't anymore, and I just shut down for a long period* "

She noted that her tendency to shut down and feel numb was, in her understanding, a symptom of PTSD a way her body and mind responded to prolonged trauma "*This is, I mean, this is a way that PTSD presents itself I just get overwhelmed and I don't function*"

MAE, Sasha, Elizabeth. M, and Katie highlighted a crucial aspect of trauma manifestations, showing how survivors actively remained alert and prepared as a means of protecting themselves when confronted with the threat of domestic violence.

For example, **MAE** explained that she had to be in a heightened state of alertness and be on guard due to an unpredictable abusive environment. In fact, **MAE** had chosen to remain in a state of hyper-alertness to survive:

> "*I think steps ahead…so I had definitely had to use that in the relationship… I had to make sure that I knew what was coming next I had to like always be vigilant, always try to anticipate what might be happening next..., so that I could be prepared right or protect the for myself* "

She added that sometimes she was in a state of intentional avoidance or hypo-alertness to reduce and tolerate the abusive relationship as survival strategies "*so certainly a lot of you know avoidance of certain things that might remind me that some of those things*"

Elizabeth. M used the metaphor of expecting a bomb to drop to highlight how she was constantly on edge, always alert in order to protect herself "*basically just felt like I was waiting for a bomb to drop, and that was always like a stressful situation*" and "*I don't feel safe I don't feel respected. I don't feel understood, so I think the probably the majority of what I would try to do is just distance myself from him so, a lot of like flight*". She chosen being vigilant and avoidance as two different strategies at the same time to help her cope with constant fear and pain of her environment.

Sasha was consumed by a deep sense of anxiety and an overwhelming feeling of constant fear as to what lay ahead. She referred to this state as hypervigilance, saying she was always 'on her toes' her way of describing the constant caution and alertness she lived with:

"*I was always on my toes about like, if I say something wrong, am I going to be physically hit so you're always constantly watching their body movements so being hyper vigilant on that and never feeling free to speak your own mind...it's trying to figure out how… I put one foot in front of the other to make me get that step, because it's so hard to think about it and I go quiet I internalize*"

She emphasized that the experience she lived through was traumatic because it was unpredictable and filled with threats, she could never foresee what might happen from one moment to the next or when she might find herself in a fatal situation "*And I just I visualize me in the fetal position like, that's I instinctively just want to do this just turn in right? yeah, it's trauma*"

Katie illustrated hypervigilance or hyper-alertness by using the metaphor of always looking over our shoulders to indicate the distressing situation where she has been constantly in a state of fear due of consent coercion and control "*We're not safe, you know, we we're just we're surviving we're not thriving like we're always hyper-vigilant, always looking over our shoulders*"

The abuser threatened to kill the children, leaving her and the children living under constant threat and in an unpredictable environment an experience she described as deeply traumatic. Even her children could not play outside freely, as she constantly anticipated that something might happen because of the abuser. This ongoing deprivation of liberty and freedom, she explained, was itself a traumatic experience you cannot truly be free, even as a child, when your father is the abuser:

"*Because we never know if he's around, or if he's going to try and steal the kids, or if he's going to try and kill them, because he threatened both of them that he would kill them if they ever told about the abuse...it is so unnerving, and I'm always on edge I'm always hypervigilant I'm always looking over my shoulder, wondering what's gonna happen I can't*

let my go kids go play freely outside because I'm scared if he's around, or if he's lurking, you know there's not that freedom"

Furthermore, **Elizabeth, M. Willow, and Katie** described the fawn response as an adaptive survival strategy, where survivors consciously worked to reduce danger by agreeing with, pleasing, or calming the abuser to avoid with the abuser in order to stay safe.

For example, **Elizabeth. M** reflected on how she moved between two adaptive survival responses sometimes using flight and other times the fawn response, depending on what was needed to stay safe:

"*I don't feel safe so I think the probably the majority of what I would try to do is just distance myself from him. so, a lot of like flight, I suppose, if you were to make it into fight flight freeze… then I would retreat…if that didn't work, it was like retreat...I recognize that I have a tendency to like again just retreat, and as soon as I felt that way it was almost like, okay well this is better for me to just deal with this by myself or I have a tendency to like over apologize for even things that I wasn't doing*"

So, she noted that she took all the blame upon herself as a way to maintain calm and safety for both her and her surroundings:

"*That was a huge tendency in our relationship was that it just got easier sometimes to accept the blame and just say that yes, I was wrong in this situation, and I shouldn't have done that, and you know I'll do anything to make it up to you, stuff like that...it was a lot of it was a lot of me going okay? well, you're so mad at me and I've tried as much as I could to it like I would. I would try to apologize, and if that didn't work I would it pretty much. It was like I would either try to apologize*"

Elizabeth. M also stated that as fawn trauma response, she suppressed her emotions and needs in favour of fulling abuse's demands. This may have made her to lose sense of self and living in fear and anxiety, which led to depression as well:

> "*I think it was causing me to become even more traumatized in the sense that I was asking for less and less, I was dealing with more stuff that he was throwing my way and, like I said, all of that really kind of snowballed into a lot of the depression and the anxiety that I was already feeling*"

Willow navigates the fawn response to trauma by emphasizing the need to "*comply and subjugate*" as the only way to survive under coercive control:

> "*The only way to survive this extreme form of coercive control it's like a form of entrapment, the only way to survive is to comply and subjugate and the only way to do that is to ruffle as little feathers as possible and hope that someday it'll get better*"

Willow highlighted toxic positivity as people thinking you are out of the relationship, so let it go. However, the reality of coercive control is more complex. Letting go is not the only option, as you might feel driven to comply with the situation to survive rather than truly thrive:

> "*We live in fear and people engage in toxic positivity to like, oh, just let it go or try to think positively I'm like, but I'm going on [number of year] years it's going to happen it's just a matter of time the only way to keep it at a low level to protect [her daughter] is to be completely compliant* "

Katie's response reflected a fawn strategy, in which she actively worked to protect herself and her children by maintaining peace and preventing conflict. She often chose to appease or please the

abuser not out of submission, but as a deliberate way to avoid danger and ensure their safety, even at the cost of her and her children's own needs and voices:

> "*So a lot of the times like, I did a appease a lot of times, because if I didn't appease, and if I didn't give in, then there was a lot more hell to pay, and I didn't want to walk that line because I had walked it a couple of times, and it hurt a lot more…I felt like I appeased and pleased a lot, and even when I didn't want to do things, I still found myself doing it because I didn't want to deal with the fallout so that was kind of how I survived I just put up with it because I was scared I was really scared of what would happen if I didn't and so that's how that's how I survived it.. I didn't really have a lot of strategies like I guess when I was in the relationship my strategy was kind of like submit, because if I didn't submit then things got bad like they got worse*"

As I previously noted, participants actively engaged in psychotherapy, learning about their lived experience, so they have been familiar with terms such as 'dissociation' as the manifestations of DV-related trauma. **MAE, Rose, Elizabeth. M, Willow and Sasha** commonly experience dissociation as a key aspect of their daily trauma responses. Dissociation serves as a survival strategy, allowing the individual to distance themselves from their thoughts, feelings, memories, and sense of identity as a way to cope with overwhelming stress, danger, and emotional and physical pain of their situation.

MAE highlighted the connection between PTSD and dissociation by explaining how questions about domestic violence triggered her and caused her to dissociate in order to protect herself from emotional pain:

"*One of my huge issues that I've experience and learned about through the PTSD and therapy I have a tendency to dissociate and I'm working on it really hard and it's better than it was but direct questions sometimes can snap that without me realizing it, and then I'll come back to it later and I'll be able to say much more but in the moment it's challenging*"

MAE has been attempting to confront her painful feelings about domestic violence and articulate them, yet the dissociation persists "*definitely dissociation at times, you know, when it's too much to process or too much to cope that happens that's still happening*"

As I discussed in methodological chapter some participants asked the research questions in advance, for instances **MAE**, being aware of dissociation as a survival response to DV-related trauma, therefore she requested the interview questions in advance. This was to give her time for reflection and avoid confrontation with the triggering questions during the interview:

"I thought about this and thank you for giving me like today's stuff as well that's very helpful for me, because it's because I do fog I do fog out and dissociate, so it was it was good to be able to think about it afterwards so, I wrote some stuff down, so I'm just gonna flip here"

During the interview, **MAE** reflected on how revisiting memories and court documents related to the abuse could trigger re-traumatization and dissociation. She experienced moments of mental fog and disconnection, at times asking me to repeat questions as she struggled to stay present:

"*So I'm just gonna preface anything I like today I didn't pull out all my legal stuff last week I waited because I knew it was gonna be difficult to look at it, so I pulled it out this morning, and I could feel myself dissociating like instantly, so I'm feeling a little foggy in my head,*

so I just want to let you know that it's just super triggering right can I get you to repeat that question"

Similar to **MAE**, **Rose** frequently experienced dissociation, which is a common manifestation of her trauma and also asked me to send the interview questions before each interview. Her dissociative episodes were marked by moments when she forgot the questions asked by me and needed frequent reminders:

"*I'm going far from your question…I don't remember where it was.. I forgot, sorry, I might go far from your question...I can't stay focused.. I don't know I know you asked the question originally but it took a long time to answer your question...so I forgot your question...I lost my train of thought…I was going somewhere with this, I'm sorry what was your question?..*"

Rose had difficulty maintaining focus, which was a direct result of her dissociation. This high level of dissociation greatly affected her ability to take part in Eye Movement Desensitization and Reprocessing (EMDR) therapy, even as she actively sought support for her PTSD:

"*When I asked to do EMDR, I think it's called we did testing and my level of disconnection was so high...I was learning I was so disconnected with life...I learned was my counselor and [sexual assault program name] could do it and so I said I would love and then we realized that my level of dissociation was too high…I can't receive EMDR because my dissociation…I was told that my level of dissociation was too high to have access to EMDR. now, this dissociation I experienced for many years must have clearly have an impact on my children*"

Willow reflected on how she had learned to dissociate and become numb as a way to protect herself from painful emotions, memories, and the threatening environment she lived in. Although she wanted to be present in her life, the constant fear, coercive control, and overwhelming experiences made it too painful, so dissociation became a survival strategy to endure what surrounded her:

> "*Even some of the symptoms from that period have absolutely evaded quite a bit like it was really bad for a long time really bad really, really, that's when I was trying to learn to dissociate those things I wanted to not feel things I didn't want to have I don't know how you would describe it, when you dissociate like an out of… I don't know but I wanted to not be present in my life because it was so it was so awful*"

Sasha employed dissociation as a survival strategy in response to her abuser's torture. She consciously suppressed her emotions and concealed her vulnerability to prevent it from being weaponized against her. This process of 'turning off' her feelings functioned as a necessary form of self-protection, allowing her to endure the abuse while psychologically distancing herself from the pain:

> "*When you're a survivor you have to pack those away and not show up, because if you showing motions with your abuser, they will use that against you, because they know that it hurts you right? so you have to turn that off and become you disassociate and or you don't survive mentally, like...it does the disassociation…I have some clear memories, but a lot of it is just this gray mush of my marriage...I had disengaged I had to shut down and not be vulnerable, and not showing motions in order to survive*"

The extent of **Sasha's** dissociation became clear one morning when she woke up unable to remember what day it was or recall events from the past two weeks. She had zoned out and lost

track of time as a way to cope with the ongoing trauma. This desperate state illustrates how deeply dissociation had become integrated into her daily life, emphasizing its protective role and the profound impact on her sense of self and reality: *"So I was desperate because I woke up one morning, and couldn't remember what day it was, and couldn't remember what it happened in the last 2 weeks because I blocked it out"*

Elizabeth. M employed dissociation as a coping mechanism during experiences of sexual violence. Despite her verbal resistance and clear disinterest, the continued aggression of her abuser led her to dissociation as a way to endure the trauma. As **Elizabeth. M** described, during these experiences, she would mentally distance herself, repeatedly focusing on the thought "*I want this to be done*". Dissociation as mental escape allowed her to endure the immediate pain, allowing her to endure the violence by disengaging from the horrific reality of the situation:

> "*Despite me saying no I'm not really feeling it, him still trying and there'd be a lot of time for I would just kind of like put up with it and feel really awful after, because in my head I would just be thinking I want this to be done I want this to be done like I need this to be done like, and I would kind of I would just dissociate while we were having sex a lot of the time, because I would just go into a space ...*"

Participants articulated their trauma responses and survival strategies across different situations, emphasizing their resilience and the complex realities of surviving within systems of coercion and control. In their lived experiences, they employed different strategies to endure and cope, sometimes remaining hyperalert in a fight response, sometimes avoiding through flight, sometimes dissociating to tolerate the unbearable, and sometimes complying or appeasing through a fawn response. All participants showed resilience and agency in coping with trauma from domestic violence by adopting their responses to ensure their survival and safety.

6.4. Social Location Amplifying Coercive Control and DV-Related Trauma (GET.4)

Grounded in an intersectional framework, this study explored how participants' social locations and structural positions shaped both their lived experiences of domestic violence and their understanding of DV-related trauma. When viewed through the lens of intersectionality, it becomes clear that domestic violence and trauma are not a singular experience. Instead, it is influenced by a complex interplay of various social factors such as gender, race, socioeconomic status, sexual orientation, disability, geographic location, and religious affiliation. These factors not only intersect with the experience of domestic violence but also intensify the trauma endured by survivors. Therefore, I delved into a discussion about the intersection of this social location with coercive control and the DV-related trauma experienced by the participants.

It is noteworthy that all six women in this study experienced domestic violence and DV-related trauma. However, within this Group Experiential Theme (GET. 4), each participant's social location was examined individually in order to honour IPA's idiographic commitment (Smith & Osborn, 2008), understood here as a focus on each woman's unique, lived experience, while also reflecting the intersectional nature of DV-related trauma. Although the women shared experiences of coercive control and trauma, their social locations shaped how these experiences were lived, understood, and narrated.

While participants held diverse social locations, five women described how living in rural areas and in different provinces significantly shaped their experiences of coercive control and DV-related trauma. In addition to this shared context, I developed individual subthemes for each participant to illustrate how various forms of structural oppression such as sexual orientation, perpetrators' professional status, residence in socially conservative environments, socioeconomic marginalization, physical disability, spiritual identity, and Indigenous identity intersected with

their experiences of coercive control and trauma. This approach was not intended to fragment the analysis but to demonstrate how intersectionality operated within individual narratives while maintaining a coherent thematic thread. Finally, a collective subtheme was developed to capture the shared experiences of the five participants who described how living in rural areas and different provinces intersected with coercive control and DV-related trauma.

6.4.1. Sexual Orientation and DV- Related Trauma

Elizabeth. M shared how her experiences of domestic violence were compounded by her pansexual and queer identity. She explained that her partner weaponized her queerness as a tool for coercion and manipulation, pressuring her into polyamorous relationships and threesomes, which she did not desire while being in a heterosexual relationship:

> "*It was definitely always like well, you should want to have this threesome with me .. I had always been from the start just because, again, there's a huge difference between queer relationships and polyamorous relationships...so, I was always very vocal about how I did not feel comfortable in a polyamorous relationship, and I think to this day I still don't feel comfortable in a polyamorous relationship I think I prefer having one partner that I'm intimate with that way*"

Elizabeth. M's partner weaponized her sexual identity, using manipulation and gaslighting to distort her expressed desires. Even when she clearly stated what she wanted, he twisted her words to exert control and erode her autonomy. The pressure to serve his demands, despite her personal boundaries and preferences, intensified the abuse she experienced:

> "*I want to keep this a monogamous relationship I don't want to bring somebody else into the bedroom like that it's something that I clearly communicated over and over and over*

again.. so I've always really been forefront of monogamy, but frequently it was like, well, of course you like women, so why don't you want to have this relationship with this woman with me why didn't you want to sleep with this woman with me"

Her partner was convincing her that she was mistaken about her own sexual orientation because she refused to serve his demands. He labeled her as "not really queer", which left **Elizabeth. M** feeling deeply frustrated and undermined. This gaslighting further eroded her sense of self, making her question her own identity while reinforcing his control over her: "*in terms of queerness again It was kind a like I said well, if you don't have a threesome, then you're obviously not queer you obviously don't want this, and that had to happen on several occasions*"

Elizabeth. M reflections reveal the intersection of sexual orientation and coercive control, while her partner used her queer identity to impose more control and derived her sexual autonomy and freedom, like coerced her into pursuing other women to prove her affection for him. This tactic of emotional manipulation exploited her sexual orientation, forcing her into situations that undermined her autonomy and self-worth, all while reinforcing his dominance in the relationship:

"*He would want me to go and hit on other girls in front of him make out with other girls in front of him as somewhat of like a sexual introduction, and it was always very much targeted towards specific women that he wanted to sleep with, so it was almost like he was trying to convince me that I like these women well, where I knew that he was the one that actually wanted to sleep with them so definitely it felt like he had played upon the fact that I did ha! I have had sexual relationships with women before and kind of using that as a I don't know a means to what he wanted to get* "

Building on **Elizabeth. M**'s narrative about the intersection of her sexual orientation and coercive control, she perceived her partner behaviour as a form of sexual violence, as it disregarded her autonomy and coerced her into a situation that violated her consent and comfort:

> "*So, when we were out or when he was drunk, for example, he would want me to go and pick up other girls so that we could pick them up knowing that I was better at dealing, knowing that I was better at communicating and dealing with people than he was it was like he wants me to do all the work in terms of bringing in the prize, and that we would go home that way, and that would happen...I would consider it sexual violence, especially because again I had been very clear about I don't want this this is not how I want to express myself and I don't want to keep saying no to a situation that I continually been very like adamant about* "

Elizabeth. M also reflected that, while she was in the situation, she did not initially perceive it as violence. Instead, she thought it was not his fault or assumed this was simply 'normal' male behavior, believing he did not act deliberately. Her account reveals how the intersections of coercive control can be subtle and hidden, leading her to internalize the abuse in ways that excused his behavior and obscured her own suffering: "*I definitely looking back, I consider it sexual violence but at the time I definitely was just like, okay well, he's just like everybody else in that sense that he doesn't get it, and it's not his fault* "

When we began discussing DV-related trauma in relation to her sexual identity, **Elizabeth. M** described how her experience of sexual violence had significantly altered her relationship with her queer identity and reshaped her understanding of intimacy. Initially, sexual violence created a lasting sense of fear and discomfort around sex. At first, she didn't think the sexual violence would influence her relationships with women, since her abuser was a man and she identifies as queer

and pansexual. But over time, she noticed how the trauma from that violence began to shape her intimacy, trust, and even how she understood her queer identity:

> "*I think because that happened within an opposite sex relationship to me it felt like okay well it doesn't affect the relationships that I have with women or like romantically speaking with women, which now I'm finding actually in my life I actually am very much affected by the relationship and my queer identity, like sex being still a very scary thing for me, like I really don't, and I have not had sex in a long...so that is affected my sexuality a lot more than I expected it to my queer sexuality as well…You know this is a male this is a man and I engaging in sex so, the sexual like danger that I was in can only happen between a male and myself and I'm now learning that's not the case, and I feel really like terrified, regardless of who I'm having sexual relationships with*"

As a result of the DV-related trauma, **Elizabeth. M** has found that even her relationships with women are impacted by her trauma. She notes that the lasting effects of sexual violence show up in her current dating experiences, highlighting a need for greater emotional support and understanding from her new/current partners. Recognizing that she needs more support emphasizes how trauma from domestic violence affects her ability to fully engage in relationships, requiring a more nuanced approach to intimacy and trust. This growing understanding underscores the ongoing impact of trauma on her relationship dynamics and emotional well-being:

> "*Now it's gotten to the point where I'm only dating females like I mean I don't date I don't date men at this point just again it being too scary but even of the females that I've been dating later in my life like it's now making me realize that I need a lot more supports in that respect than I previously have, because there's a lot of things that I've been dealing with PTSD*"

Her developing understanding of the intersection of her queer identity and sexual violence, and the necessity for specialized support, reflects a crucial aspect of her healing journey. It emphasizes the importance of addressing trauma related to domestic violence within the context of her queer identity.

6.4.2. Perpetrator's Professional Status and DV- Related Trauma

Rose was Francophone and living in a rural area, both of which may position her within marginalized social locations. However, in this analysis I focused particularly on her abusive partner's status as a police officer. I did not understand social location as a fixed attribute or individual characteristic, but as a relational position continually shaped by political and structural forces. In this case, his institutional power as a police officer, together with her gender as a woman, shaped her lived experience of domestic violence and trauma (Collins & Bilge, 2016; Yuval-Davis, 2015). **Rose** felt marginalized, as she did not hold the same power or position and was further disadvantaged as a woman. **Rose** described that her social position as a cop's wife amplified her isolation and the violence she endured, leaving her feeling powerless: "*I realize how little power I had because he was a cop, I didn't have the same weight...I didn't have this access to the same resources*". **Rose** powerfully narrated her lived experience as the wife of a police officer, revealing how his position shaped the abuse and her marginalization:

> "*And that no matter what, this was not an equal fight, and it would not be an equal fight... I didn't have all these cop friends anymore like he maintained his cops friends they go to court all the time they know how to present themselves in court they have all these lawyers friends because they go to court all the time, lawyers know them…and this arrogance it's crazy but it's like it works in their favor*"

Rose declared that as her partner's status as a police officer with certain privileges in society, making it even more difficult for her to escape or seek social support. The authority and influence tied to his profession deepened the harm and extended the reach of his abusive behavior into various aspects of her life: "*and it's like they don't even get question their credibility their integrity nothing, when you say you're involved with cops you get either like, okay?.. so, I'm complaining for nothing and others it's like, oh, okay, you another level of violence*"

Rose understood her marginalization as being tied to her position as the wife of a police officer. She highlighted that because of the abuser's professional position as a police officer, the outside world viewed him through a positive lens. He was seen as a 'good cop, good soldier' a protector and this public image worked in his favor, even when he was charged with assaulting their children. His job also gave him access to powerful layers within the system, including the police and legal networks, which further protected him:

> "*He was a police officer…he got arrested for assaulting our children, so he was violent with children and he was found guilty but he was a good cop and he was a good soldier, so that worked in his favor he pleaded guilty but with his lawyer who was the lawyer of all the police in [town name] like the charges was diminished, so he was charged for [number] counts of assault with the weapon, it all causing bodily harm so to assault with the weapon and to assault causing bodily harm against the children*"

When we began discussing DV-related trauma in relation to her social location, **Rose** highlighted the power held by her abusive partner as a police officer. For **Rose**, the fact that her perpetrator was a police officer deeply affected her ability to trust other professionals involved in her case. The fact that the perpetrator was in a position of power compounded the trauma for **Rose** and made her cautious of individuals in similar roles. Here, **Rose** was explaining the rape that she

experienced with her abusive partner. After she disclosed the rape to a social worker, she was in touch with, she was referred to the hospital. However, **Rose** was afraid to pursue further legal action because of the professional status and power of her abusive partner. She feared that everyone might be connected to the police and that the system would operate in his favour, as she had previously experienced in relation to his lawyer. This shaped Rose's lived experience of feeling that institutional networks were aligned with her abusive partner rather than with her:

> "*That's how I got access to the service at the hospital and I get it as swab kits or to get DNA I guess, and I refuse I was so afraid because I said do they work with cops like who's the cop? who's going to know this information? I didn't know the nurse, was she married to a cop? when he got a lawyer with family court was married to a cop so like the circle is always really small* "

Rose's narrative reveals the profound impact her abusive partner's authority affected her feeling of safety and trust which is manifestation of DV-related trauma. The judicial and law enforcement systems that should have protected her was not available, leaving her without a reliable source of help. Her partner's connection and ties to the police created an environment where she felt isolated and without support: "*The [women resource centre] was about you know when you're in danger you called the cops blah blah blah, but it's not relevant I'm not going to call the cops and so I was mad that they were not acknowledging women*"

She emphasized the irony that seeking help from the police should have offered safety, but for her, it only deepened the danger because her abuser was himself a police officer "*How do you find safety when those that are supposed to be safe are not safe…and so I think the implication was very deep…who am I trusting?*" As a result, she found herself constantly evaluating whom she could trust to talk to, uncertain each time about how they might respond or what consequences

might follow "*So every time at first that I was seeing I knew counselor or a new cop, or I would like not trust them I would ask them so many questions like an interrogation because I wanted to know if they were really helping me or down the road it would turn their back on me because they were the friend of someone that was not helpful* "

Furthermore, **Rose** stated that because her former partner was a police officer, she was afraid to report domestic violence to the police. This may show that she did not feel that there was a safe space within the police system to discuss domestic violence involving their colleagues. She feared there might be severe consequences for her and her children if she did report it:

> "*I called one time anonymously and I was very cautious I was always so scared of everyone, were they going to take my…were they going to listen to me? was they gonna say I'm a liar it's like I felt helpless or so terrified of the system … I was going to have a bigger monster than what was already going on… I wanted them to acknowledge what I was seeing out of the blue he goes oh, I see well, I need to know his name I need to know his badge number, and I was like no, I'm not doing that so, and then I hung up*"

Rose's story is a powerful and moving illustration of how the professional status of a perpetrator can compound the DV-related trauma. Due to the power imbalance, she could not trust the police and the broader system. This reflects a deeper issue of systemic bias and power imbalance that should be considered in survivors' experiences and healing journeys.

