From Control to Choice: A Trauma-Informed Behavioural Model for Recovery among Women Survivors of Domestic Violence

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ABSTRACT

This study examines a trauma-informed, behaviourally informed, community-based intervention for women survivors of domestic violence in rural Ireland and introduces the *Trauma-Informed Behavioural Recovery (TIBR) design*. Using a qualitative case study of the pilot programme for this innovative new model, the 4Empowerment Donegal programme, this research explores how applied behaviour analysis (ABA), Acceptance and Commitment Therapy (ACT), feminist trauma-informed care, and physical activity can be integrated without reproducing coercive or compliance-based service models. Drawing on programme-generated qualitative data, findings demonstrate that sustained engagement emerged through safety, choice, and structural accommodation rather than mandate, disclosure, or behavioural monitoring. Within the TIBR design, voluntary participation, flexible attendance, non-punitive re-entry, and practical supports functioned as core intervention mechanisms that reduced barriers to engagement and supported persistence over time. Physical activity operated as an embodied, non-clinical pathway to regulation, agency, and social reconnection, enabling recovery without requiring trauma narration or therapeutic performance. Recovery trajectories were non-linear and relational, shaped by ongoing coercive control, legal pressures, and material constraints. The study demonstrates that behavioural science, when embedded within the Trauma-Informed Behavioural Recovery design, can support ethical, non-coercive, recovery-oriented practice for women survivors of domestic violence. By reframing engagement as a function of safety rather than compliance, this research challenges dominant assumptions underpinning domestic violence interventions and offers a transferable model for trauma-informed, community-based service design.

Keywords: coercive control, trauma-informed care, domestic violence recovery, behavioural intervention, community-based intervention, women's empowerment

INTRODUCTION

Domestic violence is a pervasive global public health issue with profound and enduring consequences for women's mental health, physical wellbeing, social participation, and economic security. Survivors frequently experience overlapping harms, including coercive control, psychological trauma, social isolation, substance use, and disrupted access to education and employment (Stark, 2007; Devries et al., 2013). These impacts are often intensified in rural contexts, where geographic isolation, limited transport infrastructure, and fragmented service provision constrain access to sustained, trauma-responsive support.

Despite growing recognition of the complex and cumulative nature of domestic violence–related harm, many intervention models continue to prioritise compliance, symptom reduction, or linear notions of recovery. Survivors are frequently expected to engage consistently, disclose traumatic experiences, or demonstrate measurable progress in order to retain support. Feminist scholars have long cautioned that such models risk reproducing dynamics of surveillance, conditionality, and control that mirror abusive relationships themselves (Harris & Fallot, 2001; Stark, 2007). For women whose lives have been shaped by chronic threat and restricted autonomy, these expectations can function as barriers rather than pathways to recovery.

Applied behaviour analysis (ABA) has demonstrated strong empirical support across mental health contexts, including substance use, depression, and severe mental illness (Ferster, 1973; Petry et al., 2000; Harvey et al.,

2009). However, within domestic violence and trauma-informed fields, behavioural approaches are frequently viewed with scepticism due to concerns regarding coercion, compliance, and power imbalance. This has contributed to the marginalisation of behavioural science within violence-against-women interventions, despite its potential compatibility with recovery-oriented practice when applied ethically and contextually.

Acceptance and Commitment Therapy (ACT), grounded in contextual behavioural science, offers a bridge between behavioural theory and trauma-informed values by prioritising psychological flexibility and values-based action over symptom elimination (Hayes et al., 1999). This orientation aligns closely with survivor-defined recovery trajectories, which are often non-linear, embodied, and shaped by ongoing structural constraints rather than discrete therapeutic milestones.

An emerging body of research further highlights physical activity as a trauma-responsive, non-clinical intervention that can support embodied regulation, social connection, and re-engagement without requiring trauma disclosure (Reid et al., 2020; Letourneau et al., 2024). For survivors of coercive control, such approaches may offer safer and more accessible pathways to recovery than traditional clinical models.

This paper presents a qualitative case study of the 4Empowerment Donegal programme, a community-based intervention developed in rural Ireland that integrates applied behaviour analysis, ACT, feminist trauma-informed care, and physical activity. The programme conceptualizes the Trauma Informed Behavioural Recovery (TIBR) model, positioning trauma-informed conditions not as adjunctive values, but as mechanisms that shape how behavioural principles operate ethically. By foregrounding survivor experience, this study examines how women engage with and experience behaviourally informed interventions when delivered outside compliance-based service systems, contributing a theoretically integrated and practice-relevant model of recovery from domestic violence, including coercive control.

In response to these limitations, this study advances a novel integrative intervention model termed the Trauma-Informed Behavioural Recovery (TIBR) design. The TIBR design brings together applied behaviour analysis (ABA), Acceptance and Commitment Therapy (ACT), feminist trauma-informed care, and embodied physical activity within a non-coercive, community-based framework. Crucially, trauma-informed principles within the TIBR design are not treated as adjunctive values, but as active intervention mechanisms that shape how behavioural processes operate ethically. The model explicitly rejects compliance-based engagement, mandatory disclosure, and surveillance-driven practice, positioning recovery instead as a non-linear, relational process grounded in safety, choice, and structural accommodation. Using a qualitative case study of the 4Empowerment Donegal programme in rural Ireland, this paper examines how the TIBR design functions in practice and how women survivors of domestic violence experience engagement and recovery within its conditions. The purpose of this study is to empirically examine the Trauma-Informed Behavioural Recovery (TIBR) design and its implications for ethical, non-coercive domestic violence intervention.

Conceptual Framework: The Trauma-Informed Behavioural Recovery (TIBR) Design

Below, figure 1 illustrates the Trauma-Informed Behavioural Recovery (TIBR) design: an integrated, non-coercive intervention model for women survivors of domestic violence. Trauma-informed and feminist conditions—such as safety, choice, voluntariness, non-punitive re-entry, and structural accommodation—form the foundational context within which all intervention processes operate. Within these conditions, applied behaviour analysis (ABA) contributes a contextual account of behaviour and reinforcement, Acceptance and Commitment Therapy (ACT) supports values-based action in the presence of distress, and relational practice foregrounds dignity and social connection. Embodied physical activity functions as the primary non-clinical vehicle through which these mechanisms are enacted, enabling regulation, agency, and engagement without requiring trauma disclosure or therapeutic performance. Recovery within the TIBR design is conceptualised as a non-linear, relational process shaped by ongoing coercive control and material constraint, rather than as behavioural compliance or symptom reduction.

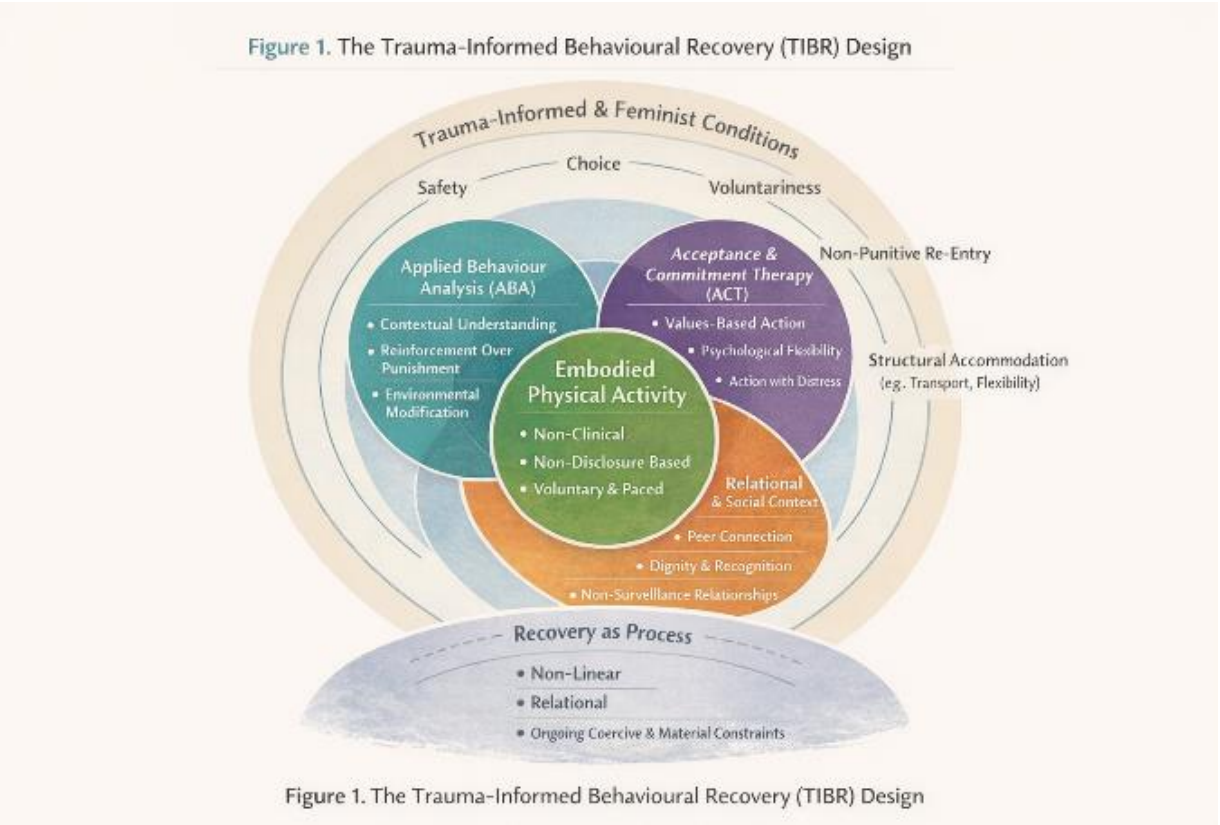

Figure 1. The Trauma-Informed Behavioural Recovery (TIBR) design.

