# “But it didn’t ruin me”: A feminist phenomenological analysis of trauma and healing after intimate partner violence

by

Paige McAllister

B.S., Brigham Young University, 2016
M.S., University of Kansas, 2019

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Applied Human Sciences
College of Health and Human Services

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2022

# Abstract

Intimate partner violence (IPV) is a common problem especially for racial and ethnic minority women and gender and sexual minority individuals. The current research on trauma and healing after IPV does not always represent the diversity of those most likely to experience IPV which is problematic as because the impacts of interpersonal and structural violence are related to and impacted by the other. This lack of attention to diverse experiences is also reflected in the systems in place to aid survivors of IPV including using models of trauma and healing that fail to account for the impacts of both structural and interpersonal violence. Therefore, understanding the lived experience of trauma and healing after IPV with a diverse sample from a critical feminist lens would be valuable to those in helping professions. In this study, interviews were conducted with 16 survivors of IPV. Using a feminist phenomenological analysis, several themes were identified that detailed the physical, psychological, and emotional wounds that occurred because of IPV (wounding systems, sexual/gender identity weaponized by partner, marginalization as a wound, impact of IPV on children), the physiological, emotional, and behavioral reactions to those wounds (PTSD symptoms, romantic relationship impacts, sexual difficulties, impact on view of self and experience), and how survivors conceptualize their own healing process (healing systems, healthy romantic relationships, working through triggers, advocating for self and others, healing as a process). Clinicians working with survivors of IPV should expand their assessment of trauma beyond PTSD criteria and focus on relational healing in their client's relationships and in the therapy room.

# “But it didn’t ruin me”: A feminist phenomenological analysis of trauma and healing after intimate partner violence

by

Paige McAllister

B.S., Brigham Young University, 2016
M.S., Kansas State University, 2019

A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Applied Human Sciences
College of Health and Human Services

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2022

Approved by:

Co-Major Professor
Dr. Amber Vennum

Approved by:

Co-Major Professor
Dr. Kristin Anders

# Copyright

# Abstract

Intimate partner violence (IPV) is a common problem especially for racial and ethnic minority women and gender and sexual minority individuals. The current research on trauma and healing after IPV does not always represent the diversity of those most likely to experience IPV which is problematic as because the impacts of interpersonal and structural violence are related to and impacted by the other. This lack of attention to diverse experiences is also reflected in the systems in place to aid survivors of IPV including using models of trauma and healing that fail to account for the impacts of both structural and interpersonal violence. Therefore, understanding the lived experience of trauma and healing after IPV with a diverse sample from a critical feminist lens would be valuable to those in helping professions. In this study, interviews were conducted with 16 survivors of IPV. Using a feminist phenomenological analysis, several themes were identified that detailed the physical, psychological, and emotional wounds that occurred because of IPV (wounding systems, sexual/gender identity weaponized by partner, marginalization as a wound, impact of IPV on children), the physiological, emotional, and behavioral reactions to those wounds (PTSD symptoms, romantic relationship impacts, sexual difficulties, impact on view of self and experience), and how survivors conceptualize their own healing process (healing systems, healthy romantic relationships, working through triggers, advocating for self and others, healing as a process). Clinicians working with survivors of IPV should expand their assessment of trauma beyond PTSD criteria and focus on relational healing in their client's relationships and in the therapy room.

# Table of Contents

# List of Tables

# Acknowledgements

While I wrote the majority of the words in this the culminating project of my graduate school, it truly took an entire village to get me through! I am grateful for the support of my co-majors, Amber Vennum and Kristin Anders, and my entire dissertation committee. I am also here because of my soulmate friends who have listened to me complain, offered unconditional love, and believed in me when I didn't believe in myself. I am grateful to my parents that instilled in me a desire for education. I am most grateful for my Steve. I am so excited to find out who we are outside of graduate school.

# Dedication

This dissertation is dedicated to survivors of violence be it interpersonal, structural or societal.

# Chapter 1 - Introduction

Intimate partner violence (IPV) is an unfortunately common problem in the United States (Smith et al., 2018) with women, gender, and sexual minorities experiencing the highest rates (Smith et al., 2018; Walters et al., 2013). This is especially so for those who also hold racial and ethnic minority identities (Smith et al., 2017). Further, the physical, mental, emotional and relational impacts of IPV can be severe and long-lasting (Coker et al., 2002, 2005; Spencer et al., 2019b). These impacts are encompassed by the term trauma which describes both the traumatic event and the ways that individuals adapt and respond to the world after experiencing violence (Burstow, 2003). In general, the research on risk factors associated with IPV and impacts of IPV is larger than the limited research on healing after IPV (Flasch, 2020). Additionally, much of the research on survivors of IPV focuses on the trauma and healing experiences of White, straight, cisgender women (Harden et al., 2020; Iverson et al., 2011), thus limiting our understanding of these experiences by diverse populations which are likely different because of the ways interpersonal violence interacts with, and is compounded by, structural violence (Lamble, 2008).

Feminist understandings of trauma after interpersonal violence highlight the need to explore the emotional, mental and behavioral impact of trauma in relational and systemic contexts and attend to how power dynamics and social hierarchies play into trauma for those in minority positions (Burstow, 2003; Root, 1992). While there are many overlaps in experiences, there are unique contextual factors that contribute to marginalized individuals' experience of IPV (Balsam, 2005; Lo et al., 2015) and the availability of affirming help (Harden et al., 2020). A hermeneutic phenomenological framework was identified as an appropriate qualitative method for this study because it provides a way for researchers to critically engage with their knowledge and experiences with a topic and allows for combining with another theory which in this study

was a critical feminist lens. Accordingly, the purpose of this phenomenological study was to explore the lived experiences of trauma and healing after IPV while using a critical feminist lens to attend to the societal context. Understanding the lived experience of trauma and healing for diverse survivors of IPV and exploring the contextual factors that impact these experiences can provide clinicians with information about how to make clinical interventions more affirming and culturally sensitive. According to Peoples (2021), phenomenological research questions must be about the lived experience of the phenomenon and must avoid language that makes assumptions about aspects of the phenomenon. Therefore, this study was focused on the following research questions:

RQ1: How do people who have experienced IPV experience trauma?

RQ2: How do people who have experienced IPV experience healing?

RQ3: How does marginalization impact the experience of trauma and healing after IPV?

**Definitions**

In this dissertation, IPV describes any type of attempted or completed violence, including physical, emotional, psychological, sexual, and financial violence, that is perpetrated by a current or former intimate partner (Breiding et al., 2015). Further, trauma was used describe both emotional, mental, and physical wounds from IPV and the emotional, psychological and behavioral reactions to those wounds (Erikson, 1995). This study approached trauma with a feminist lens thus looking at emotional, mental, relational, and behavioral reactions to a traumatic event as adaptive and understandable rather than a deficit (Root, 1992). Healing here was a word meant to capture the recovery from trauma. In this dissertation, healing did not mean a return to prior functioning, forgiveness of perpetrators of violence, or forgetting trauma (Burstow, 2003). In line with a feminist lens, prescriptive definitions of healing or definitions

that fail to account for trauma as an event that inherently changes how individuals perceive and interact with the world were avoided (Burstow, 2003; Root, 1992). Instead, this study relied on survivors' explanations of what healing has been and what they hope or expect it to be.

# Chapter 2 - Literature Review

IPV is unfortunately common (Smith et al., 2017). Although IPV can occur across all sexes, women experience higher rates of IPV (Smith et al., 2017). More than a third of women (36.4%) have experienced sexual or physical IPV or have been stalked by a partner in their lifetime, and a similar rate (36.4%) have experienced psychological aggression from a partner in their lifetime (Smith et al., 2018). These numbers are affected by data collection that only recently started to take into account sex/genders outside the binary of male and female. These rates increase for some racial and ethnic minorities: 45.1% of Black women, 47.5% of American Indian/Alaska Native women and 56.6% of Multiracial women have experienced sexual or physical IPV or have been stalked by a partner in their lifetime compared to 37.3% of White women (Smith et al., 2017).

While IPV is often studied in heterosexual relationships between cisgender men and cisgender women, IPV rates for gender and sexual minorities are often higher. In a national sample (N = 9,086 women), 61.1% of bisexual women and 43.8% of lesbian women had experienced rape, physical violence, or were stalked by an intimate partner at some point in their lives which was significantly higher than 35% of heterosexual women (Walters et al., 2013). Bisexual women (76.2%) and lesbian women (63%) also experienced higher rates of lifetime psychological aggression from an intimate partner than heterosexual women (47.5%; Walters et al., 2013). Similarly, in a large on-campus sample (N = 6,030), sexual minority students (30.3%) experienced significantly higher rates of physical IPV in the previous 6-months compared to their heterosexual counterparts (18.5%; Edwards et al., 2015). Further, research indicates that gender minorities may also be at increased risk with rates of transgender individuals experiencing any type of IPV estimated to be as high as 31.1% (Langenderfer-Magruder et al.,

2016). Valentine and colleagues (2017) calculated odds ratios for gender minority and cisgender individuals and found the odds of experiencing physical or sexual IPV were five times higher for transgender women, 2.4 times higher for transgender men, and 3.1 times higher for nonbinary individuals compared to cisgender women.

The impact of IPV can be severe and long-lasting for survivors. IPV victimization has been found to be associated with mental health outcomes such as depression (Anderson, 2002; Beydoun et al., 2012; Ferrari et al., 2016; Spencer et al., 2019b), anxiety (Ferrari et al., 2016), post-traumatic stress disorder (Birkley et al., 2016; Coker et al., 2005; Ferrari et al., 2016; Spencer et al., 2019b), substance use (Cafferky et al., 2018; Carbone-López et al., 2006), and suicidal ideation and suicide attempts (Devries et al., 2013). Health problems including injury, chronic pain, and poor health are also common (Campbell, 2002; Carbone-López et al., 2006; Coker et al., 2002). Evidence suggests that type and severity of IPV impacts outcomes with those experiencing more severe and combined types of IPV experiencing the worst outcomes (Hegarty et al., 2013). While public perceptions of IPV often view physical and sexual IPV as inherently more severe, meta-analytic evidence shows the severe impact that psychological and emotional IPV can have on well-being (Krebs et al., 2011). These impacts have also been found in gender and sexual minority samples (Charak et al., 2019; Wathen et al., 2018; Wong et al., 2017) and racial and ethnic minority samples as well (Lacey et al., 2013; Sabri et al., 2013).