6.4.3. Disability, Conservative Context, Socioeconomic Status and DV-Related Trauma

Katie's experiences of domestic violence were shaped by intersecting structures of oppression, including her location within a conservative, patriarchal social environment and her Christian identity within that context. She described how, in her conservative community, her partner, a

white male farmer, enjoyed certain privileges and a sense of superiority. This dynamic created an expectation that she should meet his needs and maintain traditional gender roles, further reinforcing the power imbalance in their relationship:

> "*I don't understand it I don't understand how these systems look at him and see a white [product name] farmer who's high in socioeconomic status and they just, you know oh, it's a so white guy with a good job…oh, yeah well, we're conservative out here, so he must be a good guy, and that's just how they look at it and so that's why you know…and being a rural area and being so conservative, maybe, that you know a lot of the views are that women have their place, and you know women are more subordinate you know, women are supposed to cook and clean and raise the kids and you know and that's just the way it*"

Another example is **Katie**, explained that being a Christian and living in a conservative area intersected during her abusive relationship, pressuring her to obey her partner as a duty "*women weren't serving the husband or whatever then it was kind of against God, although we never practiced religion a lot…*". Here she noted that "*weren't serving the husband* " was seen as going against God. She didn't share all of her feelings, but it was clear that this belief weighed heavily on her.

The dominant and patriarchal societal norms in **Katie**'s community "*It's the man's world*" not only validated his abusive behavior but also made it difficult for her to seek support or escape the cycle of violence:

> "*So and then definitely rural same too, we live in [area name] it's lots of greens, lots of farming like this whole area it's all agriculture and so that conservative way of life, and*

just very much, you know, the men run the house it's the man's world and you know women are just subordinates we're just there to do the bidding"

In reflecting on her experiences of DV-related trauma**, Katie**'s account illustrates how domestic violence, PTSD-related disability, and socioeconomic hardship intersect to intensify the trauma she endured. She shares her journey of healing while living with a disability and financial issue, revealing how systemic barriers and lack of support have deepened her suffering:

"*It's hard…I'm on employment and income assistance which is [province name] government so it's like welfare and then I'm on the disability portion for that so I get 900 a month for disability and or for being on [name of financial assistance] , and then they give me an extra 100 because I'm disabled you know so, I get a thousand dollars a month to survive off with my children*"

She powerfully compared her situation to slowly dying under the weight of disability and financial struggle, describing it as a cruel and deeply stressful reality. She explained that, as a result of PTSD-related disability and her inability to work, the welfare system feels, in her words, as though it is designed to set you up to slowly die:

" *It's like welfare is set up for you to slowly die and I'm not saying that to be you know, exaggerating or anything like they really do…they make it so uncomfortable that it's actually cruel…like we don't get fresh vegetables we don't get a lot of things because we are just we're forced to go without and that's no way to live either so yeah, it's really tough and just you know being disabled and being taken off of work the government just doesn't seem to provide for people who are in those types of situations that can't help it like I would*

love to go back to work I would love to actually not be under the poverty line, and you know, not cry every other day because we don't have money it's really stressful "

Katie's narrative underscores that being on income assistance, along with additional support for her disability, doesn't fully address the financial and emotional strain she experiences. Her account shows how her disability, combined with her experiences of domestic violence, creates a cycle of dependence and inadequacy. The lack of comprehensive support from the welfare systems contributes to her ongoing trauma as she struggles with the dual burden of abuse and systemic neglect.

6.4.4. Disability and DV- Related Trauma

MAE who lived in a rural area and experienced Myalgic Encephalomyelitis (ME) as a physical disability, highlighted how her social location intensified the impact of domestic violence. The combination of limited mobility, health challenges, and geographical isolation made her more dependent on her partner, which in turn increased her vulnerability to coercion and control. The abuser exploited both her disability and her location, knowing that her access to services, support networks, and safe alternatives was severely restricted. Through an intersectional lens, her account illustrates how disability and rural isolation can converge to deepen women's entrapment in abusive relationships. She described that she was lived in neglectful and dismissal abusive relationship as: "*He knew I had ME…he witnessed it all the time but he dismissed it all the time…and so it felt dangerous to me to be vulnerable because it was dangerous to be vulnerable to him*". **MAE** felt that her vulnerabilities were used by her partner, leading to a deep mistrust and fear of expressing her true feelings or weaknesses.

MAE believed that her abuser used her physical disability to coerce and control her. He knew that her ME caused her to have low energy on some days, making it difficult for her to take care of her children. Her account reveals how the abuser weaponized her ME-related disability to exert control over the children, forcing her involvement even when her body was in pain or exhausted. This ongoing coercion kept her in a constant state of stress, fear, and adrenaline, intensifying her trauma and deepening the physical and emotional toll of domestic violence:

> "*It was another tactic, another tool for him and his arsenal to use...to the kids and then comes back to myself…so, if he saw that I was having a really bad day, he would try to step in and force the kids to do something that they didn't want to do to manipulate them and to control them consequently, I would have to rally up with ME, use adrenaline when you have to, like if I have to do something, I can do it but it's adrenaline. it's like one more piece of that fight flight that you already have with an abuser then is now kicking in as well in addition because of the ME and so I would have to and which would make me sicker and take me longer to recover so, I always had to find that balance between*"

Also, **MAE** explained that because of her ME, she was unable to financially support herself, which made her more vulnerable to being trapped in the abusive relationship. This lack of financial independence created conditions in which her partner could exert financial abuse more easily, reinforcing her dependence and limiting her ability to leave. Therefore, her physical disability intersected with financial dependency, making it even more difficult to move forward and leave the abuser: "*This is a huge connection for me with the disability and the domestic violence, and being in and even out of it, in terms of being financially trapped…financial independence…that's liberating…that's a very hard thing...yeah .yeah, yeah, that's a big intersection for sure*"

MAE's uncovers how the abuser turned her disability into a tool of control, manipulating and ridiculing both her and her children to reinforce his power. This deliberate exploitation of her physical limitations magnified her trauma and exposed the harsh overlap between disability, coercive control, and emotional abuse. Her experience shows the devastating ways disability can be used to isolate survivors and sustain the abuser's dominance:

> "*It's like it's more like you've been up for 48 hr that's what that's sort of more with the tower, the worst sort of part of the flu it's heavy. you can't think you can't so that's already happening to me in waves, anyway and then the trauma certainly is another piece of that right, he was very dismissive of my health issues*"

6.4.5. Spiritual Context and DV-Related Trauma

Sasha found peace and connection through practicing Wicca, which is rooted in her love for nature. However, her abuser exploited her religious beliefs during their abusive relationship. He frequently used derogatory language related to her faith to intimidate her:

> "*I've always I like herbs, and I believe that everything has energy but he made fun of it he called it my voodoo…religion he just used as a tool to hurt me. it was more of an emotional tool to hurt me he called me names, and he thought it was weird, and all this stuff, but he was used more against me as a tool to hurt me emotionally*"

This emotional abuse not only eroded her self-worth but also caused a deep conflict between her spiritual identity and the fear instilled by her abuser. By weaponizing her spiritual /religious beliefs, he sought to diminish her autonomy, leaving her feeling vulnerable and isolated in her own spiritual practice:

"*He called it my voodoo he called it my crazy stuff! ..like the voodoo thing, stands out in my mind he said it was stupid, and more than one occasion like, it's just stupid like what are you doing, you crazy? right? like those types of remarks, the belittling, the discrediting, he just looking at you dumb that's dumb and then he would roll his eyes and he'd scoff and he made his opinion very clear without having to say a whole lot*"

6.4.6. Indigenous Identity and DV- Related Trauma

Willow identified herself as an Indigenous woman and expressed that her identity had been a source of pride. However, during her experiences with domestic violence and her interactions with the carceral system, she felt the need to suppress or shrink her Indigenous identity:

"*I was proud to be Métis my whole life and then I hit it I didn't mention it at all because of the way indigenous women are treated because these are all carceral systems I was forced into police child welfare the legal system and how indigenous people are so mistreated within these systems and so oppressed so, I would say, I played it down a lot I didn't make any mention of it at all*"

The oppressive dynamics she faced, both as a survivor of domestic violence and as an Indigenous woman, compounded her sense of powerlessness and invisibility within these systems. This dynamic, became a way in which her ethnicity was weaponized against her, further marginalizing her within the structures that should have provided support. **Willow's** DV-related trauma was further intensified by her Indigenous identity, revealing how domestic violence and systemic discrimination intersected to deepen her suffering:

"*You try to make yourself as small as possible like you just want to disappear right? so to be indigenous openly was just another like box to tick off for oppression in my mind and I don't think I'm wrong at all I know I'm not*"

Another layer in which **Willow's** Indigenous identity shaped her experience of domestic violence was her exclusion from her daughter's life. This marginalization was reinforced by systemic power dynamics and ongoing coercive control exerted not only by her abuser but also by her daughter's school board:

"*I think it's for some reason why people will abuse or control you by like trying to diminish your role…he registered [her daughter] in school and they wrote me down as the birth mother…it's just like this other exclusion, right? which is a form of abuse…the school is another like another system for him to you know weaponized essentially…I'm just a birth mother I'm nothing I'm not registered I have no, I mean we have 50 50 custody at this point and it's absolute exclusion and his manipulation…she was not even marked down as being Métis or Indigenous until last year, and I went to the superintendent of the school board...this sort of intersectional manipulation"*

This compounded **Willow**'s feelings of frustration and helplessness, further diminishing her sense of self-worth and cultural identity, as the dual forces of personal and institutional oppression left her feeling powerless. She reflected that the abuse she endured was not only personal but also part of a broader history of violence against Indigenous peoples especially Indigenous women. Speaking about this connection was difficult for her, yet she recognized how her experiences were rooted in generations of colonial oppression, marginalization, and gendered violence:

> "*I think the closest I felt to my roots as an indigenous women are the abuse and the system of oppression and I think that's the most connected I've felt to indigenous culture in Canada truly that is the most culturally connected I felt in [province name] because of systemic oppression against indigenous people and abuse and colonialism that is the indigenous experience that is the carceral systemic oppression that is the indigenous experience by British systems that's disgusting but true, it makes me feel sick to say that but it is so true*"

By situating her own trauma within this larger historical context, she gave voice to the collective pain carried by Indigenous women and the enduring impact of colonial abuse. As discussed before **Willow** felt excluded from her daughter's life because of her Indigenous identity an exclusion she understood as a form of intersectional abuse. Her experience resonated deeply with the broader history of colonial oppression, as she saw parallels between her own situation and the ways Indigenous families have been separated and controlled by white, colonial systems:

> "*I mean, it's really like the parallels between British people coming and taking indigenous children from indigenous mothers giving them to wealthy families hello! it's not last time me the iron a like this is my history repeating itself…that's what's happening to me. You know a [partner's race] and these systems these colonial systems are doing what they're supposed to… I have a whole problem with it ,the police were formed in Canada by the RCMP, the child welfare system was formed it's all colonial practice yeah, who to press indigenous people and I'm just one small feed, and maybe it's like a couple of generations later but it's still so prevalent*"

This marginalization was reinforced by systemic power dynamics and ongoing coercive control exerted not only by her abuser but also by her daughter's school board, police, court and welfare system as she explained.

This dynamic led her to reflect on how experiences of exclusion and erasure were shaped through the intersection of her Indigenous identity, her partner's racial identity, and broader structures of power, all of which contributed to the trauma she experienced. The confusion and distress she described reflected not only the personal impact of abuse, but also the enduring legacy of colonial power that continues to invalidate Indigenous identity and motherhood:

> "*I think that being indigenous is something that people will disregard for my daughter because he's [partner's race] so, they'll ignore her ethnicity and assigned her as being the daughter of a [partner's race] man, and completely and that affects me I mean but I don't know I don't know if it's because I'm indigenous or because he's [partner's race] I don't know, but I know that they have tried to wipe out my daughter's heritage and indigenous status they pertain to him*"

Five participants also described how living in rural areas and different provinces shaped their experiences of coercive control and DV-related trauma. They spoke about how isolation, geographical distance, limited services, and close-knit community dynamics influenced both the abuse they faced and the trauma that followed. The subtheme Geographical Location and DV-Related Trauma highlights how rural contexts and provincial differences interacted with coercive control, intensifying women's trauma and compounding the practical challenges they encountered.

6.4.7. Geographical Location and DV-Related Trauma

MAE described that in the county where she lives, the rate of domestic violence is high "*you know the stats are so dire on domestic violence in the county here, do you know this? they've just declared it as an epidemic in [County name], and this area they have declared domestic violence as an epidemic it is the prevalence of it is that high here it's higher than [city]…*". She suggested that the

high rate might be linked to rural contexts, where there is often less awareness and understanding of what constitutes domestic violence "*It's higher than I assume because it's fairly rural but yeah, the stats in [County name] County, which is where I am are pretty horrific*"

Living in rural and small community in **MAE's** viewpoint brought isolation and loss of social circle and support. Her abuser well-respected image within the small community played a significant role in downplaying his abusive behavior and domestic violence as he was able to spin a false narrative, portraying her as the problem while masking his abusive actions "*I know the story that he's spinning is very different from the reality, and that's isolated… there's so much grief around that around losing all those people*"

This false portrayal left **MAE** not only struggling with the trauma of abuse but also with profound grief as she navigated the loss of community support and the deep isolation that came with being misunderstood and alienated in such a close-knit environment "*But that's hard when you live in a small community…there's nowhere really to go*"

I reflected on **Rose** abuser's status as police officer and the marginalization. She also experienced isolation and denial from the small and rural community because no one believed that a man, especially a police officer, could be violent towards his wife and children. The community's disbelief and assumption that she was lying about the abuse against her children further compounded her isolation and emotional distress. This denial could have a profound impact on **Rose**, as it not only invalidated her experiences by her social circle but also eroded her sense of trust and safety within the community: "*when he got arrested at that point people thought that I was lying so they looked at me as the vindictive ex-wife so I attacked him by getting him arrested you know how low could I be?*"

Rose described that to protect her children from further emotional harm and fearing the small community's judgment she kept the violence a secret. However, while this secrecy shielded her children, it left her feeling trapped, as she had no opportunity to disclose the abuse and seek support in her community. No one believed her in their small community, which compounded her isolation:

> "*It was a secret that I was going through criminal court, and I stayed quiet because I didn't want my kids to be pointed finger at saying all those are the kids that the dad did this… I don't want to have them be isolated at recess…yeah so I just I thought keeping the secret that this was happening was helpful, it was not helpful for me, but that was not important I figured* "

In **Rose's** point of view how people perceive you carries significant weight in rural communities. If the violence had become public, it would have brought shame and social stigma upon her, reinforcing her decision to stay silent. Therefore, she navigated a difficult balance between shielding her children from further damage and sacrificing her own need for validation and support in a tightly knit rural environment:

> "*But I think in the city where you live anonymously anyway but out in rural, my aunts the hairdresser she knows all the stories there is to know so, I don't know I think that you call it the how people perceive you is very very ... I want to say it's not important, but it plays a big role just the way it is out here*"

In the following quote, **Rose** also explained how living in a rural area and experiencing domestic violence intersected, leading to feelings of shame when she sought help for her situation:

> "*I was so sick, calling a family clinic and the lady that the operator was the mother of a person I went to primary school with, so she knew who I was and I was a shame of calling*

because she knew me...to admit that I need help, but I don't know what I need and I was really ashamed to be admitting this to this person because I went to school with her daughter…she was like do you need help? and I was like well, I don't really know what's wrong with me I just know something's wrong and I just end up just oh, no, it's okay I'm fine I hang up the phone Gosh, it's still a shame and I didn't want to go into explaining what I was going through"

Rose also explained that there was a stigma surrounding seeking help from a therapist in rural area. While she recognized that something was wrong in her life, specifically referring to the domestic violence she was enduring, no one was willing to listen, and the community's understanding of domestic violence was disconnected from the reality of abuse in intimate relationships. As a result, she sought therapy to address the issue, but she felt unable to talk to anyone about her experience "*when I started to see a therapist that was taboo nobody go see a therapist like you see that in the movie in the city you know I like yeah it's almost shameful*"

Rose felt a deep sense of shame, believing the problem lay with her, and experienced victim-blaming from both her family and the community. Their family's and community's lack of understanding about domestic violence led them to think she hadn't made enough effort to solve the issue in her relationship, further *isolating* her in her struggle:

"*The shame and so to have people around you they are like well you're not helping yourself, and so I know I can't explain it because they don't hear what I have to say because they have their mind is like this is the definition, and so I can't come and have a different opinion*"

Sasha, who lived in a rural area, described how her location amplified her vulnerability to abuse "*we lived we moved out to the farm in rural [town name], which was a 35 min drive from [town name], where everything is to get groceries, everything so, we were out there*" She explained that how economical abuse crossed with the living in rural and far from town "*I couldn't leave without having him there with me, because if I didn't have money I couldn't put gas in the vehicle to go places right …*" Experiencing financial abuse, combined with the isolation of rural living, further trapped her in the abusive relationship, making it difficult to escape her abuser's control.

In **Sasha's** words intersectionality was reflected in this way "*outside of the norm*". She explained that "*it's more isolated like I mean domestic violence you already isolate but when you're outside of the norm, it's more isolating…so the isolation and when you're out and I mean, my closest neighbor was 2 miles away*". Therefore, living in a rural area as being "*outside of the norm*"*,* deepened her sense of isolation while she was in abusive relationship.

Sasha believed that being far away from police and support services influenced her strategy of carefully managing her behavior to prevent provoking her abuser's anger which shows her agency "*So when he got angry you couldn't make him angry*" She emphasized that the strategy she used to stay safe was shaped by the overlap of domestic violence and her rural living situation. This isolation heightened her vulnerability to more control and power by abuser:

> "*Because my safety was to call the RCMP for anything for an emergency it was a minimum of a 45 min wait minimum…and yes especially the rural, because I knew I knew that help was so far away like it wasn't accessible, right? I knew so I knew that had to mitigate* the *strategies I use definitely. we all implemented a lot of them due to the fact that we knew help was so far away*"

Sasha shared her experience of how trauma and domestic violence were deeply intertwined in her life. She explained that she had to monitor every movement, word, and reaction to avoid provoking the abuser's anger an act of constant vigilance that became a form of embodied survival. Living in continuous fear of being killed, her body remained in a heightened state of alert, reflecting the lasting impact of coercive control. The isolation of rural life further intensified this terror, as she knew that if violence escalated, there would be no one nearby to intervene or even notice:

> "*So, I really had to monitor I really had to make sure I didn't anger him too much because he honestly could have killed me and dispatched me, and nobody would have been able to find me like that , that's how it is like there were places where he could have hidden my body, and I knew it and I don't know if I'd ever would have been counted…so, isolation and the fear...I don't want to say that my situation is worse than others, or was worse than others, but it created a fear that was substantial ..I think my x thought she can't get help it doesn't matter she's not, you know, the isolation I can do what I want*"

Sasha's account sheds light the added layers of fear and vulnerability she experienced due to her geographic location. Living in a rural area not only isolated her physically, but also heightened the danger she felt, as help was far away, and her disappearance might go unnoticed. This geographic isolation intensified her trauma and required constant vigilance to survive. **Sasha**'s story underscores the increased risks and fears of living in rural areas, where isolation and lack of accessible support further compound the danger and trauma.

Katie believed that her rural living situation played a significant role in her remaining in an abusive relationship, and she made a connection between be in rural are and staying in abusive relationship in her narratives "*I definitely do because I think if I had more support, I don't think I would have stayed*". She did not recognize her experiences as domestic violence until she spoke with a

counsellor outside the rural area where she lived: "*because it wasn't until I started seeing one of my counselors that she actually started breaking it down, and it kind of gave me the fire that I needed to realize, like, oh, man, this is wrong*". As previously mentioned, she lived in a patriarchal area, where it was common for women to be viewed as submissive and expected to obey men, further reinforced her perception of the situation and contributed to her difficulty in identifying and escaping the abuse.

Therefore, all of her survival strategies such as staying in the relationship, obeying the abuser, and remaining silent were aimed at keeping herself and her children safe, and were shaped by her understanding of relationships within a rural, conservative community: "*so I definitely think that you know I did what I could with what I knew and so yeah, my strategies were definitely influenced by the fact that you know I was in a rural area I took what I could and what was given to me*"

On top of all, **Sasha** and **Willow** noted that living in their province intensified the challenges they faced, significantly shaping the dynamics of their experiences of domestic violence. **Sasha** emphasized a critical point. She believed that perspectives on domestic violence could vary significantly across different provinces in Canada. Consequently, Living in that province seemed to heighten the risk of violence, as she suggested that gaps in awareness, policy, and professional support left women like her without adequate support:

> "*Finding professionals, because it's really difficult to do, west is probably worse than out east, because I hate to say this but we in the [geographical location of province] provinces are behind the time so we can add that part to the marginalization we're like liberal way of thinking does not happen here... we're about i'm gonna say, 10 to 15 years behind what a lot of people are so, that's the top of it…we're behind the time, like, really badly here*"

Alongside **Sasha**'s reflection on province, **Willow** mentioned that she is Métis and resides in a province that is not traditionally recognized as Métis territory. However, due to post-separation violence and child custody, **Willow** feels trapped in this province, forced to live in an environment where she feels uncomfortable and vulnerable. As a result, she does not feel safe: "*I didn't feel like those right indigenous for hear I'm Métis so you know my nations in Ontario so I don't get the same support here… I want to go to Ontario I want to be there…I would feel a lot safer if I was in Ontario much safer if I was in my own territory yes absolutely*"

In summary, this chapter has highlighted the women lived experiences of coercive control and DV-related trauma, showing how they understood, interpreted, and made sense of what they had been through. While their accounts shared common patterns of coercive control , each woman's social location shaped the way coercive control was experienced, the meanings attached to it, and how trauma was felt and lived by each woman. By presenting these experiences in depth, this chapter demonstrates how individual narratives and social locations together informed their understandings of DV-related trauma.

Chapter 7. Surviving the System: PTSD, Justice, and the Search for Safety

Introduction

This chapter presents the second part of the findings, building on the previous chapter by focusing on participants' experiences with PTSD diagnosis. The themes explored here include interactions with mental health professionals, domestic violence services, and the legal system, as well as the role of social location (e.g., disability, rurality, sexuality, and Indigeneity) in shaping survivors' access to safety, healing, and recognition. These accounts reveal the ongoing struggles many survivors face when seeking justice, support, and autonomy in the aftermath of violence. The numbering of the Group Experiential Themes (GETs) continues from the previous findings chapter, beginning with GET.5 and continuing through to GET.10. As in the previous chapter, some of the Group Experiential Themes (GETs) include subthemes, which are introduced and discussed where relevant throughout this section.

Participants, who had all received the PTSD diagnosis, were asked to walk through the process that led to their diagnosis. This exercise aimed to understand how individuals interpreted their PTSD diagnosis and the steps that led to GET.5.