This study is informed by the Trauma-Informed Behavioural Recovery (TIBR) design, an integrative conceptual framework developed to support ethical, non-coercive recovery for women survivors of domestic violence. The TIBR design brings together applied behaviour analysis (ABA), Acceptance and Commitment Therapy (ACT), feminist trauma-informed care, and embodied physical activity within a community-based intervention model. Rather than presenting these approaches as parallel or additive, the TIBR design positions trauma-informed and feminist principles as the structural conditions through which behavioural mechanisms operate. Recovery is conceptualised as a non-linear, relational, and embodied process shaped by coercive control, material constraint, and access to choice, rather than as individual symptom reduction or behavioural compliance. In this way, the TIBR design explicitly responds to feminist critiques of intervention models that individualise distress, obscure power relations, and reproduce surveillance-based practices within services for survivors of domestic violence. Feminist scholarship on violence against women has consistently demonstrated that domestic abuse is not reducible to discrete incidents of violence, but is better understood as a pattern of coercive control that systematically restricts autonomy, erodes agency, and reorganises women's behavioural repertoires around survival (Stark, 2007). Survivors' post-abuse behaviours—including avoidance, substance use, emotional withdrawal, or inconsistent engagement with services—are therefore not evidence of resistance, ambivalence, or non-compliance, but predictable adaptations to prolonged conditions of threat, surveillance, and deprivation. Any intervention model that fails to account for this context risks reproducing dynamics of control and blame that mirror the abuse itself.

Reclaiming Applied Behavior Analysis as a Contextual and Anti-Pathologising Science

Within the Trauma-Informed Behavioural Recovery (TIBR) design, applied behaviour analysis (ABA) provides a contextual account of behaviour that resists trait-based and pathologising explanations of survivors' actions. Applied behavior analysis is a scientific discipline concerned with understanding behaviour as a function of environmental contingencies and learning histories (Baer et al., 1968). Despite its robust empirical base, ABA has been widely critiqued within feminist and trauma-informed literatures for its perceived emphasis on control, compliance, and externally imposed goals. However, such applications reflect ethical failures in implementation rather than inherent features of behavioural science.

Historically, ABA emerged within psychiatric and community mental health contexts, addressing depression, psychosis, institutional dependency, and substance use long before its contemporary association with autism services (Winkler, 1970; Liberman et al., 1973). At its core, ABA rejects trait-based explanations of behaviour and instead locates behaviour within context. For survivors of domestic violence, this orientation is particularly salient. Behaviours that are frequently pathologised—such as avoidance, hypervigilance, or reliance on substances—can be understood as adaptive responses shaped by environments characterised by coercive control, chronic threat, and restricted access to reinforcement (Ferster, 1973; Stark, 2007).

Within the TIBR design, ABA is explicitly decoupled from compliance-based frameworks. Behaviour change is not conceptualised as adherence to prescribed norms or service expectations, but as expanded access to reinforcing, self-determined life contexts. Transparency, voluntariness, and the absence of punishment are treated as non-negotiable ethical conditions. In this sense, behavioural principles are mobilised not to regulate women's behaviour, but to dismantle environmental constraints that have historically limited choice and safety.

ACT, Psychological Flexibility, and Resistance to Victim-Blaming Narratives

The TIBR design incorporates Acceptance and Commitment Therapy (ACT) as the motivational and meaning-oriented component of recovery, supporting values-based action in the presence of ongoing distress rather than requiring emotional regulation as a precondition for engagement. Acceptance and Commitment Therapy (ACT) extends behavioural science through a contextual behavioural lens that centres meaning, values, and psychological flexibility (Hayes et al., 1999). ACT is particularly relevant to violence against women because it rejects the assumption that distress must be eliminated before meaningful action can occur. This stance directly counters victim-blaming narratives that frame survivors as "not ready," "too dysregulated," or "non-engaging" when they are unable to meet narrow therapeutic expectations.

For women navigating post-separation abuse, legal proceedings, economic precarity, and parenting responsibilities, emotional distress is not an aberration but a rational response to ongoing structural and relational pressures. ACT supports engagement in values-consistent action in the presence of fear, shame, or ambivalence, thereby legitimising survivors' lived experiences rather than positioning them as barriers to treatment. Within the TIBR design, engagement in values-consistent action is framed as an expression of agency and resistance rather than treatment compliance.

Within the integrated model, ACT provides the motivational architecture that connects behavioural activation to survivor-defined values such as autonomy, bodily safety, connection, and parenting identity. Engagement in physical activity or community participation is framed not as treatment compliance, but as an act of resistance against isolation and constraint. This reframing is critical within feminist praxis, as it recognises recovery as an ongoing negotiation with power rather than a return to an idealised state of functioning.

Trauma-Informed Care as an Intervention Mechanism, Not a Rhetorical Overlay

In the Trauma-Informed Behavioural Recovery (TIBR) design, trauma-informed care functions as an active intervention mechanism rather than a set of aspirational values layered onto practice. Trauma-informed care, as articulated by SAMHSA (2014), has been widely adopted across domestic violence and mental health services. However, feminist scholars have cautioned that trauma-informed language can become performative when not accompanied by structural change or redistribution of power. In this study, trauma-informed care is conceptualised not as a set of values alone, but as an active intervention mechanism that materially alters the conditions shaping women's engagement. These trauma-informed conditions are the ethical infrastructure of the TIBR design, shaping the contingencies through which behavioural engagement becomes possible.

Practices such as voluntary participation, flexible attendance, non-punitive re-entry, and the absence of disclosure requirements function behaviourally to reduce avoidance, shame, and fear of surveillance. These conditions are particularly significant for survivors whose prior experiences of control make mandated participation or performance-based services inherently unsafe. By operationalising safety, transparency, and choice, trauma-informed care reshapes the contingencies that govern engagement, enabling women to participate on their own terms.

Importantly, this framework situates responsibility for safety and accessibility at the level of the system rather than the individual woman. Barriers to engagement are treated as indicators of environmental failure, not personal deficiency—a position firmly aligned with feminist and survivor-led approaches to violence against women.

Physical Activity as a Feminist and Embodied Site of Recovery

Physical activity operates within the TIBR design as the primary embodied vehicle through which behavioural, relational, and trauma-informed processes are enacted. Feminist trauma scholarship has increasingly emphasised the embodied nature of trauma, highlighting how coercive control and violence disrupt women's relationships with their bodies, autonomy, and sense of physical agency (Kearney & Lanius, 2022). In this context, physical activity offers a non-verbal, non-pathologising pathway to reconnection that does not require disclosure, narrative coherence, or emotional regulation as prerequisites. Within the TIBR design, physical activity is not positioned as treatment, exercise compliance, or lifestyle change, but as an accessible, non-clinical pathway to agency, regulation, and social reconnection.

Group-based physical activity also provides opportunities for peer connection and solidarity without imposing therapeutic identities. For many survivors, this form of engagement represents a reclaiming of public space, bodily autonomy, and social presence—dimensions of recovery that are often overlooked in clinical models. When participation is voluntary, paced, and supported, physical activity can function as both behavioural activation and a feminist act of resistance against isolation and control.

Summary: A Survivor-Centred Model of Behavioural Change

The Trauma-Informed Behavioural Recovery (TIBR) design positions recovery as a socially situated, embodied, and non-linear process shaped by power, context, and access to choice. Within the TIBR design, applied behaviour analysis contributes a contextual understanding of behaviour; ACT provides a values-based account of action under conditions of distress; trauma-informed care establishes the ethical and relational conditions for engagement; and physical activity functions as the embodied medium through which recovery is enacted. Together, these components form an integrated, anti-coercive model that challenges compliance-based intervention paradigms and centres survivor agency, dignity, and safety. This conceptual framework underpins the methodological approach and guides the analysis of the 4Empowerment Donegal programme presented in the sections that follow.

The TIBR design challenges intervention models that prioritise compliance, symptom suppression, or professional authority over survivor knowledge. Instead, it advances a model in which women's engagement, withdrawal, and re-engagement are understood as meaningful responses to shifting conditions of safety and constraint. This conceptual foundation informs the methodological approach that follows and underpins the empirical analysis of the 4Empowerment Donegal programme presented in subsequent sections. This integrated framework responds to calls for domestic violence interventions that move beyond compliance-based engagement and offers a concrete model for ethical behavioural practice in trauma-exposed populations.

METHODOLOGY

Examining the Trauma-Informed Behavioural Recovery (TIBR) Design

Epistemological Positioning and Feminist Research Framework

This study is grounded in a feminist, survivor-centred epistemology that understands domestic violence as a gendered system of coercive control rather than a series of discrete violent events (Stark, 2007; Kelly, 1988). Feminist scholars have long argued that knowledge production in the field of violence against women must centre women's lived experience, attend to power relations, and resist methodological practices that replicate dynamics of surveillance, control, or silencing (Hesse-Biber, 2014; Fontes, 2015). The epistemological positioning of this research is consistent with the TIBR design, which rejects positivist assumptions of

neutrality, linear recovery, and behavioural compliance, and instead understands engagement and recovery as relational, contextual, and shaped by structural constraint.