**Social Context of Trauma**

Although marginalized individuals experience IPV at higher rates, much of the research on trauma and healing after IPV has been done with primarily White, straight, cisgender women samples (Harden et al., 2020; Iverson et al., 2011) and, relatedly, the models of trauma (Burstow, 2003) and services developed from them for survivors of IPV are not always inclusive. Thus, it is

critical to look at this issue with diverse samples that more accurately represent all populations who experience IPV, including focusing on marginalized individuals who are at higher risk yet are underrepresented in the research on IPV. When considering how racial, sexual, and gender minority individuals experience trauma, the impacts of both structural and interpersonal violence must be taken into account (Burstow, 2003; Root, 1992). Root (1992) calls the trauma resulting from systemic and structural violence "insidious trauma" (p. 240). Insidious trauma results from the pervasive messages and examples individuals are exposed to from birth that, because society is structured hierarchically, some people matter more than others (Root, 1992). Insidious trauma often results in specific survival strategies such as splitting people into good or bad, self-referencing and egocentrism, anger, and withdrawal (Root, 1992). Congruent with a feminist lens, however, these survival strategies and other responses to traumatic events and relationships can be viewed as adaptive and protective rather than as pathology or a deficit (Burstow, 2003). When helping professionals utilize models of trauma that fail to include insidious trauma or are overly pathologizing, they risk replicating the societal messages that cause harm rather than helping survivors heal.

### *Risk Factors of IPV*

It is important to explore IPV within the social context where violence, at the systemic and interpersonal levels, against those in more marginalized positions within society is both more common and more tolerated (Burstow, 2003; Lamble, 2008). This is especially relevant since a common risk factor for IPV is actually other forms of, and previous experiences of IPV, as individuals often experience more than one type of IPV in the same relationship, and are frequently revictimized (Spencer et al., 2019a). For example, Krebs et al. (2011) found that women who had experienced violence by those who were not romantic partners are also more

likely to experience violence by a current or former partner, and that women who had been stalked by a current or former partner were at greater risk for multiple forms of IPV. Additionally, other experiences of violence outside of intimate relationships has been connected to IPV victimization (i.e., experiencing or witnessing relationship violence in childhood; Lagdon et al., 2014). Experiences of structural violence outside intimate partnerships, including systemic disadvantage, are also risk factors for IPV. A systematic review on community level factors found that concentrated disadvantage (i.e., communities where various disadvantages converge) was significantly associated with physical IPV (e.g., the percentage of a community that has single-parent or female-headed families, percentage below the poverty line, percentage unemployed, etc.; VanderEnde et al., 2012).

In addition to past experiences, dominant social narratives about the power attached to identities people hold may influence rates of IPV. For example, narratives of hegemonic masculinity that perpetuate expectations of male dominance and aggression (Connell & Messerschmidt, 2005) have been connected to heterosexual men's perpetration of IPV against women. Endorsing harmful gender norms and acceptability of violence against women is associated with IPV perpetration (McCarthy et al., 2018; Peralta et al., 2010; Willie et al., 2018). These narratives play out in heterosexual relationships regardless of racial or ethnic identity and can be exacerbated by experiences of racism. The multiple disadvantage model (Lo et al., 2015) posits that the distress experienced from personal and structural discrimination can be expressed in violent ways when stressors combine (Lo et al., 2015) and may explain higher rates of IPV among racial and ethnic minority individuals (Cheng & Lo, 2016). For example, male perpetration of emotional IPV was a stronger correlate for perpetrating physical IPV for Black men than for White men (Kelly et al., 2022). Black men who both internalize narratives of male

dominance (Connell & Messerschmidt, 2005) and are thwarted in economic advancement and physical safety by systemic racism might seek to exert more control in their romantic relationship (Kelly et al., 2022).

Similarly, minority stress theory has been utilized to explain how external and internal stressors specific to the sexual minority experience differentiate violence in same-sex relationships (Balsam, 2005). Sutter and colleagues (2019) explored profiles of types of IPV perpetrated by women in same-sex relationships and found that those who experienced and perpetrated all types of IPV measured (sexual, physical, psychological, and IPV-related injury) also experienced the most heterosexism in different contexts such as work, school, and social settings. Internalized homophobia and discrimination (Balsam & Szymanski, 2005) as well as expectations of experiencing discrimination (Carvalho et al., 2011) have been connected to IPV victimization. Although the association between outness, or how open someone is about their sexual orientation in public and private contexts, and IPV has found mixed results, some research has indicated that being more open about sexual orientation is linked to an increased risk for violence (Balsam & Szymanski, 2005; Carvalho et al., 2011). Revictimization is also a relevant risk factor for sexual minorities (Balsam et al., 2005). For example, in a study of sexual minority individuals and their straight siblings, those that identified as lesbian, gay or bisexual experienced more violence in childhood and non-relational contexts as well as more violence in relationships, therefore, revictimization as a risk factor might be particularly relevant for sexual minority individuals (Balsam et al., 2005).

**IPV Impact and Healing**

The impacts of interpersonal violence are compounded by greater societal structures and messages. In order to fully heal, both interpersonal and societal level wounds must be attended

to. Even White, straight, cisgender women are impacted by negative societal views of survivors of IPV that view them as partially or fully culpable for the violence they experience (Armstrong et al., 2018; Kogut, 2011), disparage them for staying in violent relationships (Cravens et al., 2015), or insult and belittle survivors of IPV in the public eye online (Whiting et al., 2019). Feminist theories of healing from trauma reject viewing individual adaptations to traumatic events as inherently pathological (Burstow, 2003). From a feminist framework, healing involves acknowledging harm, recognizing the protective purpose of survival strategies, and letting go of survival strategies that are no longer serving a protective purpose (Burstow, 2003; Herman, 1997). This process is greatly enhanced by the presence of a compassionate and nonjudgmental witnesser (Burstow, 2003; Herman, 1997). Exploring healing from a feminist lens that acknowledges the impact of interpersonal and structural violence and does not pathologize the ways individuals adapt to survive, can provide insight into how to best support survivors of IPV in all areas of their lives impacted by violence.

In general, the literature on healing from IPV is much more limited than the research on the impacts of IPV. Many different definitions of healing or recovery after IPV are being used, however, as Flasch (2020) identified, many of these definitions include some form of reckoning with past IPV, developing strategies to cope with the present distress, and looking toward the future. There has been some scholarship seeking to describe this process as a whole, mainly through qualitative work with survivors of IPV (Flasch, 2020). Other work has focused on elements of the healing process such as reclaiming or redefining the self outside of the violent relationship (Czerny et al., 2018; D'Amore et al., 2021), celebrating autonomy and developing strong social support (Flasch et al., 2017). Similarly, Bagwell-Gray (2019) identified that gaining confidence and ownership helped women heal from sexual impacts after IPV and spirituality has

been found to play a critical role in healing for Christian women after IPV (Drumm et al., 2014). More research is needed in this area that is conducted with diverse samples (D'Amore et al., 2021) to better understand what healing looks like from a diverse sample of IPV survivors can help these interventions increase in efficacy in working with racial, sexual, and gender minorities.

### *Impact of Marginalization on Help-Seeking*

The impacts of IPV experienced by marginalized individuals are not only likely to be amplified by social and systemic experiences of violence and discrimination (Burstow, 2003), but marginalized individuals also experience more barriers to seeking help to leave, or heal and recover from, violent relationships (Calton et al., 2016; Harden et al., 2020; Liang et al., 2005). In general, seeking professional help for IPV is a difficult step for many to take because of the stigma surrounding this issue (Overstreet & Quinn, 2013) that can be compounded by structural discrimination. For example, current understandings of IPV, even among IPV shelter workers and clinicians, are often very gendered (e.g., expecting male perpetrators and female survivors) or operate on models that work to limit perpetrator access to survivors rather than focusing on healing (Czerny & Lassiter, 2016). Helping professionals are often expecting male perpetrators and female survivors, which can lead to them invalidating the experiences of those in queer relationships (Calton et al., 2016; Harden et al., 2020). Female survivors of IPV in relationships with other women also reported avoiding seeking professional help so as to not feed into heterosexist beliefs of same-sex relationships being deficient (Harden et al., 2020). These reasons and the stigma toward IPV often lead queer and transgender survivors of IPV to rely on informal support rather than seeking out professional support (Harden et al., 2020; Hardesty et al., 2011).

Formal support opportunities are not always helpful to racial and ethnic minority survivors of IPV either. Racial and ethnic minority women are less likely to seek formal mental health services after IPV (Cheng & Lo, 2016) and to utilize social services (Hyman et al., 2009) than White women. In addition to perceiving mental health services as less helpful (Cho & Kim, 2012), racial minority survivors of IPV also face economic and cultural barriers (e.g., gender norms, beliefs about seeking help, etc.) to utilizing formal services (Lee & Hadeed, 2009). There is also evidence to support that like gender and sexual minority survivors, racial minority survivors often rely on informal supports (Lacey et al., 2021). While informal support such as supportive social networks can, and do, help, there is a role for formal interventions which can be improved to be supportive of diverse survivors of IPV. Additionally, while the lack of inclusive care is most impactful for survivors of IPV with marginalized identities, utilizing a feminist lens to attend to both interpersonal and structural impacts of violence can be beneficial for all survivors.

**Theoretical Framework: Feminist Hermeneutic Phenomenology**

Hermeneutic phenomenology is both a theoretical orientation and data analysis framework (Heidegger, 1971) that meshes well with a feminist lens. This is a framework that has been used in qualitative work with survivors of IPV previously (Reynolds & Shepherd, 2011; Lewis et al., 2015). It is a framework that highlights the complexity of lived experiences and provides a process for interacting with personal beliefs and the research data without attempting to place all beliefs or biases to the side (i.e., as is argued for in transcendental phenomenology; Peoples, 2021). Heidegger (1971) calls this reality dasein ("being there"; Peoples, 2021, p. 34). Dasein refers to the impossibility of separating one's self as a human that inhabits the world from one's work as a researcher. The hermeneutic circle is offered as a way to first make pre-

understandings (Heidegger, 1971) or fore-conceptions (Gadamer, 2004) and then to treat each belief as a lens by which the researcher sees the data. This process is described as a circle because researchers revise their understanding of the phenomenon by continually moving from their understanding to the phenomenon and back to their understanding (Heidegger, 1971). This process is critical to this study because IPV, trauma, and healing are constructs that have clinical and academic definitions that cannot be completely set aside by the coding team. One way of critically engaging with those definitions while highlighting the lived experiences of participants is feminist understandings of trauma. These understandings are person-focused and holistic (Burstow, 2003; Erikson, 1995; Root, 1992).

### *Present Study*

IPV is a common problem that is not equally distributed throughout the population with marginalized individuals being at higher risk of experiencing IPV. Yet, these individuals are often underrepresented in both research and applied work around IPV. Given the way interpersonal violence is impacted and compounded by structural discrimination, it is important for clinicians and other helping professionals to understand the concerns and experiences from those impacted by it. Therefore, more research needs to be done with diverse samples. For this current study, I will utilize hermeneutic phenomenology and a feminist lens to answer the following research questions:

RQ1: How do people who have experienced IPV experience trauma?

RQ2: How do people who have experienced IPV experience healing?

RQ3: How does marginalization impact the experience of trauma and healing after IPV?

# Chapter 3 - Methods

## Procedure

The data for this dissertation are from a larger study on IPV. Approval for all study procedures was obtained from the Institutional Review Board at Kansas State University. Participants were recruited through a flyer that was distributed on social media sites (Facebook and Twitter). The flyer was also distributed on online forums specifically for research, violence in relationships, and the LGBT community on Reddit.com with permission of the forum moderators. The flyer was accompanied by a link to a screening questionnaire administered through Qualtrics.com.