7.1. Navigating Recognition and Resistance in the PTSD Label (GET.5)

I explored the personal and emotional journeys that shaped participants' experiences leading up to their PTSD diagnoses. In these discussions, I examined what PTSD meant to participants and how they made sense of the diagnosis as a label whether it offered validation, stigma, or new ways of understanding their identities as survivors. I also asked whether professionals across domestic violence shelters, mental health services, psychotherapy, counselling, or social work had acknowledged the link between their trauma and experiences of abuse. Just to note, throughout this chapter I use the same terms participants used such as psychotherapist and counsellor to

describe the professionals they engaged with in relation to their experiences of domestic violence and trauma. **MAE** felt that her shelter psychotherapist understood the link between domestic violence and trauma, taking time to listen to her lived experiences and recognize how the signs of trauma aligned with a PTSD diagnosis. She explained that receiving a PTSD diagnosis represented an acknowledgment of pain that had previously been unrecognized and unknew for her:

> "*Absolutely, the diagnosis was just somebody acknowledging it more than anything like you're not losing your mind like this is what you've lived, and this is the natural sequence of events…she [psychotherapist] did sort of a checklist of symptoms, and said clearly clearly this is what you are suffering from so clearly be named for me was a big like, okay, I'm not losing my mind. I could see it as well in the women around me*"

Therefore, receiving the PTSD diagnosis provided her with a crucial sense of validation for the pain she had been struggling with, which had previously felt elusive and difficult to understand. By naming her condition, she found reassurance that she wasn't losing her mind, but rather, there was a concrete explanation for her experiences. As she declared that having someone in this case a psychotherapist helped her to make connection of all her trauma response, while she was in and out of the abusive relationship. This name and acknowledgement by psychotherapist allowed her to link her emotional and physical responses to what she had experienced: "*So I was really grateful that I also had someone to talk to through that and continue to name it for me, so that I knew where the like starting to make those connections back into the relationship*"

In addition, based on **MAE** experience the connection between domestic violence as traumatic experience and PTSD has been clear and inevitable for shelter workers that she has been in touch:

"*I think there's an expectation if you're walking through with these experiences of domestic violence that you've lived trauma and for most of the women to be honest with you, I think they assume everyone walking through their door has PTSD so, I think it's very taken into account*"

Similarly, **Sasha** expressed that the diagnosis provided a framework to make sense of her emotions and her body's trauma responses, which stemmed from the abusive behaviours of her partner. It offered her a sense of consolation and reassurance that she was not "*crazy*":

"*A relief because like I said, she [psychotherapist] gave me the diagnosis, and then she asked me to read The body keeps the score, so I started correlating it's like, oh, okay so, I'm not going crazy, so I had the validation and the validation of that gave me peace*"

Sasha also stated that identifying and naming her pain gave her a sense of hope and empowered her to begin addressing it. Although she was aware that the healing process would be challenging, she viewed this recognition as an important first step toward recovery:

"*I understand it's not an easy this is not easy this isn't nothing about trauma is easy, and knowing that I have trauma doesn't make the triggers go away, doesn't make the hard work go away it actually is the beginning of a very steep mountain decline, but I know that there's a summit, and I know that every time I get triggered I have the tools now to be able to work my way through it so, it's not that dark endless tunnel of nothing*"

Katie described her experience as a "*ride*", capturing the ongoing instability and emotional intensity of living with trauma. Engaging with a counsellor allowed her to recognise what had happened to her and to name her pain, leading to a diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD). Because she continues to experience post-separation violence, the dynamics

of coercion and control remain present. The CPTSD diagnosis provided a framework for understanding her experiences and validating her ongoing trauma responses:

> "*I started seeing a counselor at a [name of the clinic] which is the addiction foundation of [town name] and I started learning a lot about mental health and what trauma is and I got diagnosed with C. PTSD at the time and anxiety so, yeah, it was definitely a ride and I wish that I could say it was over, but it's not because he still stalk us.. so, the process it was lots of talking lots of talk therapy…I went in there and started talking about my alcohol addiction and all the reasons I drank, and you know what was happening my counselor started breaking down like actually she put it into clinical terms and so she helped me break down what was happening and then had explained you know I believe that you've got PTSD, C-PTSD*"

Katie articulated that the counsellor identified a clear correlation between her domestic violence experience and her trauma responses, which were understood as symptoms of PTSD:

> "*I remember her [clinic counsellor] talking a lot about like his behaviors and how he was narcissistic and then we were focusing kind of what he was doing that was abusive and you know the things he was doing , the crazy making and the mental toxicity of it all so we talked about those types of things and just like how his behaviors were abusive*"

In the following quote **Katie** described receiving a diagnosis from a physician, which was based on the counsellor's notes. In her narrative, she indicated that it was counsellor within the addiction support service who made the connection between her experience of domestic violence and the PTSD diagnosis. She did not mention that the physician made this connection directly:

> "*I got the PTSD diagnosis my doctor was the one who officially diagnosed it but it was from notes from my counselor so from like a [the name of clinic] like I said she was the one who kind of first initially said something about it…so, there was the PTSD that CPTSD and anxiety and then yeah, my doctor had diagnosed with the anxiety and depression as well, because I was put on medication for that*"

As **Katie** emphasized that simply knowing the name of her condition whether C-PTSD or PTSD did not mean that the trauma was healed. She continued to face post-separation violence and ongoing abuse, which kept the cycle of fear and distress alive. She explained that even seemingly irrelevant things could trigger intense reactions, as her body and mind made unconscious connections to past memories. Each trigger re-opened old wounds, leaving her re-traumatized and experiencing many of the manifestations of PTSD:

> "*I wouldn't say that it's healed because like I said I'm still very triggered by a lot of things you know there's certain things that take me right back that are completely irrelevant and you know I'm wondering why I'm so angry by this or why this is so upsetting and then you know I go and talk to my counselor and they say, oh, well, you know you might not be directly thinking about it but in your deep subconscious because this is where all your memories are stored this is what's actually setting it off it is that PTSD, because it's being set off by something that's happened a while ago*"

She was able to personally recognise the connection between the manifestations of PTSD, her experiences of domestic violence, and her use of addiction as a coping strategy. In doing so, she highlighted the profound impact of DV-related trauma, which she understood as Complex Post-Traumatic Stress Disorder (C-PTSD), within her lived experience*:*

"*I'm sure were PTSD but it was definitely very defined in our relationship and it was consequently because of our relationship that I got the diagnosis like it kind of came afterwards so I think there is a direct correlation there for sure…it was after that first year and a bit and then talking with the counselor about why I was drinking and particularly that last year in relationship that led to the diagnosis*"

Elizabeth. M recalled that during the relationship she experienced anxiety, depression, suicidal thoughts, and self-harm:

"*I would definitely I would think about self-harming, I would think about suicidal ideation. there was times that I did self-harm while I was in the relationship I have had the anxiety and the depression just got so bad for me during the relationship that I reverted to yeah, like suicidal thoughts, self-harm*"

And then she reflected that even after the relationship ended, she continued to experience flashbacks and intrusive memories, reliving aspects of the abuse. During the relationship, she had interpreted these experiences as symptoms of anxiety and depression but later came to understand them as manifestations of PTSD. This realisation allowed her to reinterpret her past experiences through the lens of trauma:

"*I definitely think that what the most of my symptoms were of PTSD that we're showing were like flashbacks during the relationship like it was like I was really experiencing a lot of like reliving…to be honest at the time it felt like I was like I felt like I was living that relationship, and it felt like all of the issues that I had dealt with in the relationship it was like I was carrying it on into my regular life even without him in my life anymore*"

When **Elizabeth. M** was introduced to the therapy group for survivors of sexual violence and met with the psychotherapist, she noticed that there was a name for all the trauma response that she had experienced:

> "*...introduce me to [name of organization], and [name of organization] holds group therapy for people who've gone through PTSD in particular relating to sexual violence and domestic violence…she [psychotherapist] basically was like yes, you have all the criteria of somebody who has PTSD and trauma in this respect…and she assess me as that...I held all the criteria for somebody who had PTSD and so then at that point she enrolled me in a group therapy session which had lasted for, like from [month] all the way until [month] of this past year*"

Prior to engaging with the psychotherapist, she did not understand what was happening to her. She thought she might be experiencing obsession or rumination, not realising that these could in fact be manifestations of PTSD: "*prior to all of this, it was kind of like what the hell is wrong with you like you're just obsessing over this*"

Thus, recognising her experiences as manifestations of PTSD brought her a deep sense of relief. It allowed her to understand that her reactions were normal responses to trauma rather than signs of instability, and that her experiences now had meaning and coherence: "*I think, like once I got the PTSD diagnosis that really gave me a much bit better understanding of what I was going through, and it honestly gave me a lot of relief in a lot of ways, because it made me feel a lot less crazy for lack of a better word* "

As **Elizabeth. M** experienced gaslighting and psychological manipulation, she was led to believe that she might be dramatic or exaggerating her experiences. Because of this, she struggled to find

a name for her pain and doubted her own reality, often feeling she was being overly emotional. However, receiving a PTSD diagnosis and participating in group therapy were profoundly affirming experiences. Having a name by professional in related to what she was going through opened up space for her to see that what had happened to her was real, that it had a name, and that her responses were valid:

> "*Recognizing that trauma therapy was effective and PTSD therapy was effective it was like okay maybe that's actually what I'm going through like maybe that's what's happening and I'm not trying to be dramatic and I'm not trying to just do this for attention, because I'm doing this all on my own accord* "

For **Elizabeth. M** receiving diagnosis for her DV-related trauma from the psychotherapist was deeply empowering. After being diagnosed with PTSD, she began to understand how to care for herself. Having this name gave her clarity and a sense of direction, marking the beginning of her pathway toward healing:

> "*But in reality, the label is only empowered me to go and do a lot of that kind of self-care work…diagnosis of PTSD that was initially was a huge breakthrough moment for me in terms of like loving myself and taking care of myself like I didn't realize how much I needed it in the time*"

Elizabeth. M began participating group therapy with an organisation that supports survivors of sexual and domestic violence. In this space, the psychotherapist acknowledged the connection between her abusive relationship and the manifestations of PTSD, validating that her trauma was directly linked to what she had lived through:

"*You're a perfect candidate for this group therapy session and then I was enrolled in this group therapy session, where, yeah, the main themes we talked about were abuse...sexual abuse being a huge issue there, and other forms of domestic violence and PTSD in general, and how that affects our how that creates us to have very dysfunctional thoughts, feelings, emotions, behaviours…that was the whole intake*"

In the following quote **Elizabeth. M** explained that prior to visiting the psychotherapist and receiving the diagnosis, she often questioned herself, wondering if nothing had really happened or if the manifestations she was experiencing were even real. Receiving a formal diagnosis from a professional served as external validation, helping her feel empowered to believe in her own experiences and recognise that something within her needed care:

"*Another thing that really like helped me it was this psychotherapist that's been doing this as a career for their whole life is saying, yeah, you have all the symptoms of it, and I found that label just that she put on me in that respect very helpful, because it was like well, I'm not putting the label of PTSD on me, somebody else is recognizing that these are the symptoms that I have, and that I identify so clearly with this label that it was like, well, I'm not faking it because a professional literally is telling me that you fit the criteria for this group, and you can do a whole intensive therapy session in this respect so, I think it really did help heal a lot of things in me...it helped definitely empower me on a lot of ways and diagnosis of PTSD that was initially was a huge breakthrough moment for me*"

She described the psychotherapist's acknowledgement within the sexual violence support service as deeply empowering. This external validation from a mental health expert helped her challenge her internal doubts and the persistent fear that she might be faking or exaggerating her trauma

responses. It affirmed that what she was experiencing was real and a direct result of the abuse she had endured.

Rose noted that at the time she initially consulted a doctor, her symptoms were described under a different name, reflecting the period before PTSD gained broader recognition within the DSM and among health professionals. She explained that, in the early 2000s, the terminology used for her experiences did not yet correspond to what is now formally identified as PTSD. Therefore, she was prescribed medication for a mood disorder, without acknowledgement of her trauma manifestations "*I want to say it wasn't explained it that way it was just like, oh, the chemical disbalanced in your brain and take the pills and it's fine there was no correlation to what I was going through at home*"

This is particularly relevant because **Rose** lived in a rural area, where there may have been a lack of knowledge about domestic violence and trauma. She described that due to lack of acknowledgement of what was happing in her home (domestic violence), her family doctor in rural did not recognized her domestic violence and trauma experience, the family doctor advise to pry or let it go: "*My family rural doctor that's been doctor to my parents had said well, you can try to do some pray and see if you can just kinda you know let it go or today you would call it maybe meditation but I mean people don't do meditation in rural settings people pray*"

She highlighted that due to a lack of knowledge on PTSD and domestic violence, her family doctor and other physical and mental health professionals prescribed her medication, which not only failed to help her but also made her feel like a zombie. They did not take her experience of domestic violence into account and did not take the appropriate steps to help her heal: "*so I really wanted to help for that and then they put me on heavy medication for , so every time I was more medicated, I was more zombie I want to say*"

But **Rose** came to understand that the manifestations of PTSD she experienced were not the result of a chemical imbalance or a mood disorder. Instead, she sought recognition and a name for her pain, wanting to understand its source and meaning.

As mentioned earlier, her partner was a military veteran who later worked in the police force. Through him, she gained access to mental health services and PTSD-related resources provided by the military, where PTSD was more widely recognized among veterans. She found that she could strongly relate to the PTSD manifestations described in the books and materials she encountered:

> "*I guess now it's more understood for everyone it's not limited to the military and it's still not there [rural area she meant]…some understand it but not as much...because I'll give you an example you know back when kids were starting to be given Ritalin and people said that's a city problem why, you need to medicate kids, this is crazy*"

However, when she sought help from her family physician in her rural community, the condition was not recognized or taken seriously particularly in the context of a woman experiencing domestic violence: "*…and so I guess it's the same idea, like domestic violence always existed and people survived so why now they have this big word for it…you know…I think it's important to label something that just it's just the way they are like*"

She highlighted that there is still resistance in accepting this label, as society remains unprepared to fully embrace or understand mental health issues "*I guess society didn't want to accept this as a real thing because there was so many implications for the employers so I guess*"

In line with her broader reflections on the PTSD label, **Rose** expressed that society has yet to fully accept or understand it, particularly when applied to women who have experienced domestic

violence. As she pointed out, it feels unjust that survivors especially women must carry the label and, in doing so, bear the weight of what was done to them. She highlighted that the origins of the label are rooted in social and political contexts that often overlook gendered experiences of trauma:

> "*I'm just really mad that they put a label on it and it's like, oh, it's a problem on this woman…shame yeah because how was I responsible of somebody else's actions and then yet again I felt like I had to explain why I had this label but how much can you really say and without bringing more shame up…so it was challenging to figure what to say and not to say I guess the idea of being judge…Yeah and the idea of to be like a poster that's what it looks like, right but it's just interesting how victim of domestic violence would be the one sick and the one being medicated meanwhile little is done about who's doing the violence*"

For **Rose**, living in a rural community where such labels are rarely accepted made this even more difficult. She questioned why women should have to carry a diagnosis when the violence and abuse were acts committed against them by men, noting that the label itself can sometimes bring feelings of shame rather than validation.

Willow also articulated a critical stance toward the classification of PTSD as a "disorder", suggesting that this framing represents a patriarchal way of pathologizing women's survival responses. Given that she continued to experience post-separation violence and coercive control, she questioned the validity of describing her reactions as 'post-traumatic':

> "*If you are stressed out because you're like for me I'm being stalked so that's really stressful. well so, you have like some kind of disorder, no, I'm not disordered, I'm being stalked and stuck you know there's no pill that's going to stop it it's no pill that's going to make me better so, it's to experiencing like failing health failing finances to actually have these*

systems not just be neutral anymore about you to try to bury me you know it's a lot it's a lot"

Instead, she viewed them as normal and adaptive responses to ongoing, unrelenting stress. She argued that meaningful recovery cannot occur while the structures of violence and control persist:

"*And I would say I find it very patriarchal and patronizing I think it's really unfortunate that people are labeled with disordered when they're dealing with things like this, it's not disordered to have a stress response to unthinkable acts you know of injustice it's not disordered at all* "

Willow acknowledged that the manifestations associated with the PTSD label resonated deeply with her she could identify with symptom described. Yet, she firmly rejected the classification of these experiences as a "*disorder*", emphasising instead that they were normal and understandable trauma responses to an overwhelming and ongoing situation:

"*I mean I don't disagree with whatever sentence they talk about [she referred to the clinical symptoms of PTSD] , like nightmares and heart rates and fainting, that's all real and being hypervigilant those symptoms they can tick all those boxes off that they want but I also think that those would be normal responses to having to endure what I endure that's my problem with psychiatry? right?*"

Willow believes that trauma responses are adaptive and normal survivor responses to threat, which, in her case, are ongoing due to post-separation violence and stalking by her former partner:

"*I guess trauma responses to highly stressful situations…I don't think it's disordered at all… you know, you're supposed to be afraid of scary things...right? you know you're reasonably humans are supposed to be afraid of scary things it's not made up and that*

would not be a disorder in my mind, but that's just, I guess snip picking the medical model if that makes sense"

She considers that the PTSD diagnosis will be used against her to keep her away from her daughter as a coercive tactic and tool by the systematic abuse. While she admitted that the PTSD 'symptoms' resonates with her trauma response, she doesn't like the diagnosis term:

"*It's a psychiatric label that would be weaponized to keep me and my daughter apart...I don't want to label...I mean as a whole, I'm certainly going through it but I think it's people should be wary of applying psychiatric labels to people who actively experiencing trauma*"

Willow also noted that due to ongoing post-separation violence, she believed her ADHD symptoms had worsened. However, during an appointment for ADHD medication with psychiatrist, she received a PTSD diagnosis:

"*When the trial was I thought my symptoms of ADHD were getting more and more strong like I was unmanageable…it was so crazy.. I was fainting a lot so, I just thought it was symptoms of ADHD that were escalating and aggravated by the stress that I was feeling. so finally, as my physical health was failing, and I was feeling really on edge, like really like anxious, so I got the appointment I had with psychiatrist to like address my ADHD needs got escalated so I went into this appointment about ADHD, and I came out with the diagnosis of PTSD*"

However, she emphasized that the diagnosis is not fair and accurate as coercive control continued and ongoing part of her life "*it still doesn't make sense to me, because we're still going through it*"

Although it's unclear which professional made the connection, **Willow** indicated that either the psychiatrist or family physician or trauma psychotherapist acknowledged the link between her

experiences of coercive control and other forms of interpersonal violence and her PTSD: "*She wrote the report, and it went to my doctor, and it's explicitly states that it's from family violence and the use of children protection services and the police*"

In the study, all six women mentioned that receiving a PTSD or trauma-related diagnosis helped them understand their feelings, providing clarity for both the emotional and physical pain they had been carrying. It allowed them to see their reactions as part of a legitimate and authentic experience. However, not all of them felt comfortable accepting this label. For some, it seemed unjust, as the focus appeared to be on what was 'wrong' with them, rather than on the control and coercion they had suffered at the hands of their abuser.

When participants spoke about navigating the PTSD label, I began to reflect on how this diagnosis was perceived and managed within professional and legal contexts. Knowing that several participants had been involved with the court system and child custody proceedings, I became interested in how a PTSD diagnosis arising from domestic violence was considered during interventions by professionals in these settings. This line of inquiry led to the development of the following Group Experiential Theme (GET.6): Weaponizing PTSD Diagnosis.

7.2. Weaponizing PTSD Diagnosis (GET.6)

When five participants described their lived experiences with the courts and child custody process, their responses illuminated important themes, revealing how the institutional system like family court, criminal court, child custody services, is not a safe place for these women to disclose their experiences and the impact of domestic violence.

Sasha believed she had to guard herself by concealing her PTSD, as she feared it would be used against her role as a mother in family court. She shared her PTSD diagnosis with her lawyer;

however, he chose not to disclose it in her case. This, she believed, reflected his awareness that the label could be used against her to portray her as unstable and therefore an unfit mother. What was meant to validate her experience of trauma instead became a source of vulnerability within a system that often weaponizes mental-health diagnoses against survivors:

> "*My lawyer had it I gave him the medical evidence of it but I'm actually pretty glad he didn't give them that, because I think it would have been another avenue to use to against me… I mean he [abuser] never had the opportunity to do it but I fully believe him and his lawyer would have used that to say I wouldn't capable to raise the kids...they would have used the mental illness diagnosis that I couldn't look after them [children], that I was too ill… that would have been the other assassination which is why my lawyer didn't use it because I mean he warned me about that*"

Sasha also chose not to share her PTSD diagnosis with her children, as they remained in contact with their abusive father. She described this as a protective strategy to shield both herself and her children from potential harm. She feared that revealing the diagnosis could be used against her, possibly altering the narrative of her parenting and allowing the abuser to portray her as unstable. By keeping the diagnosis private, she sought to protect her children and maintain her ability to care for them, demonstrating once again how survivors must navigate safety through constant vigilance and strategic silence:

> "*My x has no idea like I said he would use that actually , none of my kids know about it, either they don't want them to slip it up and tell their father that right? I'm not ashamed of it there's nothing to be ashamed of it, it's not my actions that caused it but it is it will be used against me, and I am fully aware of that*"

Similar to **Sasha**'s experience, **Katie** also asserted that her diagnosis was weaponized against her in family court and child custody process: "*I think something like that probably hurt me more just because of the fact that it went towards like oh, well, look, she's unstable*"

Katie feared that her PTSD diagnosis or visible trauma manifestations such as anxiety could be used against her, labelling her as unstable or untrustworthy. Having endured ongoing trauma, she was aware that during court proceedings she might appear distressed, and that these natural trauma responses could be misread as signs of emotional instability. This misunderstanding, she felt, ignored the reality of her DV-related trauma and risked further victimising her within systems that fail to recognise the effects of abuse: "*Look she's got mental conditions she's got anxiety she's got PTSD, so how can we trust her? so, I think it kind of went against more because I wasn't presenting myself well, because I was traumatized*"

MAE also concealed her PTSD diagnosis to prevent it from being misused against her in family court proceedings. The entire situation around custody and the legal process was terrifying for her, and she felt she had to be extremely cautious about what she disclosed. She feared that her abuser who had previously weaponised her physical disability against her would do the same with her mental health diagnosis, using it to question her credibility and fitness as a mother. This constant vigilance reflected the ongoing coercive control she continued to experience, even within institutional systems meant to provide justice and protection:

> "*I was terrified he was going to try to come for some sort of custody access…he didn't know about the PTSD, they didn't know about the PTSD diagnosis…what do you sort of share mentally with the court situation when you know that that person's entire M.O. is about turning that against you because he did that with ME*"

As mentioned, she was attending psychotherapy sessions, and her therapist also cautioned her to be careful about what was shared with the court, particularly regarding her PTSD diagnosis. Together, they took precautionary steps to protect her, such as avoiding detailed written records or explicitly using the PTSD label in documentation. These measures were intended to prevent the diagnosis from being used against her in court proceedings. For both her and her therapist, this approach became a protective strategy balancing the need for therapeutic support with the realities of navigating a legal system that could misinterpret or weaponize her mental health information:

> "*The PTSD diagnosis the therapy all I never reveal the name of my therapist, or where it was going, either because she [therapist] had warned me about that if you go to court they can subpoena everything and if they subpoena all your documents...I [therapist] don't write a lot down...I'm really careful because if they go to court they can pull everything that you've said and it can go to court if you go to it, is the PTSD Diagnosis, or just the just the name of the truck…should I be saying this in here? should I be? what? what's he going to think?*"

As **MAE** experienced disability and feared being institutionalized by the judicial system, she was reluctant to disclose her PTSD. She did not want to provide another tool that could be used against her, as her abuser had already exploited her vulnerabilities. She was threatened with accusations of parental alienation, and her physical disability was used to question her capability as a mother:

> "*The legal process and the parental alienation threats, and are you capable, then are you really sick?...I was a trying to prove I had ME...I don't think you matter in that moment…because you either are going to give up and will allow to give up custody with your kids or you have to downplay anything that might be a struggle for you because everything is a weapon in that process, everything is weaponized that you say so you have*

to be very thoughtful and considered with your language, with your words, with what you're asking for and don't offer anything else"

Willow additionally concealed PTSD diagnosis to prevent weaponization in family court and child custody services**.** She believed that a psychiatric diagnosis, grounded in a patriarchal system, would be used against her capabilities as a mother:

"*It wouldn't surprise me if it was, it's a psychiatric disorder I mean, I know what I've experienced with them it's just everything's been weaponized and that having a psychiatric disorder really is not going to bode well for me, you know that's pretty common, though women are end up with PTSD, and then it's used to keep them from their children unfortunately…if it comes up in court, and if they request things like this it'll probably be used against me to say I am not able to parent because I have PTSD…like I think everyone could use therapy but they weaponized it, saying, there's some, you know there's something wrong with me...I've always thought counseling and therapy just for my own needs, that decision was used against me in court, my personal self directed want for therapy was weaponized…it's stigmatized here badly*"

In addition, **Willow** described that she is experiencing situational anxiety, which refers to her trauma response as a survival strategy. She believes that all anxiety responses are normal reactions to extraordinary and traumatic situations that she has been experiencing:

"*I'm not depressed and even though I would have situational anxiety, it's it just happens to be the situation very long it's prolonged exposure to stress that's causing it but it is still situation you know I've never been anxious or depressed to my life... you're supposed to be afraid of things that are scary so, you know, anxiety is your body telling you…healthy*

anxiety is telling you there's some you know, telling you there's something to be afraid of that's not disordered"

Rose discussed that she chose not to disclose her PTSD or mental health status in family court. At the time, she feared that revealing her mental health struggles would make her vulnerable. Her ex-partner was a police officer, and she believed his professional status gave him significant power and influence within the system. As a result, she felt that she had no power, and disclosing her diagnosis might be used against her rather than in support of her safety and wellbeing:

"I had no credibility I had no power I don't wear a uniform for a living I'm not a cop, that's what's clear to me that the balance of power was so unequal and I had a lawyer standing beside me who said nothing nothing...that family court judge to credibility of him because he was a cop so it played against me it played against me and the kids…no one got the violence seriously as he was cop...he is a cop and it was always well, it couldn't be that bad because he's still a cop…so I was always fighting to get anybody to believe me"

7.3. Response to DV-Related trauma by Professionals (GET.7)

When reflecting on their experiences of DV-related trauma, participants spoke about their encounters with a range of professionals including family physicians, counsellors, social workers, psychiatrists, and psychologists across both mental health and domestic violence support settings. Their accounts revealed that professional interventions were not always experienced positively; while some encounters understanding and support, others left participants feeling dismissed, re-traumatized, or unheard. These experiences shaped how they understood help, recovery, and recognition as survivors.

This Group Experiential Theme (GET.7) explores participants' diverse experiences of professional intervention and the meanings they attached to these encounters. It includes the following subtheme(s): Experiences recognized, not dismissed, When help fails, Psychiatry as medical model falls shorts for survivors, and Unseen and overlooked survivors' social locations.

7.3.1. Experiences Recognized, Not Dismissed

Under this sub-theme, participants expressed that their lived experiences were recognized and named as domestic violence by professionals they encountered. These included shelter workers, psychotherapists, social workers, psychologists in private practice, sexual violence support staff, hospital-based mental health professionals, and others offering support through various survivor-focused services.

MAE reflected that language carries power, and being able to name her experiences as coercive control a term introduced by shelter staff and her therapist was a pivotal moment in her healing journey. This act of naming provided clarity, validation, and a framework for understanding the abuse she had experienced:

> "*[shelter's name] was huge for me, and in terms of identifying coercive of control as well because that's not something that I had language for before…the therapist certainly naming the violence and recognizing you know, because when I first went there, this is something that's lacking to my mind*"

She reflected that finding the words to describe the abuse and trauma she experienced was an important milestone in her healing journey. Trauma, she explained, had left her feeling voiceless and unable to articulate what had happened to her. During the interview, she noted moments when

she needed to stop and think carefully about how to express her experiences, illustrating both the enduring effects of trauma and the empowering nature of reclaiming her narrative:

> "*Not being able to articulate it, I was always amazed at how inarticulate I was at the beginning I couldn't and I'm even with you at times I'm having to stop and think right...I know that there's you know, part of your brain that takes in that lives the trauma that until you can verbalize it, it can't cross over, and you can get it out of your brain right?*"

MAE stated that while she admitted to the group therapy within shelters and verbalized her experience, she noticed that there are words for her experience and received compassionate support. Additionally, she noted that other female participants had encountered similar patterns of abuse:

> "*The counselor [shelter's name] she was very strong she was very empathetic we talked a lot about you know the realities like we made lists of both what had happened, and how it made us feel, and what the trauma did and what the triggers did and it was a probably the most memorable and powerful group, because it basically put everything into words and it was really incredible to go around the room and maybe say a couple of things each and then listen to all these other women also cropping up it was huge I mean*"

MAE expressed that hearing other women in group therapy at the shelter describe similar patterns of abusive behaviour was a powerful and affirming experience. She shared that recognising these commonalities helped her better understand her own situation and made her feel less alone.