Consistent with this tradition, the present research rejects positivist assumptions that privilege researcher objectivity, standardisation, or behavioural compliance as indicators of rigour. Instead, it adopts a contextual, interpretivist stance in which meaning is understood as co-constructed within relational and structural conditions shaped by gender, trauma, and inequality. This epistemological positioning is particularly critical when researching survivors of domestic violence, whose voices have historically been marginalised, medicalised, or rendered suspect within institutional systems (Dobash & Dobash, 2004; Stark & Hester, 2019).

The study further draws on feminist critiques of intervention research that individualise women's distress while obscuring the ongoing impacts of coercive control, economic abuse, and structural exclusion (Sharp-Jeffs et al., 2018). In response, this research explicitly situates women's engagement, disengagement, and recovery trajectories within broader social, relational, and material contexts rather than attributing outcomes to motivation, readiness, or treatment adherence.

Study Design: Trauma-Informed Qualitative Case Study

A qualitative case study design was employed to examine the implementation and lived experience of the 4Empowerment Donegal programme, a community-based intervention supporting women survivors of domestic violence in rural Ireland. A qualitative case study design was employed to examine how the Trauma-Informed Behavioural Recovery (TIBR) design operated in practice within the 4Empowerment Donegal programme. Case study methodology is particularly well suited to feminist and violence-against-women research, as it allows for in-depth exploration of complex, contextually embedded phenomena that cannot be meaningfully isolated from their social and institutional environments (Yin, 2018).

The case study approach enabled examination of how behaviourally informed strategies were experienced when embedded within a trauma-informed, non-clinical, community-based programme. Importantly, the case was not treated as a bounded "intervention" detached from context, but as a relational system shaped by interagency collaboration, rural infrastructure, gendered service provision, and survivor histories of coercive control.

Consistent with trauma-informed feminist research principles, the study prioritised ecological validity over experimental control, recognising that methodological practices that impose structure, assessment demands, or disclosure requirements may replicate coercive dynamics experienced by survivors (Elliott et al., 2005; Harris & Fallot, 2001).

Behavioural Components of the Trauma-Informed Behavioural Recovery (TIBR) Design

Behavioural Principles and Techniques Within the TIBR Design

Although the Trauma-Informed Behavioural Recovery (TIBR) design is grounded in applied behaviour analysis (ABA), behavioural techniques were employed in a deliberately non-coercive, transparent, and survivor-centred manner. Behavioural strategies therefore focused on altering environmental conditions and increasing access to reinforcing experiences rather than imposing behavioural expectations or contingencies. The specific ABA techniques utilised within the TIBR design are outlined below.

Functional, Contextual Understanding of Behaviour

Rather than conducting formal functional behaviour assessments, practitioners employed informal functional analysis to understand engagement patterns as contextually situated responses to environmental contingencies. Disengagement, avoidance, or inconsistent participation were interpreted as functionally related to factors such as fear of surveillance, transport barriers, childcare demands, ongoing contact with perpetrators, or emotional exhaustion.

From a TIBR perspective, these behaviours were treated as adaptive survival responses rather than deficits or resistance. This functional orientation informed programme design decisions, such as removing attendance mandates, allowing flexible participation, and supporting non-punitive re-entry. Importantly, behavioural hypotheses were used to guide environmental modification rather than to categorise or evaluate individual women.

Behavioural Activation Through Access to Reinforcement

Behavioural activation was a central ABA-informed mechanism within the TIBR design. Participation in group-based physical activity functioned as a low-demand, non-clinical entry point that increased access to naturally occurring reinforcement, including social connection, embodied relief, routine, and a sense of competence.

Unlike traditional behavioural activation protocols, participation was voluntary, self-paced, and not contingent on attendance thresholds, goal attainment, or symptom change. Reinforcement occurred through naturally embedded consequences (e.g. enjoyment, reduced isolation, improved sleep) rather than through externally imposed incentives or performance monitoring. This approach aligns with feminist critiques of contingency-based systems that risk reproducing control and conditionality.

Positive Reinforcement and the Elimination of Aversive Control

Consistent with the ethical commitments of the TIBR design, punishment, response cost, and extinction-based strategies were explicitly excluded. Instead, engagement and re-engagement were supported through positive reinforcement and the removal of aversive contingencies commonly present in service systems.

For example, the absence of attendance monitoring, disclosure requirements, or progress evaluation reduced fear of judgement and surveillance—conditions that had previously functioned as aversive stimuli for many participants. Non-punitive re-entry following absence or relapse functioned behaviourally to reinforce return to participation rather than to punish disengagement. From a behavioural standpoint, this increased response persistence over time; from a feminist standpoint, it restored autonomy and dignity.

Antecedent Modifications and Reduction of Response Effort

Antecedent strategies were widely employed to reduce barriers to participation. These included provision of transport, flexible scheduling, simplified enrolment processes, and the absence of prerequisite assessments or disclosures. Within ABA, such strategies are understood as antecedent modifications that reduce response effort and increase the likelihood of engagement.

Within the TIBR design, antecedent modifications were conceptualised not as accommodations for individual limitation, but as structural interventions that redistributed responsibility from women to service design. This approach aligns behavioural science with feminist commitments to equity and structural accountability.

Shaping Engagement Without Prescribed Behavioural Targets

Engagement within the TIBR design was supported through **informal shaping**, whereby small, self-directed steps toward participation were recognised and supported without formal goal-setting or behavioural targets. Attendance, duration, and intensity of participation were determined by women themselves and allowed to fluctuate in response to changing circumstances.

Importantly, shaping did not involve escalation of demands or withdrawal of support. Instead, it operated through sustained availability, relational continuity, and affirmation of choice. This approach resists compliance-based models while remaining consistent with behavioural principles that recognise behaviour change as gradual and context-dependent.

Transparency and Informed Participation

Consistent with ethical ABA practice, behavioural strategies within the TIBR design were implemented transparently. Women were not subject to covert behavioural manipulation, reinforcement schedules, or assessment procedures. Participation was framed explicitly as optional, and engagement was not linked to service eligibility, evaluation, or external outcomes.

This transparency is a defining feature of the TIBR design and distinguishes it from behavioural interventions that rely on implicit contingencies or professional authority.

Analytic Use of Behavioural Data

Attendance and engagement records were used descriptively to understand patterns over time rather than as outcome measures or indicators of success. From a TIBR perspective, such data were interpreted relationally and contextually, with fluctuations understood as meaningful responses to safety, capacity, and external pressure rather than as treatment failure.

This approach aligns with Wolf's concept of social validity and reinforces the study's emphasis on survivor-defined significance over standardised behavioural metrics.

Trauma-Informed and Anti-Coercive Research Practices

Research with survivors of domestic violence carries inherent ethical risks, particularly when traditional research practices reproduce hierarchies of power, extractive data collection, or expectations of emotional disclosure (Campbell et al., 2009). In recognition of these risks, research practices in this study were deliberately designed to mirror the ethical commitments of the Trauma-Informed Behavioural Recovery (TIBR) design, particularly its emphasis on safety, choice, voluntariness, and resistance to surveillance-based practices. Participation in the research did not require women to recount experiences of abuse, justify their engagement, or demonstrate progress according to externally defined criteria. This TIBR-aligned approach is informed by feminist critiques of "testimonial burden," whereby survivors are expected to repeatedly narrate trauma in order to be believed or supported (Fricker, 2007; Brison, 2002). Instead, data were drawn from naturally occurring programme materials that reflected engagement, perceived impact, and meaning-making without requiring retraumatisation.

The TIBR-consistent research design also aligns with Stark's (2007) analysis of coercive control, which emphasises that survivors' autonomy is often undermined not through overt violence alone, but through cumulative restrictions on choice, movement, and self-determination. Consequently, preserving participant choice within the research process was treated as an ethical imperative rather than a methodological preference.

Participants and Context

Participants were adult women engaged with the 4Empowerment Donegal programme who had experienced domestic violence, coercive control, and associated mental health and substance use challenges. Many participants were mothers and were navigating ongoing contact with perpetrators through family courts, child protection systems, or community surveillance—factors widely recognised in feminist literature as extending abuse beyond relationship separation (Morris, 2009; Stark & Hester, 2019).

Participants were not recruited for the purposes of research but were already engaged in the programme through routine service provision. This decision reflects feminist commitments to minimising power asymmetries and avoiding the creation of artificial research roles that may pressure women to participate (Hesse-Biber, 2014).

Patterns of participation, disengagement, and re-entry were interpreted through the Trauma-Informed Behavioural Recovery (TIBR) design, which conceptualises fluctuating engagement as a meaningful response to safety, coercive pressure, and competing demands rather than as attrition or non-compliance.

Levels of engagement varied substantially across participants, with patterns of consistent attendance, intermittent participation, disengagement, and re-entry. These patterns were not conceptualised as attrition or failure, but as meaningful data reflecting women's ongoing negotiation of safety, capacity, and competing demands—an interpretation consistent with feminist understandings of non-linear recovery (Kelly, 1988; Herman, 1992).

Data Sources

Data sources were intentionally selected to align with the ethical and conceptual commitments of the Trauma-Informed Behavioural Recovery (TIBR) design. Data sources were deliberately limited to non-clinical, programme-generated materials to protect participant safety and autonomy. These included:

- Anonymised participant feedback surveys focusing on wellbeing, safety, confidence, and social connection
- Attendance and engagement records documenting patterns of participation over time
- Voluntary participant impact statements
- Programme documentation and reflective practitioner field notes

No clinical files, diagnostic assessments, or therapeutic records were accessed. This decision reflects feminist critiques of surveillance-based research practices that replicate institutional control and pathologisation (Monahan, 2010). The exclusion of clinical assessments, diagnostic measures, and disclosure-based data was not a limitation but a methodological requirement of the TIBR design, which resists surveillance, pathologisation, and compulsory trauma narration.