Respondents to the screening questionnaire were informed of potential risks and benefits of participating and written informed consent was obtained. The screening questionnaire assessed types of violence experienced, as well as participant and participant partner demographics. Respondents were eligible if: (a) they had been in at least one past relationship where they experienced IPV victimization within the past five years, (b) they were over 18 and under 65, (c) they identified as a cisgender or transgender woman or any non-cis gender (e.g., non-binary, genderqueer, etc.). Respondents to the screening questionnaire were not eligible to participate in interviews if: (a) they were currently in a relationship where violence had occurred within the past 6 months, (b) if they were under 18 or over 65, or (c) if they identified as a cisgender man. Those who met criteria were contacted by myself or my co-investigator for an interview through the email they provided in the screening questionnaire. Information on finding professional and mental health resources were provided to participants after the screening questionnaire and again after the interview.

## Data Collection

There were 71 responses to the screening questionnaire, 44 of which were excluded for not meeting study criteria. Of the 27 participants that were invited, 16 people completed interviews. Interviews were conducted over Zoom from June to July 2020. Both interviewers conducted these interviews in private spaces in their own homes. Participants were instructed to find private spaces and the safety of their current space was established verbally with participants prior to starting interviews. Interviewers followed a semi-structured interview plan (see Appendix A). To increase safety in discussing difficult topics, participants who identified as a racial or ethnic minority were interviewed by the co-investigator of this study, a Black woman. Interviews ranged in length from 35 minutes to 89 minutes (M = 51.6 minutes). Participants who completed an interview received a $20 gift card to Amazon.com. Interviews were recorded through the Zoom platform and saved on an encrypted cloud platform without any personal identification information. The audio of the interviews was transcribed through a third-party service (Rev.com).

## Participants

See Table 3.1 for the demographic information for the 16 participants that completed interviews. Because convenience sampling was used, three of the research participants were known to the interviewers and coding team. These participants volunteered to be in the study and the researchers were not in positions of power over these participants, so no undue influence was used in recruiting.

Table 3.1. Participant Demographics

| Participant Pseudonym | Gender Identity | Sexual Identity | Race/ Ethnicity | Age | Number of Violent Relationships |
|---|---|---|---|---|---|
| Cam | Cisgender woman | Lesbian | Black | 27 | 1 |
| Emily | Cisgender woman | Bisexual | White/Alaska Native | 27 | 1 |
| G | Cisgender woman | Straight | White | 49 | 2 |
| Genevieve | Cisgender woman | Straight | White | 26 | 1 |
| Hannah | Cisgender woman | Bisexual | White | 24 | 3 |
| Jane | Cisgender woman | Bisexual | White | 44 | 5 |
| Julia | Cisgender woman | Straight | White | 28 | 1 |
| Moe | Cisgender woman | Lesbian | Black | 29 | 1 |
| Overcomer | Cisgender woman | Straight | Black | 51 | 2 |
| Rachel | Transgender woman | Bisexual | White | 23 | 2 |
| Sarina | Cisgender woman | Pansexual | White/Black | 25 | 4 |
| Stacey | Cisgender woman | Straight | Black | 25 | 2 |
| Star | Cisgender woman | Straight | White Hispanic | 25 | 1 |
| Susan | Cisgender woman | Straight | White | 48 | 1 |
| Tallulah | Nonbinary | Queer | Black | 27 | 1 |
| Venus | Cisgender woman | Bisexual | White/Hispanic | 22 | 2 |

**Design and Rationale**

Compared to transcendental phenomenology that requires researchers to bracket, or set aside completely, their personal understandings of violence in relationships and trauma and healing (Moustakas, 1994), hermeneutic phenomenology provides a framework for exploring those personal understandings, or fore-conceptions (Gadamer, 2004), and allows them to be

altered through the research process. The three-member coding team journaled in order to engage meaningfully with personal understandings and biases throughout the coding procedure. Additionally, hermeneutic phenomenology emphasizes how context impacts an individual's experience of a phenomenon (Neubauer et al., 2019) which fits the purpose of this study to explore trauma and healing after IPV within greater social contexts (the experience of being a racial, sexual, or gender minority).

**Researcher Roles**

A diverse coding team representing various life experiences and knowledge coded the interview transcripts. The first author was the first coder and identifies as a White, straight, cisgender woman who's clinical and research interests include trauma after interpersonal violence and positive aspects of sexuality. The second coder and other interviewer identifies as a Black, bisexual, cisgender woman whose research and clinical focus includes: racial justice, social justice, and intimate partner violence. The third coder identifies as a White, queer, nonbinary person whose research and clinical interests center on critically thinking about the gender binary in efforts to create inclusive communities for queer and nonbinary people as well as improving affirmative therapy for LGBTQ+ people. Both interviewers and all members of the coding team are trained therapists.

**Data Analysis**

Data analysis followed the steps detailed by Peoples (2021): a) data cleaning, b) identifying preliminary meaning units, c) using meaning units to identify themes and codes within those themes, d) organizing each transcript into a situated narrative, e) aggregating situated narratives into general narratives for each theme, f) creating a general description of the phenomenon based on the research questions. Data cleaning (step a) included quality-checking

all transcripts by listening to the recordings and making edits. Filler words and phrases (e.g., "um", "yeah") were removed from the transcripts to prepare for coding.

### *Coding*

Coders read through all 16 transcripts and identified preliminary meaning units (i.e., pieces of data) that highlighted key parts of trauma and healing after IPV (i.e., step b). Specifically, guided by a feminist understanding of trauma, coders looked for descriptions of wounds, reactions to wounds, and the healing of wounds while paying close attention to how marginalized identities impacted these experiences (Erikson, 1995). They met together to create a preliminary coding structure. The majority of the codes specifically addressed the first two research questions. While there were some codes that directly related to research question three (i.e., sexual/gender orientation weaponized), the main analysis for this research question occurred when the coding team met to discuss general narratives. These discussions were guided by the situated narratives.

Kappa values were calculated in IBM SPSS (version 27) to evaluate intercoder reliability. A kappa is measure of intercoder reliability scaled from zero to one that statistically accounts for the level of agreement coders would reach by random chance making it a more robust measure of intercoder reliability (Landis & Koch, 1977). A kappa between .81-1.00 can be considered to be almost perfect agreement (Landis & Koch, 1977). Following the steps outlined in O'Connor and Joffe (2020) in order to calculate intercoder reliability, the primary author coded four transcripts and the other coders coded two of those transcripts. Two of those kappa scores were below .81 (.36 and .57). The coders met together to identify patterns of disagreement such as codes that were being used in different ways and clarifying the meaning of codes. This information was used to edit the codebook (i.e., step c).

Using the updated codebook, the remaining 12 transcripts were each coded by two coders (the primary author coded all 12 and the other two coders split the 12 and completed 6 each). Kappas were calculated for these transcripts. For any transcript that the kappa was below .81, those coders met to compare how they had coded transcripts and made changes to their coding to improve agreement (see Table 3.2 for kappa values; O'Connor & Joffe, 2020). The situated narrative for each transcript was created by condensing each transcript into the themes identified through the coding process with direct quotes as examples of those themes (i.e., step d).

Table 3.2 Kappa Values for Intercoder Agreement

| Participant Pseudonym | Kappa |
|---|---|
| Cam | .84 |
| Emily | .85 |
| G | .83 |
| Genevieve | .88 |
| Hannah | .85 |
| Jane | .90 |
| Julia | .87 |
| Moe | .81 |
| Overcomer | .81 |
| Rachel | .84 |
| Sarina | .85 |
| Stacey | .84 |
| Star | .85 |
| Susan | .96 |
| Tallulah | .83 |
| Venus | .88 |

How often each theme was used in the situated narratives was quantified (see Tables 3-5) and the labels identified by Peoples (2021) are used to discuss these themes. Most is used to denote when the theme was identified in more than half of the transcripts, many is used to denote when the theme was identified in about half of the transcripts, and some is used to denote when the theme was identified in less than half of the transcripts but represents an important aspect of the lived experience. Using the situated narratives, the coding team then met to discuss a general

narrative for each of the themes (i.e., step e). The primary author used these general narratives to create a general description of trauma and healing after IPV which was sent to the coding team for approval (i.e., step f).

**Validity and Reliability**

In addition to steps already detailed that increase the validity and reliability of this study, all coders engaged in journaling. Coders first make an initial journal entry regarding their own beliefs and fore-conceptions regarding trauma and healing after IPV. Coding team members were free to refer to and add to this journal throughout the coding process as was helpful to them. Particular attention was paid to data that did not line up with fore-conceptions in order to track the hermeneutic circle (Heidegger, 1971). Coders also reviewed these journals before the meeting where general narratives were discussed and included in these discussions were emotional reactions and surprises in the data. To increase the richness of the descriptions of the phenomena in the results section, the context of participants are included (Peoples, 2021).

# Chapter 4 - Results

Themes were selected for relevance to the research questions in line with a feminist theoretical lens and were separated into 3 categories: what participants described as the wounds from their violent relationships (see Table 4.1), their emotional, psychological and behavioral reactions to those wounds (see Table 4.2), and the way they conceptualize their healing from those wounds (see Table 4.3; Erikson, 1995). The results from this study will be presented this way with the caveat that these categories are not entirely separate and distinct. There were themes that participants used to describe both their wounds and their emotional or psychological reactions to their wounds. There were also themes that came up for participants as they were describing both their reactions to the wounds inflicted and how they have healed from those wounds. These overlaps will be discussed where applicable. The coding team discussed research question three during the coding meetings. The main features of the phenomenon that were impacted by racial, sexual or gender identity will be highlighted throughout. To add richness in the results section, the racial, sexual, and gender identity of participants is included. There were only two gender minorities in the final sample. The experiences of these participants are included in order to not contribute to the erasure of gender minority individuals from IPV research, however, this will impact the generalizability of our results.

