Research Article

Finding the Strength to Heal: Understanding Recovery After Gender-Based Violence

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Abstract

Little research has focused on the trauma healing processes of gender-based violence (GBV) survivors, with most research focusing on adverse outcomes. The purpose of this study, therefore, was to explore the nature of GBV healing through survivor narratives. Our analysis revealed important barriers and facilitators of trauma healing. Social context was discovered to have a powerful influence over both barriers and facilitators. Analysis of the nature of healing revealed three main objectives: reconnecting with the self, others, and the world. This information can be utilized by clinicians to create safer, more empowering, healing spaces for survivors.

Keywords

gender-based violence, trauma recovery, healing, posttraumatic growth

Introduction

Gender-based violence (GBV) is recognized as a major public health concern and violation of human rights (World Health Organization [WHO], 2013). GBV can encompass such acts as intimate partner violence, sexual violence, forced prostitution, genital cutting, and stalking (Heise, Ellsberg, & Gottmoeller, 2002). While GBV can be experienced by any gender, women face disproportionately high rates, with one in seven women in the United States compared with one in 18 men reporting severe physical violence by an intimate partner and one in five women compared

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with one in 71 men reporting an attempted or completed rape at some point in their lives (Black et al., 2011).

Although the physical and mental impact of GBV both generally and in specified forms has been well documented (see Heise et al., 2002, for review), many women choose not to disclose or seek help for their GBV experiences (Fugate, Landis, Riordan, Naureckas, & Engel, 2005; Saint Arnault & O'Halloran, 2016). For example, in a multinational survey of 42,000 women across 28 European Union Member States, it was found that help-seeking rates for GBV ranged from 4-27% depending on the country (European Union Agency for Fundamental Rights, 2014). Reasons why survivors were not seeking help from formal resources included the perception that violence was "normal/not serious," feeling burdened by their symptoms, emotional investment in the relationship, protecting the children, and shame (Fugate et al., 2005; Murray, Crowe, & Overstreet, 2015; Saint Arnault & O'Halloran, 2016). Other reasons included believing they should "deal with it alone," feeling frozen, and feeling internalized stigma, manifesting as feelings of weakness, helplessness, or blame (Fugate et al., 2005; Murray et al., 2015; Saint Arnault & O'Halloran, 2016). Internalized barriers such as previously mentioned can cause an increased symptom burden, inhibiting the help-seeking and recovery process.

For the purpose of this study, we have conceptualized recovery from trauma as *trauma healing*, which we defined based on Judith Herman's final stage of trauma recovery as rebuilding the self through reconnecting to oneself and reintegrating to one's environment (Herman, 1997). Despite the growing understanding of the impact of GBV on health outcomes, little research has focused on the trauma healing processes of GBV survivors, with most research primarily focusing on identifying factors associated with distress and/or adverse outcomes (Draucker et al., 2009). For example, in a qualitative metasynthesis of 51 reports discussing trauma healing, one limitation identified by the authors was that only 12 synthesized reports stated their purpose was to describe how individuals heal, adapt, or recover from sexual violence. Other reports included in the review focused on survivors' "lived experience" more broadly without specifically asking the survivor about their healing goals and desires, potentially missing important intricacies contributing to trauma healing (Draucker et al., 2009). Reports that did discuss healing revealed important benchmarks in the trauma recovery process, namely, the importance of relating to others, feeling safe, and reevaluating the self (Draucker et al., 2009). It is important to note, however, that this qualitative review focused solely on sexual trauma, potentially missing important healing themes pertaining to GBV more generally.

A growing body of literature focused on trauma healing highlights the idea of posttraumatic growth. Posttraumatic growth is conceptualized as positive changes that are attained by some individuals as a result of their survival of a highly stressful event (Tedeschi & Calhoun, 1995). The literature on posttraumatic growth has encompassed a wide variety of traumatic experiences (e.g., natural disasters, community violence, medical diagnoses), highlighting the importance of three general domains: changes in the perception of the self, changes in the experience of relationships with others, and changes in one's general philosophy of life (Tedeschi & Calhoun, 1996). The

posttraumatic growth literature proposes that positive posttrauma changes occur through the process of making meaning out of a traumatic event and overcoming initially high levels of psychological distress (Tedeschi & Calhoun, 2004).

While posttraumatic growth research has been done with trauma survivors, the measure has been generalized to all forms of trauma, potentially missing important nuances associated with GBV specifically. For example, a study conducted by Shakespeare-Finch and Armstrong in 2010 revealed that sexual assault survivors had significantly higher post-traumatic stress disorder (PTSD) levels and greater difficulties relating to others and appreciating life, two subscales of the posttraumatic growth inventory, when compared with survivors of motor vehicle accidents and those in bereavement. The authors attribute this difference to be related to the direct personal and physical integrity threat of sexual violence, paired with intentionality of perpetration by another person. This may add another dimension to the trauma recovery experience in survivors of interpersonal violence beyond that experienced in bereavement, motor vehicle accidents, or other noninterpersonal traumas (Shakespeare-Finch & De Dassel, 2009).