In **Rose** lived experience firstly she received validation by social worker through a support service that assists women involved in the criminal and family court proceedings. The social worker named her experience as rape within an intimate partner relationship. Before this acknowledgment,

she believed that what she was experiencing was normal that this was simply how relationships were supposed to be:

> "*You need some services I'm going to send you to the hospital this is a rape and I said really but this happens a lot so until somebody labels it I don't know that it is what it is I just know I'm sick I'm not well, that's how I would explain it*"

Rose also spoke about a social worker she met through a hospital-based sexual assault support program, describing the interaction as helpful and supportive to give the name and explanation of the dynamics of power and control that **Rose** had been experiencing by her abusive partner:

> "*She [another social worker] was a great professional that followed me and she took this seriously...she was acknowledging like how unfair more than unfair it was just disgusting the disgust of just the power of abuse …she was on point to talk about the manipulation and just the complexity of like trying to get away but then going back...and so I didn't have to explain that to her she knew that so there was a lot more awareness of what's domestic violence...I think what was helpful and for me with [sexual assault support centre] was that the acknowledgment that there was sexual violence and it's obvious*"

Furthermore, **Rose** reached out to the hospital in city when she experienced manifestations of PTSD. She said that when mental health professionals in the hospital listened to her story, they validated the connection between her abusive experience and the trauma response that she felt:

> "*I was just dying of like not well I would drive to the city and at the city they would bring me to the mental health floor and they would get me to talk to psychologist or whoever was working and then I would tell them my story, and then they would say, well you have a*

reason to be not well and I remember they say it's it's not a normal circumstance you're going through, and that was validating"

Similarly to **Rose and MAE, Katie** found validation regarding her experience of domestic violence through the counsellor's affirmation, otherwise she thought that she was the problem in her relationships because she didn't understand what she was experiencing. She believed that she was to blame, which shows how abusers manipulate survivors into thinking they are at fault for the abuse:

"*I'm so thankful that I did start talking to counselors, because had I not started doing that I would have believed forever that I was the problem, because he had everything so flipped backwards and I couldn't see a way out and I did think I was the problem I was suicidal*"

Sasha also felt empowered when psychotherapist has knowledge and had skill to recognize coercive control and make a connection with trauma and CPTSD:

"*The counselor I'm saying now that takes in it is also a survivor I don't have to explain a whole lot, and she gives me the tools to empower me and she understands because coercive control is so nuance*"

Sasha pointed out that her counsellor's own experience as survivor of domestic violence, and because of her lived experience, she had a deeper underrating of coercive control. In addition, Sasha believed that because of the counsellor's expertise in coercive control, she knew how to help **Sasha** in reclaiming the autonomy she had lost as result of coercive control and DV-related trauma:

"*My counselor now she's helping me find my autonomy again, because when you're in the abusive situation, you give that autonomy away right? so now she's helping me assert my*

autonomy and find it and bring it back to me, which empowers me right I think that is one of the things and those counselors are so hard to find "

Elizabeth. M felt truly understood for the first time, as the psychotherapist's confirmation validated her experiences, giving her the assurance that her pain was real and recognized:

"*So it's only really until I got the PTSD diagnosis from the [organization's name] psychotherapist that I actually started feeling like understood, supported and like, okay, we can actually go forward from here like there is a path going forward versus before it felt like I was kind of just doomed to be that way forever so they recommended me once they gave me the PTSD diagnosis they recommended me for this group therapy which ended up being very helpful for me in the end* "

7.3.2. When Help Fails

Participants also highlighted the limitations in professional responses to their experiences of domestic violence and trauma across various sectors, including psychologist, counsellors and family physicians. In the following quotes **MAE, Sasha, Rose and Elizabeth. M** described their experiences when reaching out to professionals such as couple therapist, psychologist, counsellors and family physicians. They shared that in their cases, domestic violence was not recognized or acknowledged by some of those they turned for help. They spoke about actively seeking support in order to have their lived experiences received validation. They also highlighted the limitations of mental health services, noting that the current approach like CBT or limited sessions of therapy fails to meet the needs of survivors of trauma and domestic violence. Rather than short term interventions, they insisted the need for longer-term, trauma and violence informed support that address the depth and complexity of their experiences.

MAE recounted that, during the relationship, she and her partner attended couples therapy, as she hoped it might help resolve their issues and believed that his behaviour could be addressed through professional support. Yet, she found that the therapist failed to recognise or name the abusive dynamics at play. Instead, the sessions centred on her perceived role in managing the relationship and helping her partner, which not only silenced her experiences of abuse but also replicated the patterns of blame and control she faced at home:

> "*I didn't matter it was like my marriage was magnified in this therapy room we talked about him we talked about how I could help him…that was terrible it was really…he just learned from it…very manipulative how he would maneuverer people around him and get them to do things for him*"

As she spoke about this experience, she recognized that recalling the therapist and those sessions brought up feelings of anger. She reflected that this anger was an important turning point, it helped her decide to end the therapy and realise that nothing could be resolved through couples counselling, because the problem was not a relationship issue but one of power and control:

> "*I mean I can feel the anger now, and I can feel that I felt in her in the moment, and at least I had the anger to say enough I'm not doing this anymore, because I've been trying to help this man for fucking 16 years and look at look at what's happened so*"

In a similar vein, **Sasha** recounted a comparable experience with a psychotherapist. **Sasha** believed that coercive control was often unrecognized by some psychotherapists, who tended to frame it as a surface-level conflict between partners rather than as a pattern of power and control directed toward her. She explained that even her therapist, who diagnosed her with PTSD as a result of domestic violence, at times encouraged her to "step back" and not react to the abuser's behaviour.

Although the therapist identified as trauma-informed, she was often advised to be more understanding of the abuser's actions an approach that felt disempowering and invalidating. For her, this experience illustrated how therapeutic practices can unintentionally reproduce dynamics of control when coercive power is not fully recognized:

> "*She did give me the diagnosis, and she did give me some things, but she also told me I had to step back and look at it from all sides because I reacted to how my x texted me or sent an email to me one time, and she didn't like how I reacted so again, there was some trauma informed in, but not completely trauma informed…she [psychotherapist] said, you have to be bigger than that, and just let it go and look at it from his point of view and I'm like, I don't have to do that like I don't want to do that that isn't I don't have to be bigger anymore I have left I don't need to give him give into that anymore that was the main reason why I left …ha! think about it from this point of view, or what happens if you did this, it was, or even help me like...that didn't empower me that was giving my power away again*"

Sasha believed that coercive control was not clearly understood by some professionals, particularly in her interaction with some psychologists. She felt that psychologists approached the situation through a mainstream psychology lens, emphasizing that a relationship is 50/50. This perspective placed the responsibility on her shoulders and blamed her, rather than empowering her. As **Sasha** was trying to speak about the various forms of control she had experienced, the response left her feeling blamed and unsupported, rather than recognising the dynamics of coercive control in her life:

> "*He was telling me what I needed to do during my parenting time and it seems like a little thing but that it was his power over it that is what I'm talking because my relationship was financially emotional and coercive control those are the things that people really don't*

understand it's so not recognized by so many people psychologist, psychiatrist, you name it it's just not recognized...I was at a counselor and she said well, every relationship is 50 50 when there's violence involved there's no 50 50 I'm sorry it's not so when you have that happen to you it damages"

Sasha emphasized that simply labeling her experience as trauma or using a trauma-informed approach by psychologists is not enough to fully understand the domestic violence patterns. She stressed the professionals in nay filed should be able to recognize and address coercive control during therapy sessions.

Sasha shed light on how limitations in accessing mental health professionals knowledgeable about trauma and PTSD could hinder survivors from fully progressing in their healing journey "*But when you're dealing with trauma there's a lot of counselors or psychologists that actually don't understand it…and then they give you these well, you just have to get through it and get past it and get over, you know*"

Rose noted PTSD was not initially recognized by the mental health professionals she reached out to, as it was still largely associated with military veterans rather than women experiencing domestic violence:

"*At the very beginning, like, let's say [year-early 2000s] it was called mood disorder…I think when I was at the hospital in [name of town] with the social worker it became clear that I wasn't well I didn't have the vocabulary but then I could label it all right so okay PTSD...and she [social worker] was the one putting words to what I was like explaining...it just seems like it's clear that military have that it's clear that police have it now but a woman for domestic violence I want to say it's still not clear*"

Elizabeth. M also mentioned that there was a lack of knowledge and resources among healthcare providers left her without the support she needed. In the midst of coping with DV-related trauma, she had to take on the burden of researching her own options and navigating long waiting periods for assistance:

> "*I was kind of battling this with myself, but I was also kind of battling this with my parents to like admit me, admit me back into the into the [hospital's name], because I couldn't go on, and I knew that with a lot of the way that our psychiatric system works, or just even getting pharmaceuticals in general for things it's a lengthy process it doesn't really have a lot of support and you really have to do it kind of all on your own…I was waiting a long time*"

Elizabeth. M described that, in the absence of understanding or acknowledgment of her pain and abusive experiences, she constantly found herself struggling to prove that the suffering and trauma she carried within were real. She spoke of the exhaustion of repeatedly seeking support waiting on long lists for services, receiving medication instead of meaningful help, and feeling as though her distress was being managed rather than understood. This ongoing struggle for recognition left her feeling unseen and further isolated, reinforcing the emotional toll of her trauma:

> " *From [date] yeah, like [date] all the way basically until when I got actually referred to the [name of sexual violence service] it felt like I was completely on my own, like I didn't feel supported I felt like I was battling with everybody I was battling with wait times like I was waiting to get diagnosed with things I was waiting for medication for ADHD to just even help me with things like…like with things like motivation like I couldn't get myself out of bed, I was like something needs to change and the support the therapy…I was like looking both for medication as well as therapy*"

Additionally, **Sasha** believed that professionals lacked sufficient training in domestic violence, noting that understanding abuse patterns requires more than a brief course, it demands extensive and ongoing training:

> "*I have learnt that a lot of programs don't have intimate partner violence in it so a lot of psychiatrists, a lot of medical, a lot of social workers, a lot of are not trained or if they do have training, it's maybe a day when it really is as you probably understand...IPV is not something that can be said in a 4 hr course like it is…it is huge, it should be probably a semester's worth of work in itself, like my mind, like it should be there should be…it is to understand the effects of it, it takes years for a lot of people who specialize in it to really kind of see the pattern of what victims go through*"

Therefore, from **Sash's** perspective, finding a therapist with expertise in trauma and domestic violence is challenging, which can leave survivors struggling to succeed in their healing process "*finding counselors that do get it and haven't and can help find your empowerment is really difficult but that is a problem…that leaves us survivors that fails us in a lot of ways*"

Similarly to **Rose** and **Elizabeth. M**, **Sasha** mentioned the long wait lists survivors face while dealing with trauma, as well as the underestimation of DV-related trauma by professionals even after prolonged access to these services:

> "*To get into them [she meant access to services] is a 6 to 8 month waiting list and when you're in a crisis that's [showing frustration with her face] so you have a 6 to 8 month waiting list for people that don't understand so, when you finally get there, you don't feel any better because you're not being in heard you're not being validated* "

MAE, Elizabeth. M, Rose and Katie shed light on how short-term therapy and the search for trauma and violence-informed therapists highlight the deficiencies in mental health and shelter services available for survivors of domestic violence.

As **MAE** mentioned, addressing her PTSD and DV-related trauma required long-term therapy. Consequently, she sought therapists outside of shelter services who had a deep understanding of both domestic violence and trauma:

> "*Thought I need something deeper… so, I found this place in [town name] got myself on a wait list…I would have gone for more groups if they had gone even deeper but reached a sort of a point where I just felt like I was okay, I've done that I would have gone further, but I don't know that everybody I don't know that they had enough people who would do those, or if they had enough resources frankly to do that* "

Reflecting on **Katie, Elizabeth. M and Rose** lived experience, they highlighted how the barriers of short, limited therapy sessions and the challenge of finding the right therapist forced them to actively search for different counselors, underscoring the significant obstacles they faced in getting the support they needed:

> "*So it was hard to get a lot of the help that I needed so I did a lot of bouncing around through different counselors to try and get help*" ***(Katie)***

> "*The therapy kept falling short like there was nothing that I was finding that was clicking...even olds psychologists or psychotherapists that I've had just really had no idea how to help me that, like they didn't deal so specifically with the type of issues that I was going through*" ***(Elizabeth. M)***

"*So I guess the biggest problem had been to have long term services so every time it was 3 session here that's it so then I would look for another service so there's a lot of places that I went but it's because it was such short time because I was like I'm not okay so I kept trying to find something else…I think I was stubborn in wanting to have a solution and so I kept bothering all the agencies …one time at the hospital in city they say, oh, we have outreach services and we'll call you in the week and they call in the week and they say oh you're not on our territory so it's very discouraging but I kept knocking on doors*" ***(Rose)***

7.3.3. Psychiatry as Medical Model Falls Shorts for Survivors

Elizabeth. M, Sasha, Willow and **Rose** uncovered how the medical and psychiatric system failed to recognize trauma responses resulting from domestic violence and address it. As **Elizabeth. M** explained that she reached out doctor (family physicians) for help, her 'symptoms' were viewed through the lens of the mainstream psychiatric or medical model: "*I went to my doctor basically saying, when I get anxious I can't eat I can't really sleep so, it was like I'm not functioning any more, and she gave just an anti- psychotic...it would just basically sedate me*". Instead of exploring her experience of domestic violence and trauma, the doctor focused on symptoms management and prescribed antipsychotic medication. She was not asked deeper questions that might have uncovered the context of coercive control and trauma underlying her distress

She now realized that her symptoms like panic attack were manifestations of DV-related trauma as flashbacks, but at the time those symptoms were misinterpreted and leading to inappropriate medication and a lack of validation for what she had actually been through: "*Basically stayed on these antipsychotics [date]…so, it's about 6 months of me just taking antipsychotics because the panic attacks which now I can understand is flashbacks and now understand, as my body, just*

reliving a lot of that trauma was just unbearable to feel, and I really it was kind of like either I am the sedated version of myself, or I might drive myself to act on my suicidal ideations or self-harm"

Also, **Sasha** had an overlooked experience with a psychiatrist who did not consider or ask about her history of domestic violence, focusing solely on her symptoms without exploring the roots causes. She spoke about psychiatrist's dismissive behaviour, without considered or listened to her narratives. This left her feeling abandoned and questioning her own reality and led to victim blaming and internalized DV-related trauma:

> "*The psychiatrist was just give me medicine make me sleep he saw me for 5 min and was just he gave me antidepressant, a sleeping pill and an antipsychotic I find a lot of the medical society don't understand trauma…the psychiatrist actually made me feel like I had something mentally going wrong…he actually made me feel like I was crazy he didn't want to hear it he literally did not want to hear it and he goes oh, well, you're not sleeping, so we'll give you sleeping pills most I saw him was 5 min*"

In **Saha's** viewpoint, while medication have some effect, it could not address the root of her trauma, which stemmed form domestic violence. She believed that her trauma was not the result of a hormonal imbalance, but it was a response to prolonged control rooted in power inequality:

> "*As far as I'm concerned in all the research, sometimes medication helps but ultimately, when you're dealing with trauma being medicated, isn't you? you've got to reconnect your brain waves it's more than medication…you need more than medication in order to heal.. so we're failing a lot of people yeah it's failing a lot of people*"

She believed that approach and support beyond medication and medical model was essential to recognize the social and relational aspects of domestic violence and trauma.

Sasha provided further insight into how the psychiatric system and reliance on medication made her feel isolated. She also shed light on the historical treatment of women in psychiatry, particularly the dismissal of their experiences as hysteria. She described how misogynist and dismissive behaviours have led to shame, isolation and victim blaming among women:

> "*So, it's more isolating you know that women are hysterical…it's also that well, if it's medication, it's just because you're crazy so, you also have there's something wrong with me mentally so that there's the shame of that as well do you know what I mean by that you have the shame, and then the guilt and then there's the stereotypes of hysterical, crazy woman who who's just the top and over, you know, dramatic and blah! blah, blah, you've got all that going on and you just won't call shell and hide and that's so it's really*"

Instead of recognizing trauma response in women through the context of historical violence inequality and patriarchal control, the medical and psychiatric system often labels women as dramatic, failing to address the structural violence they endure.

Sasha added that systems tend to treat you as a number to be medicated, rather as a human being who deserve care, support and dignity, especially when dealing with the impacts of trauma and domestic violence which are never the survivor's fault:

> "*You're just a number you're just a number and you're treated like you're just a hysterical over dramatic number when you're treated like you're hysterical, and that is you're fluffed off like that there is like, I said, there is no hope and you think are?*"

Rose mentioned that every time she visited a psychiatrist or family doctor, she was given heavy medication which made her feel like a zombie. This indicates that the psychiatric system focuses solely on medication rather than addressing the trauma she experienced and providing proper

therapy: "*So, every time I was more medicated, I was more zombie I want to say*". In addition, **Rose** mentioned that during her first appointment with the psychiatrist, he told her it would take a year to provide a formal diagnosis and, shockingly he fell asleep during the sessions:

> "*First psychiatrist I met he was very old and he said I will need to meet with you one year after one year I can give you a diagnostic the worst it was yet to happen he fell asleep…I was like is this a movie like he's this for real he's sleeping on his chair right now fell asleep while I'm talking…I'm like this can't be…come on it's ridiculous*"

This experience left her feeling dismissed and devalued, reinforcing her sense that even within mental health services, her pain and trauma were not being taken seriously and made **Rose** angry:

> "*I went back a second time he fell asleep again so it happened twice I called the clinic of my family doctor, and I said I want a new doctor, and I can't get a diagnostic from somebody that falls asleep on me*"

As discussed, **Willow** believed that the psychiatric system has been oppressive and patriarchal, giving labels to women:

> "*I don't think psychiatry is a safe place for women in general I don't think the DSM is safer the DSM is the Bible it's very patriarchal and colonial the DSM, but I mean, there's so many labels out there that are so oppressive and so heavily applied to women*"

Willow also sheds light on how the psychiatry system has historically treated women. She critiqued the tendency of psychiatry to label normal trauma response. She pointed out that diagnoses like hysteria or borderline personality disorder have often been used to dismiss women. viewed women and its patriarchal, potentially harmful impact on women:

"*And what was the hysteria so, the hysteria was about how women are often diagnosed with borderline personality disorder which was previously known as hysteria…it's a throwaway diagnosis, in my opinion but it's based on like a wandering womb and female hysteria, it's so bad now that people experiencing, you know, natural and expected range of emotions to distress, or grief, or loss or being pigeonholed as having mental illness which is very damaging*"

Willow referred to the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the bible of psychiatry and argued that it reduces the normal human reactions into a rigid set of criteria. She noted that western psychiatry is based on a model of pathologizing normal responses to trauma, diagnosis and labelling instead of underrating the broader social and structural context:

"*How did we come to this point where the DSM is the Bible you know I think it's delusional in a way. I mean what I read in an article recently where they said now that grief is now a disorder added to the DSM that's insane to me you know my mom died 10 years ago. I so grief for her does that drive another mental illness? because I miss my mom and I struggle with her death? you know this is, I don't believe that everything's disordered think that psychiatry is very oppressive*"

Like **Elizabeth. M**, **Sasha** and **Rose, Willow** mentioned that medication made her trauma worse and made her numb, which is not actually healing:

"*But taking a pill that numbs your feeling so the agitation and it was so intense [she meant the ongoing dynamics of post-separation coercive control] and then I really wonder why would I want to take a drug that makes me lose my mind for 6 weeks…I'm living in extraordinary circumstances If that makes sense*"

By considering **Elizabeth. M, Sasha, Willow** and **Rose's lived** experiences within the psychiatric system regarding their trauma, it seems that they have been re-traumatized through neglect and dismissal system.

7.3.4. Unseen and Overlooked Survivors' Social locations

When I asked the six participants whether professionals including domestic violence service or mental health services considered their social locations, such as living in rural areas, their religion, sexual orientation, disability, or ethnicity, they had little to share. When seeking help and support, their social locations were either not addressed by professionals or overlooked by the participants themselves, as they didn't perceive it to be an important factor at the time.

MAE stated that because her disability (ME) was invisible, she had not received the proper accommodations she needed. No one seemed to recognise or take into account that she was living with a disability, and as a result, her needs were consistently overlooked. The lack of visible markers of illness meant that her condition was often dismissed or misunderstood, leaving her without the support or adjustments necessary to manage daily life and recovery:

> "*The side of it that encompassed the disability was really challenging... I didn't really put it into play for quite a while I told everybody both at [shelter's name] and the therapist that I was seeing that I have ME, and I tried to explain it but there wasn't much that came back to me around that at all… and I think that's the invisibility of it.. I do have mobility issues at times, but I'm not in a wheelchair with some people with ME are, so that was never something I had to take into account it's so unseen (she meant ME)*"

Professional failed to consider **MAE** disability condition which has been affected by her daily energy levels: "*I get up with x amount of battery, and I don't know every day what that's gonna*

look like it.. and it's beyond just feeling tired…there's no with ME sleep doesn't they call it nonrestorative sleep, so sleep doesn't make you feel better"

Living in rural area made things even more difficult as she had to travel to town to meet a lawyer or shelter services which was emotionally and physically exhausting, especially while she was dealing with DV-related trauma "*So for me appointments were really hard…but I had to drive to [town's name] to go see my lawyer it drain physically it drain emotionally, and the scheduling was really tough…I wasn't accommodated at all and so that was tough*". Despite **MAE** needs, no adjustments were made to support her through the process of separation and healing.

Further, **MAE** felt that the intersection between disability and domestic violence was overlooked by the professional she interacted with, who in this case was a shelter worker who had herself experienced domestic violence. Because the worker was financially independent and able to manage her own circumstances, she repeatedly told the **MAE** that she needed to 'move forward', implicitly comparing their situations and expecting her to do the same. However, the **MAE**'s physical disability played a significant role in shaping her experiences both within and beyond the abusive relationship:

> "*So the woman who runs the satellite office [satellite office of the shelter]...she had her own experience, and she was very empathetic…but I found that she certainly had limits up to a point, she left her relationship with money with a house she had a very different experience, and she had the ability to build her life back again financially, which I don't...and she kept telling me that I would…but you're not actually hearing the others the other thing that I have going on here in the corner, which is ME, she kept putting it all down to the domestic violence*"

Katie also described how her socioeconomic status and financial limitations intersected with living in a rural area, prevented her from accessing an appropriate therapist to heal from PTSD and trauma caused by domestic violence:

> "*So I mean over 10 years of counseling, and it's kind of sad to say that I don't feel like I've made any progress because being in a rural area and with my socioeconomic status and, you know being financially abused those services just aren't available unless you've got the money for them to actually get the proper help you need.. what free public health will offer as opposed to what you can pay for and unfortunately, those services don't equate like if you have money you're going to get better services…so yeah, I find that the availability of help to you is dependent on how much you make and that's unfortunate*"

Katie narrative pointed out how socioeconomic privileges play a significant role in accessing and receiving the quality of support services.

Additionally, **Willow** expressed that she chose to hide her Indigenous identity, concerned that it might be used against her in a harmful way: "*Nobody knows nobody knows I was indigenous…so, it's safeguarding…knowing that how it will be used how being indigenous will be used…nobody knows…like, I said, I try to keep myself small…I try to disappear*". She used the metaphor "*I try to keep myself small*" to express how she felt the need to conceal her ethnicity to avoid discrimination or being dismissed by professional, whether in the justice systems, medical services or other support systems.

In addition to above experiences, **Elizabeth. M** shared that she never disclosed her queer identity while in the group therapy through sexual assault support group, as she had been in an abusive heterosexual relationship at the time:

"*It was like easier to talk as if I was a heterosexual person so, looking back at those circumstances, there's been a lot of times throughout my life where I've really denied my own queerness...It feels like not that I can't talk about the queer relationships that I have, but I am just the outlier in that respect*"

Rose described her experience of living in a rural area and accessing support systems for mental health and domestic violence services as complex. She explained how difficult it was to access support while living in a rural area, as it required several hours of driving to reach available services: "*I think it would have been very different in the city definitely the amount of time travel I mean to get to somewhere is 1 hr and come back is another hour so that's 2 hr traveling*"

She further explained that, because she lived on the border between two provinces, professionals from different organisations kept referring her back and forth between services. As a result, her experiences of domestic violence, DV-related trauma, and the challenges of living in a rural area were overlooked, and she was denied the consistent, trauma-informed support she needed: "*You're not on our territory, okay? and then I wouldn't get services…oh you're not on our territory, so there's no services for you... the different Territory children services don't talk to each other…this is ridiculous I said there is a concern, and nobody is listening*". Therefore, she felt that no one was listening to her pain and concerns regarding herself and her children.

Sasha lived in a rural area with limited resources, and the access to professionals such as lawyers or psychologist through the shelter was not possible due to lack of available services in rural setting:

"*I went to the [shelters name] there wasn't legal resources at that place there wasn't so I couldn't talk to a lawyer I couldn't talk to...I mean, all I had was the people that worked*

within the [shelters name] there was no psychologist, there was no, there was really no counseling services it was just the people that work there…"

Because of limited resources in rural area and a lack of awareness about her legal rights and available supports in rural area, she remained in the relationship longer. She expressed a need for someone who could help her make sense of her situation and guide her toward taking the difficult steps to leave the violence:

"*It was hard so that also kept me in the situation longer, because there wasn't those resources that I could reach out to make for legal representation for my kids like I had to put all those things in place before I could safely leave*"

Sasha recalled that she wanted to have made sure her and her children were safe before fleeing her abusive partner. However, living in rural aera with limited resources made it difficult to access the support she needed. She described experiencing trauma response such as freeze, which left her feeling stuck, it took her two years to better understand her situation and to prepare emotionally and practically for leaving the relationship: "*So in a lot of ways it kind of made me freeze it took me a really long time to well, it took me about 2 years after I did that course to really get out , I needed to get out and make the plan to go because it overwhelmed me*". Across the interviews, it became clear that each woman employed unique survival strategies to protect herself and her children while living in abusive relationships. This insight led to the development of a Group Experiential Theme under Everyday Survival Under Coercive Control.