Table 4.1 Wounds from IPV

| Theme | Emily | Rachel | Overcomer | Sarina | Hannah | G | Jane | Julia | Cam | Genevieve | Moe | Stacey | Star | Susan | Tallulah | Venus |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Physical Violence | | | X | X | X | X | X | X | X | | X | | | X | X | X |
| Emotional/Psychological violence | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |
| Sexual Violence | X | | | | X | | X | | | | | | X | | X | X |
| Sexual/gender identity weaponized by partner | X | X | | X | X | | X | | X | | X | | | | | X |
| Wounding Systems (i.e., family, therapist, police, etc.) | X | X | X | X | X | X | X | | X | X | X | | | X | X | X |
| Impact of IPV on Children | | | | | | X | | | | X | X | | | X | | |
| Marginalization as a Wound | | X | X | X | X | | | | X | | | X | | | X | X |

Table 4.2 Reactions to Wounds from IPV

| Theme | Emily | Rachel | Overcomer | Sarina | Hannah | G | Jane | Julia | Cam | Genevieve | Moe | Stacey | Star | Susan | Tallulah | Venus |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PTSD Symptoms | X | X | X | X | X | X | X | X | | X | X | X | X | X | X | X |
| Romantic Relationship Impacts | X | X | X | X | X | | X | X | X | X | X | X | X | X | X | X |
| Sexual Difficulties | X | X | | | X | | | | | | | | X | | | X |
| Impact on View of Self and Experience of Violence (i.e., minimizing, blaming self, etc.) | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X | X |

Table 4.3 Healing from Wounds from IPV

| Theme | Emily | Rachel | Overcomer | Sarina | Hannah | G | Jane | Julia | Cam | Genevieve | Moe | Stacey | Star | Susan | Tallulah | Venus |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Healing Systems (i.e., family/friends, therapy, police etc.) | X | X | X | X | | X | X | X | X | X | X | X | X | X | X | X |
| Entering into Healthy Romantic Relationships | X | | | | X | X | | X | X | | | X | X | | X | X |
| Working through Triggers | X | | | | | X | X | X | X | X | | | X | | X | X |
| Advocating for Self (i.e., boundaries, autonomy, etc.) | X | X | X | X | | X | X | | X | X | | X | X | X | | X |
| Advocating for Others | X | | | | X | X | | X | X | | X | | X | X | | X |
| Healing as a Process | X | X | X | | X | X | X | X | | | X | | X | X | | X |

## General Narratives: Trauma and IPV

Both what participants described as the wounds from violent relationships and their emotional, psychological and behavioral reactions to those wounds were considered the trauma of experiencing IPV (Erikson, 1995). These themes will be introduced with examples from participants.

### *Wounds from IPV*

All participants described instances of emotional or psychological violence, most participants described instances of physical violence, and some described instances of sexual violence. There were also other experiences or features of being in a violent relationship that participants described as a wound.

**Wounding Systems.** Participants identified systems that by not being affirming or being dismissive of their descriptions of IPV or how harmful it was contributed to the overall violent experience. These systems included friends and family, therapists, and police. Participants described friends or family members who did not believe their experience of IPV or questioned their perceptions. “Some people, mutual friends, were just kind of like, ‘Are you sure that's how it went?’" (“Hannah”, 24, White, bisexual, cisgender woman). “Emily” (27, White/Alaska Native, bisexual, cisgender woman) highlighted how misconceptions of what violence in relationships looks like impacted how people responded to her talking about her experiences:

> I have had, not very many, but a couple of experiences where people don't really believe that emotional abuse is real or they don't really believe that there can be sexual abuse once you're already in a marriage with someone.

***Normalization of Violence.*** This was compounded when participants talked about family members who had also been in violent relationships. “Moe” (29, Black, lesbian, cisgender

woman) described discussions where her mother discussed her own experiences of violence with her:

> It's usually coming when she's telling me to be strong. Like, I've been through X, Y and Z, just you got to do what you got to do and don't stay anywhere that you're not welcome. And I was just kind of like, why are we so okay with this narrative?

Many participants described watching IPV occurring between parents or hearing of IPV in extended family relationships. They explained how this impacted both what they saw as a normal relationship and how their families reacted to their disclosures of violence such as "Cam"'s (27, Black, lesbian, cisgender woman) experience talking to others about what she was experiencing in her relationship, "It's like saying, 'XYZ is happening to me,' and it's like, 'Oh girl, that's normal.'"

Participants discussed how when violence within relationships was more common in their circles, there was less support or more silence around the issue. More Black participants discussed wounding systems and normalization of violence in this way, highlighting the impact of intersectionality on experiences of violence. For example, "Overcomer" (51, Black, straight, cisgender woman) specified "I think as African-American families, we don't talk enough about the things that hurt us like abuse."

***Therapy.*** Therapists could also be a wounding source for participants. While most participants discussed their positive experiences with therapy and the role it played in their healing, many identified that therapist fit was crucial. Specifically, some participants described dismissive and unhelpful experiences with White, straight, cisgender male therapists (e.g., "It was kind of like he was discrediting everything I was saying"; "Venus", 22, Hispanic/White, bisexual, cisgender woman). Hannah (24, White, bisexual, cisgender woman) described two

experiences with White, straight, cisgender male therapists who disregarded that Hannah wanted to discuss the violence she had experienced and instead attributed her emotional and mental distress to her relationship with her parents and a recent arrest for drug possession.

Most participants of color identified feeling more comfortable with or needing to have a therapist who shared their racial or ethnic identity. This was described as a necessity so that their therapist could understand their experience or because they had had poor experiences with White therapists.

> At the time my therapist was White, and I felt like there was definitely some blind spots and just certain things that I didn't feel I could really talk with her about because I didn't feel like she would understand or get it. ("Sarina", 25, Black/White, pansexual, cisgender woman)

***Law Enforcement.*** Participants also reported wounding interactions with police officers, law enforcement, and the criminal justice system. "This is really sad, but the female cop said to me, 'You're just going to let him back, so.' I mean, I know they see some stuff, but keep that to yourself" ("Jane", 44, White, bisexual, cisgender woman). Holding marginalized identities heavily influenced how comfortable participants felt going to the police or how helpful they were. More White women, but not all, said that the police were helpful. While "Genevieve" (26, White, straight, cisgender woman) did not feel her race impacted her experience with police, "Susan" (48, White, straight, cisgender woman) reported "Some of the officers were good. Some of them were not… I think my privilege impacted the way I was treated in a positive way." Venus (22, Hispanic/White, bisexual, cisgender woman) had interactions with police through her job and her violent relationship and reported: "Reporting it to police officers is so hard because of the fact that as a woman of color I just feel like my voice is not heard that much." "Rachel"

(23, White, bisexual, transgender woman) did not consider reporting any violence to police because she felt it would be more dangerous:

> I don't trust police, especially since everyone involved in the situation is a disabled trans woman. I don't feel like there would be much that would come of getting any officials involved, or at least any like law enforcement people involved or anything.

**Sexual/Gender Identity Weaponized by Partner.** Participants who identified as a sexual or gender identity minority detailed how these identities contributed to the violence their partner perpetrated against them. Participants described this as emotional or psychological violence as it was often connected to power, control, and jealousy.

> Once we were already married, I came out to him and he would often threaten to tell people. I'm not out to my family and I certainly wasn't out in our religious community and he would oftentimes use that as a method of control (Emily, 27, Alaska Native/White, bisexual, cisgender woman).

> With that, coming out to him as bisexual, he immediately turned that into jealousy against me, and basically the trust issues were amplified, and to him thinking that I was going to leave him for like anybody that we would walk by on the street (Hannah, 24, White, bisexual, cisgender woman).

Moe described how staying in the violent relationship for as long as she did was in part because she was gay which was not accepted by her religious community. When she came out to her partner, the relationship ended, and he retaliated by refusing to move out and other harmful behaviors: “I'm sorry I'm gay but he made my life a living hell” (Moe, 29, Black, lesbian, cisgender woman).

**Impact of IPV on Children.** Most participants who had children discussed how the violence impacted their children as a part of the wound. Both "G" and Susan discussed how they left the violent relationship to protect their children (e.g., "I was not going to have her grow up around that"; Susan, 48, White, straight, cisgender woman). G (49, White, straight, cisgender woman) also described how it still hurts to see the ways in which her relationship with their father impacts her children such as seeing their fear when her partner was being violent to her. Moe (29, Black, lesbian, cisgender woman) also described the complexity of co-parenting with a violent ex-partner:

> I know it would be good for my daughter to see her father. So I didn't want to not let him see her. But I didn't think he deserved it so it's a lot of moments of you having to be mature that get annoying because he doesn't deserve the amazing daughter that we created.

**Marginalization as a Wound.** Some participants discussed experiencing marginalization on a societal level was also an aspect of the wounds from IPV. Hannah and Rachel discussed specifically how violent partners used- or were influenced by- being in more privileged positions within the relationship: "I think toxic masculinity was a really big thing in the relationship where he always felt like he needed to be in charge" (Hannah, 24, White, bisexual, cisgender woman). Rachel (23, White, bisexual, transgender woman) discussed how her violent partner relied on Rachel having less community and societal supports as a transgender woman:

> She very much exploited the very fear of transphobia, and she used that to further the isolation and the trusting and depending on her. And specifically, the moment you leave me, you have nowhere else to go kind of thing.

***Reactions to Wounds from IPV***

**PTSD Symptoms.** Almost all participants described PTSD symptoms as listed in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association [APA], 2013). These symptoms included nightmares and flashbacks, sleep disturbances, cognitive impacts such as memory disturbances, hypervigilance, increased startle responses and difficulty concentrating. Participants also described trauma responses to triggering situations. Both G (49, White, straight, cisgender woman) and Genevieve (26, White, straight, cisgender woman) described having anxious trauma responses to court dates and anniversaries. "Julia" (28, White, straight, cisgender woman) described trauma responses to comments her current romantic partner has made that were reminiscent of their violent ex-partners, and "Tallulah" (27, Black, queer, nonbinary) described "The idea that I'm never safe has been my one main take-away." Rachel (23, White, bisexual, transgender woman) explained that being in the same neighborhood where she used to live with her violent ex-partner makes her nauseous. There were a lot of overlaps between this theme and the relational impacts and sexual difficulties themes and these tended to be areas where participants experienced triggers and hypervigilance.

**Romantic Relationship Impacts.** Almost all participants described that the IPV they experienced impacts how they show up in relationships. Rachel (23, White, bisexual, transgender woman) and Susan (48, White, straight, cisgender woman) shared that they are choosing to not be in a romantic relationship currently because of the violence they experienced. "Stacey" (25, Black, straight, cisgender woman) and Genevieve (26, White, straight, cisgender woman) described that they were somewhat open to dating but were less willing to commit and were more cautious in the early stages of dating than they had been previously. "Star" (25, White Hispanic, straight, cisgender woman) shared a similar sentiment: "I do wonder sometimes if it makes me not give people a chance in relationships because I'm just like, 'No, strike one. Bye.'"

Other participants are currently in romantic relationships and explained how the violence they experienced impacts their reactions to their current partners: “I second guess just about every thought that crosses my mind in the parameters of my new relationship” (Julia, 28, White, straight, cisgender woman).

> I'm in a very happy, healthy relationship now, for two years, and even still, my husband can say nothing, he can move in a certain way, and I'll feel triggered, because I'll be like, “How dare you make that face when I communicate my thoughts to you.” (Tallulah, 27, Black, queer, nonbinary)

Sarina (25, Black/White, pansexual, cisgender woman) described it as wanting to unlearn things she did not want to be a part of her anymore, while Overcomer (51, Black, straight, cisgender woman) described wanting to avoid past situations:

> It's hard to not remember those things happened in the past, to bring them into what you're doing now, so you have to be very conscious of it. So you're constantly thinking. Maybe not constantly, but you're thinking more on a level of, “Okay, I need to remember what happened,” as to not do it all over again.