From a feminist methodological standpoint, these data sources prioritise women's self-defined indicators of impact over externally imposed outcome measures. From a behavioural perspective, they capture socially significant behaviour—engagement, persistence, and re-engagement—within real-world contexts.

Researcher Positionality and Reflexivity

The researcher occupied a dual role as programme developer and practitioner, a position that affords deep contextual insight while necessitating sustained reflexive accountability. Feminist scholars have emphasised that reflexivity is not a disclosure exercise but an ongoing ethical practice that interrogates power, authority, and interpretation (Finlay, 2002; Pillow, 2003). The researcher's dual role as programme developer and practitioner is consistent with the Trauma-Informed Behavioural Recovery (TIBR) design, which prioritises relational continuity, trust, and contextual knowledge over methodological distance. From a TIBR perspective, external detachment or imposed researcher neutrality may itself reproduce dynamics of surveillance and power asymmetry that the model explicitly seeks to resist.

Rather than striving for false neutrality, the researcher explicitly acknowledges alignment with survivor-centred, trauma-informed values and a commitment to resisting coercive and deficit-based narratives. Reflexive strategies included continuous journaling, transparent documentation of analytic decisions, and prioritisation of participant voice over interpretive abstraction.

This positionality aligns with feminist participatory traditions that recognise knowledge as situated and relational, particularly within violence-against-women research where survivors' expertise has historically been discounted (Harding, 1987).

Ethical Approval and Safeguarding

Ethical approval for the study was obtained in accordance with institutional research ethics requirements. Safeguarding procedures were consistent with national domestic violence and child protection guidelines. Importantly, safeguarding was conceptualised not solely as risk management, but as the creation of conditions that reduce harm, fear, and coercion.

Participants were informed that their involvement in programme activities was independent of research participation and that choosing not to engage with research-related processes would have no impact on access to support. This separation of service and research roles is a critical feminist safeguard against perceived coercion (Campbell et al., 2009). Ethical and safeguarding procedures were implemented in a manner consistent with the Trauma-Informed Behavioural Recovery (TIBR) design, with safeguarding conceptualised as the creation of conditions that reduce fear, enhance autonomy, and preserve choice rather than as surveillance or risk containment alone.

Ethical Considerations: Anonymity, Visibility, and Risk in a Rural Irish Context

Research with women survivors of domestic violence in rural Ireland presents distinct ethical challenges related to anonymity, visibility, and safety. In small and geographically dispersed communities, social networks are dense, services are limited, and participation in community-based programmes can render women identifiable despite the removal of names or demographic markers. These conditions complicate conventional assumptions about anonymity and confidentiality in qualitative and mixed-methods research and require context-specific ethical mitigation beyond standard procedural safeguards.

Anonymity was treated as a situated and relational risk requiring ongoing management. This recognition informed both the design of the Trauma-Informed Behavioural Recovery (TIBR) model and the associated research practices. Rather than relying solely on de-identification of data, the study prioritised risk minimisation through choice, control, and participant-led boundaries.

Several strategies were employed to mitigate risks associated with visibility and potential identification. First, participation in research components was entirely voluntary and decoupled from programme access, ensuring that women could engage in services without any obligation to contribute data. Second, data collection avoided the use of detailed demographic descriptors, geographic markers, or unique biographical details that could render participants identifiable within local contexts. Quotes were carefully screened to remove references to specific locations, events, or relational configurations that might inadvertently reveal identity.

Third, the research design deliberately avoided group-based data collection methods that would require participants to disclose experiences in the presence of others or risk being recognised through shared narratives. Written feedback and individual qualitative data were prioritised, allowing women to control the content, depth, and timing of their contributions. This approach was particularly important in rural settings where participants may know one another through schools, services, or extended family networks.

Fourth, dissemination practices were guided by the principle of protective ambiguity. Findings are presented at an aggregate level, and attendance trajectories and engagement patterns are anonymised and illustrative rather than exhaustive. Figures depicting longitudinal engagement (e.g., anonymised attendance trajectories) are intentionally non-traceable and do not correspond to specific individuals or identifiable participation timelines. This approach balances analytic transparency with participant safety.

Importantly, the study also recognised that non-participation and selective engagement are ethical outcomes in themselves. Within both the TIBR design and the research process, women's decisions to withhold information, disengage temporarily, or decline participation were treated as expressions of agency rather than as limitations or missing data. This stance is particularly salient in rural contexts where over-visibility can heighten risk and where survivors may be navigating ongoing coercive control, post-separation abuse, or legal proceedings.

Finally, ethical reflexivity was maintained throughout the study, with continuous assessment of whether data collection or representation could inadvertently increase risk. Where such risk was identified, analytic restraint was exercised in favour of participant safety. In this way, the ethical constraints associated with rural anonymity were not merely acknowledged but actively shaped methodological choices, reinforcing alignment between feminist ethics, trauma-informed practice, and the principles underpinning the TIBR design.

Analytic Strategy

Data were analysed using a reflexive thematic approach guided by the Trauma-Informed Behavioural Recovery (TIBR) design. Analysis prioritised patterns of safety, agency, embodiment, and relational engagement, reflecting the core mechanisms of the TIBR design rather than symptom change, behavioural compliance, or linear progression.

Themes were interpreted through the integrated lens of applied behaviour analysis, ACT, and trauma-informed care, while remaining grounded in feminist understandings of coercive control and structural inequality. Participant voice was embedded throughout analysis to resist abstraction and maintain accountability to lived experience.

Methodological Integrity and Feminist Rigour

Methodological integrity in this study was established through credibility, reflexivity, transparency, and analytic coherence rather than through standardisation, replication, or behavioural compliance. Consistent with feminist qualitative research traditions, rigour was understood as the ethical and epistemic alignment between research questions, methodological choices, analytic processes, and the lived realities of women survivors of domestic violence. This approach recognises that conventional indicators of rigour—such as uniform participation, complete datasets, or linear engagement—may be neither attainable nor desirable when researching populations affected by coercive control and trauma.

Credibility was supported through prolonged engagement with the programme context, triangulation across multiple naturally occurring data sources, and sustained attention to patterns of convergence and divergence across participant accounts. Reflexivity functioned as a core analytic practice rather than a procedural addendum, with the researcher maintaining ongoing critical awareness of positionality, power, and interpretive authority throughout data collection and analysis. Transparency was ensured through detailed documentation of analytic decisions, explicit articulation of theoretical lenses, and clear justification of methodological boundaries, including the deliberate exclusion of clinical assessments and disclosure-based data.

Analytic coherence was achieved by interpreting findings consistently through the integrated framework of applied behaviour analysis, Acceptance and Commitment Therapy, trauma-informed care, and feminist theories of coercive control. Rather than seeking thematic saturation in a positivist sense, the analysis prioritised depth, contextual sensitivity, and ethical accountability to participant experience. In this way, methodological rigour was not treated as a neutral technical standard, but as a feminist commitment to producing knowledge that is credible, situated, and resistant to practices that reproduce surveillance, coercion, or epistemic injustice. While the findings are not intended to be statistically generalisable, their analytic transferability lies in the detailed explication of mechanisms, ethical conditions, and contextual processes through which engagement and recovery were supported, enabling relevance to comparable trauma-informed, community-based interventions.

Methodological integrity in this study was therefore achieved through fidelity to the Trauma-Informed Behavioural Recovery (TIBR) design, ensuring alignment between epistemology, ethics, analytic strategy, and the lived realities of women survivors of domestic violence. In this way, the TIBR design demonstrates how applied behaviour analysis can be mobilised as a contextual, ethical, and anti-coercive science when embedded within feminist and trauma-informed systems of care.

RESULTS

Survivor Experiences Within the Trauma-Informed Behavioural Recovery (TIBR) Design

Participant Profile and Engagement Over Time

Across the two-year period (2024–2025), programme engagement increased both in duration and breadth, indicating sustained participation rather than short-term uptake. In 2025 Q3, 39.3% of respondents reported participation of over one year, compared to 24.4% in early 2024, suggesting growing retention over time, which is shown in Figure 2. Table 1 shows the duration of participant engagement over time.

Participants represented diverse age groups, ethnicities, and residency statuses, with a consistent predominance of women aged 36–55, reflecting the demographic most affected by prolonged coercive control and post-separation abuse in rural contexts.

Importantly, engagement was non-linear, with many women cycling in and out of participation depending on safety, health, legal, or caregiving demands.