7.4. Everyday Survival Under Coercive Control (GET.8)

This theme demonstrates participants resilience and ability to adapt in difficult circumstances. These strategies may indicate their desire to regain control and stability in unstable and dangerous environments. Furthermore, these survival tactics show the profound impact of abuse on their lives

and their commitment to shielding their children from similar experiences. In summary, these findings shed light on how these women navigate their lives in the context of domestic violence.

Participants described a range of strategies for survival and coping, which reflected the complexity and individuality of their lived experiences. While these strategies differed in form and intention, they shared a common thread of agency and resilience in navigating ongoing abuse and coercive control. Participants described a range of strategies to manage ongoing violence and maintain safety for themselves and their children. While these strategies varied ranging from silence and emotional compliance to documentation and sexual negotiation, they all reflected acts of survival and agency within highly constrained circumstances.

For **Sasha,** survival meant creating physical and emotional distance from the abuser. **Sasha** explained that she used to keep her distance from her abuser to keep him calm. However, she provided a different example of creating distance as she described. She and her children used walking not only to keep themselves calm but also as they found out he doesn't like walking, so they have time to spend together while they are away from abuser: "*We just really tried not to make him angry we went for walks outside because he didn't walk, so we would go for walks*"

Additionally, one of her daughters spent a summer away to maintain distance and safety from her abusive father: "*I actually had my second daughter go spend a summer at my mom and dad's instead of being around to just to get her away from him…*"

Sasha explained that she encouraged her daughters to take part in activities outside the home, giving them the chance to spend time in safer environments and momentarily escape the tension and fear of the abusive partner:

> "*My older [children] were in [activity's name] in [sprot's name], so we could get them out at least once or twice a week to get them away…I allowed them to join sports at the school because he wouldn't come*"

MAE and **Willow** strategies also functioned as survival mechanisms to create emotional and psychological distance between themselves and the abusive environment they lived in. They highlighted the importance of grounding themselves through small, meaningful activities such as reflecting on her children, gardening, walking in nature, or consciously seeking positive moments. These practices provided emotional stability and served as subtle acts of resistance, enabling her to preserve hope and a sense of identity within the constraints of continued abuse.

MAE said that finding positive things to move forward has been her strategy even within the abusive relationship:

> "*I would get up every day and think, okay, he's a piece of shit, and this is awful but look outside the sun of shining, your kids are amazing, you know, I always got up and actively looked for something positive as much as I could, didn't erase anything but I'd been doing that I continue to do that so, I continued to try to find small things in my day that were positive and then I worked hard at trying to find joy, too*"

Further, **Willow** mentioned that engaging in activities like retreating into nature and running has been a beneficial coping strategy for her: "*I would became a gardener, a pretty heavy gardener that's how I coped…I used to run per day*"

While creating a distance provided temporary relief from the immediate threat of violence, for **Sasha**, **MAE** and **Willow**, others developed additional strategies to protect themselves. One such strategy involved recording the abuse keeping written notes, calendar entries, or digital screenshots

of conversations. **Rose** described how she wisely began documenting the abusive behaviours in her calendar, specifically noting incidents of abuse directed at the children by their father. This strategy allowed her not only to gather evidence that could later be shown to others and to the abuser himself, but also to protect herself from being gaslighted or dismissed as imagining the abuse. By writing everything down, she created a tangible record that affirmed her reality and countered attempts to label her experiences as all in her head: "*So one time I had a calendar and I started to write down on the calendar every time he would lose it and hit the kids and then I was like if I make it visual you'll see it's not in my head it's for real…another incident happen at by [month] and I had pictures to prove it and that's what made the case for him to be charged in [month]*". She explained that her careful strategy of recording the incidents of abuse contributed to legal action being taken, resulting in her partner being charged for the abuse of their children.

To survive the persistent gaslighting and psychological manipulation of her abuser, **Katie** also adopted a strategy of documentation. She systematically captured screenshots of conversations to preserve evidence of the abuse. This practice became a form of self-protection and empowerment, helping her reclaim a sense of truth when her reality was repeatedly denied:

> "*There would just be like if catch him in a liar, or we'd be having a conversation and I know he'd say one thing, and I would call him on it, and he'd be like well, I didn't say that well, you just did, and so I would start saving conversations and try and catch things in text, so I could screenshot them so I could say, look like, you did say this because I felt like I was going crazy*"

In addition to documenting the abuse, some participants employed strategies of compliance, silence, minimisation, and emotional caretaking to regulate the abuser's behaviour and preserve safety within the household. They clarified that such responses did not represent submission or

acceptance of abuse, but rather intentional, adaptive acts aimed at preventing violence and ensuring the safety of themselves and their children.

Rose, Willow, Elizabeth. M and MAE described using forms of submission as a protective strategy to survive within the abusive relationship. However, this submission was not an act of passivity, but rather as forms of strategic agency calculated responses to ongoing coercion and threat. While the forms of submission varied, each represented an active effort to preserve safety and autonomy within conditions of extreme constraint.

Willow explains that compliance to minimize the consequences is the only way to survive: "*I'm a totally compliant now…completely compliant…the consequences are so high the stakes are so high for me*". She emphasised that, for her, being safe now means complying. The meaning of safety has changed in the context of post-separation violence. Compliance has become a deliberate strategy one she chooses to protect herself and her daughter. She explained that maintaining a degree of contact and cooperation with her abusive partner is necessary to ensure her daughter's safety, as any resistance could lead to serious consequences for them both:

> "*So, the only way to keep [her daughter] safe is to be compliant to him that means to not try to talk to her [her daughter] only see her for [number of days] days out of every [number of weeks] weeks …I'm not safe what have I tried to do? I'm not safe due to our circumstances all I can do is be compliant that's the only way we can stay safe, you know that's what safe is for us is to not…like anything that sets him off comes to me*"

For **Elizabeth. M**, he reflected that her survival required managing her abuser's emotions and prioritising his needs above her own. To survive, she adopted the role of the caring and compliant partner a role that aligned with traditional gender expectations but served, for her, as a protective

strategy rather than passive acceptance. She prioritised his emotional needs over her own, recognising that doing so reduced conflict and potential harm. Although she acknowledged that these dynamics reflected stereotypical gender roles, she consciously used them as a means of survival within an unsafe relationship:

> "*I don't know necessarily if it would be more specific as to me just being a woman and being supposedly the one that had to be the caretaker of the emotions and vulnerability in that sense I definitely felt like there was a lot of pressure...it's my duty in this relationship to take care of him, just because, again, that was kind of a duty that my mother took on, and her mother took on, and even when I was a child with my two younger brothers, it was kind of expected that I was the one that you know…being there for him, consoling him when he needed it and felt very much neglected on the opposite*"

MAE described adopting silence and minimisation as conscious survival strategies. At times, she acted as though nothing had happened, maintaining a sense of normalcy in the relationship such as sitting down for family dinners to prevent escalation. She described how staying quiet and downplaying the abuse were deliberate ways to keep him calm and to protect herself and the children. Whenever possible, she would remove the children from his presence to ensure their safety: "*keeping him calm so that nothing happened keeping him calm and away from the kids...I coped and I minimized it when I needed to…and then what did we do? we all went downstairs and had a fucking dinner with him and pretended it was nice to keep him calm*"

Among the various survival strategies described**, Rose** illustrated how sexual negotiation functioned as both a means of survival and protection. She adopted this strategy to safeguard her children in the absence of any effective external systems capable of ensuring their safety. With no institutional or systemic support to ensure her children's safety from their abusive father, she

employed the strategies available to her in an effort to minimise risk and prevent further harm: "*I just want my kids to be safe? and it was clear to me that no one else was goanna look after my kids safety and so after we finished the criminal court, I realized that it was really my responsibility, like the system was not going to be there every day 24 hr a day like..*"

Rose did what she could to survive. At times, she used sex as a negotiating tool a way to maintain a sense of control and to anticipate her abuser's next moves. She explained that by staying connected with him in this way, she could sometimes predict his behaviour, especially when it came to preventing potential harm toward the children. For her, this was not an act of choice or desire, but a survival strategy within an environment of ongoing threat and coercion:

> "*I had to find a way to make sure, these kids were safe…so I became his mistress, so from being his wife, his ex-wife, now is the mistress...I slept with him because at that point that's what I understood was my negotiating tool…because it was the only way for me to know what was happening on the other side*"

Building on these survival strategies, **Elizabeth. M** and **Katie** also explained that seeking counselling, contacting helplines, and engaging with health professionals played a crucial role in helping them endure and make sense of their experiences while the abuse was ongoing:

> "*I had been frequently on the like suicide helpline was another resource that I accessed a lot while we were in our relationship, and even when I was in those very, very vulnerable points*" ***(Elizabeth. M)***

> "*I've tried to put myself in lots of counseling I've tried to put myself with healthy people I'm in [support group name] now I've been sober for going on [number of years] years with my kids and myself*" ***(Katie)***

Another important perspective raised by the women in this study concerned issues of accountability and justice. They reflected on who should be responsible for holding perpetrators accountable and how such accountability could be meaningfully linked to their sense of justice and safety. These issues are explored further in the GET.9.

7.5. When Justice Remains Out of Reach (GET.9)

Under this theme, **Sasha, Willow, MAE, Katie** and **Rose** shared their experiences with professionals across family court, criminal court, and child custody systems. They spoke of a deep sense of injustice in spaces where they had expected fairness and protection. Their reflections revealed how the absence of perpetrator accountability shaped their understanding of what justice and safety truly mean from the perspective of survival.

Sasha discussed accountability and how the faulty system, including the family court is not equipped to hold perpetrators accountable. She believed that if action on accountability had taken place earlier, survivors would not have faced this abuse and trauma:

> "*To hold accountable those behaviors… it is still up to victims to go to our lawmakers and to go to it is still up to the survivors to advocate for themselves and to fight for our children, and to do those things when we are traumatized, and we have that going on and it is expected of us, instead of just holding the perpetrators accountable for their behavior*"

She believed that survivors carry the responsibility for advocating to end violence against women, otherwise it seems that this issue is ignored by the wider society and no one else cares. **Sasha** expressed that during our previous interview, we had not discussed the issue of accountability, which she now identified as an essential part of the healing process. This highlighted for me how survivors are often ready and willing to talk about accountability for perpetrators, recognising it

as a vital step toward justice and recovery. However, she observed a broader unwillingness both in society and within institutional systems such as the courts to confront the question of responsibility: Who is accountable for the abuse, and how are perpetrators held to account? **Sasha** acknowledged that while there is some emerging awareness of the need to hold abusers responsible for their actions, much more effort is required to make accountability a consistent and meaningful part of societal and institutional responses to domestic violence:

> "*We haven't discussed because I don't know how we make a difference there, because it is so staggering and unbelievable to me the unwillingness to do that…it seems so simple and so common sense and so if we actually held the perpetrators accountable at the beginning, the first time it happened none of this it would keep…it would stop so much of it.. it would cost less on our court system, it would cost less than our mental health system*"

Sasha believed that the weight of DV-related trauma she carried as a survivor was overwhelming. She reflected that systems such as family courts and child-custody processes should be responsible for holding perpetrators accountable and ensuring the safety of survivors and their children. However, in her experience, the burden of safety was often placed on survivors themselves rather than on the systems designed to protect them. This misplaced responsibility deepened her sense of exhaustion and injustice, as she felt that survivors were expected to manage the consequences of abuse while perpetrators and institutions remained largely unaccountable:

> "*The amount of things we as survivors have to do in order to stay safe is ridiculous and this is because the failure to acknowledge and to hold those accountable that reluctance to admit, I don't understand it, but that is one thing that I will put out there that we didn't talk about* "

Sasha added that abusive behaviours are often committed by perpetrators without facing any real consequences. It felt to her as though society and even the courts expect survivors to take responsibility for preventing violence or managing its impact, as if domestic violence were merely a private 'family issue'. This perception, she argued, reinforces the harmful idea that women are somehow at fault for the abuse they endure, while perpetrators remain largely unchallenged. She questioned, "*where are the consequences for abusive behaviour?*" and emphasised that accountability must be directed toward those who cause harm. For her, naming perpetrators as responsible was essential, survivors should not be burdened with labels, blame, or the lifelong task of carrying the consequences of violence they did not create: "*My x has been allowed to do all this stuff, and no repercussions…having consequences like it's not...that's one meaning by accountability it's their behavior, not mine…*"

Sasha went on to describe several forms of abuse she had experienced in the relationship, including assault: "*You know you assault your wife or your partner it's an assault it's not well, it's just a disturbance, and it's a family issue, and we're not going to get no! you don't need counseling you need to do this*". By sharing these examples, she wanted to make clear that understanding who is responsible for abuse should be a matter of common sense. Yet, she pointed out that within systems such as the courts, it often feels as though survivors are the ones held accountable for the violence inflicted upon them. In her words, "*everything seems to spin the wrong way back toward us*". This reversal of responsibility left her feeling unheard and unjustly blamed, reinforcing her belief that societal and institutional responses continue to protect perpetrators rather than those who survive their abuse: "*it's just common sense it's their behavior, not ours but yet we are the ones treated like we have done something wrong that's when the meaning of accountability*"

The following passage by **Sasha** highlights the profound importance of accountability. She emphasised that holding the abuser accountable brings a sense of validation, healing, and justice affirming that the violence she and her children endured truly happened and was unfair. For her, accountability was not only about punishment but about recognition, an acknowledgment that women and their children matter as human beings whose pain deserves to be seen and taken seriously: "*when perpetrators are held accountable you feel validated and again, you feel like your life matters… that women and children's lives matter because right now we don't...*"

Katie articulated that the absence of perpetrator accountability and justice is a major obstacle to healing from DV-related trauma that she has been experiencing : "*I found with the PTSD like in trauma obstacles that would have helped for obviously, you know, getting justice you know, having laws in place that actually held our abuser accountable or encompassed all of the different types of views*"

She outlined that justice should mean holding the abuser accountable, not merely determining whether there is enough evidence to prove that the violence occurred. For her, justice was about feeling safe and finding resolution not being dismissed with the message that "*nothing happened*" simply because it could not be legally proven. This narrow, evidence-based approach left her feeling invalidated and unprotected, highlighting the gap between institutional justice and survivors' need for acknowledgment and safety: "*So for me any way, I think that one thing that would have helped a lot in the healing process would have been to get some sort of justice you know to feel safe at the end of the day to have some sort of resolution other than it just be well the evidence that we're taking says that nothing happened so nothing happened and have a good day!*"

In **Katie's** view, justice means being safe and safety, for her, comes from holding perpetrators accountable for their abusive behaviours. She explained that justice cannot exist while abusers

continue to walk freely, maintaining power and control through post-separation violence and creating an unsafe environment for her and her children: "*we're not safe still there is no justice our abuser still walks free and he is still free to come after us*"

Willow brought attention to accountability and justice from a different angle. During our conversation, she raised a question that I, as a researcher, had not asked: "*Is there any way to be free from this situation?*" Her question made me realise that accountability and justice are not only essential but often missing elements in survivors' journeys toward healing from violence and DV-related trauma. She described feeling entrapped and deprived of liberty not only because of the abuser's ongoing control but also due to systemic control such as the courts and child custody processes, which continued to tie her to the abuser. In her words, There seems to be no way to be free, but there should be it's simple: hold the abuser accountable and bring justice:

> "*You haven't asked me if I think I'll find a way out of this and the answer is no...unfortunately no, do you think I'll find a way out of this, it's a hard question to be honest it shouldn't be, though right? that's the problem it shouldn't be you know so that's it right? I mean this shouldn't be hard and that points to all the problems that exists*"

Willow continued by explaining that, while policies and laws may appear fair on paper and are intended to deliver justice, the reality in practice is often very different. She recalled that even the police had told her coercive control was not criminalised, which led her to question, does that mean perpetrators are still free to continue their behaviour without consequences? For her, the absence of meaningful legal protection and enforcement gave abusers greater freedom to maintain power and control, even after separation. Confronting this reality that no law or policy, even those claiming to protect survivors, truly safeguarded her was overwhelming, traumatic, and profoundly unjust:

> "*I mean on paper all these systems should function but they don't so I think we both know that is very telling into itself…and it's crazy to be aware that is the reality its hard…under some of them claim they do, but I don't think they understand like a police officer told me coercive control isn't illegal…or with child welfare*"

Reflecting on her own experience, she said: "*They had to fabricate things about me just to keep investigating... it's just crazy*" illustrating how the system sometimes targets survivors instead of protecting them. She questioned why systems such as the courts, child custody services, and police, and the professionals within them "*why do they need to change, when it's so easy for them to blame us and make us feel guilty, instead of holding perpetrators accountable?*" Her reflection revealed how survivors are positioned as the vulnerable and problematic ones within institutions that fail to recognise their own complicity in sustaining injustice and accountability: "*why would they change? they can do what they want*"

Willow continued by expressing that many professionals within these systems seemed, in her view, cold-hearted and lacking empathy toward survivors. Their actions and attitudes, she said, often imposed further harm, adding new layers of violence and trauma to what she and her child had already endured. She described feeling as though some professionals were, consciously or not, collaborating with perpetrators reinforcing their power and control instead of challenging it. For her, this institutional indifference felt like another form of betrayal, one that deepened her mistrust in systems meant to provide safety and justice:

> "*I think you have to be cold hearted you have to have a lack of empathy to do these jobs. we are literally that one life is enough that you're destroying but you're doing this to my child over the course of [number of years] years they all know*"

Willow pointed out that coercive control is deeply insidious often invisible to others unless they have experienced it themselves. She also criticized the way terms like 'trauma-informed' are frequently used as buzzwords, disconnected from genuine understanding or action. In her view, such language feels empty when the abuse continues unchecked and survivors remain without meaningful protection or support. For her, real justice and healing require more than terminology; they demand recognition, accountability, and systemic change:

> "*I think I think it's a very hard thing to explain and let until you experienced it, though firsthand. like the very like the nature of it is so insidious I mean, if people say, they're trauma informed I'm, like what does that mean to you. you know, I don't think trauma seems to be you know like a buzzword lately I think I don't know it's tough* "

Here, **MAE** similarly shed light on the same issue that **Willow** had mentioned earlier. In **MAE**'s view, although laws and policies appear to uphold justice on paper, the reality is entirely different. Within the family court system, justice often depends on who holds power, privilege, and financial resources rather than on truth or fairness. She explained that those with greater access to money, legal representation, and the ability to intimidate others are more likely to prevail, leaving survivors at a profound disadvantage. For her, this imbalance reveals how systemic inequality continues to silence and disempower those most in need of protection:

> "*It's all there in the law that it should happen but in reality it doesn't, and the reality is the person with the most power... exerting control and aggression and intimidation over you with more money to pay the lawyer…because it's a fucked up it's not balanced in any way, shape or form*"

MAE continued by sharing an example from her experience in family court. One of the judges acknowledged that abuse had occurred and even said so to her directly. However, the judge also

warned that the only way to challenge it would be to go to trial and that even then, she would "never get rid of him". The judge explained that her partner could continue manipulating the process by changing his finances or other circumstances each year, especially since he was self-employed. This conversation made **MAE** realise that the court process itself had become part of the abuser's control, a never-ending game designed to exhaust and entrap her. She was even advised to end the proceedings because pursuing justice seemed futile in a system that allowed the abuser to keep using legal mechanisms to maintain power over her:

> "*The last judge saying to me that's all he'll do it's not fair there's no justice in this there's no equality in this but the only way you'll fight it is if you go to trial and you'll never ever get rid of him... you'll just be going back he'll change things year after year, especially because he's self-employed he'll change his finances he'll change, right, like tons of manipulations in there*"

MAE revealed that each time she appeared in court, she was re-traumatized, experiencing intense manifestations of trauma. Because of this, continuing with the court process or going to trial felt impossible. She emphasised that without genuine justice and accountability for the abuser, survivors like her cannot heal. The process left her feeling voiceless and unable to fully express either the abuse she had endured or the ongoing injustice she continued to face through the legal system. For her, the court became not a place of protection, but another arena where her pain was silenced and her trauma repeatedly reopened:

> "*So, this whole time I've got this like can't breathe, panic on me I cannot sit in a courtroom and do trial with this man I cannot I don't have the voice for it I don't have the clear path to articulate what we've lived* "

Rose also spoke about the intersecting power dynamics within institutional systems that shaped her experience, noting that her partner's position as a police officer profoundly influenced how her case was treated. She described how this imbalance of power contributed to ongoing systemic abuse, leaving her feeling powerless and restricted in accessing protection or support. Reflecting on this, she said, "*I didn't have the same weight*", expressing a deep sense of injustice and unfairness as she struggled to seek safety, pursue justice, and hold the perpetrator accountable. For her, the overlap between personal abuse and institutional power magnified the sense of entrapment and reinforced her belief that the system itself protected those in positions of authority:

> "*I realize how little power I had because he was a cop, I didn't have the same weight... this was not an equal fight I had no power I'm not a cop, that's what's clear to me*"

The power imbalance created by the abuser's professional status intensified her trauma and sense of injustice, as his position allowed him to manipulate systems of authority that were meant to protect her: "*It was even more traumatizing because he was a cop, because I was never equal... wherever I would talk*". In her words, **Rose** was just "*a mom*" trying to defend her rights while she felt dismissed and discredited when compared to her partner whose uniform alone carried authority and influence: "*I was like I had no credibility I'm just a mom... when you say you're involved with cops you get either like, okay? so, I'm complaining for nothing*"

In the following quotes, **Rose** explained that the family court failed to consider the violence against her child, even though it had been clearly documented in the criminal court. As she put it, "*The family court does not look into what has happened in the criminal court*" . She described how the family court dismissed the evidence and acted as if nothing had occurred, disregarding the documented violence toward her children. This disconnection between the two courts left her feeling deeply frustrated and betrayed, as the harm recognized in one system was completely

ignored in another: "*So the judge and the family court is like okay so what's the issue here?... they didn't even acknowledge that he had been charged in the criminal court so, hmm the fact that they don't acknowledge that he'd been violent with the kids and that there's consequences*". **Rose's** narrative is the visible symbol of institutional power made her feel small, unheard, and less believable in the eyes of the system "*that family court judge to credibility of him because he was a cop, so it played against me it played against me and the kids*". **Rose** believed that abusers should be held accountable and questioned for their abusive actions. However, she observed that the system often operates in reverse where survivors being investigated, questioned and labeled. This in her view reflects a deep injustice.

7.6. One Journey, Many Realities (GET.10)

Participants offered reflections rooted in their social locations, highlighting how different aspects of their social locations such as disability, ethnicity, geography, and sexual orientation shaped not only their access to support but also how they navigated safety, healing, and recognition as survivors of domestic violence. This theme underscores how survival and recovery are influenced by the complex interplay of social position, systemic barriers, and the availability of responsive, trauma-informed support.

MAE explained that financial abuse was a significant part of her experience. She recounted that when she married her partner, her disability benefit was cut off by the government: "*So the first part is related to financial which cut by the government because you get married…so, the fund related to disability will cut off* ". This policy effectively made her financially dependent on her husband, assuming that he as the man would provide for her. In reality, this dependence enabled his financial control and abuse, leaving her without independent resources or access to her own

income. For **MAE**, this experience illustrated how systemic structures can unintentionally reinforce gendered and economic power imbalances within abusive relationships:

> "*I couldn't support myself with an income...I couldn't get [name of financial assistance] being in marriage… that's horrific as a woman especially… and that's my disability that has stopped me from being able to earn to get myself financially on my feet*"

There are often hidden intersections and overlooked needs within the experiences of domestic violence survivors, particularly among those living with disabilities. These needs become more visible throughout their journeys toward empowerment and healing, revealing how disability and violence interact to shape unique barriers and forms of resilience.