**Sexual Difficulties.** Sex was also an area where participants who had experienced sexual violence described triggers, anxiety and apprehension. It was more the partnered aspect of sex that brought up anxiety, for example, Rachel (23, White, bisexual, transgender woman) explained: “I'm okay engaging with sexuality by myself. But if any other person enters the equation, it immediately becomes uncomfortable, panic inducing triggering, all those nasty things.”

**Impact on Perceptions of Self and Experiences.** All participants described ways the violence they experienced impacted their view of themselves or their experience of violence. For

some this looked like minimizing the severity of the violence they were experiencing such as Moe (29, Black, lesbian, cisgender woman) explaining how she felt she could not leave her violent relationship “I did want to break up before but I felt like I didn't have a good enough reason because he never hit me.” Star (25, White Hispanic, straight, cisgender woman) described how this process for her was at least in part because she did not want to confront that violence:

> It's hard because you always want to think, or at least I feel like what happens is you want to think, “Oh, well that didn't really happen to me,” but I would say some of his behaviors were probably also emotionally abusive.

There was also a common thread to participants responses that emotional or sexual violence were harder to identify because it did not fit with primarily physical depictions of violence in relationships. For example, Emily (27, White/Alaska Native, bisexual, cisgender woman) explained, “Because I wasn't experiencing much overt physical violence, I think I told myself a lot that what was happening wasn't really a problem or I was just being dramatic about it or things like that.” Similarly, Julia (28, White, straight, cisgender woman) described how she knew about emotional and verbal violence and would have never not believed someone else’s story, however, “when it happened to me, I had a really hard time wrapping my head around the fact that it was abuse.”

For some participants, this also looked like blaming themselves for the violence because they had chosen to stay in the relationship or because their partner was blaming them for their violent actions. For example, Emily (27, White/Alaska Native, bisexual, cisgender woman) explained:

> A lot of the time he wouldn't accept any responsibility and he tried to really lay the blame on me and so I think I started to internalize that a lot and feel like I must be doing something that's causing him to be this way.

Jane also described how her feelings of blame changed when she ended the relationship: "I reacted badly to things and then would subsequently blame myself for them. I thought it was my fault. But after getting out of it and really thinking about it, I don't feel I'm to blame."

Participants also described how they felt they had to minimize the violence in order to protect someone they loved. Sarina (25, Black/White, pansexual, cisgender woman) explained they at the time the violence was occurring, she thought if she disclosed it to her therapist, her therapist would be required to report it to the police, so she did not discuss those aspects of her relationship. Similarly, when Venus (22, Hispanic/White, bisexual, cisgender woman) explained why she kept what was happening from others she said, "I thought that I was protecting somebody that I loved and that loved me equally."

**General Narratives of Healing from IPV**

**Healing Systems.** Most participants reported that therapy was a crucial element of their healing from the trauma they experienced. For some participants, therapy was even a key element in why they were able to leave or end a violent relationship:

> Throughout the course of that therapy, I started discussing it. And that's what really made me realize or it confirmed to me that what I was going through was abuse and it made me feel more empowered to be able to leave the relationship. And I think without going to therapy during that time, I probably wouldn't have ever left. (Emily, 27, White/Alaska Native, bisexual, cisgender woman)

Therapy also provided a validating and normalizing place for participants where they did not feel they needed to minimize their experience (e.g., “I think it's just important to be able to talk about your own feelings and your experiences to know that you're not crazy, you're not insane. What you're feeling is real.”; Overcomer, 51, Black, straight, cisgender woman). Participants also described learning coping skills and strategies for soothing trauma responses.

Therapist fit was critical, as Jane (44, White, bisexual, cisgender woman) explained, “It's like dating, in a way. You've got to find the right one.” Black participants explained that they prefer Black therapists or are only willing to see a Black therapist: “Now going forward I would probably only go to Black therapists” (Cam, 27, Black, lesbian, cisgender woman). Moe (29, Black, lesbian, cisgender woman) explained that there are aspects of her lived experience that she would not have to describe to a Black therapist like she would a White therapist:

> I just don't have the patience or time or energy to explain things. I think I appreciated having Black women as therapists. I'm also a therapist too so that it's ... I think because I'm hypersensitive to body language and energy and all that that good stuff, it's hard to be in a room with someone who doesn't get it.

Participants also described healing relationships with friends and family. For some of them, they reconnected with family they had become distant from due to IPV or were honest with them about what was happening in the relationship. Other participants described healing relationships with friends. Susan (48, White, straight, cisgender woman) explained, “Every happy, fulfilled woman I know has a group of happy, fulfilled women that she leans on. And I'm lucky to have my group.” Venus (22, Hispanic/White, bisexual, cisgender woman) was visibly emotional when she described how her best friend had supported her in her healing process after leaving her violent partner:

> She helped me learn how to be patient with myself and be patient with other people and to realize that it's going to take some time to feel like myself again and it's going to take time to love someone again and it's going to take time to be okay with myself and be okay with what happened to me.

**Healing as a Process.** Most participants discussed healing as a process. They acknowledged ways they had healed but expressed they were not completely healed. Julia (28, White, straight, cisgender woman) said, “I feel like I'm still very much doing the work.” Moe (29, Black, lesbian, cisgender woman) described experiencing less trauma responses as evidence that she had made progress: “Like I feel like I’m not really done with it, but I do think I've come such a long way with it that I'm not as triggered by it”. Rachel (23, White, bisexual, transgender woman) used the imagery of wounds to explain her experience of healing while recognizing the lasting impact of violence: “A lot of them [wounds] are just more scar tissue, now. They've healed, they're scars, but it's not an immediate present need or pain”. For Overcomer (51, Black, straight, cisgender woman), discussing her violent relationship with a researcher was evidence of healing:

> Do I think that I've been healed? Yes. Do I think that I'm still being healed? Yes. Yes. I think it's an ongoing process and I think that to allow myself to even have this conversation is great because it gives you reflection, reflection on your past and where you've been and where you are now, and I think that's so important.

**Working Through Triggers.** Strategies for managing trauma responses was a part of healing for most participants. Many of them learned these strategies in therapy and explained that understanding why they were responding in specific ways was also helpful. Genevieve (26, White, straight, cisgender woman) reported: “I was given some techniques that would help

recognize what I was feeling or what I was going through and accept it and understand that it was fleeting, like it sucks now but it's going to move". Because many participants experienced triggers in the context of relationships, there was overlap between this theme and the healthy romantic relationships theme.

**Entering into Healthy Romantic Relationships.** Many participants described experiencing healing through healthy romantic relationships. Supportive and reciprocal romantic relationships were described as a safe place to work through relational triggers. "He's opened up about things and he's been very supportive of the things that I have shared with him, but that's still very scary for me" (Julia, 28, White, straight, cisgender woman). Participants also described the differences between their current romantic relationship and their past violent one as evidence of their healing process. For example, Sarina (25, Black/White, pansexual, cisgender woman) described going to couples therapy with her new partner as a way that she knows he is willing to work on things with her which increases her safety in the relationship.

**Advocating for Self.** Most participants discussed various ways they were learning to, or had, advocated for themselves as part of their healing. This included setting boundaries, asserting their autonomy and asking for help. Star (25, White Hispanic, straight, cisgender woman) explained, "It was a lot of paying attention to me and what I wanted to do." Participants also detailed the ways that they unlearned the minimizing and self-blaming narratives they ascribed to in their violent relationship: "I took a lot of the blame whenever I was in the relationship but as soon as I got out I kind of just loved myself so much more" (Venus, 22, Hispanic/White, bisexual, cisgender woman).

Part of ending the pattern of minimizing and blaming self for wounds was accepting they had experienced violence and being honest about the impact of that. Rachel (23, White, bisexual, transgender woman) explained:

> My brain does not function the same way that someone else who doesn't have those experiences would. And so a lot of healing for me has just been learning how my brain does function, and allowing myself to function within those parameters, instead of the parameters that society wants me to function in.

Acceptance was also a big part of healing for Star (25, Black, straight, cisgender woman):

> After I accepted that it was something bad and traumatic that had happened to me, it was easier to acknowledge that, "Okay, this really is something that you need to take time to heal from and it's okay to do that. It's okay if you don't have a boyfriend right now. It's okay if you do these life milestones by yourself because this happened to you and it's okay that you need to heal from it.

**Advocating for Other Women.** Many participants became stronger advocates for others through formal and informal methods. Emily (27, White/Alaska Native, bisexual, cisgender woman) shared her experiences of IPV with other survivors which strengthened their relationship and provided healing. G (49, White, straight, cisgender woman) reported really positive experiences volunteering for the organization that helped her leave her violent ex-husband. When Hannah (24, White, bisexual, cisgender woman) described the impact of opening up to family, volunteering with an organization that supports survivors of violence, and advocating for co-workers who had come forward with sexual harassment allegations she said that the benefit was “just being able to open and be like, ‘This happened to me, but it didn't ruin me.’” In addition to experiencing IPV, Moe’s (29, Black, lesbian, cisgender woman) sister was killed by a

same-sex romantic partner. She described becoming involved in community efforts to raise awareness of what violence can look like, “healing sometimes looks like me having hard conversation with the community at large and hosting community circles to talk about those things and understand the signs and symptoms.”

Participants also became stronger advocates by pointing out warning flags of violence they noticed in friends’ relationships. Cam (27, Black, lesbian, cisgender woman) explained, “I think that I'm way more vocal than I was before, and I'm quicker to try to tell my friends that stuff is not okay.” Star (25, White Hispanic, straight, cisgender woman) related similar sentiments, “I also think it's helped me because I've watched lots of friends be in relationships that just kind of suck, and I'm like, ‘Why are you putting up with this guy? You know you don't have to, right?’” For some participants, this attending to and advocating for friends seemed to be a part of their own hypervigilance. There was a fine line between advocating for friends because they had learned more about red flags of IPV and reading danger into many behaviors in romantic relationships.

# Chapter 5 - Discussion

While racial and ethnic minorities and gender and sexual minorities experience the highest rates of IPV, the majority of the research on trauma and healing focus on the experiences White, straight, cisgender female survivors (e.g., Harden et al., 2020). This lack of focus on those most likely to experience IPV is reflected in formal systems of help available. Accordingly, feminist understandings of trauma highlight the need to attend to the impacts of interpersonal and structural violence together and explore how these levels of violence interact and are compounded for survivors. Therefore, the purpose of this study was to explore survivors' lived experiences of trauma and healing after IPV using a feminist hermeneutic phenomenological lens in order to answer the following research questions:

RQ1: How do people who have experienced IPV experience trauma?

RQ2: How do people who have experienced IPV experience healing?

RQ3: How does marginalization impact the experience of trauma and healing after IPV?

## Main Findings

### *Trauma after IPV*

Utilizing a feminist lens of trauma and healing that evaluated participants descriptions of the wounds experienced from violent relationships and their emotional, psychological and behavioral reactions to those wounds, this study generated the following general description of trauma after IPV. Beyond the physical impacts of violence, survivors of IPV are also wounded by the ways in which others respond to their experiences especially when they are dismissive, invalidating or perpetuate victim-blaming narratives. Survivors with marginalized identities view formal systems, specifically mental health and criminal justice systems, as less helpful and

sometimes harmful especially when those working in the system with more privileged identities. For sexual minorities in relationships with straight people, their sexual identity is often weaponized to wound the individual. For those with children, these wounds are compounded by watching how IPV impacts their children and by co-parenting with violent ex-partners.

