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TRAUMA, GENDER AND SPACE

Insights from Bangladesh, Malaysia and the UK

Rachel Pain, Nahid Rezwana and Zuriatunfadzliah Sahdan

Introduction

In recent years, trauma has escalated as an issue for public and scholarly attention. It is evident throughout history and across space that how we understand it is shaped by the cultural and political contexts in which trauma, and we, are located. As a psychiatric disorder, it was formally identified in the 1980s as ‘the response to an unexpected or overwhelming violent event or events that are not fully grasped as they occur, but return later in repeated flashbacks, nightmares, and other repetitive phenomena’ (Caruth 1996, 91). As we show in this chapter, trauma is also understood as a social and spatial condition with broader causes and consequences.

While single-instance events (such as car accidents) may lead to debilitating symptoms of post-traumatic stress disorder (PTSD), theorizing trauma beyond an individual ailment is central to feminist understandings. Trauma may manifest as a collective condition that affects communities, social groups and even whole societies (Schwab 2010). This recognizes the scale and reach of the after-effects of violence, which are repeated over a longer timeframe and are open to structural analysis: systemic violence relating to uneven distributions of power, such as slavery or racism. Our focus in this chapter is gender-based violence (GBV), ‘violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships’ (Bloom 2008, 14), an especially common cause of trauma. We examine some of its various forms in Bangladesh, Malaysia and the UK. While men and boys can be its targets, it is most common against women and girls, and our discussion reflects this.

Feminist researchers and activists have played an important role in challenging medical and popular understandings of trauma. GBV is marked by its ‘everywhereness’ and paradoxical invisibility (Pain 2014). In the late-twentieth century, feminists questioned which traumas are taken seriously, given that survivors of war and GBV experience similar rates of PTSD (Herman 1997). Before then, the history of trauma from GBV is harder to locate, and social status and geographical location still profoundly influence whose traumas are recognized and responded to. The psychiatrist Judith Herman (1997) played a key role in identifying ‘chronic’ trauma arising from entrapment and repeat victimization. Intersectional analyses view trauma as folded into inequalities of gender, sexuality, race, class and colonial oppression, producing uneven
experiences; and we try to illuminate these differences across and within the three case studies that we refer to in this chapter. There is also irregularity in who gets to narrate trauma, reflected in debates over its history, meaning and treatment. Trauma, then, is not a fixed or objective medical state but culturally constructed and enmeshed in social politics (Nguyen 2011; Tamas 2011).

In particular, Western perspectives on trauma have had a disproportionate influence on theories of causation and treatment. Post-colonial and Indigenous analysts argue that this dominant Western trauma paradigm, heavily influenced by Freud, tends to reflect single-event trauma and privileges the suffering of White Europeans (Fassin and Rechtman 2009). This paradigm depoliticizes and dehistoricizes others’ trauma (Visser 2015), especially connected to historical colonial violence and its contemporary traces. Fanon (1963) famously observed that the causes of psychological trauma in soldiers and civilians during the French/Algerian war were far deeper than conventional psychiatry could address, and Brave Heart (2000) identified historical trauma among Indigenous Native Americans as the direct result of colonization and racism. For Black feminist bell hooks (2003), slavery and racism underpin contemporary trauma for African–Americans, and contemporary re-enactments retraumatize the population. There is deep suspicion among some communities that medical science can provide resolution, given its historical role in oppression: ‘until the legacy of remembered and re-enacted trauma is taken seriously, black America cannot heal’ (hooks 2003, 24). The diagnosis of PTSD, so widespread in the West, is sometimes little known in the regions where traumatic events are most frequent.Yet the many traditional methods of healing and rebuilding were disrupted by colonialism, globalization and the export of Western medical practices, and there are now movements to reconnect and establish them. We return to the issue of recovery at the end of the chapter.