MAE highlighted this by noting the stark difference in outcomes between survivors who are financially independent and those who have additional needs. She illustrated this through the example of a friend who had also experienced domestic violence but was financially self-sufficient and therefore able to rebuild her life more easily. In contrast, **MAE's** own experience was shaped by her disability, which not only created daily challenges but also compounded the financial abuse she endured. Because she was unable to be fully independent, she faced greater barriers to recovery. For her, living with a disability meant that financial hardship was not just an economic issue but a factor that deeply influenced her ability to heal and move forward after abuse:

> "*You know I have a really close friend who actually met at [shelter's name] and we are sort of our timeline is very similar, and she's just bought a house she has a good job she's been able to slowly over the last 5 years kind of climb her way out financially*"

This overlooked intersection carried a profound sense of shame for her, even though she understood that her circumstances were beyond her control. She described experiencing feelings

of self-blame and a loss of dignity, explaining that her inability to work or fully participate in life made her feel inadequate. She reflected, *"I can't play that game"* as her body doesn't let her. Although **MAE** recognized that her disability was physical and outside her control, and systemic neglect surrounding it left her internalising feelings of failure and worthlessness:

> "*And I can't get that game because I can't work and there's not a lot of dignity there for that in it that's a hard that's gonna come back to that shame but blaming yourself for something that you can't control on your body but yeah…*"

Elizabeth. M highlighted the specific needs that emerged at the intersection of domestic violence and her queer identity. She explained that while she was in the abusive relationship and even afterward, as she sought support her queer identity was pushed aside. With all her energy focused on surviving and moving forward, she felt there was no space to consider or express this part of herself: "*I think during the moment my brain was already too like occupied with a lot of stuff like it didn't really feel like I was even like I said it didn't even feel like I was thinking about queer identity like it didn't feel like it feels so detached* "

She reflected that she had felt detached from her queer identity throughout and after the abusive relationship. Looking back, she expressed sadness not only because she herself had set aside this part of her identity, but also because no one within the support or intervention processes acknowledged it: "*looking back, I honestly feel more sad looking back at my life and feeling like, okay well, I wish I had been able to be much more connected, even just to a community of more like of queer people*"

Elizabeth. M explained that people often assumed she was heterosexual because she had been in a relationship with a man. As a result, while she was coping with multiple challenges including

DV-related trauma, PTSD, and ADHD there was little room to reaffirm or express her queer identity. In prioritising survival and healing, she felt compelled to set aside this essential part of herself. **Elizabeth. M** lived experience revealed an ongoing struggle to remind others that she was queer; it felt like a constant battle to assert her identity in spaces that defaulted to heteronormative assumptions. While seeking support, she often had to choose which part of her identity to foreground, treating this selective visibility as a survival strategy within systems unequipped to embrace her whole self*:*

> "*Because I had been so used to being in straight environments and me being very straight passing as well people don't really assume that I'm queer it felt like normally that was like a battle that I was putting up with in straight spaces to be like, yeah, actually, I'm not straight like let's not forget that I'm not straight and that just felt like a battle*"

Sasha reflected on the question concerning requirements and needs based on one's social location. During our pre-interview meeting, she mentioned that she did not initially consider herself marginalized because she is Caucasian. However, through our conversation, she began to recognise how her geographical location in a rural area and her religious and spiritual beliefs had contributed to a sense of marginalization. She realised that these intersecting aspects of her identity shaped how she experienced domestic violence and trauma, as well as how she accessed or was limited in accessing support. I observed that the research question about the meaning of marginalization helped her make this connection, revealing how rural isolation and Wicca intersected with her lived experience of abuse and healing:

> "*When we talked about it the first time you asked me that I thought no, because I'm Caucasian right? but when we start thinking about it I realize I am pro marginalized, but I also as survivors I don't want to take away from how so, how much more severe it is for*

ethnic and I'm very cognizant of that, because I understand, I mean yes, I'm Caucasian, but and I am marginalized because of the wicca, and because of the rural, and because of all that "

Sasha believed that women and their children who live in rural needs resources not only shelter, legal advisory but also and trauma-informed mental health support to could get out of the abusive relationship also to move forward in recovery process:"*One of the things that needs to be looked at is the services around, because as soon as a home, or whatever it is that they have in place is full, there's no other resources*"

In the example **Sasha** shared, she spoke about her daughter, who had experienced trauma as a result of her father's abusive behaviour:

"*I was just talking to my [age of daughter] year old daughter today…she says, Mom, I'm trying to find a counselor because she's got trauma, too…she was raised in the house with trauma, right?*"

Because they live in rural area, her daughter does not have access to mental health support such as a trauma and violence- informed psychotherapist: "*She has trauma as well and she can't find anybody to help her she can't find anybody to help her…so I'm actually going to share the resources you give me I'm going to share them with my daughter so she can find somebody…we can't find anybody around here [rural area name]*"

Therefore, the only available option was medication prescribed by a psychiatrist, without consideration of the domestic violence and trauma her daughter had experienced: "*All they wanted to do is send you to a psychiatrist who will give you meds, who sees you for 5 10 min tops and then your prescribed medication that is how we're treated here [she meant rural]*"

Moreover, **Rose** shared how living in a rural area continued to affect her access to mental health support, both in the past and in the present: "*I think the rural area is limited and resources because there's less people so their need would be to have somebody 24 hr*". In addition, she highlighted that having one consistent counsellor throughout her healing journey would have been far more helpful than repeatedly speaking with different counsellors across various services. She explained that the lack of continuity in therapy caused by limited session availability, financial constraints, and frequent staff changes in rural areas made it difficult to build trust and maintain progress in her recovery: "*So if there would be in the same counselor I could speak at all time, that would have been more helpful*"

Rose pointed out the severe shortage of services available for children in rural areas, where long waiting lists are common. She explained that when seeking help at the local hospital, she ahs been often handed a card with the contact information of a counsellor or social worker, rather than receiving direct, in-person support from someone available on site: "*Yeah services for children should be accessible…no waiting list…yeah, I'm giving you the list, yeah, no waiting list but yeah hospitals should have services like not just give a card…it's like rural hospital should have a counselor that you can speak with*"

Rose offered another recommendation based on her experience with an abusive partner who was a police officer. She believed that police institutions must acknowledge when their officers commit abuse within their families and called for the creation of a dedicated unit to address such cases:

> "*For the police what specifically is needed is to have acknowledgment and to have real actions and real solutions so when you know, there's a problem, here are the steps to handle it but it just seems to be very blind everybody keeps being blind and it's best to stay blind not for the women's nor for the kids best interest, but for public relations I guess it's better*

that the public doesn't know it just very unhelpful.. but it would be the most beneficial was to have an acknowledgment and specific resources for the families in place"

However, she observed that existing responses often prioritised the reputation and interests of the police force particularly the officer involved over the safety and well-being of women and children. In her view, this lack of accountability and institutional responsibility reflected a deeper failure to take meaningful action toward ending violence against women.

Katie articulated marginalization through the intersection of how her mental disability, socioeconomic position, and residence in a rural, conservative area collectively shaped her experiences. In doing so, she framed these intersections as points of specific needs and requirements, where access to appropriate support and recognition was often limited:

"*So, for me I would think that marginalization was definitely you know, the mental disabilities the underlying ADHD that was in there as well and then socioeconomic status as well you know...we were in a quite rural area, so there wasn't a whole lot of other people around, or anything like that...being a white woman, just expected to be the slave essentially...you know that you're expected to be do the bidding just that very classic, conservative chauvinistic you know*"

Considering the rural setting, **Katie** expressed that "society really needs to catch up," noting that awareness and responses to domestic violence and even sexual assault remain far behind. She emphasised that there are few available supports or resources to protect women in such communities, leaving many without meaningful help or safety options: "*I just think society really needs to catch up in these rural areas and there aren't those types of supports around like, even with the sexual assaults and stuff, people are really slow moving*"

Katie spoke specifically about how child support services failed to respond appropriately to the sexual assault her children experienced at the hands of their abusive father. She emphasised that intervention and support systems are not integrated or connected in ways that genuinely help survivors:

> "*Like I've even had [child and family services name] tell me that, you know, unless the RCMP gets a confession, they're not going to work it. they don't have it within them to care so yeah, that's how I feel about it I feel very helpless, and that, you know, I'm just banging my head against the wall a lot of times praying that there's some sort of divine intervention, or miracle that comes along because there just seems to be no help*"

Neither **Katie** own narrative nor her children's accounts were believed, which not only denied them protection but also deepened the trauma they had already endured. She described feeling frustrated, helpless, and hopeless in her attempts to secure safety and support. As she expressed, "*miracle comes along,*" reflecting her sense that, in rural areas, meaningful support often feels absent an unreachable ideal rather than a lived reality.

Katie continued by highlighting that there is no dedicated unit within the police service to respond to domestic violence in rural areas, which leaves survivors without specialised support or timely intervention, further reinforcing their sense of isolation and vulnerability:

> "*I would say because being in a rural area there isn't so much like there are specialized task forces or things like that you know, there isn't a sexual violence group within our police force... they don't have the resources to maybe look after things that are a little bit more heavy [she meant sexual assault and domestic violence]*"

Katie believed that in the rural, conservative area patriarchal values still dominate, shaping how institutions respond or fail to respond to abuse. She felt that police often dismissed domestic violence as a private matter between "*a guy and a girl*", something to be handled within the home: "*when it comes to domestic violence it's like, oh, well, it's just a guy and a girl, and because it's a very conservative farming rural area and you know kind of religious and in that sense too*"

In her view, living in a rural and conservative community often meant that men were seen as the heads of households, which contributed to minimising the seriousness of men's abusive behaviours and left survivors without meaningful protection. She explained that even when incidents were reported, the police would often just write it down without taking further action or offering real support to the victim:

> "*And you know and saying that having the very conventional while the man runs the household, the woman just does everything there's a lot of that black and white thinking still out here so when these types of people get called to these calls [a call from a victim of domestic violence] well it doesn't go anywhere because they just write it off immediately…*"

Katie suggested the establishment of specialised police units in rural areas that could intervene effectively and take concrete action in domestic violence cases: "*So I think in that regard having some sort of specialized workers that can actually dedicate their time to it or at least be solely on that area might be beneficial* "

She suggested that it should be a person or unit knowledgeable about domestic violence who responds to such cases, as they might be best equipped to assist survivors: "*So that's what I would think you know, being able to provide those resources so that you know, police who are usually the*

first people who have contact or , you know, a sexual violence unit or a rape unit or something like that, they can actually look after it "

Katie emphasised that what is needed in rural areas is not simply more police presence, but specialised officers who are trained and knowledgeable about domestic violence. She explained that, in her experience, police in rural communities often focus on traffic or drug violations and lack the understanding required to respond appropriately to domestic violence cases. In her view, establishing dedicated units or ensuring that officers receive specialised training would make a significant difference in how survivors are protected and supported:

> "*We're throwing Joe the traffic cop we're just putting him on your case well, he normally deals with traffic cops or traffic violations and drug violations, and you know, nobody really has the expertise to deal with domestic violence so, there's a lot of there's a lot of people who, you know maybe get into the police force as well around here because they want to do high speed chases and stuff* "

Willow highlighted the intersection of need and support for Indigenous women experiencing domestic violence, pointing out that throughout Canada's history, Indigenous women have faced disproportionately high levels of violence and systemic oppression:

> "*They need stronger supports from their community and I mean, I think you know they're slowly emerging as having better support, because they have Jordan's principal and stuff but indigenous women are much greater risk of harassment and violence from police and from child welfare people basically… it's so racist and so misogynistic*"

Willow's reflection reveals how her experience of domestic violence cannot be separated from her social location as a Métis woman. She articulated that systemic racism, and colonial legacies

continue to shape institutional responses to Indigenous survivors. Her frustration about how government funding is allocated money that they spend on harassing or to foster your child underscores the way state systems often prioritise surveillance and intervention over meaningful, preventative support for Indigenous families:

> "*The money that they spend on harassing they need that money to support themselves imagine paying someone like to take to foster your child when that you know what is that money that you went to foster like the money that they give to take children what if that goes to the families who need the support? what a difference that would make*"

By pointing out that the resources used to remove children could instead be directed toward supporting families in crisis, Willow highlights the need for reparative, community-based, and culturally safe responses. Her acknowledgment reflects how ethnic identity itself becomes a barrier to receiving care within systems steeped in structural racism:

> "*I can't really I can't really answer that easily, except for you know it's it's racist backward system, so I can't access the supports that you're talking about because I'm only Métis that's hard for me to speak on it*"

Through her narrative, **Willow** exposes a double marginalization: first, as a survivor of domestic violence, and second, as an Indigenous woman navigating institutions that have historically harmed her community "*But I know historically, indigenous women are repressed at a far greater rate than Caucasian women of color in general*". Her insight points to the need for systemic transformation shifting resources away from punitive systems like child removal and toward Indigenous-led, trauma-informed, and culturally grounded supports that empower survivors and strengthen families.

This chapter explored how participants perceived and made sense of a PTSD diagnosis and how the PTSD label was treated within family court systems. It also examined how professionals, including psychiatrists, psychologists, and social workers, intervened in their cases and how participants navigated these interventions. The women discussed their everyday practices of resistance while living under coercive control, as well as what justice and accountability meant to them. Finally, the chapter highlighted how their social locations shaped their specific needs and informed their recommendations regarding responses to coercive control and DV-related trauma.

Chapter 8. Discussion

Introduction

Building on the participants' meaning-making addressed in the findings chapters, this chapter critically examines how women situated in marginalized social locations experience coercive control, DV-related trauma, the diagnosis of PTSD, and the professional responses they encountered. These experiences are interpreted within broader structures of gendered and social inequality, drawing on an intersectional feminist framework (Crenshaw, 1991) to demonstrate how women are positioned within patriarchy alongside other interacting forms of power and marginalization (Davis, 2008). In this study, Collins and Bilge's (2016) six core elements of intersectionality, including inequality, relationality, power, social context, complexity, and social justice, together with Collins's (2000) four domains of power, interpersonal, disciplinary, cultural, and structural, provide the conceptual foundation for understanding how these forces shape women's narratives and their experiences of abuse, recognition, and support.

By centring the voices and meaning-making practices of marginalized women, this chapter contributes to feminist scholarship on coercive control and trauma by moving beyond universalised and individualised models. It demonstrates how survivors actively interpret, negotiate, and resist systems of power that shape their lives and responses to violence and trauma. In doing so, it advances an intersectional understanding of coercive control and DV-related trauma as not only lived experiences, but as socially produced phenomena embedded within unequal structures that demand critical, relational, and transformative responses (Collins & Bilge, 2016; Collins, 2000; Herman, 2015; Stark, 2007, 2009; Tseris, 2013, 2018, 2019b).

This chapter is organised into five sections. The first section considers coercive control as an intersectional and relational system of power, including participants' experiences of professional responses. The second section reflects on how participants made sense of DV-related trauma and the diagnosis of PTSD within their social and political contexts, drawing on an intersectional lens and the domains of power. It also discusses their encounters with professionals and institutions. The third section focuses on women's experiences of resistance and resilience through an intersectional lens. The fourth section discusses the limitations of this study. The fifth section outlines the implications of the findings for intersectional feminist research, policy, and practice, with a focus on advancing trauma- and violence-informed, intersectionality grounded, socially just, culturally responsive, and structurally informed responses to domestic violence and trauma.

8.1. Coercive Control within Intersectional Systems of Power

The findings suggest that coercive control was not experienced by participants solely as an interpersonal form of abuse, but as a gendered and structural system of domination embedded within intersecting relations of patriarchy, heteronormativity, ableism, colonial histories, socio-economic marginalization, and geographical inequality (Sokoloff & Dupont, 2005). Participants described sustained patterns of coercive control that frequently produced no visible physical injuries but as an ongoing condition that structured their daily lives, identities, relationships, and possibilities for safety and freedom. This supports feminist scholarship that conceptualises coercive control as an ongoing system of inequality rooted in male domination and patriarchy, rather than as a series of isolated or discrete incidents (Dobash & Dobash, 1979; Kelly & Westmarland, 2016; Stark, 2007, 2009).

Through their accounts, coercive control emerged as a deeply relational and intersectional form of male domination (Collins & Bilge, 2016). At the level of the interpersonal domain of power (Collins, 2000, 2017), women described patterns of ongoing surveillance, intimidation, emotional manipulation, sexual violence, and enforced social isolation within intimate relationships. For women, these behaviours did not end with separation but continued through stalking, threats, and the strategic misuse of child custody and family court processes. These experiences were shaped not only by gender but also by participants' specific social locations, including race and ethnicity, sexual orientation, disability, religion, and geographic or cultural context. For example, participants with disabilities described how their need for mobility support, caregiving, or medical assistance was exploited to heighten dependence and restrict autonomy, while women living in rural or socially conservative contexts explained how geographic isolation, community surveillance, and limited anonymity intensified their entrapment. These intersecting identities shaped how coercive control was enacted and experienced, showing that the patterns of abuse were tied to the unique combination of social locations each woman occupied rather than to gender alone (Sokoloff, 2008). As a result, the form that coercive control took and the depth of its impact varied across these intersecting identities, revealing how women's social locations influenced both the tactics used against them and the constraints they faced in seeking safety and recognition.

Participants also described how male violence and patriarchal authority were frequently normalised within these rural and conservative environments. The findings align with understandings of coercive control as operating within the structural and hegemonic (cultural) domains of power (Collins, 2017), where gendered violence is often minimised or treated as a private family matter rather than recognized as a form of structural inequality and social injustice (Stark & Flitcraft, 1996; Stark, 2012). These accounts also reflect and extend existing literature by

illustrating that coercive control must be understood within its broader social context, shaped by both cultural norms and structural conditions (Collins, 2000, 2017; Drumm et al., 2006; Elizabeth, 2017; Katz, 2016; Katz et al., 2020; Magnus, 2023; Mitchell & Raghavan, 2021; Peek-Asa et al., 2011; Spearman et al., 2023; Thiara et al., 2011; Toews & Bermea, 2017; Tutty et al., 2024; Zamora Arenas et al., 2023; Walter et al., 2024). Furthermore, the study demonstrates the intersectional principle of relationality, showing that coercive control was shaped through the relationships between gendered power operating within the interpersonal and structural domains and the other dimensions of women's social locations, rather than by gender alone (Krane et al., 2000; McCall, 2005; Merry, 2011). At the same time, the findings demonstrate the complexity at the heart of intersectionality (Collins & Bilge, 2016), as the participants' accounts showed how each domain of power interpersonal, structural, disciplinary, and cultural shaped their experiences of coercive control. Taken together, these accounts illustrate that coercive control cannot be understood through a single form of oppression or a single level of analysis, but rather through the interaction of these interconnected domains (Collins, 2000; Carastathis, 2014; Sokoloff & Dupont, 2005). Participants also emphasised that coercive control was not confined to the interpersonal relationship but was reinforced through the structural and disciplinary domains of power by the very professionals and institutions meant to provide protection (Collins, 2000, 2017; Montesanti & Thurston, 2015). In the structural domain, laws, policies, and institutional arrangements shaped the conditions under which women sought help, often creating barriers to safety through limited services, restrictive eligibility criteria, or systems that failed to recognise coercive control as a legitimate form of abuse. In the disciplinary domain, the everyday practices, routines, and professional norms within legal, health, and mental health settings influenced whether women were believed, how their experiences were interpreted, and what forms of support were made

available to them. These dynamics were evident in participants' accounts of misrecognition and inadequate responses from psychologists, counsellors, family physicians, psychiatrists, and other practitioners. Rather than having their experiences of coercive control acknowledged, many described their accounts being minimised, reframed as "mutual conflict," or dismissed altogether. Some reported that professionals failed to ask even basic questions about their living conditions or ongoing safety. Such misrecognition shows how coercive control is sustained beyond the private relationship, when institutions do not recognise or respond appropriately to women at the margins of social power, they inadvertently reproduce the conditions that allow control to continue. This illustrates how power operates simultaneously through structural arrangements and disciplinary practices, shaping both women's experiences of abuse and their access to meaningful support (Alaggia et al., 2012; Bagwell-Gray et al., 2020, 2025; DeKeseredy et al., 2016; Donovan & Barnes, 2020; Fotheringham et al., 2021; Nayak, 2025).

As Crenshaw (1991) argues, social locations such as gender, race/ethnicity, disability, and class do not operate in isolation, but intersect to produce unequal experiences of violence, oppression and differential access to institutional recognition and protection. Women described significant barriers to accessing protection through legal systems, including challenges within family court and child custody processes, as well as difficulties in securing financial support, safety, and freedom, particularly when their social locations placed them at a structural disadvantage. For example, participant from Indigenous backgrounds described how ongoing colonial violence and institutional racism within the structural and disciplinary domains of power shaped their encounters with legal and social service systems, undermining their safety and credibility when they sought protection. Another participant explained that her abuser was a police officer, which made seeking help particularly dangerous. She feared retaliation and believed the system would

protect him rather than her. This example shows how social location shaped her experience not only within the interpersonal domain of power but also within the structural and disciplinary domains, as her partner's position within law enforcement afforded him institutional credibility and protection that further constrained her options for safety. These accounts illustrate how coercive control is embedded within broader systems of inequality shaped by intersecting structures of oppression and inequality including patriarchy, colonialism, ableism, class marginalization, heteronormativity, and the marginalization experienced in rural or conservative contexts (Armstrong et al., 2018; Belisle et al., 2024; Behrendt, 2022; Collins, 2012, 2017; Day & Gill, 2020; Heidinger, 2021, 2022; Klingspohn, 2018).

This study makes a theoretical contribution to knowledge on coercive control by centring the narratives of marginalized women and applying an intersectional feminist framework (Collins & Bilge, 2016; Cho et al., 2013; Collins, 2017) to illustrate how coercive control (Stark & Hester, 2019; Stark, 2012) is shaped through the interaction of women's social locations and multiple forms of systemic inequality. Patriarchy, colonialism, racism, class inequality, and ableism intersect in ways that influence how coercive control is enacted, understood, and resisted, demonstrating that it is not a uniform or universally gendered experience but one structured by broader systems of oppression and inequality in relation to participants' unique social locations (Bograd, 1999; Cardenas, 2023; Decker et al., 2019; Dill & Zambrana, 2019; McCall, 2005; Sokoloff & Pratt, 2005).

This study also makes a theoretical contribution by advancing an intersectional feminist understanding of coercive control that places social justice at its centre, both as an analytical principle and as a transformative political aim. Rather than merely identifying inequality, the findings show that intersectionality requires attention to how systems of power sustain women's

vulnerability to abuse and therefore calls for collective efforts to change those conditions. By placing social justice at its core, this perspective highlights the need to challenge the interconnected forms of power that shape coercive control and restrict women's access to safety, recognition, and support. It also demands a transformative and social justice approach, one that not only addresses interpersonal abuse rooted in patriarchy, but actively works to change the social, cultural, and institutional conditions that place women at risk. Such an approach seeks to restructure the inequalities that produce women's vulnerability and to ensure fair, equitable access to safety, recognition, and support, so that coercive control can no longer be normalised or legitimised within broader systems (Baird, 2023; Collins, 2000, 2012; Coker, 2016; Dill & Kohlman, 2012; Kelly, 2011).

8.2. Trauma and PTSD within Intersectional Systems of Power

Building on participants' experiences of ongoing coercive control during and after separation, this study makes a contribution by demonstrating how women make sense of trauma in the context of domestic violence (DV-related trauma), how they understand and engage with a diagnosis of PTSD, and how processes of reclaiming agency are shaped by professional responses. Through a feminist phenomenological and Interpretative Phenomenological Analysis (IPA) approach, the study foregrounds women's voices and lived experiences, offering an in-depth, survivor-centred understanding of DV-related trauma and PTSD diagnosis as label.

Rather than locating trauma in single violent incidents, participants consistently described it as emerging from a prolonged condition of control and entrapment that became deeply internalised and difficult to articulate. They understood their trauma as profound, enduring, and inseparable from the ongoing experience of coercive control, which aligns with existing literature (Dobash & Dobash, 1979; Humphreys & Joseph, 2004; Stark, 2007; Van der Kolk, 2014). Aligned with the

participants' lived experiences, analysing their narratives through an intersectional framework (Collins & Bilge, 2016) demonstrates that DV-related trauma cannot be understood solely as an individual psychological aftermath (Brown, 2004, 2008; Tseris, 2015, 2018). Instead, it must be situated within broader systems of inequality and oppression where social locations heighten women's exposure to violence and trauma. The contribution of this research study lies in its analysis across multiple domains of power and in centring women's voices, showing how trauma was produced not only through a partner's interpersonal tactics but also through the cultural, institutional, and structural conditions that restricted what women could do, say, or access. For example, women who were disabled or living in rural areas described how perpetrators exploited these social locations through financial control and by limiting access to transport, thereby deepening their entrapment.

In the disciplinary and structural domains, interactions with legal and health systems often reinforced trauma when women's accounts were minimised or disbelieved. These patterns make a theoretical contribution by demonstrating how trauma is constituted through the relationality central to intersectionality (Collins & Bilge, 2016). Trauma emerges not only from individual experiences of abuse, but through relationships with family, community, and professionals that can either validate or silence women's voices. It is also shaped by broader social contexts, where cultural norms influence how violence is recognized, interpreted, and responded to. Taken together, the in-depth, voice-centred analysis informed by IPA illustrates the complexity component of intersectionality, showing how women's experiences of DV-related trauma are shaped in distinct ways by their specific social locations (Brown, 2017; Burstow 2003, 2005; Berg, 2002; Bowleg, 2012; Collins & Bilge, 2016; Collins, 2000).

Participants described their trauma as “torture”, a “daily battle”, and an “everlasting deep scar”, capturing the cumulative, layered, ongoing nature of psychological harm produced through ongoing domination which eroded their sense of authenticity, agency, identity and losing trust in themselves which resonate with Stark’s (2007) conceptualisation of coercive control as a condition of captivity and Herman’s (2015) argument that trauma involves the destruction of autonomy, connection, and control over one’s life. This study makes a theoretical contribution by strengthening our understanding of how gender inequality and male domination operate within the structural domain of power (Collins, 2000, 2017) and are enacted through coercion and control within the hegemonic and interpersonal domains, thereby shaping the production and lived experience of DV-related trauma. According to the domains of power, and grounded in women’s voices in this study, trauma was produced not only through the actions of abusive men (interpersonal power), but also through institutional and disciplinary responses embedded in psychiatry, psychology, legal systems, and other professional structures. In doing so, the findings make a theoretical and methodological contribution by drawing on an intersectional feminist perspective and feminist phenomenology to deepen understanding of trauma and to support ongoing efforts to reconceptualise trauma as rooted in sustained patterns of social oppression and power imbalance, rather than as a response to isolated incidents (Baird, 2018; Buchanan & Wiklund, 2021; Logan, 2017; Salter et al., 2020).

Participants’ voices consistently conceptualised their trauma as social and political, rather than purely personal or psychological (Alford, 2016). Many explicitly located their distress within wider systems of oppression including patriarchy, colonialism, racism, heteronormativity, ableism, socio-economic inequality, religion, and geographic or cultural marginalization (such as rurality or residence in socially conservative environments). This highlights the role of social context and

structural discrimination in shaping trauma and, through an intersectional lens, reflects how trauma is produced through interlocking systems of oppression and power relations rather than emerging solely from individual pathology (Burstow, 2003, 2005; Brown, 1991, 2004; Quiros & Berger, 2015; Seng et al., 2012).