While survivors experience PTSD symptoms in response to these wounds, the PTSD criteria do not fully capture all responses to wounds. Because these wounds occurred in a relational context, survivors often experience these PTSD symptoms in relation to others including anxiety, trauma responses, and hypervigilance in the context of romantic relationships and partnered sexual activity. Minimizing the experience of violence or blaming themselves for the violence are often responses to those wounds. Sometimes participants perceptions of themselves or their experiences was warped by violent partners specifically blaming the survivor for the violence they perpetrated. Other times this minimizing or taking blame served a protective purpose. Survivors might be trying to protect violent partners, but often they are protecting themselves from the impact of identifying as a survivor of IPV.

**Wounding Systems.** These findings highlight elements of traumatic experiences and responses beyond just the physical, emotional, or sexual violence survivors experience within their relationship. This is supported by a feminist conceptualization of trauma that attends to harm on the interpersonal and the societal levels present in a single traumatic event or relationship (Burstow, 2003). Specifically, participants identified that therapists and members of criminal justice organizations as well as friends and family also perpetrated harm during or in the aftermath of IPV. These wounding systems perpetrated harm through systemic marginalization and victim blaming narratives. Even when marginalized participants had not experienced being treated poorly by mental health or criminal justice professionals, they held beliefs that those

avenues would be less helpful or harmful to them. This is supported by previous research on help-seeking behaviors that highlights that gender and sexual minority individuals (Harden et al., 2020) and racial and ethnic minority individuals (Lee & Hadeed, 2009) are less likely to seek help when experiencing IPV.

Feminist writers on trauma have highlighted the importance of having an empathic witness to the trauma to the process of healing (Herman, 1997; Burstow, 2003). When a perpetrator of violence is not willing to take accountability for the harm caused, an empathic witnesser can validate the experience of harm and feel the pain with the survivor (Herman, 1997). However, when a survivor of IPV seeks help and is dismissed, invalidated, and questioned, they are denied witnessing. This is especially harmful when that denial comes from a system that is purportedly in place to offer help. These organizations and helping professionals could serve as a refuge from the violence, the lasting trauma of the violence, and the victim-blaming messages from a society that questions the validity of the victim's story of violence and then belittles the experience of the survivor because they should have left much sooner (Kogut, 2011; Cravens et al., 2015; Whiting et al., 2019). Instead, they perpetrate those same victim blaming narratives such as emotional violence not being as impactful as physical violence. The systems in place to help survivors of IPV need to be conscious of the real potential to perpetrate harm in these spaces.

**Insufficiency of PTSD Criteria Alone**

Another critical finding from the results of this study are the limitations of the PTSD criteria in the DSM-5 (APA, 2013) for adequately describing the experience of trauma after IPV. These criteria are primarily individualized; they focus on symptoms of traumatic stress that exist within the person. Feminist theorists have criticized this individual focus and have argued that

even singular traumatic events occur within important societal and relational contexts (Burstow, 2003). The participants in this study described PTSD symptoms of re-experiencing, activation and avoidance (APA, 2013), but they described them in the context of relationships. This makes sense given the relational nature of the trauma from IPV and supports previous research on difficulties survivors of IPV experience in relationships after the violent relationship (Flasch et al., 2019).

These relational traumas also occur within great societal contexts. The gendered power imbalances present in heterosexual relationships and the overall experiences of minority stress (Balsam, 2005) and multiple disadvantages that stem from systemic oppression (Lo et al., 2015) cannot be ignored. The nesting of violent relationships within violent systems creates a layering of trauma that is not always captured the PTSD criteria alone (APA, 2013). Feminist conceptualizations such as insidious trauma (Root, 1992) might aid in fully assessing the impact of IPV on someone's life because they provide language for the ways individuals adapt to survive in oppressive systems.

### *Healing from IPV*

This study generated the following general description of healing from IPV. Healing from trauma from IPV is a process. Just as survivors' wounds and reactions to wounds were most impactful and evident in relational contexts, the healing process often occurs in relation to others. Therapy was a key part of this process for participants, but they needed a relationship with their therapist where they felt validated and affirmed. For marginalized participants, this often meant sharing identities with their therapist. Some of these contexts are romantic relationships where when survivors experience support and compassion rather than violence, they are able to work through triggers and unlearn harmful narratives. Survivors also experienced

healing by being supported by friends and family who believed their stories and showed love. Surviving IPV made participants stronger advocates for others at risk of or experiencing IPV. Finally, survivors healed in their relationship with themselves as learned to accept how their wounds impacted them and asserted autonomy over their responses to those wounds.

**Relational Healing.** It is not surprising that because the trauma occurred in the context of a relationship, the most powerful healing also occurred in relationships as well including family and friends, romantic relationships, and in safe healing relationships with therapists. These findings fit well within previous research on healing and recovery while expanding in critical areas. Themes of healing the relationship with self (Reynolds & Shepherd, 2011), advocating for others, and viewing healing as a process have been explored in previous literature (Flasch, 2020). Exploring the experience of healing with a diverse sample revealed that the process of healing was similar for participants with a variety of identities with the important caveat that this healing process could not occur within relationships that were not affirming, especially formal therapeutic relationships. Finding this type of relationship might be more challenging for marginalized individuals as mental health fields tend to be dominated by White women (e.g., American Psychological Association, 2020; American Association of Marriage and Family Therapy, 2022). Clinicians with privileged identities can be affirming in these therapeutic spaces but it takes more intentionality and education.

There is limited research on how survivors of IPV function in intimate relationships after a violent relationship (Flasch et al., 2019). These findings highlight that new relationships are a place of struggle and can be a space for healing. Some of the participants were in multiple violent relationships where, instead of experiencing healing, they were further traumatized. When there was emotional safety to share about experiences, patience in navigating trauma

responses and a willingness to work together, participants experienced healing in subsequent intimate relationships. These findings are in line with previous research that has highlighted similar themes (Flasch et al., 2019).

**Clinical Implications**

The findings of this study highlight that clinicians working with survivors of IPV need to expand their assessment of trauma beyond PTSD diagnostic criteria in the DSM-5 (APA, 2013), promote relational healing within safe contexts, and attune to the sociocultural realities of their clients' lives (Knudson-Martin et al., 2017). The PTSD criteria might be most useful in determining physiological reactions associated with trauma, and further assessment can clarify other areas for intervention. This assessment should include perceptions of self and others, relational functioning, and discussions about how marginalization impact all these traumatic reactions (Root, 1992). These perceptional changes are covered more fully in the diagnostic criteria for complex PTSD (Courtois & Ford, 2016) which has been used throughout the mental health profession. These physiological and perceptional changes can be explored in non-pathologizing ways by focusing on adaptation as survival.

These findings also support the benefit of healing from trauma in relational contexts. The participants in our study identified that they healed as they intentionally created relationships that were the opposite of what their traumatizing relationships had been. These new relationships were safe, reciprocal, and supportive. Further, these new relationships required work and attention on the part of the IPV survivor to how past trauma was impacting how they showed up in the current relationship. This supports previous work on how survivors learned how to establish boundaries and communicate in healthy relationships following violent relationships (Flasch et al., 2019). Therapists working with an individual survivor of IPV can support their

clients in developing these types of relationships. Clinicians should be careful they are not encouraging clients to override all internal signals that people are unsafe (Burstow, 2003). Rather, the goal should be to help clients determine who might be safer people to develop deeper relationships with or to disclose elements of their trauma to.

For survivors of IPV who are in safe romantic relationships, couples therapy can play a role in this relational healing. Individual therapy is an appropriate setting to process specific traumas in a targeted way and evaluate how current survival strategies are serving or not serving the individual. Couples therapy can provide a supportive environment where survivors of IPV can practice self-soothing techniques for working through relational triggers, address attachment issues, and confront negative perceptions of themselves and others. Courtois and Ford (2016) detailed a tri-phasic model for couples therapy for complex PTSD in general that could be adapted to IPV specifically. These phases operate similarly to individual trauma tri-phasic modalities (Strand et al., 2013). Phase one involves helping the couple develop communication and self-regulation techniques. After these skills are solidified, partners share openly about experiences and impact of IPV on how they are showing up in their current relationship in phase two. Phase three synthesizes the skill-building phase and processing phase to tackle other relationship concerns like sexuality and parenting.

Regardless or therapeutic modality or setting, clinicians that have more privileged identities (e.g., White, male, straight, cisgender etc.) should explore their beliefs and narratives about survivors of IPV, especially survivors with more marginalized identities. Therapists need to reckon with their ability to do harm and reflect on the implications of their power and privilege in the room. Burstow (2003) describes the importance of developing "political empathy" by learning about historical and intergenerational traumas groups of people have

experienced. In addition, to this knowledge, clinicians should develop skills to address systemic harms through socioculturally attuned practice (Knudson-Martin et al., 2017). A socioculturally attuned practice involves highlighting context and power, naming what is unjust, disrupting power dynamics, and imagining and working toward just therapeutic outcomes (Knudson-Martin et al., 2017). This requires self-reflection and might be uncomfortable but leaning into that discomfort is a requirement for therapists to avoid bringing systemic harms into the therapeutic process.

**Limitations, Strengths, and Future Directions**

One of the limitations of this study was the lack of gender diversity in the sample with only two participants who identified as a gender minority. However, more representation from transgender, genderqueer, and nonbinary people is needed in this work to fully explore their experiences of trauma and healing after IPV. Similarly, while we were able to sample several sexual minority individuals, most of these participants described violence in a relationship with a man so we were not able to represent violence in gay or lesbian relationships. These limitations impact the generalizability of these findings. Future research should focus specifically on trauma after IPV and the healing process for women in relationships with other women since there are likely aspects of marginalization and discrimination that are influencing this process (Harden et al., 2020).

Although not necessarily a limitation of the study, another unique feature of our sample was that most participants had been in therapy specifically to heal from IPV. Three of our participants were therapists themselves: Susan, Sarina, and Moe. This therapeutic history impacted the findings since most participants had taken time to process their experiences with a professional prior to our interviews. This processing might have helped participants gain insight

into their experiences, and thus, we recognize that participants were reflecting on their trauma through a lens that was shaped by processing with a mental health professional.

Other strengths of this study include using a broader definition of trauma and healing and incorporating a feminist lens. This allowed participants to fully explore their experiences of IPV within a non-pathologizing framework. This study also makes a large contribution to the limited research on how survivors of IPV are navigating healthy, nonviolent relationships after being in a relationship (Flasch et al., 2019). Historically, due to the high rates of revictimization or survivors entering into subsequent violent relationships, this area has received more research attention (Ørke et al., 2018).More research is needed in this area to understand how survivors can create healing relationships with future partners and be successful in future romantic partnerships.