Our first aim in this chapter is to highlight these structural roots of trauma. Our second aim is to signal the importance of trauma’s geographies. As an immediate experience, trauma is inherently geographical, involving spatial and temporal psychological dislocation and triggered by aspects of place or particular sites where memory, pain or ongoing violence linger. Place thus becomes hardwired in trauma, and trauma can become hardwired in place, affecting the possibilities for recovery. For example, and as feminist geographers have long argued, the home may become a traumatic space when violence is experienced there, holding negative memories. Trauma is also present across scales, as our discussion above of collective trauma shows, and produces scales. And trauma is mobile and multidirectional, as Pratt et al. (2015) describe in trauma narratives that travel between places with specific historical politics. As Coddington and Micieli-Voutsinas (2017, 52) put it, ‘trauma has a productively complex relationship to space … it is both rooted in place, yet defies geospatial logics’.

In the rest of the chapter, we discuss trauma arising from a number of forms of GBV in Bangladesh, Malaysia and the UK. In each context, trauma is privately and publicly recognized, contested, treated and reinforced to varying degrees. Our intention is to show something of the situated everyday experiences of trauma, the combined significance of trauma’s effects and the importance of spatial setting in offering or closing down possibilities for survivors’ empowerment and recovery.

**Chronic trauma: multiple forms of gender-based violence in Bangladesh**

Gender-based violence is a major social problem in Bangladesh. Domestic violence, rape, sexual abuse and verbal public sexual harassment are common forms, and early/forced marriage and wife abandonment take place at alarming rates. Many women are subject to multiple forms of GBV. In 2016, the country was in fifth position for the rate of child marriage (UNICEF 2016a); 66 per cent of girls are married before the age of 18 (UNICEF 2016b), and Bangladesh has the
highest rate of child marriage for girls below 15 years (UNCF 2014). This usually ends female education and increases economic dependency. A high number of Bangladeshi women experience domestic violence. According to a Government report in 2016, 72.6 per cent of married women are abused at least once in their lifetime, including physical, sexual, economic and emotional abuse as well as controlling behaviour. Around 41.7 per cent of those experiencing physical or sexual violence suffer injuries (BBS 2016), but most face psychological impacts that are not usually recorded.

Recent qualitative research on GBV was undertaken in the coastal region of Barguna, a remote, cyclone-prone coastal district of Bangladesh. Four group discussions, 45 individual interviews and observations were conducted to identify and explore GBV with female and male key informants and survivors.

The research revealed very common signs of psychological trauma (Rezwana and Pain 2018); feelings of intense fear, deep sadness, helplessness, loss of control, hyperarousal and intrusion. One survivor describes her experience:

My body … my blood might have become black … I was beaten so many times after I have been married to him. Everyone beats me, my husband, my mother-in-law, father-in-law and even sister-in-laws. I cannot show all the bruises, there are many more … I was working with the sticks, she (mother-in-law) took them and poked me … I could not get any treatment. It was so painful … I wanted to die … I cannot go back to my parents.

The reasons for domestic abuse vary from disagreements over dowry payments and poverty to extra-marital relationships, extra marriages and keeping discipline in the family in the name of tradition. Violence, however, has profound psychological impacts. According to Pain (2014), domestic abuse can be considered a form of everyday terrorism, creating long-lasting fear and chronic trauma that reinforce the perpetrator’s control over the abused person. Survivors in this study were in constant fear that their husband would become violent, which intensifies trauma symptoms. They abided by all their husbands’ rules and orders in order to keep them calm in an effort to avoid violence: ‘I do whatever he says, never disobey him now … he is like my master’; ‘I never want anything from him to buy, I do it myself, I want him to be calm’. Being beaten in one’s own house not only creates immense fear but decreases self-confidence and changes self-perception.

Wife abandonment is another significant fear for these women. Being abandoned means losing the shelter, economic security and social status that come with living in their husband’s house. Abandoned married women are not welcomed back to their parents’ house due to cultural traditions, and this increases their social insecurity; they often become the target of local miscreants who may threaten or abuse them further. This woman describes her feelings of trauma and intrusion after her husband left her:

They roamed around outside my house at night, I could hear them whispering, they wanted to come near to the door … I called loudly … they went away … I could not sleep for many nights. It became a trauma for me. I left that house, which was near the bazaar. Now, I stay in my rural home. However, I cannot visit the bazaar now. I feel frightened.