"I'm still part of the group and can attend any classes if it suits. That means everything — I don't feel like I've failed." (Participant, 2024)

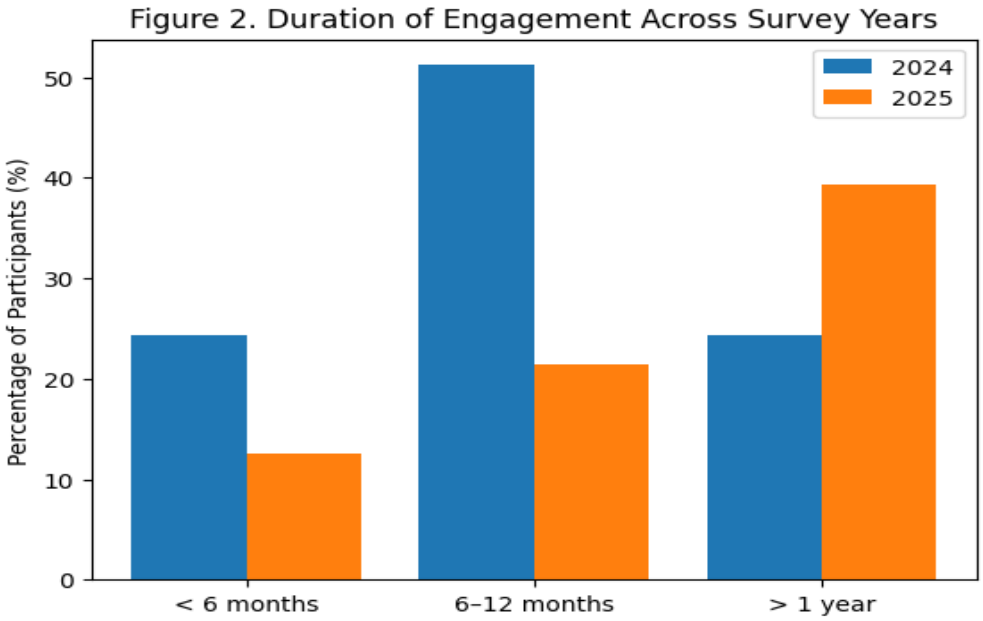

Figure 2. Duration of engagement across survey years within the Trauma-Informed Behavioural Recovery (TIBR) design.

The figure illustrates changes in participant engagement duration between 2024 and 2025. The increasing proportion of women engaged for over one year reflects sustained, voluntary participation consistent with the TIBR design's emphasis on safety, choice, and non-punitive re-engagement rather than compliance-based retention strategies.

Table 1. Participant Duration of Engagement Across Survey Waves (2024–2025)

Duration of Participation	2024 (%)	2025 Q1 (%)	2025 Q3 (%)
< 6 months	24.4	22.8	12.5
6–12 months	51.2	26.3	21.4

> 1 year	24.4	26.3	39.3

Table 1. Participant duration of engagement across survey waves within the Trauma-Informed Behavioural Recovery (TIBR) design (2024–2025).

This table presents the distribution of participants by length of programme engagement across survey waves conducted in 2024 and 2025. The data illustrate shifts toward longer-term participation over time, with an increasing proportion of women engaged for over one year. Engagement duration is interpreted within the TIBR design as a function of safety, choice, and structural accommodation rather than as a measure of compliance or retention.

Barriers to Engagement as Contextual, Not Individual, Factors

Across all survey waves, women consistently identified confidence, financial constraints, transport, childcare, and mental health challenges as primary barriers to participation prior to programme involvement. Rather than diminishing over time, these barriers persisted — but their behavioural impact was mitigated through structural supports embedded within the TIBR design.

Transportation assistance (taxis and fuel vouchers) was accessed by 58.9% of participants in 2025, while 28.6% utilised childcare supports, demonstrating that antecedent modification was central to sustained engagement.

"If transport wasn't there, I couldn't go. It's not about wanting to — it's about getting there." (Participant, 2025)

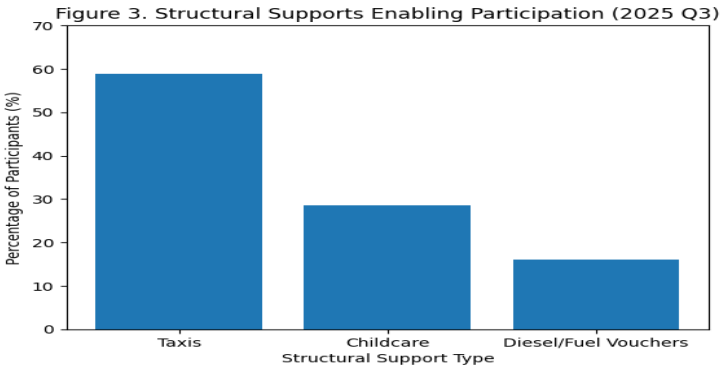

Figure 3. Structural Supports Enabling Participation (2025 Q3)

Bar chart showing taxis, childcare, and fuel vouchers.

Mental Health Outcomes: Regulation, Connection, and Hope

Baseline data across all years indicate extremely high prevalence of anxiety (70–83%), depression (54–71%), PTSD (39–49%), and suicidal ideation (26–39%), underscoring the severity of need among participants. Despite this, participants reported substantial improvements in felt safety, hope, social connection, and self-efficacy following programme involvement. In 2025 Q3:

- **71.4% felt less alone**
- **67.9% felt more confident reaching out for support**
- **64.3% reported increased social engagement**
- **57.1% reported renewed hope**

"It has saved my life. I didn't want to live anymore. Now I have hope and I know I can say when I'm not okay without being judged." (Participant, 2024)

Table 2. Self-Reported Psychosocial Outcomes Since Programme Participation (2025 Q3)

Outcome	% Reporting Yes
Feel less alone	71.43
More confidence to seek support	67.86
Increased social engagement	64.29
Improved self-care	55.36
Renewed hope	57.14

This table summarises participant-reported psychosocial outcomes following engagement with the programme, including reduced isolation, increased confidence, improved social engagement, and renewed hope. Outcomes reflect the TIBR design's emphasis on relational safety, agency, and voluntary engagement rather than symptom reduction, behavioural compliance, or clinical assessment metrics.

Physical Health and Embodied Recovery

Participants consistently reported improvements in mobility, sleep, pain management, and confidence in movement, particularly through yoga, aqua aerobics, fitness groups, and equine therapy. Women described physical activity not as fitness pursuit but as regulation, reconnection, and relief from trauma-related hyperarousal:

"Even on a bad day I know there's a ray of sunshine if I have a class. My breathing is calm. I can manage stress now." (Participant, 2024)

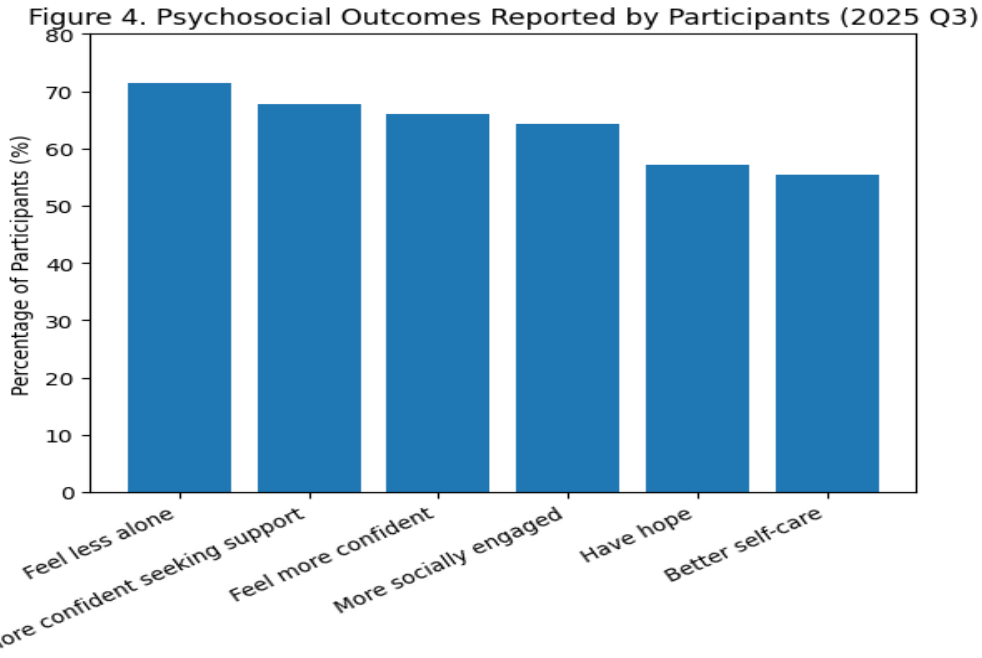

Figure 4. Psychosocial Outcomes Reported by Participants (2025 Q3)

This figure presents the proportion of participants reporting key psychosocial outcomes since engaging with the programme, including reduced isolation, increased confidence, improved social engagement, renewed hope, and enhanced self-care.

Skill Development, Agency, and Future Orientation

Across 2024–2025, engagement in confidence workshops (73%), education supports, and employment readiness activities increased, though uptake remained voluntary and self-paced.

Participants frequently articulated not being "ready yet" as a legitimate state, with programme staff maintaining relational continuity rather than pressure.

"I'm not ready yet — but now I know I will be." (Participant, 2025)

Relational Safety and Social Validity

Perceived safety and respect remained consistently high across all waves, with mean scores above 4.6/5 for safety, being heard, and overall satisfaction in 2025. Participants repeatedly contrasted the programme with clinical or statutory services:

"Not being across the table from someone in a white coat judging you — this feels safe." (Participant, 2024)

DISCUSSION

Engagement Reframed: From Compliance to Safety

Traditional service models often interpret engagement through behavioural compliance, attendance metrics, or treatment adherence. A central contribution of the Trauma-Informed Behavioural Recovery (TIBR) design is its reframing of engagement as a function of perceived safety rather than motivation, readiness, or compliance. For women subjected to coercive control—characterised by surveillance, monitoring, punishment, and conditional access to resources—such frameworks risk replicating the very dynamics they are intended to address.