## Conclusion

IPV continues to be a traumatizing experience for many individuals. This feminist hermeneutic phenomenological study focused on the lived experience of trauma and healing after IPV while attending to the impact of marginalization in order to provide more socioculturally attuned clinical recommendations for those helping survivors of IPV in therapy. This study contributes to feminist research on trauma and healing by examining how structural violence interacts with interpersonal violence. Results from the analysis of 16 interviews with survivors of IPV show that there are many aspects of trauma that go beyond just the violence experienced including interactions with wounding systems such as dismissive and invalidating therapists, law enforcement officers, and friends and family. Further, the results also show that healing is a relational process but that survivors need to assess the safety of each potentially healing relationship. These findings highlight the importance for helping professionals working with

survivors of IPV to expand their assessment of trauma beyond PTSD criteria, focus on relational healing, and do the work to be a safe space for marginalized survivors of IPV.

# References


Anderson, K. L. (2002). Perpetrator or victim? Relationships between intimate partner violence and well-being. *Journal of Marriage and Family, 64*(4), 851–863. https://doi.org/10.1111/j.1741-3737.2002.00851.x

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi-org.ezproxy.frederick.edu/10.1176/appi.books.9780890425596

Armstrong, E. A., Gleckman-Krut, M., & Johnson, L. (2018). Silence, power, and inequality: An intersectional approach to sexual violence. *Annual Reviews of Sociology, 44*, 99-122. https://doi.org/10.1146/annurev-soc-073117-041410

Bagwell-Gray, M. E. (2018). Women's healing journey from intimate partner violence: Establishing positive sexuality. *Qualitative Health Research, 29*(6), 779-795. https://doi.org/10.1177/1049732318804302

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*(3), 258–269. https://doi.org/10.1111/j.1471-6402.2005.00220.x

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology, 73*(3), 477–487. http://dx.doi.org/10.1037/0022-006X.73.3.477

Beydoun, H. A., Beydoun, M. A., Kaufman, J. S., Lo, B., & Zonderman, A. B. (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. *Social Science & Medicine, 75*(6), 959–975. https://doi.org/10.1016/j.socscimed.2012.04.025

Birkley, E. L., Eckhardt, C. I., & Dykstra, R. E. (2016). Posttraumatic stress disorder symptoms, intimate partner violence, and relationship functioning: A meta-analytic review. *Journal of Traumatic Stress, 29*(5), 397–405. https://doi.org/10.1002/jts.22129

Breiding, M. J., Basile, K. C., Smith, S. G., Black, M. C., & Mahendra, R. (2015). Intimate partner violence surveillance uniform definitions and recommended data elements. Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women, 9*(11), 1293–1317. https://doi.org/10.1177/1077801203255555

Cafferky, B. M., Mendez, M., Anderson, J. R., & Stith, S. M. (2018). Substance use and intimate partner violence: A meta-analytic review. *Psychology of Violence, 8*(1), 110–131. http://doi.org/10.1037/vio0000074

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma, Violence, & Abuse, 17*(5), 585–600. https://doi.org/10.1177/1524838015585318

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359,* 1331-1336. https://doi.org/10.1016/S0140-6736(02)08336-8

Carbone-López, K., Kruttschnitt, C., & Macmillan, R. (2006). Patterns of intimate partner violence and their associations with physical health, psychological distress, and substance use. *Public Health Reports, 121*(4), 382–392. https://doi.org/10.1177/003335490612100406

Carvalho, A., Lewis, R., Derlega, V., Winstead, B., & Viggiano, C. (2011). Internalized sexual minority stressors and same-sex intimate partner violence. *Journal of Family Violence, 26*(7), 501–509. https://doi.org/10.1007/s10896-011-9384-2

Charak, R., Villarreal, L., Schmitz, R. M., Hirai, M., & Ford, J. D. (2019). Patterns of childhood maltreatment and intimate partner violence, emotion dysregulation, and mental health symptoms among lesbian, gay, and bisexual emerging adults: A three-step latent class approach. *Child Abuse and Neglect, 89*(1), 99-110. https://doi.org/10.1016/j.chiabu.2019.01.007

Cheng, T. C., & Lo, C. C. (2015). Racial disparities in intimate partner violence and in seeking help with mental health. *Journal of Interpersonal Violence, 30*(18), 3283-3307. https://doi.org/10.1177/0886260514555011

Cheng, T. C., & Lo, C. C. (2016). Racial disparities in intimate partner violence examined through the multiple disadvantage model. *Journal of Interpersonal Violence, 31*(11), 2026–2051. https://doi.org/10.1177/0886260515572475

Cho, H. & Kim, W. J. (2012). Racial differences in satisfaction with mental health services among victims of intimate partner violence. *Community Mental Health Journal, 48*, 84-90. https://doi.org/10.1007/s10597-011-9398-5

Cho, H., Velez-Ortiz, D., & Parra-Cordona, J. R. (2014). Prevalence of intimate partner violence and associated risk factors among Latinos/as: an exploratory study with three Latino subpopulations. *Violence Against Women, 20*(9), 1041-1058. https://doi.org/10.1177/1077801214549636

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and

women. *American Journal of Preventive Medicine, 23*(4), 260–268. https://doi.org/10.1016/S0749-3797(02)00514-7

Coker, A. L., Weston, R., Creson, D. L., Justice, B., & Blakeney, P. (2005). PTSD symptoms among men and women survivors of intimate partner violence: The role of risk and protective factors. *Violence and Victims, 20*(6), 625–643. http://doi.org/10.1891/088667005780927421

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society, 19*(6), 829–859. https://doi.org/10.1177/0891243205278639

Courtois, C. A., & Ford, J. D. (2016). *Treatment of complex trauma: A sequenced, relationship-based approach.* The Guilford Press.

Cravens, J. D., Whiting, J. B., & Aamar, R. O. (2015). Why I stayed/left: An analysis of voices of intimate partner violence on social media. *Contemporary Family Therapy, 37*, 372-385. https://doi.org/10.1007/s10591-015-9360-8

Czerny, A. B., & Lassiter, P. S. (2016). Healing from intimate partner violence: An empowerment wheel guide to the recovery journey. *Journal of Creativity in Mental Health, 11*(3-4), 311-324. https://doi.org/10.1080/15401383.2016.1222321

Czerny, A. B., Lassiter, P. S., & Lim, J. H. (2018). Post-abuse boundary renegotiation: Healing and reclaiming self after intimate partner violence. *Journal of Mental Health Counseling, 40*(3), 211-225. https://doi.org/10.17744/mehc.40.3.03

D'Amore, C., Martin, S. L., Wood, K., & Brooks, C. (2021). Themes of healing and posttraumatic growth in women survivors' narratives of intimate partner violence. *Journal of Interpersonal Violence, 36*(5-6), NP2697–NP2724. https://doi.org/10./10.1177/0886260518767909

Devries, K. M., Mak, J. Y., Bacchus, L. J., Child, J. C., Falder, G., Petzold, M., Astbury, J., & Watts, C. H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine, 10*(5), e1001439. https://doi.org/10.1371/journal.pmed.1001439

Drumm, R., Popescu, M., Cooper, L., Trecartin, S., Seifert, M., Foster, T., & Kilcher, C. (2014). ‘‘God just brought me through it’’: Spiritual coping strategies for resilience among intimate partner violence survivors. *Clinical Social Work Journal, 42*, 385-394. https://doi.org/10.1007/s10615-013-0449-y

Edwards, K. M., Sylaska, K. M., Barry, J. E., Moynihan, M. M., Banyard, V. L., Cohn, E. S., Walsh, W. A., & Ward, S. K. (2015).Physical dating violence, sexual violence, and unwanted pursuit victimization: A comparison of incidence rates among sexual-minority and heterosexual college students. *Journal of Interpersonal Violence, 30*(4), 580–600. https://doi.org/10.1177/0886260514535260

Erikson, K. (1995). Notes on trauma and community. In C. Caruth (Ed.), *Trauma: Explorations in memory* (pp. 183-199). Johns Hopkins University Press.

Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T. J., Sardinha, L., & Feder, G. S. (2016). Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. *Global Health Action, 9*(1), 29890. https://doi.org/10.3402/gha.v9.29890

Flasch, P., Boote, D., & Robinson, E. H. (2019). Considering and navigating new relationships during recovery from intimate partner violence. *Journal of Counseling and Development, 97*, 148-159. https://doi.org/10.1002/jcad.12246

Flasch, P. (2020). A narrative review of the literature on recovery from intimate partner violence: Developmental processes and facilitating elements. *Partner Abuse, 11*(1), 39-56. https://doi.org/10.1891/1946-6560.11.1.39

Gadamer, H. (2004). *Truth and method*. Continuum.

Harden, J., McAllister, P., Spencer, C. M., & Stith, S. M. (2020). The dark side of the rainbow: Queer women's experiences of intimate partner violence. *Trauma, Violence, & Abuse*, 1-13. https://doi.org/10.1177/1524838020933869

Hardesty, J. L., Oswald, R. F., Khaw, L., & Fonseca, C. (2011). Lesbian/bisexual mothers and intimate partner violence: Help seeking in the context of social and legal vulnerability. *Violence Against Women, 17*(1), 28–46. https://doi.org/10.1177/1077801209347636

Hegarty, K. L., O'Doherty, L. J., Chondros, P., Valpied, J., Taft, A. J., Astbury, J., Brown, S. J., Gold, L., Taket, A., Feder, G. S., & Gunn, J. M. (2013). Effect of type and severity of intimate partner violence on women's health and service use: Findings from a primary care trial of women afraid of their partners. *Journal of Interpersonal Violence, 28*(2), 273–294. https://doi.org/10.1177/0886260512454722

Heidegger, M. (1971). *Poetry, language, thought*. (A. Hofstadter, Trans.). Harper and Row.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* Basic Books.