In Barguna, survivors of GBV are trapped by overlapping layers of location (due to the remoteness of the region and poor level of service provision), socio-economic conditions, gender
identity and responsibilities, social attitudes, culture and traditions. Geographical location increases the vulnerability of women in Barguna to cyclones and GBV following disasters; domestic violence, forced marriage, rape, sexual assault and trafficking increase during and after each cyclone (Rezwana 2018; Rezwana and Pain 2018). Women are victimized in the name of traditions of early/forced marriage, family discipline, dowry and the priority given to sons, and their complaints are considered through the lens of these traditions. They are often advised to tolerate the violence due to social stigma and fear of the perpetrator, to avoid the further embarrassment of abandonment or divorce and to maintain tradition and social status (‘Bangladesh’ 2016; Hossain and Suman 2013).

All of these factors increase and intensify chronic trauma. Most harmful, as the respondents describe it, is being unable to express their feelings and share their experiences with anyone in a position of responsibility, such as law enforcement, doctors or psychologists, or religious or community leaders. This increases their vulnerability to mental health problems, as well as leaving the violence unreported (Hossain and Suman 2013). Some 72.7 per cent of women who have been abused in the home do not share their experiences and only 2.6 per cent seek legal support (‘Bangladesh’ 2016; BBS 2016). Family members are the first with whom GBV is shared and then, sometimes, local leaders are informed. Many women do not wish to report violence, as this can aggravate trauma. Social stigma, economic dependency and the lack of victim support facilities, healthcare centres and knowledge about government helplines are also key reasons for not seeking formal support. Thus, too many Barguna women are trapped within a cycle of GBV, trauma, economic dependency and lack of empowerment – four cornerstones that compound each other.

### Understandings of trauma: domestic abuse in Malaysia

In Malaysia, there is very little understanding of GBV or associated trauma. Furthermore, domestic violence, despite its major contribution to women’s mental and physical ill health, is understudied. Women become more vulnerable to violence if they marry without their family’s approval, enter into arranged marriages or are involved in deception (‘marriages’ set up for human trafficking). Their vulnerability is reinforced by the resulting social and spatial isolation from their families, homelessness and economic exploitation by their partner. Malaysian law does not recognize informal partnerships, including dating relationships and unmarried sexual relationships, and thus does not offer legal protection to those women.

A recent study with survivors of domestic violence in a women’s refuge in a large urban area in Malaysia (the location of which cannot be disclosed) has documented the significant effects of trauma (Sahdan 2018). The research with ten women involved interviews, storytelling, photovoice and the production of a mural. Violent events such as the one recalled by Rekha (below) have a long-term impact:

**Rekha:** When the clock hit 12, I was petrified. I went to my room, and kept quiet.
**Lieya:** You mean every day?
**Rekha:** Yes … I’m scared out of my wits.
**Lieya:** Did he drink every day at 12?
**Rekha:** Yes, at night. At 12 … Or one in the morning … Then, he would break into the room. Smashing it. When I see the clock reached 12 … there was a sound, ‘ting, ting, ting, ting’, I quickly ran into the house, went into the next room, locked myself up and 20 minutes later, he would show up.
Lieya: So he’d break into the room?
Rekha: Yes.
Lieya: Are you still living in fear?
Rekha: Yes, I can still sense it (shaking in fear). I can’t let it go, I won’t forget it till my death (sighing).

Trauma is compounded by the spatial settings of the abuse experienced, first at home and later in wider society. However, its relationship to public and private spaces depends on the cultural, ethnic and religious background of the perpetrator. Perpetrators negotiate and use the spaces in which the abuse occurs, and their power is expressed in different ways. The spatial dynamics of trauma centre on the politics of home or ‘private’ space in multicultural societies such as Malaysia. As Herman (1997, 74) argues, ‘a man’s home is his castle; rarely is it understood that the same home may be a prison for women and children’. This invisible prison, as other scholars have pointed out, involves stretching the practices and times of domination, before and after women leave the abusive relationship (Warrington 2001). It is multi-sited, beyond the limits of the visible space of the house and bounded by the physical and invisible barriers created by psychological, economic, social and legal subordination (Stark 2004). The home setting is therefore flexible but under the perpetrator’s intimate control, as is the woman’s psyche and the body it contains. Intimate settings may promote resistance as well as domination (Pain and Staeheli 2014), but every action or sign of resistance is countered with tactics by perpetrators. This prevents the abused women from fleeing, deepening the coercive relationship and rendering them prisoners. Being entrapped in this way results in post-traumatic stress symptoms such as contradictory thoughts, trauma-bonding, hyper-alertness, flashbacks and re-enactment (Herman 1997).