Findings from this study challenge these assumptions. Women engaged when they knew they could disengage without consequence and return without explanation. This reframing aligns with feminist analyses of coercive control, which emphasise that autonomy is constrained not by individual deficits but by relational and structural conditions.

By removing attendance mandates, progress monitoring, and disclosure requirements, the programme disrupted dominant power hierarchies embedded in many support systems. Behaviourally, this reduced aversive control and increased response persistence; politically, it restored choice in a context where choice had long been undermined.

The findings suggest that the TIBR design reshapes engagement contingencies by removing punitive consequences for absence and reinforcing voluntary re-engagement, a mechanism that is particularly salient for women whose lives have been shaped by coercive control.

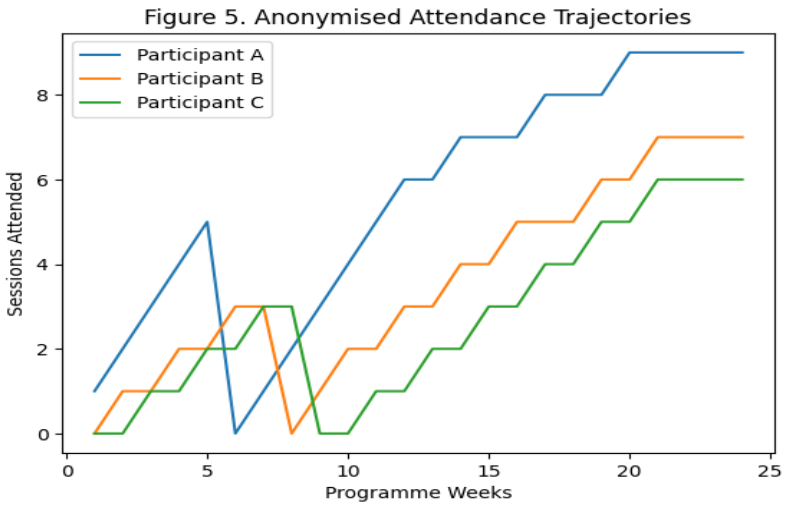

Figure 5. Anonymised attendance trajectories within the Trauma-Informed Behavioural Recovery (TIBR) design.

This figure illustrates longitudinal patterns of programme attendance for three anonymised participants over a 24-week period. Attendance trajectories are non-linear, with periods of disengagement followed by voluntary re-engagement, reflecting the TIBR design's emphasis on safety, choice, and non-punitive re-entry rather than continuous participation or compliance. Variability in attendance is interpreted as a contextually meaningful response to changing safety, health, caregiving, and legal demands, rather than as attrition or treatment failure. The figure demonstrates how sustained engagement within the TIBR design is supported over time without mandate, surveillance, or attendance-based conditionality.

Scope, Transferability, and the Value of a Single-Programme Case Study

A potential limitation of this study is its focus on a single community-based programme. However, within the context of model development and ethical intervention research with women survivors of domestic violence, this focus is both methodologically appropriate and conceptually necessary. The purpose of this research was not to evaluate programme effectiveness through comparison or replication, but to develop and empirically examine the Trauma-Informed Behavioural Recovery (TIBR) design as an integrated, ethically grounded model of practice.

Case study methodology is widely recognised as a rigorous approach for theorising complex social interventions where outcomes are contingent upon context, relationships, and structural conditions. In this study, the depth of engagement within a single programme enabled detailed examination of how trauma-informed, behavioural, and feminist principles were enacted in practice, how women experienced these conditions over time, and how engagement trajectories unfolded under non-coercive service arrangements. Such analytic depth would not have been possible through multi-site comparison without significantly compromising relational continuity, ethical integrity, or methodological coherence.

Importantly, the TIBR design is not synonymous with the 4Empowerment Donegal programme in which it was examined. Rather, the programme functions as a situated instantiation of the TIBR design, allowing for close observation of the model's mechanisms, ethical contingencies, and practical implications. The design itself is defined by transferable principles—such as safety as a precondition for engagement, structural accommodation, non-punitive re-entry, embodied practice, and resistance to surveillance—that can be adapted across diverse settings, populations, and delivery formats.

From a trauma-informed and feminist perspective, prioritising breadth over depth risks reproducing extractive research practices that privilege generalisability over survivor safety and relational trust. The single-programme focus of this study enabled sustained, ethically grounded engagement with participants over time, aligning the research process itself with the values embedded within the TIBR design. This methodological fidelity strengthens, rather than weakens, the study's contribution.

Finally, the longitudinal patterns observed across two years of data—including sustained voluntary engagement, non-linear participation trajectories, and consistent psychosocial outcomes—provide robust evidence that the TIBR design operates as intended within real-world constraints. While future research should examine the application of the TIBR design in additional contexts, populations, and service systems, the present study establishes a necessary foundation by demonstrating how the model functions in practice before replication or adaptation is pursued.

Physical Activity as Feminist and Trauma-Informed Practice

Within the TIBR design, physical activity functions as the primary embodied mechanism through which behavioural, relational, and trauma-informed processes are enacted. Physical activity functioned as a central vehicle for intervention, not as lifestyle enhancement but as an embodied, relational mechanism of change. For many participants, movement provided an entry point that felt safer than talk-based or diagnostic services—particularly given histories of bodily violation and control.

Feminist trauma theory has long argued that trauma is embodied and that recovery cannot rely solely on cognitive or narrative processing. The findings extend feminist trauma scholarship by demonstrating how embodied physical activity within the TIBR design can support regulation, agency, and social reconnection without requiring trauma narration, diagnostic framing, or therapeutic performance. Participants' accounts support this position. Physical activity enabled regulation, routine, and reconnection without demanding emotional exposure or narrative coherence. In doing so, it resisted the extraction of trauma narratives as proof of deservingness or readiness.

From a behavioural perspective, physical activity served as behavioural activation—systematically increasing access to reinforcing experiences. Critically, this occurred within conditions of consent and choice, ensuring that behavioural mechanisms operated ethically rather than coercively.

Non-Linear Recovery and Resistance to Pathologisation

Participants' recovery trajectories were marked by fluctuation, relapse, and re-engagement. Rather than framing these patterns as failure, the programme treated them as expected responses to ongoing coercive, legal, and economic pressures. The Trauma-Informed Behavioural Recovery (TIBR) design explicitly rejects linear models of recovery, a position strongly supported by the non-linear engagement trajectories observed in this study.

This stands in contrast to dominant service narratives that moralise relapse and disengagement—particularly for women navigating substance use alongside domestic violence.

The findings demonstrate that when services refuse to punish instability, women are more likely to re-engage sooner and with less shame. Behaviourally, this reflects reinforcement of re-engagement rather than extinction following absence; politically, it resists gendered narratives of failure. By treating relapse, withdrawal, and re-engagement as expected responses to ongoing coercive, legal, and economic pressures, the TIBR design resists pathologising survival strategies that are often moralised within domestic violence and substance use services.

Structural Accommodation as Anti-Coercive Practice

Structural accommodation emerged as a defining mechanism of the TIBR design**,** rather than an ancillary or supportive feature. Participants were explicit that practical supports—transport, flexibility, reduced participation demands—were not ancillary but essential. Importantly, women did not interpret these accommodations as charity. Instead, they experienced them as recognition of structural realities.

This finding is critical in the context of feminist critiques of service provision, which have long highlighted how systems reproduce inequality by ignoring material constraints. By embedding structural accommodation into programme design, the intervention redistributed responsibility away from individual women and toward

institutional accountability. From a behavioural lens, these adaptations functioned as antecedent modifications that reduced response effort. From a feminist lens, they constituted anti-coercive practice.

Within the TIBR design, practical supports such as transport, flexible attendance, and reduced participation demands functioned both behaviourally—by reducing response effort—and politically, by redistributing responsibility from individual women to service design.

Behavioural Science Without Behavioural Control

A key contribution of this study is its articulation of the Trauma-Informed Behavioural Recovery (TIBR) design as a model of behavioural intervention without behavioural control. Within this intervention, behavioural principles such as reinforcement, activation, and environmental shaping were effective precisely because they were embedded within a trauma-informed, feminist framework.

Participants' repeated emphasis on dignity- "*being treated like a person, not a problem*"—underscores this point. Behaviour change was not experienced as manipulation but as possibility.

This challenges critiques that position behavioural approaches as incompatible with trauma-informed or feminist practice. Instead, the findings suggest that ethical behavioural intervention requires not less structure, but different structure—one that foregrounds consent, relational safety, and survivor-defined outcomes. The findings further demonstrate that applied behaviour analysis is not inherently coercive, but becomes ethically viable within the TIBR design because behavioural mechanisms are subordinated to survivor-defined values, choice, and relational safety.

Contribution to Violence Against Women Scholarship

This study contributes to violence against women scholarship through the development and empirical examination of the Trauma-Informed Behavioural Recovery (TIBR) design.

1. **Empirical evidence** that the TIBR design supports engagement without coercion
2. **Conceptual reframing** of recovery consistent with the TIBR design
3. **Practice-relevant insights** into non-clinical mechanisms within the TIBR design

By centering survivor voice and resisting deficit-based interpretation, this research advances an intervention model that aligns with feminist commitments to autonomy, dignity, and structural accountability.

Implications

The findings have significant implications for policy and practice arising directly from the Trauma-Informed Behavioural Recovery (TIBR) design. Taken together, the findings demonstrate that behaviourally informed interventions can support meaningful recovery for women survivors of domestic violence when delivered within trauma-informed, feminist systems that explicitly resist coercion. The final section synthesises these insights into a coherent intervention model and considers implications for policy, practice, and future research.