Women's narratives also drew on powerful metaphors to demonstrate the embodied, everyday experience of DV-related trauma, describing themselves as "walking on eggshells," "tiptoeing constantly," and living in a state of persistent hypervigilance. These accounts, by amplifying women's voices as a central contribution of this study, illustrate how the interpersonal domain of power reflects Stark's (2007) description of the micromanagement of victims' lives under coercive control, as well as Herman's (2015) conceptualisation of complex trauma arising from prolonged exposure to fear and powerlessness. This study also extends these frameworks by showing that DV-related trauma is relational and shaped by complex systems of power (Brown, 2017; Burstow, 2003; Collins, 2000; Sokoloff & Dupont, 2005) that are intertwined with participants' social locations, including gender, race/ethnicity, sexual orientation, disability, religion, and geographic or cultural context. For example, one queer participant described how enduring heterosexist violence across the structural, interpersonal, and cultural domains of power shaped her DV-related trauma and later affected her ability to form intimate relationships with women. Another participant living in a rural area emphasised how geographical isolation and limited access to services such as police, shelters, and mental health professionals as features of the structural domain of power deepened her sense of entrapment and restricted her freedom to seek safety.

Another central contribution of this study lies in analysing PTSD diagnosis from the perspectives and meaning-making practices of the women themselves. Through a feminist phenomenological and Interpretative Phenomenological Analysis (IPA) approach, the study centres women's voices and lived experiences, demonstrating that receiving a PTSD diagnosis was not experienced in a fixed way. Drawing on women's narratives, the findings show how the diagnosis could simultaneously be experienced as validating, relieving, and helpful in accessing support and services, while also generating shame, discomfort, fear, and concerns that the label could be weaponized against them, particularly within family court proceedings. In this sense, the findings highlight the double-edged nature of the PTSD diagnosis, revealing its simultaneous role as both a source of recognition and a mechanism of institutional and disciplinary power. While some women experienced the diagnosis as acknowledging the impact of DV-related trauma, others experienced it as pathologizing and individualising their trauma responses, rather than recognising the structural violence, including patriarchy, shaping their experiences. By centring women lived experiences, this nuanced analysis reflects and extends feminist critiques of the medicalization of trauma and the PTSD diagnostic label, while illustrating the tensions between psychiatric categories and the complex realities of DV-related trauma (Brown, 2004, 2008, 2017; Tseris, 2013, 2015, 2018).

Participants' voices highlighted how institutional and disciplinary practices within mental health and psychiatric systems could reproduce and reinforce dynamics of coercion and control beyond intimate relationships across structural and interpersonal domains of power. In this context, the PTSD diagnosis contributed to the medicalization and depoliticization of women's DV-related trauma by translating their experiences into psychiatric classifications. Rather than functioning solely as a clinical tool, the diagnosis also operated as a mechanism of institutional power, shifting

attention away from coercive control as the root of DV-related trauma and toward the management of survivors' psychological responses (Burstow, 2005, 2018, 2024; Brown & Tseris, 2025; Tseris, 2019b).

Women's voices in this study demonstrated that DV-related trauma and PTSD cannot be fully understood without recognising coercive control by male partners as the underlying context in which trauma is produced. A strong focus on psychiatric models of trauma and symptom-based disciplinary practices can further position survivors as carrying a "disorder," rather than recognising their responses within the context of ongoing abuse and coercion. Through the PTSD label, DV-related trauma may be reframed in narrow psychiatric terms, shifting responsibility for violence away from perpetrators and onto women's bodies and minds. In doing so, diagnostic classification can obscure the centrality of coercive control as a structural, interpersonal, and cultural form of power by prioritising the management of psychological symptoms over accountability for abuse. The findings therefore highlight how DV-related trauma may become depoliticised when the coercive conditions that produce it, together with broader systems of gendered and social inequality, remain insufficiently addressed. These findings align with and extend feminist critiques that challenge the depoliticising effects of psychiatric diagnosis (Brown, 2017; Burstow, 2003, 2005; Tseris, 2019b).

In terms of professional responses, participants described how the PTSD diagnosis became weaponised within institutional contexts, particularly in family court proceedings, where they feared it would be used to question their credibility, stability, or parenting capacity. These experiences reveal how power operates simultaneously across the structural, disciplinary, and cultural domains of power (Collins, 2000). The structural domain is evident in legal frameworks that allow mental health labels to influence custody decisions. The disciplinary domain appears in

professional practices that translate women's DV-related trauma into assessments of risk or deficiency. The cultural domain is reflected in stigma and societal narratives that pathologies women while minimising men's violence. Together, these domains create institutional conditions in which coercive control and DV-related trauma are extended, and institutional betrayal is enacted (Lahav et al., 2025; Lee et al., 2021). In this context, PTSD was no longer simply a clinical label applied within psychiatric institutions, but a resource mobilised within legal power, one that re-traumatized survivors rather than protecting them. Women's distress, rooted in DV-related trauma, was reframed as personal instability and used against them, thereby undermining both their sense of safety and their pursuit of justice (Blewitt et al., 2023; Clark, 2016; Cooper & Sweet, 2025; Epstein & Goodman, 2019; Gutowski & Goodman, 2023; Johnston, 2020; Lapierre et al., 2024; Laing, 2017; Rivera et al., 2012; Reeves et al., 2025; Thompson, 2021).

Taken together, the findings on how the PTSD diagnosis was perceived and how professionals, particularly within family court, responded to it demonstrate this study's contribution to survivor-centred knowledge by applying a feminist phenomenological approach, centring women's voices, and offering an in-depth analysis of their lived experiences and perspectives. Women did not simply reject the PTSD diagnosis, rather, they actively reframed it, positioning it as only one part of their story rather than its defining feature. They also resisted institutional interpretations that overlooked their experiences of DV-related trauma and the structural, interpersonal, disciplinary, and cultural forms of oppression shaping their lives, instead prioritising their own understandings of safety and care. This contribution reflects intersectionality's principles of relationality and complexity, showing that survivors made sense of the PTSD diagnosis in relation to wider systems of power including coercive control, psychiatric and legal practices, and their own social locations rather than as an isolated medical label. In doing so, the findings advance a social justice

perspective (Brown, 2024; Brown & Tseris, 2025; Coker, 2016; Cardenas, 2023; Dill & Kohlman, 2012; Tseris et al., 2024) by highlighting women's interpretive agency in resisting purely medicalised understandings of DV-related trauma while navigating systems that require diagnostic labels to access care and resources.

Moreover, these power dynamics as explained above, and complexity of inequality, power relations, and social context through intersectional lens also shaped how participants understood safety, accountability, and justice. For women in this study, safety was not experienced merely as physical protection from further violence, but as emotional, relational, and institutional security including being believed, being taken seriously, and being free from ongoing legal or professional harm. Similarly, justice was not understood solely in terms of legal punishment, but as recognition, accountability, and restoration of dignity. Participants described how the absence of justice when perpetrators remained unaccountable, or institutions dismissed their experiences prolonged their trauma and deepened their sense of vulnerability. From an intersectional feminist perspective, participants' accounts highlight that justice is experienced not only through outcomes, but through process, through how survivors are treated, heard, and positioned within legal and professional systems. These findings resonate with feminist critiques of legal responses to violence, which have long argued that formal systems often privilege procedures over women lived realities (Coker, 2002; Epstein & Goodman, 2012; Herman, 2005, 2023). However, this study contributes original insight by centring how marginalized women themselves articulate justice in relation to safety, recognition, and ongoing healing. Their accounts highlight how social injustice is reproduced within structural and disciplinary domains of power (Collins, 2000), where institutional actors focus on symptoms or diagnostic labels rather than on the violence itself (Tseris, 2019b), thereby

re-traumatizing survivors instead of supporting their empowerment through a social justice framework (Brown, 2024).

Overall, this study contributes to existing knowledge by demonstrating that DV-related trauma is not simply a psychological consequence of violence, but a relational, structural, and political experience embedded within coercive control and shaped by intersecting systems of inequality and oppression. By integrating survivors' meaning-making with critical feminist trauma scholarship and intersectionality (Brown 2004, 2008, 2017; Burstow 2003, 2005; Collins & Bilge, 2016; Collins, 2000, 2017), this research shows that DV-related trauma, PTSD, safety, and justice must be understood within the interconnected interpersonal, structural, disciplinary, and cultural domains of power, as previously outlined. These domains clarify how power is enacted in relationships, reinforced through institutions, normalised through cultural narratives, and sustained through broader social structures. In doing so, the study calls for more intersectionality informed and socially just responses to domestic violence and mental health responses that recognise trauma not as an individual dysfunction but as a socially produced outcome of enduring and unequal power relations.

8.3. Resistance, Resilience and Meaning-Making as Intersectional Practice

Although participants met diagnostic criteria for PTSD, interpreting their experiences solely through a psychiatric lens risks pathologizing their responses while obscuring the resilience, agency, and resistance embedded in their everyday responses to reclaim their agency (Tseris, 2019b; Thompson, 2021). An intersectional analysis reframes resilience not as an internal personality trait, but as a relational response even inviable to structural violence, shaped by systems of inequality, power, social context, complexity, and social justice (Collins & Bilge, 2016; Collins, 2015, 2017). Participants described drawing on strong inner resources and sources of

meaning, including their relationships with their children, spirituality, time in nature, and creative or bodily practices such as singing, gardening, and walking. These practices were not detached acts of "self-care" but deeply situated strategies through which women attempted to reclaim agency, maintain dignity, and preserve emotional stability within conditions of constraint (Davis, 2002; Hage, 2006; Lempert, 1996). Similar findings have been documented in feminist and survivor-centred research on domestic violence, which highlights women's strategies for safety, agency, and resiliency practices (Anderson et al., 2012; Campbell et al., 1998; Cordero, 2014; Goodkind et al., 2004; Kelsall-Knight et al., 2025).

When domination is treated as ordinary or taken for granted, acts of resistance are framed as rare or unexpected. Understanding oppression through the intersection of domains of power helps reveal how domination and resistance continually shape one another, showing that these processes are interconnected rather than separate (Collins, 2000, 2015, 2017). Within the interpersonal domain of power (Collins, 2000), participants described actions such as emotional distancing, documenting abuse through messages and photographs, setting psychological boundaries, or negotiating interactions to minimise danger. What could appear from the outside as compliance, silence, or passivity often reflected highly calculated decisions based on their intimate knowledge of the perpetrator's behaviour and risk patterns, as also noted in earlier feminist work on women's resistances strategies (Brown & Tseris, 2025; Cavanagh, 2003; Lempert, 1996).

Participants sometimes drew on clinical and therapeutic language, using terms such as "freezing," "fawning," "hypervigilance," "fight or flight," and "dissociation" to make sense of their experiences. However, their narratives often moved beyond these clinical descriptions, reflecting active meaning-making and agency in how they understood and responded to trauma. For example, when participants spoke about 'dissociation', they described it not simply as a 'symptom', but as

a protective form of mental distancing that enabled them to endure and survive everyday life under coercive control. These accounts illustrate how women actively engaged with available clinical language while simultaneously resisting the reduction of their lived experiences to psychiatric categories such as PTSD (Brown & Tseris, 2025; Tseris, 2019b; Tseris et al., 2022). Therefore, behaviours often interpreted clinically as 'symptoms' can instead be understood as embodied and relational acts of resistance to disciplinary and hegemonic narratives of trauma, enacted within highly constrained conditions (Brown & Tseris, 2025; Collins, 2015, 2017; Helsel, 2015; Humphreys, 2009; McCann et al., 1988; Tseris, 2018, 2019b).

Within the cultural (hegemonic) domain of power, participants challenged dominant narratives of victimhood (Goodman & Epstein, 2008; Hoff, 2016; Oke, 2008; Profitt,1996). Their stories resisted stereotypes of "broken", passive, or permanently damaged survivors, instead asserting complex identities as mothers, workers, believers, carers, creative individuals, and advocators. Their meaning-making practices, such as finding purpose through parenting, spirituality, connection to land and nature, or solidarity with other survivors, served to counter hegemonic and disciplinary discourses that frame DV-related trauma solely in terms of pathology, inequality, and oppression. In theoretical terms, these findings broaden understandings of DV-related trauma by foregrounding agency, resistance, and relational sources of healing. Methodologically, they demonstrate the value of approaches that centre women's voices and lived experiences in generating survivor-centred knowledge.

Because domination and resistance are organised differently across social contexts, women's resilience was both shaped and constrained by their access to resources, services, and institutional response (Collins, 2000, 2017). Participants' ability to enact survival strategies varied depending on their social locations, including disability, race/ethnicity, sexual orientation, socio-economic

status, religion, and geographic context (such as rurality or living in socially conservative areas). For example, women living in rural or isolated communities described using nature as one of the only accessible spaces for emotional regulation, while women with disabilities developed strategies specifically adapted to their physical and social limitations. This study contributes to the core intersectional concept of complexity, demonstrating that resilience and resistance are not universal, but emerge differently across unequal structural conditions (Collins & Blige, 2016).

Importantly, this study situates survivors' resilience within a social justice framework. While participants demonstrated remarkable adaptability and strength, an intersectional perspective cautions against celebrating resilience in ways that obscure or excuse ongoing structural violence (Collins, 2017; Tseris, 2019b). Their resilience often emerged in response to institutional failure rather than institutional support. For this reason, resilience should not be romanticised or used to shift responsibility away from systems that failed to protect them. Instead, this study contributes to highlight the need for structural change so that such resilience is no longer required for basic safety and survival (Tseris, 2019b, 2024).

In summary, this study makes a unique contribution by demonstrating how survivors draw on personal meaning-making in relation to DV-related trauma and PTSD, as well as embodied practices, to construct their own understandings of trauma, resilience, and healing. Their narratives reveal alternative ways of knowing trauma that move beyond symptom-based models and instead emphasise survival, agency, relationality, and socio-political context. By centring survivors' voices and framing resilience as intersectional resistance across interpersonal, disciplinary, cultural, and structural domains of power, this research extends existing literature on domestic violence and trauma and contributes to more socially just and survivor-informed approaches to understanding and responding to DV-related trauma.

8.4. Limitations

This study was designed to explore the lived experiences of survivors in domestic violence and trauma through a feminist phenomenological and feminist intersectional lens. While the findings offer rich, in-depth insights, several limitations must be acknowledged. The use of a small sample limits the extent to which these findings can be generalised, however, this approach is consistent with phenomenological methodology, which prioritises depth, richness, and detailed exploration of participants lived experiences rather than broad representativeness. In addition, the sample was limited to women who had received a diagnosis of post-traumatic stress disorder (PTSD) by health or mental health professionals. This may not reflect the experiences of women who have experienced similar forms of violence and trauma but have not received a PTSD diagnosis, whether due to barriers in accessing mental health services or for other reasons.

At the time of the interviews, I noticed that all participants were either currently accessing, or had previously accessed, psychotherapy or counselling related to their DV-related trauma. This is an important consideration when interpreting the findings, as therapeutic engagement may have influenced both their willingness to participate, given their insights into DV-related trauma, and their familiarity with trauma-related terminology, such as dissociation, freeze, or fight-or-flight responses, which some participants mentioned briefly when describing their experiences. However, the findings clearly showed that their accounts and narratives were not limited to psychological language. Participants vividly conveyed the embodied nature of their trauma through metaphors, everyday expressions, and culturally grounded language, reflecting their own frameworks of meaning-making in relation to DV-related trauma both during the abusive relationship and after leaving it. Nevertheless, the use of clinical concepts alongside personal understandings of trauma may partly reflect the influence of therapy, shaping both how experiences

were narrated and how the meaning of trauma was constructed within this study. It therefore remains unclear whether women who have not accessed therapy would employ similar metaphors, expressions, or narrative forms. Future research could examine trauma narratives among women without therapeutic exposure in order to further understand the role of therapy in shaping how trauma is articulated.

Another important limitation of this study relates to the application of an intersectional feminist framework. While the inclusion criteria focused on marginalized women, the sample did not capture the full range of social locations or forms of structural oppression. For example, I made efforts to disseminate the flyer through a range of organizations in order to include racialized and immigrant women, but certain racialized, ethnic, and religious identities were not represented in the final sample. More specifically, although the study was informed by an intersectional feminist framework, which originates from Black feminist scholarship and activism (Crenshaw, 1991), and despite my efforts as the researcher to reach out to communities to include Black women in the study (as mentioned in the section 4.3.2), Black women were not represented in the final sample. This absence is significant, as intersectionality was specifically developed to centre the lived experiences of Black women (Crenshaw 1991; Collins, 2000). Despite this limitation, the intersectional feminist framework remains a relevant critical lens for linking individual narratives to broader structures of inequality and for showing that the social locations of each participant are relationally shaped by political, cultural, and structural forces rather than being isolated or individual (Crenshaw, 2011; Collins & Bilge, 2016). As a result, the findings cannot fully reflect the diversity and complexity of varied social locations or fully capture intersectionality as originally conceptualised within Black feminist thought. They nevertheless highlight

marginalization as a structural condition, demonstrating how institutional, cultural, and policy contexts sustain inequality (Crenshaw, 1991).

A further limitation concerns the absence of financial incentives for participation. I recognise, as the researcher, that this may have influenced recruitment and participation, particularly given the sensitive nature of the topic and the emotional labour involved in discussing experiences of domestic violence and trauma. Offering no compensation may have limited participation to those who had the time, capacity, or personal motivation to engage in the study, an issue I will carefully consider in future research. Nevertheless, six participants chose to take part in this study, and I deeply appreciate their participation and their contribution to generating knowledge. Several participants noted that some of the interview questions helped them connect their social locations with their experiences of domestic violence and trauma. Some also described speaking about their experiences as therapeutic and as creating moments of insight or realisation.

8.5. Implications for Future Studies, Policies and Practices

Building on the findings of this study, this section outlines the key implications for future research, policy, and practice. The results demonstrate that women lived experiences of coercive control, DV-related trauma, institutional responses (including family court), and everyday strategies of resistance cannot be understood solely at the level of individual experience. Rather, they reflect the operation of structural, cultural, and relational power conditions that shape how violence is enacted, recognized, and responded to. These implications therefore highlight the need for approaches that are intersectionality informed, trauma - and violence-informed, and grounded in social justice approaches that address not only the immediate harms women endure but also the wider systems and contexts that contribute to their entrapment or facilitate their safety, healing, and autonomy.

8.5.1. Implications for Future Research

Despite its limitations, this study offers several important directions for future research. First, it demonstrates the need to explore trauma as a potential outcome of coercive control, rather than treating trauma as merely an individual psychological outcome, emphasising the deep and often overlooked link between domestic violence and DV-related trauma (Baird, 2018; Humphreys, 2009; Tseris 2015, 2018). Participants' accounts consistently showed that trauma emerged from prolonged entrapment, psychological domination, and structural failures to protect them, rather than from isolated violent incidents. This aligns with contemporary understandings of complex trauma, which emphasise the cumulative impact of sustained abuse, fear, and disempowerment over time (Herman, 2015). This supports emerging research that conceptualises trauma as deeply embedded in ongoing power relations (Brown, 2017; Kassing & Collins, 2025; Lohmann et al., 2024a, 2024b; Tolmie et al., 2024) indicate the need for future studies that explicitly centre coercive control and complex trauma within trauma analysis. Future research should also extend intersectional scholarship by examining how different social locations, including gender, race/ethnicity, disability, sexuality, religion, socio-economic status, and geographic or cultural context, shape not only survivors' vulnerability to coercive control, but also their access to recognition, safety, and justice (Collins & Bilge, 2016). Participants in this study highlighted how sexism, ableism, classism, heterosexism, rural marginalization, and colonial power intensified their experiences of violence and trauma. This underscores the need for further research that explores how intersecting systems of inequality shape coercive control, DV-related trauma, and institutional responses in different contexts (Burdett, 2025; Stark, 2007; Tolmie et al., 2024; Tseris 2019b).

Importantly, this study demonstrates the value of participatory and phenomenological approaches that centre survivors' knowledge and meaning-making, rather than imposing dominant psychiatric or legal frameworks (Hesse-Biber, 2013; Tseris, 2015; Tseris et al., 2022; van Manen, 2016). Participants generated alternative understandings of trauma, justice, accountability, and resilience that challenged narrow clinical models of trauma (Burstow, 2005; Brown & Tseris, 2025; Tseris, 2019b). Future research should therefore prioritise methodologies that allow survivors to articulate their own frameworks of healing, justice, and resistance, including non-medical, culturally grounded, creative, or community-based approaches (Brown, 2024; Herman, 2005, 2023; Tseris, 2015, 2019b). This would contribute to knowledge that is not only trauma-informed, but also survivor-informed and intersectionality grounded.

8.5.2. Implications for Policy

The findings of this study have significant implications for trauma- and violence-informed policy. However, they also highlight the limitations of many existing trauma-informed policies, which often emphasise psychological recovery and treatment without sufficiently addressing the structural and institutional conditions that reproduce trauma (Kulkarni, 2019; Shaia et al., 2024; Tseris, 2024).

Participants' reluctance to disclose trauma-related diagnoses (PTSD) in legal contexts, such as family court or child custody proceedings, demonstrates how psychiatric labels can be experienced as sources of stigma, surveillance, victim-blaming and potential harm rather than protection (Burstow, 2018; Johnston, 2020; Tseris, 2024). Women in this study feared that diagnoses such as PTSD would be used against them to undermine their credibility or parenting capacity. This finding echo feminist critiques that diagnostic frameworks can operate through the disciplinary domain of power, regulating and evaluating survivors rather than protecting them (Burstow, 2003, 2005;

Tseris et al., 2024). Trauma-informed policies must therefore move beyond encouraging disclosure, and instead critically address how legal and welfare systems themselves contribute to institutional harm (Reeves et al., 2025; Smith & Freyd, 2014; Tseris, 2024).

Policies must also explicitly address coercive control as a structural and ongoing form of violence (Stark & Hester, 2019; Stark, 2007), not only as a criminal or interpersonal issue (Aspinall et al., 2024). Participants described how court orders, custody arrangements, and welfare policies often forced continued contact with perpetrators, reproducing coercive control through institutional mechanisms. This reflects how violence operates across the structural domain of power, where legal systems can become sites of continuation rather than interruption of abuse (Douglas, 2018; Gutowski & Goodman, 2023). Trauma- and violence- informed policy must therefore integrate understandings of coercive control into family law, child protection, and welfare systems, ensuring that survivors are not placed at further risk through legal processes (Bowen & Murshid, 2016; Wathen et al., 2023).

Structural interventions are also essential. Participants' safety and recovery were deeply shaped by access to housing, income, healthcare, disability support, and social resources. As participants' experiences illustrate, trauma recovery cannot occur in conditions of ongoing economic insecurity, housing instability, or institutional neglect (Goodman et al., 2009; Hetling et al., 2018; Kulkarni, 2019). This aligns with literature showing that social determinants such as housing and financial security are crucial for survivor safety and wellbeing (Clark et al., 2019; Ogbe et al., 2020). Policies that rely solely on medical diagnoses as gateways to resources risk excluding those who resist or critique psychiatric labels (Tseris, 2015, 2019b; Tseris et al., 2022). Instead, trauma- and violence-informed policy must recognise trauma as socially and structurally produced and provide

multiple, non-medicalised pathways to support (Levenson, 2017; Ross et al, 2023; Tseris, 2019b; Wathen & Mantler, 2022; Wilson et al., 2015).

Finally, policies must centre perpetrator accountability and survivor safety (Devaney, 2014; Heward-Belle & Hughes, 2025; Herman, 2005; Wiley, 2020). Participants consistently described how a lack of meaningful accountability mechanisms contributed to their ongoing fear and trauma. Justice, as articulated by participants, was not limited to punishment but included being believed, validated, and protected from further harm. This requires policy frameworks that prioritise survivor-defined safety and justice rather than procedural neutrality or institutional convenience (Brown, 2024; Coker, 2002; Goodman & Epstein, 2011; Herman, 2005).

8.5.3. Implications for Practice

This study also offers important implications for trauma- and violence-informed and intersectionality informed practice across domestic violence, mental health, legal, and social service sectors (Kulkarni, 2019; Mattsson, 2014; Scott & Jenney, 2023; Sokoloff, 2008; Wathen & Mantler, 2022; Wathen, et al., 2023; Wilson et al., 2015).

First, practitioners must move beyond narrow, universal PTSD frameworks and recognise DV-related trauma as a relational, structural, and political experience, rather than solely an individual psychological condition (Baird et al.,2021; Bograd, 1999; Bryant-Davis, 2019). Participants' accounts demonstrated how trauma was shaped by coercive control, institutional responses, and intersecting systems of inequality. Practice must therefore adopt trauma- and violence-informed approaches that explicitly connect trauma to power, coercive control, and social context, rather than reducing it to internal dysfunction (Burstow, 2005; Brown, 2017; Tseris, 2018).

Second, practitioners should adopt intersectionality frameworks that recognise how social locations such as disability, race/ethnicity, sexuality, rurality, and socio-economic status shape survivors' experiences of violence and help-seeking (Day & Gill, 2020; Mattsson, 2014; Nixon & Humphreys, 2010; Sokoloff, 2008). Participants described misrecognition by professionals who failed to consider these dimensions, often minimising their experiences, or interpreting coercive control as mutual conflict. This reflects how disciplinary and cultural domains of power shape professional knowledge and practice (Collins, 2000, 2017; Nixon & Humphreys, 2010; Sokoloff & Dupont, 2005). Therefore, professional education must include training on coercive control, intersectionality, and culturally responsive trauma- and violence-informed approaches (Williams et al., 2024; Wilson et al., 2015).