These symptoms of trauma are very close to societal beliefs about demonic possession. In many societies, there is a widespread cultural belief that spirits may inhabit the body. In Malaysia, this idea of demonic possession becomes part of the widespread culture that sustains domestic violence. Symptoms of trauma, and the cumulative effects on personality and identity of those experiencing long-term abuse, were identified as either the causes or consequences of demonic possession by many of the survivors and perpetrators in the research (Sahdan 2018) just as, in Western contexts, cultural beliefs about women’s roles and culpability for violence against them are often mobilized. The result is to divert attention from the structural explanations for violence that highlight societal gender inequality. Meanwhile, patriarchy and religious beliefs are used to justify abuse (in this study, Hinduism and Islam, but other religions are used in this way elsewhere), based on the perpetrators’ assumed position in traditional culture in Malaysia. Some are seen to use religion as a ploy to dominate their wife, on the grounds of solidifying the religion. As in many other contexts, the wife is pressured into believing that it is her fault that her husband becomes abusive, and those around her may reinforce this belief.

Yet, to the outside, perpetrators appear to be ‘normal husbands’, making it hard for women to seek help. The government and NGOs in Malaysia are engaged in combating violence against women, yet without any culturally specific understanding. Formal assistance is the only way out for abused women in some ethnic groups, but the police do not always treat domestic violence as a serious issue, siding with the perpetrators or assuming that it is a private family matter. Meanwhile, the abused women do not consider healthcare facilities as independent agencies that might intervene and help. Some women do not seek treatment because their condition is too critical, and they feel trapped and under the control of perpetrators. This is also the case
for women in the study who were pregnant, in confinement or suffering from other diseases such as cancer. Effective physical liberation, for many abused women, only comes when they are able to escape to a secret place not in the intimate knowledge of the perpetrator, such as an NGO-run refuge.

Refuges, however, are a short-term intervention, and resettlement services for domestic violence are not yet established in Malaysia. After the three-month period of protection at the shelter, women are expected to live independently. Because other formal interventions are less effective, the majority of women then face difficulties, often with no financial backup, safe shelter or reliable childcare. Many survivors come out of the shelter to return to perpetrators or to live in their family’s house, where the perpetrator finds them. They sometimes hand over their children to their perpetrators because they are unable to support them alone, or they lose custody battles or the children are forcibly taken by the perpetrators. Living alone after leaving the shelter involves a magnification of trauma and fear. A space that would promote stable recovery is difficult to secure.

Contested trauma: sexual assault and UK universities

In the UK, the nature of the spaces in which GBV occurs, and contested public understandings of its different forms, also influence the societal and institutional impetus for intervention. This section examines GBV in a particular institutional space, rather than a domestic space. The issue of sexual assault on the university campus has become visible only recently, and many would argue that inadequate responses still largely fail to protect survivors. The problem is widespread. In the US one in five women is sexually assaulted at college (Krebs et al. 2016) and in the UK one in seven female students suffers a serious physical or sexual assault (NUS 2010). Perpetrators are usually students known to those whom they victimize. In the UK, the reported rates are higher at elite institutions. For example, Durham University, which promoted itself in 2014 as one of the top five safest universities in the UK (Durham University 2014), went on to reveal in 2017 that it has the highest level of reported sexual assault among students in the UK, jointly with Oxford (The Times 2017).