Hyman, I., Forte, T., Du Mont, J., Romans, S., & Cohen, M. M. (2009). Help-seeking behavior for intimate partner violence among racial minority women in Canada. *Women's Health Issues, 19*, 101-108. https://doi.org/10.1016/j.whi.2008.10.002

Iverson, K. M., Bauer, M. R., Shipherd, J. C., Pineles, S. L., Harrington, E. F., & Resick, P. A. (2011). Differential associations between partner violence and physical health symptoms

among Caucasian and African American help-seeking women. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 158-166. https://doi.org/10.1037/a0025912

Kelly, L. C., Spencer, C. M., Keilholtz, B., McAllister, P., & Stith, S. M. (2022). Is separate the new equal? A meta-analytic review of correlates of intimate partner violence victimization for Black and White women in the United States. *Family Process,* 1-16. https://doi.org/10.1111/famp.12754

Kogut, T. (2011). Someone to blame: When identifying a victim decreases helping. *Journal of Experimental Social Psychology, 47,* 748-755. https://doi.org/10.1016/j.jesp.2011.02.011

Knudson-Martin, C., McDowell, T., & Bermudez, J. M. (2017). From knowing to doing: Guidelines for socioculturally attuned family therapy. *Journal of Marital and Family Therapy, 45*(1), 47-60. https://doi.org/10.1111/jmft.12299

Krebs, C., Breiding, M. J., Browne, A., & Warner, T. (2011). The association between different types of intimate partner violence experienced by women. *Journal of Family Violence, 26*(6), 487–500. https://doi.org/10.1007/s10896-011-9383-3

Lacey, K. K., Jiwatram-Negron, T., & Sears, K. P. (2021). Help-seeking behaviors and barriers among Black women exposed to severe intimate partner violence: Findings from a nationally representative sample. *Violence Against Women, 27*(6-7), 952-972. https://doi.org/10.1177/1077801220917464

Lacey, K. K., McPherson, M. D., Samuel, P. S., Sears, K. P., & Head, D. (2013). The impact of different types of intimate partner violence on the mental and physical health of women in different ethnic groups. *Journal of Interpersonal Violence, 28*(2), 359-385. https://doi.org/10.1177/0886260512454743

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *European Journal of Psychotraumatology, 5*(1), 24794. https://doi.org/10.3402/ejpt.v5.24794

Lamble, S. (2008). Retelling racialized violence, remaking white innocence: The politics of interlocking oppressions in transgender day of remembrance. *Sexuality Research and Social Policy, 5*(1), 24–42. https://doi.org/10.1525/srsp.2008.5.1.24

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33*(1), 159-174. https://doi.org/10.2307/2529310

Langenderfer-Magruder, L., Whitfield, D. L., Walls, N. E., Kattari, S. K., & Ramos, D. (2016). Experiences of intimate partner violence and subsequent police reporting among lesbian, gay, bisexual, transgender, and queer adults in Colorado: Comparing rates of cisgender and transgender victimization. *Journal of Interpersonal Violence*, *31*(5), 855–871. https://doi.org/10.1177/0886260514556767

Lee, Y., & Hadeed, L. (2009). Intimate partner violence among Asian immigrant communities: Health/mental health consequences, help-seeking behaviors, and service utilization. *Trauma, Violence, and Abuse, 10*(2), 143-170. https://doi.org/10.1177/1524838009334130

Lewis, S. D., Henriksen Jr., R. C., & Watts, R. E. (2015). Intimate partner violence: The recovery experience. *Women and Therapy, 38*(3-4), 377-394. https://doi.org/10.1080/02703149.2015.1059223

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence.

*American Journal of Community Psychology*, *36*(1/2), 71-84. https://doi.org/10.1007/s10464-005-6233-6

Lo, C. C., Howell, R. J., & Cheng, T. C. (2015). Racial disparities in age at time of homicide victimization: A test of the multiple disadvantage model. *Journal of Interpersonal Violence, 30*(1), 152–167. https://doi.org/10.1177/0886260514532720

McCarthy, K. J., Mehta, R., & Haberland, N. A. (2018). Gender, power, and violence: A systematic review of measures and their association with male perpetration of IPV. *PLOS ONE, 13*(11), e0207091. https://doi.org/10.1371/journal.pone.0207091

Moustakas, C. (1994). Phenomenological research methods. SAGE.

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*, 90-97. https://doi.org/10.1007/s40037-019-0509-2

O'Connor, C., & Joffe, H. (2020). Intercoder reliability in qualitative research: Debates and practical guidelines. *International Journal of Qualitative Methods, 19*, 1-13. https://doi.org/10.1177/1609406919899220

Ørke, E. C., Vatnar, S. K. B., & Bjørkly, S. (2018). Risk for revictimization of intimate partner violence by multiple partners: A systematic review. *Journal of Family Violence, 33*(5), 325–339. https://doi.org/10.1007/s10896-018-9952-9

Overstreet, N. M., & Quinn, D. M. (2013). The intimate partner violence stigmatization model and barriers to help seeking. *Basic & Applied Social Psychology, 35*(1), 109–122. https://doi.org/10.1080/01973533.2012.746599

Peoples, K. (2021). *How to write a phenomenological dissertation: A step-by-step guide*. SAGE.

Peralta, R. L., Tuttle, L. A., & Steele, J. L. (2010). At the intersection of interpersonal violence, masculinity, and alcohol use: The experiences of heterosexual male perpetrators of intimate partner violence. *Violence Against Women, 16*(4), 387–409. https://doi.org/10.1177/1077801210363539

Reynolds, F., & Shepherd, C. (2011). Young women's accounts of intimate partner violence during adolescence and subsequent recovery process: An interpretive phenomenological analysis. *Psychology and Psychotherapy: Theory, Research, and Practice, 84*, 314-334. https://doi.org/10.1111/j.2044-8341.2010.02001.x

Sabri, B., Bolyard, R., McFadgion, A. L., Stockman, J. K., Lucea, M. B., Callwood, G. B., Coverston, C. R., & Campbell J. C. (2013) Intimate partner violence, depression, PTSD, and use of mental health resources among ethnically diverse Black women, *Social Work in Health Care, 52*(4), 351-369. https://doi.org/10.1080/00981389.2012.745461

Smith, S. G., Chen, J., Basile, K. C., Gilbert, L. K., Merrick, M. T., Patel, N, Walling, M, & Jain, A. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010–2012 state report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., & Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

Spencer, C. M., Stith, S. M., & Cafferky, B. (2019). Risk markers for physical intimate partner violence victimization: A meta-analysis. *Aggression and Violent Behavior, 44*, 8–17. https://doi.org/10.1016/j.avb.2018.10.009

Spencer, C., Mallory, A. B., Cafferky, B. M., Kimmes, J. G., Beck, A. R., & Stith, S. M. (2019). Mental health factors and intimate partner violence perpetration and victimization: A meta-analysis. *Psychology of Violence, 9*(1), 1–17. http://doi.org/10.1037/vio0000156

Strand, V. C., Hansen, S., & Courtney, D. (2013). Common elements across evidence-based trauma treatment: Discovery and implications. *Advances in Social Work, 14*, 334-354. https://doi.org/10.18060/3052

Valentine, S, E, Peitzmeier, S. M., King, D. S., O'Cleirigh, C., Marquez, S. M., Presley, C., & Potter, J. (2017). Disparities in exposure to intimate partner violence among transgender/gender nonconforming and sexual minority primary care patients. *LGBT Health, 4*(4), 260-267. https://doig.org/10.1089/lgbt.2016.0113

VanderEnde, K. E., Yount, K. M., Dynes, M. M., & Sibley, L. M. (2012). Community-level correlates of intimate partner violence against women globally: A systematic review. *Social Science & Medicine, 75*(7), 1143–1155. https://doi.org/10.1016/j.socscimed.2012.05.027

Walters, M. L., Chen, J., & Breiding, M. J. (2013). The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation: (541272013-001). American Psychological Association. https://doi.org/10.1037/e541272013-001

Wathen, C. N., MacGregor, J. C. D., Tanaka, M., & MacQuarrie, B. J. (2018). The impact of intimate partner violence on the health and work of gender and sexual minorities in

Canada. *International Journal of Public Health, 63*(1), 945-955. https://doi-org.er.lib.k-state.edu/10.1007/s00038-018-1127-1

Whiting, J. B., Olufuwote, R. D., Cravens-Pickens, J. D., & Witting, A. D. (2019). Online blaming and intimate partner violence: A content analysis of social media comments. *The Qualitative Report, 24*(1), 78-94.

Willie, T. C., Khondkaryan, E., Callands, T., & Kershaw, T. (2018). "Think like a man": How sexual cultural scripting and masculinity influence changes in men's use of intimate partner violence. *American Journal of Community Psychology, 61*(1–2), 240–250. https://doi.org/10.1002/ajcp.12224

Wong, J. Y. -H., Choi, E. P. -H., Lo, H. H. -M., Wong, W., Chio, J. H. -M., Choi, A. W. -M., Fong, D. Y. -T. (2017). Dating violence, quality of life and mental health in sexual minority populations: A path analysis. *Quality of Life Research, 26*(4), 959-968. https://doi.org/10.1007/s11136-016-1415-2

# Appendix A - Interview Script

My name is [name and pronouns]. I am a doctoral student at Kansas State University in the Couple and Family Therapy program here in Manhattan, Kansas. I and my fellow students are incredibly grateful for your willingness to participate. Throughout this interview, to protect confidentiality, I will be referring to you as the pseudonym that you identified [verify pseudonym and that it's ok for us to use that in published papers]. As a therapist I am a mandated reporter. This means that anything I hear about current child, elder, or dependent adult abuse, I will need to report that as well as if I feel you are immediate danger of harming yourself or others. In order to use this interview in our research, it is being recorded and the audio will be transcribed by a third party. When we have completed interviews and analyzed the data, we will be sharing our results with participants to make sure that we are representing your experiences accurately.

In our interview today we will be focusing more on the impact of intimate partner violence on your life rather than the specific details of the violence you experienced. You are welcome to take a break or end the interview at any time. Do you have any questions about the research process? Do you give consent to continue with the interview?

**Interview Questions**

- Do you know what Intimate Partner Violence is?
    - How would you define it?
    - What type of abuse were you experiencing?
- How long were you with your most recent abusive partner?
    - Verify partner demographics from screening survey.
    - How old were you at the start and the end of this relationship?
    - How did you and your partner meet?
    - Did your partner work during your relationship?
    - When did you decide you no longer wanted to be in that relationship?
    - Is there something about your partner that you think is important for me to know?
- How many people knew you were in an abusive relationship?
    - Who were those people?
    - If you told no one, why?
- Did you feel responsible or take any of the blame for the abuse you experienced?
- Did you seek out any formal services (mental health, police, etc.) during or after being in this relationship?
    - If you did not seek out formal services, why not?
    - If you did seek out formal services, how was your experience with these services?
        - Would you recommend another woman to go to these sources?
        - Do you feel you were treated with respect at these services?
        - Do you think your race or ethnicity impacted your experience?
- Has anyone in your family been in an abusive relationship?
    - If yes, who and how did you know it was abusive?
- Out of emotional, physical, sexual, and psychological abuse do you think that one is less serious than the others?

    - Why do you or do you not think so?
- Do you feel that your race, sexual, or gender identity impacted your experiences of violence?
    - Was your gender identity or sexual orientation disclosed to your partner
- Do you feel that your past experience of being in an abusive relationship impacts you today? If so, how?
    - Your romantic relationships?
    - Your relationship with your communities (religious, local, etc.)?
    - Your relationship with and to other women/other people in general?
    - Emotionally/psychologically?
- We use the word "trauma" to describe the emotional and mental distress following particularly difficult experiences. Would you consider the abuse you experienced traumatic?
    - If YES: Why? And how would you describe your experience of trauma?
    - If NO: Why not?
- Do you think you have healed from being in this abusive relationship?
    - YES: In what ways do you feel that you have healed from your abusive relationship?
        - What has healing looked like?
        - What resources/people/things have been helpful?
    - NO: What do you think your healing will look like?
    - What would you have needed from someone else during this time of your life that would have helped your situation?
    - What would you have needed from yourself during this time in your life that would have helped you in that relationship?
    - We talked about one partner is there another partner that you feel like we should talk about?
    - Is there anything that you wished I would have asked you about your experiences as a person who survived IPV?