Implications for Policy and Practice

The findings of this study have significant implications for domestic violence policy, trauma-informed service provision, and the ethical application of behavioural science within community-based interventions. Taken together, the results challenge dominant service models that prioritise compliance, linear engagement, and disclosure-based assessment, and instead support policy and practice frameworks that recognise recovery from coercive control as non-linear, relational, and structurally constrained.

Policy Implications

At a policy level, the findings underscore the need to move beyond incident-based and symptom-focused models of domestic violence intervention. Survivors' engagement trajectories in this study were shaped not by motivation or readiness in isolation, but by the presence—or absence—of safety, autonomy, material support, and freedom from punitive consequences. This aligns with feminist analyses of coercive control, which conceptualise abuse as an ongoing pattern of domination that erodes liberty, agency, and access to resources rather than a series of discrete violent events.

Policy frameworks that condition service access on attendance thresholds, disclosure requirements, abstinence, or behavioural compliance risk replicating the very dynamics of surveillance, control, and punishment that characterise abusive relationships. The findings support policies that explicitly prohibit coercive engagement practices within domestic violence and mental health services and instead mandate trauma-informed standards that protect choice, pacing, and voluntary participation.

In particular, funding and commissioning structures should recognise engagement, re-engagement, and relational safety as legitimate outcomes in their own right. Current performance indicators that prioritise throughput, session completion, or short-term symptom reduction are poorly aligned with the realities of recovery following coercive control. Policy reform is therefore required to support longer-term, flexible, community-based interventions that can accommodate fluctuating participation without penalising survivors or services.

Practice Implications for Domestic Violence Services

For frontline practice, the findings demonstrate that trauma-informed care is not simply a set of values but an active intervention mechanism. Participants consistently identified non-punitive re-entry, absence of surveillance, and respect for autonomy as central to their ability to remain connected to the programme. These conditions enabled survivors to re-engage following relapse, crisis, or withdrawal without fear of judgement or exclusion.

Practitioners working with survivors of domestic violence should therefore conceptualise disengagement not as resistance or failure, but as an adaptive response to ongoing trauma, competing demands, and environmental stressors. Practice models that allow survivors to "come and go" safely—without explanation or sanction—may paradoxically increase long-term engagement and trust.

The study also highlights the value of non-clinical, non-disclosure-based entry points to support. Physical activity functioned as an embodied, relational vehicle through which safety, routine, and connection were established without requiring survivors to narrate trauma or perform recovery. This has important implications for practice, particularly for survivors who are ambivalent about formal therapy or who have been harmed by previous service encounters.

Implications for Behavioural and Trauma-Informed Practice

From a behavioural science perspective, the findings challenge the mischaracterisation of applied behaviour analysis as inherently coercive or incompatible with trauma-informed care. When stripped of punitive contingencies and embedded within feminist, trauma-informed principles, behavioural concepts such as reinforcement, behavioural activation, and antecedent modification supported engagement, flexibility, and recovery rather than compliance.

This suggests that ethical behavioural practice with trauma-exposed populations requires a fundamental shift away from control-based intervention models toward those that prioritise choice, transparency, and participant-defined goals. Behavioural interventions should be evaluated not only on their capacity to change observable behaviour, but on whether they enhance agency, reduce fear, and expand access to reinforcing life opportunities.

For practitioners integrating behavioural approaches within domestic violence contexts, the study emphasises the importance of attending to power dynamics, historical trauma, and structural barriers. Behaviour does not occur in a vacuum; it is shaped by coercive social conditions, gendered violence, and systemic inequities. Ignoring these realities risks individualising harm and misattributing survival strategies as pathology.

Implications for Interagency and Community-Based Service Design

The interagency, community-based structure of the 4Empowerment Donegal programme offers a model for service design that counters fragmentation and siloed provision. Collaboration between domestic violence services, community development organisations, and physical activity providers enabled a holistic response to survivors' needs without requiring them to navigate multiple systems independently.

This has particular relevance for rural contexts, where geographic isolation, transport barriers, and service scarcity compound the impacts of domestic violence. Policy and practice must therefore prioritise place-based, relational interventions that bring services to survivors rather than requiring survivors to adapt to rigid systems.

Structural supports—such as transport, childcare consideration, and flexible scheduling—should be recognised as core components of trauma-informed intervention rather than ancillary "add-ons." From both feminist and behavioural perspectives, these supports function as mechanisms of liberation, reducing environmental constraints and enabling meaningful choice.

Taken together, the findings position the Trauma-Informed Behavioural Recovery (TIBR) design as a viable, ethical, and transferable model for supporting recovery among women survivors of domestic violence.

To encapsulate the framework, Table 3 maps the six trauma-informed principles articulated by SAMHSA against the operational practices of the 4Empowerment programme, illustrating how these principles are enacted in practice through the Trauma-Informed Behavioural Recovery (TIBR) design rather than applied as aspirational values.

Table 3. Mapping of SAMHSA Trauma-Informed Principles to 4Empowerment Practices Within the Trauma-Informed Behavioural Recovery (TIBR) Design

SAMHSA Trauma-Informed Principle	Definition (SAMHSA)	Operationalisation in 4Empowerment	Function Within the TIBR Design
Safety	Physical and psychological safety are prioritised	Non-clinical, community-based settings; absence of surveillance, disclosure requirements, or behavioural monitoring; consistent facilitator presence	Establishes safety as the primary antecedent for engagement, reducing avoidance and fear responses associated with coercive control
Trustworthiness & Transparency	Decisions are transparent and consistently applied	Clear communication that participation is voluntary; no penalties for absence; explicit reassurance that services are not contingent on attendance or disclosure	Removes aversive contingencies and restores predictability, supporting voluntary persistence over time
Peer Support	Mutual self-help and shared experience are central	Group-based activities emphasising shared participation rather than shared disclosure; informal peer connection through embodied	Reinforces relational connection without requiring trauma narration; increases naturally occurring

		activities	reinforcement
Collaboration & Mutuality	Power differences are minimised; healing happens in relationships	Facilitators positioned as companions rather than experts; participant feedback actively shapes activities and scheduling	Redistributes power within behavioural processes, preventing compliance-based dynamics
Empowerment, Voice & Choice	Individuals' strengths and agency are prioritised	Self-directed participation; choice over activities, pacing, and level of engagement; non-punitive re-entry after disengagement	Positions agency as the mechanism of change rather than readiness, motivation, or performance
Cultural, Historical & Gender Sensitivity	Trauma is understood in social, cultural, and gendered contexts	Feminist framing of domestic violence as coercive control; responsiveness to rural isolation, migration status, poverty, and caregiving roles	Ensures behavioural strategies are contextually embedded and ethically constrained

This mapping demonstrates that the Trauma-Informed Behavioural Recovery (TIBR) design not only aligns with established trauma-informed principles, but extends them by specifying how such principles operate behaviourally and ethically within non-coercive, community-based interventions for women survivors of domestic violence.

While SAMHSA's trauma-informed principles provide an essential ethical framework, they do not in themselves specify *how* services should be designed to produce safety, engagement, and recovery in practice. Without explicit operationalisation, trauma-informed care risks remaining aspirational, inconsistently applied, or co-opted into compliance-based systems that reproduce surveillance and conditionality. The Trauma-Informed Behavioural Recovery (TIBR) design addresses this gap by translating trauma-informed principles into concrete behavioural and structural mechanisms—such as antecedent modification, voluntary engagement, non-punitive re-entry, and embodied practice—that actively shape participant experience. In this way, TIBR does not replace SAMHSA's framework but extends it, offering a coherent model for enacting trauma-informed principles ethically and consistently within community-based interventions for women survivors of domestic violence.

CONCLUSION

This study set out to examine whether behaviourally informed interventions could support recovery for women survivors of domestic violence without reproducing the coercive dynamics that so often characterise both abusive relationships and the systems designed to respond to them. Through a qualitative case study of a community-based intervention in rural Ireland, the findings demonstrate that such an approach is not only possible, but ethically and practically viable when behavioural mechanisms are embedded within feminist, trauma-informed conditions of care. In doing so, this research advances the Trauma-Informed Behavioural Recovery (TIBR) design as an integrative, non-coercive model for supporting recovery from coercive control.

Across the study, engagement was sustained not through mandate, surveillance, or behavioural compliance, but through safety, choice, and structural accommodation—core components of the TIBR design. Women engaged when they were able to disengage without punishment and return without scrutiny, directly challenging dominant service models that equate recovery with consistency, disclosure, or linear progress. Physical activity functioned as a central embodied mechanism within the TIBR design, supporting regulation, agency, and social reconnection without requiring trauma narration, diagnostic framing, or therapeutic performance. Recovery trajectories were non-linear and relational, shaped by ongoing coercive, legal, and material constraints, underscoring the inadequacy of intervention frameworks that individualise instability or pathologise survival strategies.

The central contribution of this study lies in its demonstration that behavioural science is not inherently incompatible with trauma-informed or feminist practice. Rather, the ethical viability of behavioural intervention depends entirely on the conditions under which it is applied. Within the TIBR design, behavioural mechanisms such as reinforcement, behavioural activation, and environmental modification supported engagement and recovery precisely because they were subordinated to survivor-defined values, relational safety, and freedom from coercion. Trauma-informed care, in this model, is not a rhetorical overlay but an active intervention mechanism that reshapes contingencies, redistributes power, and restores choice. Structural accommodations—such as flexible participation, transport provision, and non-punitive re-entry—are shown to be both behaviourally consequential and politically significant, operating as mechanisms of equity rather than ancillary supports.