Trauma is shaped by the setting of the campus, and it profoundly changes the experience of this space. Prolonged or repeated exposure to a perpetrator compounds the effects of trauma (Herman 1997). Half of survivors reported mental health issues, and two-thirds said their relationships had been affected after serious sexual assault on campus (NUS 2010). To date, survivors have been more likely than perpetrators to leave university after an assault, either pausing their studies or dropping out. Living and working on campus means exposure to the contextual and sensory triggers associated with the attack, and risks seeing the perpetrator, keeping present a space in which the double-bind of the PTSD symptoms intrusion/constriction can flourish and where managing trauma is difficult. Despite this, the responses of government and the institutions involved have been extremely slow. An inquiry into campus violence against women in 2015 found that fewer than half of the elite universities monitored sexual violence and that one in six had no procedure for reporting it. As Dowler, Cuomo and Laliberte (2014) argue in their analysis of the long-term cover-up of campus sexual assaults in the US, the neoliberal cultural economies of universities lead them to prioritize institutional reputation over individual welfare.

Since recent publicity, UK universities have made efforts to address sexual assault on campus. Unlike the US, there has been no legislative change, but the umbrella organization Universities UK has established a taskforce that produced guidelines in 2016. These
guidelines spell out universities’ duty of care to students since the 2010 equality legislation, which had previously been overlooked. The responses of individual universities have varied, but new policies and practices have included clear procedures for reporting and training and guidance for staff and students, the provision of specialist counselling and peer support, and joint working with local police forces and rape crisis centres. While, on one hand, the changes are dramatic, on the other they are often in the early stages of development, rarely involving trauma-informed care or environments addressing the range of ways that trauma inflects the campus (and vice versa). Nor do they commonly acknowledge intersectional differences or the structural roots of discrimination and violence on campus. While sexual assault targets mostly young women, there are higher risks for students of colour and LGBTQ students. Micro-aggressions – ‘brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults’ (Sue et al. 2007) – may also compound trauma. Trauma is most common for students who come to university with previous experiences of violence and more limited access to healthcare, social and financial resources. In this way, as Carter (2015) argues, inequalities of race, class, gender, sexuality and citizenship determine who lives with trauma and where.

Collective traumas may also be etched into the space of the university campus, given elite Western universities’ role in historical and contemporary forms of social and political violence. Many have historical connections to imperialism, built on slavery or functioning as seats of science in the service of colonial power and subjugation (Chatterjee and Maira 2014). Today, universities function within the logics of global capitalism and its uneven development, and globalized higher education markets have not been accompanied by significant action on campus racism. Similarly, as Phipps and Young (2015) have argued, the neoliberalization of higher education encourages a competitive and masculinized ‘lad culture’ among students, which many students experience as hostile.

Efforts to bring campus trauma to wider attention have been met by a forceful backlash. The political contestation that often accompanies public uncovering of private trauma is illustrated by recent debates on trigger warnings, the content alerts on educational materials designed so that people who have experienced trauma can prepare themselves and manage the symptoms. Trauma destroys the sense of time, and sensory cues in the present can cause time-space slippage so that our bodies take pre-cognitive action (‘fight, flight or freeze’) in the present. This experience can prevent us from engaging with the present: in the classroom, for some students this affects their access to the education they have the right to.

In a notorious critique of the use of trigger warnings, Lukianoff and Haidt (2018) contend that these are more harmful than the supposed traumas they protect from, infantilizing students, restricting their education and worsening their mental health. Such an argument is ignorant of the scientific and social realities of PTSD and the long-term effects of intimate and racist violence. For Carter (2015), it is an ableist and White supremacist critique that further silences already marginalized groups; it misconstrues ‘what students are actually requesting: recognition of their lived experiences and institutional support regarding how those experiences influence their education’. Some feminists express concern that trigger warnings may unintentionally set up a hierarchy of trauma, further marking out certain groups as vulnerable. From a geographical perspective, however, we might argue that the spaces of education are distinct, heavily imbued with particular relations of power – students have little choice but to engage in classrooms that are captive as well as potentially empowering. Carter (2015) calls, instead, for classroom pedagogies that incorporate and teach trauma as a justice issue.
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Researching trauma

Researching trauma also requires that we adopt caring professional practices. As researchers working with survivors, we have experienced secondary trauma through prolonged contact with stories of violence and their close analysis, as well as retraumatization when memories of past experiences are brought back to the surface (see Coddington 2017; Tamas 2011). These impacts, while less severe than the trauma that our respondents tell us about, are important to recognize in research that embodies a feminist ethics of care (Drozdzewski and Dominey-Howes 2015).