Third, this study highlights the importance of integrated and coordinated care systems (Larance et al., 2025; Pitts et al., 2009; Jordan et al., 2024). Participants described being required to repeatedly recount traumatic experiences to different professionals, which they experienced as exhausting and re-traumatizing. Trauma-informed practice should reduce this burden through collaborative, well-communicating service systems that respect survivors' boundaries, consent, and control (Dichter et al., 2021; Kulkarni, 2019). This aligns with trauma- and violence-informed care models that emphasise safety, choice, collaboration, trustworthiness, and empowerment, while also addressing power dynamics within service delivery (Tseris, 2024).

Finally, practitioners must engage with survivors not only as service users, but as knowledge holders and moral agents (Tseris, 2019b). Participants in this study actively interpreted, critiqued, and resisted dominant clinical discourses, demonstrating sophisticated understandings of their trauma and survival. Practice must therefore shift from expert-driven models to collaborative, survivor-led approaches that honour women's agency, lived knowledge, and political

consciousness (Tseris, 2019b; Tseris et al., 2022). This reflects an intersectional and feminist commitment to social justice, where healing is not about adapting to oppression, but about challenging the conditions that sustain it.

Conclusion

This study set out to explore how women from marginalized social locations in Canada understand and make meaning of trauma within the context of domestic violence. Guided by an intersectional feminist framework and a feminist phenomenological approach, the research centred women's lived experiences to illuminate how social location, structural inequality, and power relations shape not only the experience of coercive control, but also how DV-related trauma is interpreted, lived, and responded to. By foregrounding women's voices, this thesis moves away from abstracted or universalised accounts of trauma and instead situates DV-related trauma within women's relational, social, and political realities.

The findings demonstrate that trauma cannot be adequately understood through clinical or diagnostic frameworks such as PTSD alone. Rather, participants' narratives revealed trauma as a deeply relational, social, and political experience, rooted in prolonged coercive control and sustained through intersecting systems of patriarchy, racism, ableism, classism, heteronormativity, colonialism, and geographic marginalization. Trauma, as described by participants, extended beyond psychological distress to encompass a profound disruption of safety, autonomy, identity, belonging and freedom. At the same time, women's accounts also reflected agency, resilience, and resistance, as they reinterpreted their suffering through meanings of survival, care, and justice, refusing to be defined solely by their victimisation.

Academically, this study contributes to feminist scholarship on domestic violence, trauma, and mental health by challenging dominant biomedical and individualised narratives of trauma. By examining how women themselves negotiate, critique, and sometimes resist the label of PTSD, the research expands existing understandings of trauma as an embodied, contextual, and power-laden experience rather than a purely clinical condition. Through its intersectional lens, the study

deepens knowledge of how structural inequalities and diverse social locations shape women's experiences of coercive control, trauma, institutional responses, and healing in complex and uneven ways.

Methodologically, this research advances feminist qualitative inquiry through the use of feminist phenomenology combined with interpretative phenomenological analysis (IPA). This approach allowed women's meaning-making, embodiment, and lived knowledge to guide not only the analysis but the very structure of understanding applied to trauma. In doing so, the study demonstrates the value of feminist phenomenological methods in capturing the complexity of trauma, power, and identity in ways that more traditional or positivist approaches often overlook.

Practically, the findings hold important implications for domestic violence and mental health systems in Canada. They highlight the urgent need for intersectionality-informed and trauma- and violence-informed policies and practices that move beyond individualising models of trauma to address the broader social and structural conditions shaping trauma in women's lives and their journeys toward freedom. The study shows that services and legal responses must recognize coercive control, institutional betrayal, and trauma, take into account women's diverse social locations, and actively avoid reproducing harm through misrecognition, pathologizing, or procedural indifference. It also calls for greater recognition of survivors as knowledge holders and moral agents whose lived experiences should inform service design, professional practice, and policy development.

Ultimately, this thesis reaffirms that knowledge and meanings of trauma must emerge from those who live it. Listening to women's voices, particularly those positioned at the intersections of multiple marginalizations, opens space for more just, nuanced, and transformative understandings of violence, resilience, and healing.

By centring these perspectives, this research contributes to the broader feminist project of challenging dominant knowledge systems and reshaping how trauma, justice, and accountability are understood within institutions and communities. In doing so, it reflects an intersectional feminist commitment to social justice, where healing and justice involve resisting the systems that perpetuate oppression rather than adjusting to them. Rather than merely documenting women's suffering, this research seeks to honour their agency, amplify their resistance, and support the ongoing work of transforming the social conditions that make such suffering possible.

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Appendices

Appendix I. Consent Form

uOttawa

Faculté des sciences sociales
Faculty of Social Sciences

École de service social
School of Social Work

Women's Lived Experiences of Domestic Violence and Trauma

Researcher: Raheleh Sazgar, PhD candidate, School of Social Work, University of Ottawa, email address:

This Doctoral Thesis project is conducted under the supervision of Simon Lapierre, PhD, Professor in the School of Social Work at the University of Ottawa.

Supervisor: Simon Lapierre, Professor, School of Social Work, University of Ottawa, email address:

Purpose of the Study:

The primary research objective is to advance our understanding in how marginalized women who have experienced domestic violence and who have been diagnosed with PTSD understand trauma, and how they experience interventions in this area.

Participants

Participants will be required to meet the following inclusion criteria: a) self-identify as women (cisgender or trans); b) be aged 18 or older; c) have experienced domestic violence (Which may include physical, sexual, psychological, emotional, financial and coercive control); d) have been separated from their abusive partner (no time limit); e) have received a PTSD diagnosis by a professional in relation to their experiences of domestic violence; f) identify with one or more of the following marginalized groups: racialized women, women identifying with the LGBTQIA2S+ community, women with a disability (long-term or recurring, visible or invisible impairment affecting physique, mental, sensory, or psychological capacities), women belonging to religious and ethnoreligious minorities (Muslim, Buddhist, Jewish, Hindu); g) live in Canada; h) speak English.

Participation

If you agree to participate, you will be invited to take part in multiple interviews (between two and four), which will address the following themes: domestic violence, domestic violence and trauma, PTSD/Trauma and interventions by

professionals, mental health services and domestic violence services. The researcher would then narrow the questions down to obtain the required information The duration of each interview will be between 60 and 90 minutes.

The interviews will be conducted on Zoom. However, if you live in Ottawa and would prefer in-person interviews, the researcher will provide a secure room at the University of Ottawa. All interviews will be audio recorded.

The project is conducted independently from the organizations from which you received information regarding the study. Nobody will know if you opted to participate (or not) and there will be no impact on the services you may receive.

Advantages

There may be no clear or direct advantage for the participants to take part in this study. Nonetheless, it is an opportunity for you to share your experiences in relation to domestic violence and trauma. Moreover, by taking part in this study, you will contribute to enhance knowledge on domestic violence and trauma, and to improve policies and practices in this area.

Risks

Given that this study focuses on domestic violence and trauma, it is possible that some questions trigger painful memories. The participants can stop or take a break at any time in the process and may refuse to answer any questions. In this regard, the researcher will be attentive to the participants' emotions and attitudes, thus will suggest a break if needed. In addition, participants can verbally signal to the researcher when they need a break. The researcher will also provide participants with a list of specialized domestic violence resources, which are free and available 24 hours/7 days.

Confidentiality

In order to ensure the participants' confidentiality, identifying information will be deleted and names will be replaced by a pseudonym for any publication in the future.

All electronic data will be stored in the Principal Investigator's computer, which is password protected and encrypted. All electronic documents will be deleted in a secure way at the end of the retention period.

The principal investigator and the participants will access Zoom through the University of Ottawa's network, which is password protected and encrypted. Data will be audio recorded.

*In order to minimize the risk of security breaches and to help ensure confidentiality, it is recommended that you use standard safety measures, such as signing out of your zoom account and closing the browser after interview.

The participant has received assurance from the researchers that the information they will share will remain strictly confidential and the data will only be used for the purpose of this research project.

Voluntary Participation

Participation in this project is voluntary. You can also withdraw from the project at any time prior you agree to take part in the research project (oral consent submitted). If you choose to withdraw from the study, the data will be destroyed and will not be used for the purpose of this study.

Should you wish to withdraw, you must e-mail Raheleh Sazgar at email address: to indicate as such.

For any questions concerning the ethical aspects of this research, please contact the ethics committee at the University of Ottawa: University of Ottawa, Tabaret Hall, 550, Cumberland St, room 154, Ottawa, Ontario, K1N 6N5. By phone: (613) 562-5387. By Email: ethics@uottawa.ca

The researcher recommend that you print or save a copy of this consent form for your personal records.

By giving the oral consent statement, you agree to participate in this research study.

Yes, I want to participate.

No, I do not want to participate.

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School of Social Work

Appendix II. Recruitment Script

(Email, phone, or in-person, Posters Advertisements in social media)

My name is Raheleh Sazgar. I am a doctoral student in social work at University of Ottawa. I am conducting a research project called ***Women's lived Experiences of Domestic Violence and Trauma***, for my PhD degree under the supervision of Dr. Simon Lapierre.

The aim of this research project is to advance our understanding in how marginalized women who have experienced domestic violence and who have been diagnosed with PTSD understand trauma, and how they experience interventions in this area.

You may participate if you meet following criteria: a) self-identify as women (cisgender or trans); b) be aged 18 or older; c) have experienced domestic violence (Which may include physical, sexual, psychological, emotional, financial and coercive control); d) have been separated from their abusive partner (no time limit); e) have received a PTSD diagnosis by a professional in relation to their experiences of domestic violence; f) identify with one or more of the following marginalized groups: racialized women, women identifying with the LGBTQIA2S+ community, women with a disability (long-term or recurring, visible or invisible impairment affecting physique, mental, sensory, or psychological capacities), women belonging to religious and ethnoreligious minorities (Muslim, Buddhist, Jewish, Hindu); g) live in Canada; h) speak English.

If you would like to participate in this study, I would like to meet you for between two and four interviews, which will be held online via Zoom. Each interview will last between 60 and 90 minutes.

As this project is independent study, the domestic violence shelters, workers and the other community organizations directors will not be notified about who are interested in participation in this project. Your responses to the researcher's email will be kept confidential.

If you are interested to take part in this project or if you have any questions about the project, please contact me privately by email at: Email address

[Using in Snowball Recruitment: If you know anyone who may be interested in participating in this study, please give them my contact information (email address) so they can contact me privately if they have any questions or would like additional information.

Pièce 12002 / Room 12002
12e étage / 12th floor
120, rue Université / University Pvt.
Ottawa ON K1N 6N5

Thank you in advance for considering my request,

Raheleh Sazgar

uOttawa
Faculté des sciences sociales
Faculty of Social Sciences

École de service social
School of Social Work

Appendix III. Recruitment Flyer

Invitation to participate in the research project: **Women's Lived Experiences of Domestic Violence and Trauma**

If you:

- Self-identify as women (cisgender or trans)
- Are aged 18 or older
- Have experienced domestic violence (Which may include physical, sexual, psychological, emotional, financial and coercive control)
- Have received a PTSD diagnosis in relation to their experiences of domestic violence
- Identify with one or more of the following marginalized groups. Examples:
  - Indigenous women (First Nation, Métis Or Inuit)
  - Racialized women (for example: South Asian, West Asian, Latin American, Black women, etc.)
  - Women identifying with the LGBTQIA2S+ community
  - Women with a disability (long-term or recurring, visible or invisible impairment affecting physique, mental, sensory, or psychological capacities)
  - Women belonging to religious and ethnoreligious minorities (Muslim, Buddhist, Jewish, Hindu, etc.)
- Have been separated from their abusive partner
- Live in Canada
- Speak English

We invite you to participate in this research project.

Pièce 12002 / Room 12002
12e étage / 12th floor
120, rue Université / University Pvt.
Ottawa ON K1N 6N5

Research objectives:

To advance our understanding in how marginalized women who have experienced domestic violence and who have been diagnosed with PTSD understand trauma, and how they experience interventions in this area.

Participation:

If you participate in this study, you will be invited to take part in multiple interviews (between two and four) in order to share your experiences in relation to domestic violence and trauma. Interview that will last between 60 and 90 minutes, and they will be held on Zoom. However, if you live in Ottawa and would prefer an in-person interview, the researcher will provide a secure room at the University of Ottawa.

Contact:

The research is led by Raheleh Sazgar, a PhD Candidate in the School of Social Work at the University of Ottawa.

For more information or to take part in this study, please contact to Raheleh Sazgar by email at : Email address

Participants will be selected on a first come-first-serve basis.

Appendix IV. Interview Guide

- **Introduction**

My name is Raheleh Sazgar. I am a PhD Candidate in the School of Social Work at the University of Ottawa. I am seeking your collaboration for a research project entitled Women's Lived Experiences of Domestic Violence and Trauma, conducted under the supervision of Dr. Simon Lapierre.

The aim of this research project is to advance our understanding in how marginalized women who have experienced domestic violence and who have been diagnosed with PTSD understand trauma, and how they experience interventions in this area.

- **Read Consent form with participant**
- **Answering participant's questions**
- **Recording starts**
- **Do you have consent to participate in this project?**
  - Yes
  - No
- **Sociodemographic information**

Could you please introduce yourself: Your name?

What are your preferred pronouns, i.e.: She, they?

How old are you?

How do you describe your gender identity? [Female, Transgender]

How do you describe your sexual orientation? [Asexual, Bisexual, Lesbian, straight, queer, Two-spirit, pansexual]

Would you consider yourself to have a disability? Yes/ No [According to Stats Canada, disability is defined as a long-term physical, mental, emotional/psychiatric or learning disability, which may result in a person experiencing disadvantage or encountering barriers to employment, public appointment or other opportunities for full participation in society.]

How do you describe your race or ethnic group? [Indigenous (Aboriginal, First Nations, Inuit, Métis, Multiple Indigenous Identities)/ Arab (Syrian, Lebanese, Palestinian, Moroccan, Egyptian, etc./ Black (Caribbean, African, Latin American, Black Canadian, etc.)/ East Asian (Chinese, Japanese, Korean, etc.)/ Latin American (Peruvian, Brazilian, Argentinian, etc.)/ South Asian (Indian, Pakistani, Sri Lankan, etc.)/ Southeast Asian (Vietnamese, Cambodian, Malaysian,

Laotian, Filipino, etc.)/ West Asian (Iranian, Afghan, etc.)/ White (European descent)/ Mixed Race/ Other (please specify)]

Do you consider yourself related to any religious community? Or What religion, if any, do you identify with? [Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, Spiritual but secular Wiccan/pagan]

Where are you located? [In which city of Ontario]

What is the highest level of education you have completed? [Grade school, High school, Some high school, College (degree, diploma, certificate), University undergraduate, University Master's Degree, University PhD, Some university]

What is your current employment status? [Full-Time/ Part-Time/ Contract or Temporary/ Unemployed/ Retired/ Seeking opportunities/ Unable to work/ Self-employed/Freelance]

What is your approximate individual income annually, before taxes? $0-$9,999 /$10,000-$18,499/ $18,500-$29,999/ $30,000-$49,000/ $50,000-$74,999/ $75,000-$99,999/ $100,000-$124,999/ $125,000 and up]

Side note: As the participants of this research project will belong to marginalized groups, I should consider their social identity alongside all questions. I use a **"Lesbian woman"** as an example through this interview guide. However, it will be different based on women's diverse social identities in their interviews.

- **Domestic Violence**

You have experienced domestic violence, let's go more in-depth about your lived experiences in an abusive relationship.

When did you notice that something was wrong in your relationship or in your ex-partner's behaviours?

How would you describe your ex-partner's behaviours?

What were the things that you could not do, because your ex-partner did not want you to or because you were worried of your ex-partner's reactions?

What things or issues in your relationship caused you stress?

As a lesbian woman, what was it like to go through this situation?

What strategies did you put in place to ensure your safety and well-being in this context?

Do you think that your strategies were influenced by the fact that you were a lesbian woman? [If so, please describe this experience further].

- **Domestic violence and trauma**

You just told me about your experience of domestic violence, do you consider it as a traumatic experience? [if so, please describe this experience further]

What does the word "trauma" mean to you? what they thought of when they heard the word trauma, what the word trauma meant to them?

In your view, what does it mean to experience trauma as a result of domestic violence? How does experience trauma have been impacted your personality?

Do you think that a woman's experience of trauma as a result of domestic violence would be influenced by the fact that she is a lesbian woman? If so, how?

- **PTSD/Trauma - Intervention by Professionals**

You told me that you received a PTSD diagnosis, when have you been diagnosed with PTSD?

Could you please walk me through the process that led to your diagnosis?

Do you see a connection between your experience of domestic violence and the PTSD diagnosis? [If so, please describe this experience further]

What was it like for you, as a lesbian woman, when you received this diagnosis?

To what extent did the professional who gave you the PTSD diagnosis take your experience of domestic violence into account? [could you please describe this experience further]

- **Mental health services**

I would like to know more about your experience with mental health professionals. We'll address your experiences with domestic violence services later.

Tell me about the mental health services that you have been in contact regarding your PTSD?

As a lesbian woman who has experienced domestic violence, what was it like to be in contact with these professionals?

To what extent did these professionals take your experience of domestic violence into account? [could you please describe this experience further]

Would you say that these professionals have helped you to heal from domestic violence? [if so, could you please describe this experience further]

- **Domestic violence services**

I would like to know more about your experience with domestic violence services.

Tell me about the domestic violence services that you have been in contact with.

As a lesbian woman, what was it like to be in contact with these services?

How did these services deal with the fact that you had a PTSD diagnosis?

Was trauma address by these services? If so, how?

Would you say that these services have had an impact on your mental health? [if so, could you please describe this experience further]

Would you say that these services have helped you to heal from domestic violence? [if so, could you please describe this experience further]

- Post Traumatic Growth (PTG)

When it comes to the recovery/ healing process from PTSD, have you found any facilitators and/or obstacles (factors) that might help you to process your trauma? [for example: if laws, regulations and the social support system]

Have you experienced positive transformation in your value, relationships, and actions during the recovery from trauma? [if so, could you please describe this experience further]

Conclusion

What do you think women who have experienced domestic violence and who have been diagnosed with PTSD need to be able to heal from this experience?

Do you consider that lesbian women have specific needs in this regard?

What changes are necessary to improve professionals' responses to these situations, including mental health and domestic violence services?

Is there anything I have not asked you that you think would be important for me to know? Any areas of difficulty in domestic violence and trauma experience, or in terms of professional intervention in these areas we haven't talked about? Anything you'd like to ask?

Appendix V. Specialized Domestic Violence Resources

- **ALBERTA**

Family Violence Info Line – Toll-free, 24/7, multilingual service available: 780-310-181

Alberta Abuse Helpline: 1-855-443-5722

Alberta's One Line for Sexual Violence: 1-866-403-8000

Distress Line: 780-482-4357

- **BRITISH COLUMBIA**

VictimLink BC – 24/7 help line providing crisis support in 130 languages. It can connect you to safe emergency shelter, counseling programs and other treatment and healing programs

1-800-563-0808

TTY 604-875-0885

Text: 1-800-563-0808

VictimLinkBC@bc211.ca

Battered Women's Support Services Crisis Line: 1-855-687-1868

- **MANITOBA**

Domestic Abuse Crisis Line: 1-877-977-0007 (toll-free, 24/7)

Klinic Crisis Line: 1-888-322-3019

Klinic Sexual Assault Crisis Line: 1-888-292-7565

- **NEW BRUNSWICK**

Crossroads for Women 24/7 Crisis Line: 1-844-853-0811

Sexual Violence New Brunswick 24/7 Sexual Assault Support Line: 506-454-0437

Chimo Helpline: 1-800-667-5005 (toll-free, 24/7)

Beauséjour Family Crisis Resource Centre

- 506-533-9100 (daytime crisis line)
- 506-312-1542 (evening crisis line)

- **NEWFOUNDLAND AND LABRADOR**

Domestic Violence Help Line – 24/7: 1-888-709-7090

NL Sexual Assault Crisis and Prevention Centre 24/7 Support and Information Line: 1-800-726-2743

- **NOVA SCOTIA**

Provincial Domestic Violence Line (run by the Transition House Association of Nova Scotia) – 24/7: 1-855-225-0220

Avalon 24/7 Sexual Assault Helpline: 902-421-1188

Eskasoni 24/7 Crisis Line: 1-855-379-2099

- **NORTHWEST TERRITORIES**

YWCA – toll free (no TTY compatibility): 1-866-223-7775

NWT Help Line: 1-800-661-0844 (toll-free, 24/7)

Native Women's Association of the NWT 24/7 Crisis Line: 1-866-459-1114

- **NUNAVUT**

Baffin Regional Agvvik Society – Qimaavik Transition House (Iqualuit) 24/7 crisis line, English and Inuktitut: 867-979-4500

Kamatsiaqut Nunavut Helpline: 1-800-265-3333 (toll-free, 24/7)

- **ONTARIO**

  Assaulted Women's Helpline – Free, confidential counseling, emotional support, safety planning and referrals for women needing a shelter, legal advice or other supports. Available 24/7, province-wide in more than 100 different languages including 17 Aboriginal languages.

  Toll-free:1-866-863-0511

  Toll- free TTY: 1-866-863-7868

  Mobile (On Rogers, Fido, Bell and Telus networks): #SAFE (#7233)

  Fem'aide – For francophone women, toll-free, province-wide, safety planning and referrals

Toll-free: 1-877-336-2433

TTY: 1-866-860-7082

Anishnaabe Kwewag Gamig Northern Ontario First Nations crisis line

1-800-388-5171

Talk4Healing- Get 24/7, culturally sensitive crisis counselling, advice and support for Indigenous Women and their families living in urban, rural and remote communities, both on and off reserve.

Support is available in English, Ojibway, Oji-Cree and Cree.

Text or call the Talk 4Healing helpline toll- free at Toll-free: 1-855-554- 4325 (1-855-554-HEAL).

- **PRINCE EDWARD ISLAND**

PEI Family Violence Prevention Services 24/7 Crisis and Support Line: 1-800-240-9894

Island Help Line: 1-800-218-2885 (toll-free, 24/7)

- **QUEBEC**

SOS violence conjugale – Province-wide toll free crisis line, 24/7, toll-free, TTY compatible: 1-800-363-9010 (bilingual service available)

Women Aware Support Line: 1-866-489-1110

Helpline for Victims of Sexual Assault: 1-888-933-9007

- **SASKATCHEWAN**

24 Hour Crisis and Abuse Line – 1-800-214-7083

Abused Women's Crisis Line – 1-888-338-0880

Mobile Crisis 24/7 Helpline: 306-757-0127

Saskatchewan 24/7 Response and Crisis Lines

  - Prince Albert and area: 306-764-1011
  - Saskatoon and area: 306-933-6200
  - Regina and area: 306-757-0127

- **YUKON**

VictimLink BC (toll-free, 24/7, multilingual service available): 1-800-563-0808

Victim Services/Family Violence Prevention Unit: 1-800-661-0408 (ext. 8500)

Women's Transition Home 24/7 Crisis Line: 867-668-573

Appendix VI. Ethical Approval Certificate

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-08-22-7980
Titre du projet / Project Title	Women's Lived Experiences of Domestic Violence and Trauma
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	19/09/2022
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	18/09/2025

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Raheleh SAZGAR	École de service social / School of Social Work	Chercheur Principal / Principal Investigator
Simon LAPIERRE	École de service social / School of Social Work	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

Tables

Table 1. Seven Recommended Steps of Interpretative Phenomenological Analysis by Smith et al. (2021)

Step	Stage Name	Description
1	Reading and Re-reading	Immersing yourself in the data to become familiar with the participant's account and World
2	Exploratory noting	Making detailed notes on language, content, and concepts in the transcript.
3	Developing Experiential Statements	Creating short, meaningful statements that reflect both participants lived experiences and the researcher's interpretation.
4	Searching For Connections Across Experiential Statements	Clustering related experiential statements to identify patterns within a case.
5	Naming the Personal Experiential Themes (PETs)	Clustering experiential statements for each participant, assigning titles that capture their essence.
6	Continuing the Individual Analysis of Other Cases	Repeating Steps 1-5 for each participant individually
7	Developing Group Experiential Themes (GETs)	Identifying similarities and differences across all participants and Building higher-level themes that capture shared group experiences.

Table 2. Group Experiential Theme and Subtheme

Group Experiential Themes (GETs)	Subthemes
Unseen Scars of Coercive Control (GET.1)	• It Was Hidden Bruise • Emotional Wounds of Control • Sexual Violence as Unseen and Unspoken Layer of Coercive Control
Post-Separation Coercive Control (GET. 2)	N/A
From Experience to Understanding: Seeing Domestic Violence as Trauma (GET.3)	• Living on the Edge • Detachment and Loss • Abuser as the Root of the Wound • Shame Came Before Trauma Was Named • Finding Words for the Inner Experience
Social location Amplifying Coercive Control and DV-Related Trauma (GET.4)	• Sexual Orientation and DV- Related Trauma • Perpetrator's Professional Status and DV- Related Trauma • Disability, Conservative Context, Socioeconomic Status and DV- Related Trauma • Disability and DV- Related Trauma • Spiritual Context and DV-Related Trauma • Indigenous Identity and DV- Related Trauma • Geographical Location and DV-Related Trauma

Navigating Recognition and Resistance in the PTSD Label (GET.5)	N/A
Weaponizing PTSD Diagnosis (GET.6)	N/A
Response to DV-related Trauma by Professionals (GET.7)	• Experiences Recognized, Not Dismissed • When Help Fails • Psychiatry as Medical Model Fall Shorts for Survivors • Unseen and Overlooked Survivors' Social locations
Everyday Survival Under Coercive Control (GET.8)	N/A
When Justice Remains Out of Reach (GET.9)	N/A
One Journey, Many Realities (GET.10)	N/A