By reframing engagement and recovery as functions of safety and autonomy rather than motivation or readiness, the TIBR design challenges dominant assumptions underpinning domestic violence intervention, policy, and funding frameworks. Compliance-driven metrics, disclosure-based assessment, and performance-oriented service models risk replicating dynamics of surveillance and control that mirror coercive abuse itself. The findings of this study call for a reorientation of domestic violence services away from monitoring and symptom correction and toward models that prioritise relational continuity, embodied agency, and sustained access to reinforcing life contexts.

Ultimately, this research argues that recovery from coercive control is not achieved by fixing women, but by transforming the environments in which they are asked to survive and heal. The Trauma-Informed Behavioural Recovery (TIBR) design offers a coherent, transferable model for doing so—one that demonstrates how behavioural science can be mobilised in the service of choice rather than control, and how trauma-informed care can be enacted as structural practice rather than aspirational language. In a field where women's autonomy has too often been compromised in the name of support, the TIBR design provides a pathway toward ethical, non-coercive, and durable recovery-oriented practice.

Ethical Statement

This study was conducted in accordance with institutional research ethics approval and in compliance with national and international guidelines for research involving human participants. Ethical approval was obtained from the relevant institutional research ethics committee prior to data collection. Given the study's focus on women survivors of domestic violence, ethical design prioritised safety, autonomy, and the avoidance of practices that could replicate coercive control or retraumatisation.

Women were not required to disclose experiences of abuse, provide trauma narratives, or demonstrate engagement or progress in order to access support or to be included in the study. Informed consent procedures emphasised choice, transparency, and the right to withdraw from participation at any point without consequence or impact on service access.

Data were drawn exclusively from non-clinical, programme-generated materials, including anonymised participant feedback, engagement records, and practitioner reflections. No clinical files, diagnostic assessments, or therapeutic records were accessed. This approach was adopted to minimise risk, reduce surveillance, and uphold feminist commitments to dignity, privacy, and epistemic justice. All data were anonymised prior to analysis, securely stored, and handled in accordance with data protection regulations.

Safeguarding procedures were implemented in line with national domestic violence and child protection guidelines. Importantly, safeguarding was conceptualised not solely as risk management but as the creation of conditions that reduce fear, enhance safety, and support participant autonomy. The researcher's dual role as programme developer and practitioner was addressed through reflexive practice, transparent documentation of analytic decisions, and prioritisation of participant voice over interpretive authority.

Data Availability Statement

The data supporting the findings of this study are not publicly available due to ethical and safety considerations. The dataset contains sensitive information related to women survivors of domestic violence, and public sharing could pose risks to participant privacy, safety, and confidentiality. In keeping with trauma-informed and feminist ethical principles, as well as the conditions of ethical approval, the data were restricted to prevent potential identification, surveillance, or misuse. De-identified or aggregated data may be made available upon reasonable request to the corresponding author, subject to ethical review and approval.

REFERENCES

1. Baer, D. M., Wolf, M. M., & Risley, T. R. (1968). Some current dimensions of applied behavior analysis. Journal of Applied Behavior Analysis, 1(1), 91–97. https://doi.org/10.1901/jaba.1968.1-91
2. Best, D., & Hennessy, E. A. (2021). The science of recovery capital: Where do we go from here? Addiction, 116(6), 1139–1145. https://doi.org/10.1111/add.15349
3. Budney, A. J., Higgins, S. T., Radonovich, K. J., & Novy, P. L. (2001). Adding voucher-based incentives to coping skills and motivational enhancement improves outcomes during treatment for marijuana dependence. Journal of Consulting and Clinical Psychology, 69(6), 1051–1061. https://doi.org/10.1037/0022-006X.69.6.1051
4. Carlisle, S., Bunce, A., Prina, M., McManus, S., Barbosa, E., Feder, G., & Lewis, N. V. (2025). Effectiveness of UK-based support interventions and services aimed at adults who have experienced or used domestic and sexual violence and abuse: A systematic review and meta-analysis. BMC Public Health, 25, Article 1003. https://doi.org/10.1186/s12889-025-1003
5. Cooper, J. O., Heron, T. E., & Heward, W. L. (2007). Applied behavior analysis (2nd ed.). Pearson.
6. Devries, K. M., Mak, J. Y. T., Baccus, L. J., Child, J. C., Falder, G., Petzold, M., & Watts, C. (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
7. Ekers, D., Webster, L., Van Straten, A., Cuijpers, P., Richards, D., & Gilbody, S. (2014). Behavioural activation for depression: An update of meta-analysis of effectiveness and subgroup analysis. PLoS ONE, 9(6), e100100. https://doi.org/10.1371/journal.pone.0100100
8. Epstein, D. H., Hawkins, W. E., Covi, L., Umbricht, A., & Preston, K. L. (2003). Cognitive-behavioral therapy plus contingency management for cocaine use: Findings during treatment and across 12-month follow-up. Psychology of Addictive Behaviors, 17(1), 73–82. https://doi.org/10.1037/0893-164X.17.1.73
9. Ferster, C. B. (1973). A functional analysis of depression. American Psychologist, 28(10), 857–870. https://doi.org/10.1037/h0035605
10. Friman, P. C., Hayes, S. C., & Wilson, K. G. (1998). Why behavior analysts should study emotion: The example of anxiety. Journal of Applied Behavior Analysis, 31(1), 137–156. https://doi.org/10.1901/jaba.1998.31-137
11. Gallagher, J. (2026). ABA outside the spectrum: A systematic literature review. International Journal of Science and Research Archive, 18(1), 150–161. https://doi.org/10.30574/ijsra.2026.18.1.0017
12. Gentsch, A., & Kuehn, E. (2022). Clinical manifestations of body memories: The impact of past bodily experiences on mental health. Brain Sciences, 12(5), 594. https://doi.org/10.3390/brainsci12050594
13. Harris, M., & Fallot, R. D. (2001). Using trauma theory to design service systems. Jossey-Bass.
14. Harvey, M. T., Luiselli, J. K., & Wong, S. E. (2009). Application of applied behavior analysis to mental health issues. Psychological Services, 6(3), 212–222. https://doi.org/10.1037/a0015782
15. Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). Acceptance and commitment therapy: An experiential approach to behavior change. Guilford Press.
16. Hayes, S. C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. Annual Review of Clinical Psychology, 7, 141–168. https://doi.org/10.1146/annurev-clinpsy-032210-104449

17. Huys, Q. J. M., Russeck, E. M., Abitante, G., Kahnt, T., & Gollan, J. K. (2022). Components of behavioral activation therapy for depression engage specific reinforcement learning mechanisms. Computational Psychiatry, 6(1), 238–255. https://doi.org/10.5334/cpsy.81
18. Iguchi, M. Y., Lamb, R. J., Belding, M. A., Platt, J. J., Husband, S. D., & Morral, A. R. (1996). Contingent reinforcement of group participation versus abstinence in a methadone maintenance program. Experimental and Clinical Psychopharmacology, 4(3), 315–321. https://doi.org/10.1037/1064-1297.4.3.315
19. Ingvarsson, E. T., Hanley, G. P., & Welter, K. M. (2009). Treatment of escape-maintained behavior with positive reinforcement: The role of reinforcement contingency and density. Education and Treatment of Children, 32(3), 371–401.
20. Kearney, B., & Lanius, R. (2022). The brain–body disconnect: A somatic sensory basis for trauma-related disorders. Frontiers in Neuroscience, 16, 950880. https://doi.org/10.3389/fnins.2022.950880
21. Kelly, L. (2003). The wrong debate: Reflections on why force is not the key issue with respect to trafficking in women for sexual exploitation. Feminist Review, 73(1), 139–144.
22. Letourneau, N., McManus, C., Novick, J., & Silverstone, A. (2024). Impacts of peer support on coping and cortisol levels for women affected by domestic violence and coercive control. Canadian Journal of Nursing Research, 56(4), 457–467.
23. Lohmann, S., Cowlishaw, S., Ney, L., O'Donnell, M., & Felmingham, K. (2023). The trauma and mental health impacts of coercive control: A systematic review and meta-analysis. Trauma, Violence, & Abuse, 25(1), 630–647. https://doi.org/10.1177/15248380221123456
24. Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. PLoS Medicine, 6(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097
25. Petry, N. M., Martin, B., Cooney, J. L., & Kranzler, H. R. (2000). Give them prizes, and they will come: Contingency management for treatment of alcohol dependence. Journal of Consulting and Clinical Psychology, 68(2), 250–257. https://doi.org/10.1037/0022-006X.68.2.250
26. Reid, N., Kron, A., Rajakulendran, T., Kahan, D., Noble, A., & Stergiopoulos, V. (2020). Promoting wellness and recovery of young women experiencing gender-based violence and homelessness. Violence Against Women, 26(3–4), 345–368. https://doi.org/10.1177/1077801219836731
27. Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., & Feder, G. (2016). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. Cochrane Database of Systematic Reviews, 2016(12), CD005043. https://doi.org/10.1002/14651858.CD005043.pub3
28. Skinner, B. F. (1963). Operant behavior. American Psychologist, 18(8), 503–515. https://doi.org/10.1037/h0045185
29. Stark, E. (2007). Coercive control: The entrapment of women in personal life. Oxford University Press.
30. Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.
31. Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. Journal of Applied Behavior Analysis, 11(2), 203–214. https://doi.org/10.1901/jaba.1978.11-203