Recovery, rebuilding, resistance

Our three case studies illustrate the influence of physical, social and political dimensions of space on trauma following GBV. All the survivors we have spoken to work to resist violence and trauma in different ways, drawing on available individual and collective resources. Most formal trauma interventions that are provided by the state, NGOs or the private sector are premised on a notion of ‘recovery’ that implies a return to previous life. We suggest that the term ‘rebuilding’ captures better the challenges of moving forward into the future: as these case studies illustrate, there is no ‘before’ or ‘after’, rather a series of interconnected experiences of violence and abuse. Tamas (2011) critiques the recovery paradigm in Western responses to trauma, which assumes that psychotherapeutic interventions effect a linear process of recovery. Not only is this a poor fit with complex everyday experiences but it can hold responsible those whose post-violence path differs. For Herman (1997), individual treatment must be tied to social movements that challenge oppression, and many other feminist and post-colonial scholars also direct attention to the structural underpinnings of ongoing violence that survivors continue to deal with (e.g. Brave Heart 2000; Fanon 1963). Before feminists brought to light the nature of GBV-related trauma, the psychiatric profession considered to be symptomatic the way that the survivors told their stories; nightmares, intrusive thoughts, dissociation and self-doubt were even seen as failings or illness that caused, rather than resulted from, the abuse (Alcoff and Gray 1993). More recently, in the West, trauma discourses have moved further away from survivors’ empowerment, acquiring neoliberal and neocolonial logics as they are co-opted by the state and mainstream medicine (Tseris 2013). Yet, in some countries, as we see in Bangladesh, trauma is rarely reported or treated because of the negative social consequences of making it known.

The wider social setting also plays an important role in rebuilding after trauma. For Herman (1997), on the one hand, healing requires strong and caring connections with others, and the sense that the wider community condemns the violence experienced. On the other hand, the social and institutional dissociation that we have seen in the examples above tends to compound the psychological effects on individuals. In the case of collective trauma, predominant social narratives may deny the wrong committed or blame the survivors, as in many instances of genocide and oppression of Indigenous people. Collective experience, however, has traditionally provided social support and mechanisms for challenging further violence (hooks 2003; Marshall 2014).

In our three case studies, we see that survivors take various paths of resistance and rebuilding, working within and also against wider cultural framings of trauma. This may include simply surviving or coping with the everyday effects of trauma. In the coastal communities of Bangladesh, contesting entrapment with the extremely limited economic resources that are available is challenging. There is little or no provision within healthcare systems for the psychological effects of GBV, even where women can access healthcare, and often limited family support and societal recognition of victimization (Rezwana 2018; Rezwana and Pain 2018). Local NGOs are aware of the extent of trauma, yet the limited treatment that they provide does not always work...
within the precarious contexts of many women’s lives (Rezwana 2018). In Malaysia, NGOs working with domestic abuse survivors also employ psychotherapeutic treatments based on Western models of trauma. However, the research suggests that this often conflicts with lived experiences and beliefs about trauma (Sahdan 2018). There are no local culturally sensitive alternatives within formal healthcare or the voluntary sector (see also Marshall 2014), and many people seek treatment instead from spirit healers. Elsewhere, Western secularism, hand-in-hand with colonialism, has led to a loss of the Indigenous belief systems and practices that were previously used to treat trauma (Visser 2015). In the UK, survivors of campus sexual assault may receive therapeutic support, although this is limited by cuts under recent austerity and the tighter rationing of mental health services. Therapy helps some survivors to build resilience and rebuild their lives yet rarely acknowledges the structural and everyday contexts of GBV, which, as we have shown, may continue to re-traumatize.

Fassin and Rechtman (2009) state that trauma is now such a dominant discourse in the West that there is widespread public support for survivors but, for many GBV survivors, the everyday reality depends who and where you are (Pain 2014). As we have seen from our three examples, the existence of trauma among marginalized social groups may be denied or disputed, yet the intersectional nature of trauma is centrally important, producing very uneven experiences. Attention to the everyday environments that retraumatize (see Nguyen 2011) and to societal trauma narratives is an important task for geographers. Trauma is best understood as a social, spatial and political condition, and so addressing its social, spatial and political contexts has a key role in prevention and healing.

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Key readings


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