In addition, research in posttraumatic growth primarily associates personal characteristics and traits (e.g., positive emotions, optimism, extraversion, and acceptance) with posttrauma growth (see Joseph & Butler, 2010 for review), finding that personal characteristics interact with one's social environment to either facilitate or create barriers to positive change, impacting their healing process. Despite acknowledging that meaning-making is central, this literature has not examined in depth *how* survivors achieve posttraumatic growth. This understanding is crucial to develop interventions to support this growth outcome. Moreover, not all survivors may value this growth outcome, perhaps seeking other trauma recovery goals.

Interventions to promote trauma recovery have focused primarily on adapting cognitions, improving coping styles, and facilitating social support. In this literature, individuals who perceive others as being helpful following violence experience more positive life changes and less psychological distress (Frazier, Mortensen, & Steward, 2005; Steel, Sanna, Hammond, Whipple, & Cross, 2004). In addition, active, approach-oriented coping styles have been shown to facilitate healing by aiding individuals in improving their engagement with others as well as their emotional expression (Frazier et al., 2005; Frazier, Tashiro, Berman, Steger, & Long, 2004). Finally, cognitive restructuring has also been shown to improve one's perceived control over their healing process, improving their help-seeking abilities (Frazier, 2003; Frazier et al., 2005; Frazier et al., 2004). Noticeably absent from these interventions, however, is the link between how these interventions support survivors' healing goals and what those broader healing goals actually are.

The purpose of this study is to explore survivor perspectives of their trauma recovery journey by learning more about the nature of their healing process, as well as their healing goals for the future. The specific aims of the study are to (a) identify the contextual and internal factors that influence healing after GBV, and (b) explore the nature of healing through survivors' narratives. While this study samples people who define as women, we plan to examine the unique experiences of men and

transgender persons in future studies. Understanding these aims from a survivor's perspective is important to ensure future interventions are tailored to survivors' healing needs, goals, and desires.

Method

Study Design, Sample, and Procedure

This study is part of a larger multinational ethnographic study that examines cultural barriers and facilitators of distress, help-seeking, and healing for survivors of GBV. This study reports on findings from our American sample only, to fully understand American women's healing goals and desired outcomes prior to cross-cultural comparison. Women were included in this study if they were 18 years or older and self-identified as "experiencing gender-based violence of any type." Women were excluded from this study if they were in an active GBV situation. All procedures and materials for our study were approved by the University of Michigan Institutional Review Board (HUM00091662). The primary recruitment site was a Southeastern Michigan university health research portal, designed to connect individuals who utilize the wider university health care system with research opportunities.

Women who responded to the recruitment invitation through the portal were contacted by phone to schedule an interview at the location of their choosing. All eligible participants provided informed consent. Each interview was 1-1.5 hr in length, recorded by digital tape recorders. After the interview, local psychological support resources were given, and materials were photocopied and returned to the participant.

A total of 37 women connected with us via phone to participate in this study. Six women expressed interest, but did not want to schedule an interview. Eight women scheduled, then asked for a reschedule but were then unavailable, or did not come to their scheduled interview. In all, 23 women participated in the interview process. Two were excluded from analysis because they denied a history of GBV. Our final sample consisted of 21 female participants ages 20-81 who all resided in Southeast Michigan. Consistent with qualitative methodology, sampling was concluded once data saturation was reached.

Measures. The Clinical Ethnographic Narrative Interview (CENI) was used to collect data for the study (Saint Arnault, 2017). The CENI is a semi-structured interview developed for a National Institute of Mental Health (NIMH)-funded research study aimed at examining the interactions between distress experiences, cultural interpretations, social structures, and help-seeking for first-generation Japanese women living in the United States (Saint Arnault & Fetters, 2011; Saint Arnault & Shimabukuro, 2012). Since its development, the CENI has been adapted to study trauma recovery (Saint Arnault, 2017). Currently, the CENI has been utilized with more than 100 survivors of trauma in seven different countries to identify sociocultural themes of help-seeking and the trauma recovery journey after GBV. Evidence from several studies has revealed that the CENI assists the participants to organize and articulate meaning about

emotionally difficult experiences (Hatashita et al., 2015; Saint Arnault & Fetters, 2011; Saint Arnault & O'Halloran, 2016; Saint Arnault & Shimabukuro, 2012).

The CENI lasts about 90 min and utilizes four unique participant activities (social network, body map, lifeline, and card sort) to investigate social and cultural experiences, beliefs, barriers, and facilitators to healing from GBV. Each activity's product remains in view during the interview, with the opportunity for the individual to have a copy of her products at the end of the interview. We begin the interview with a *social network map* to frame help-seeking within the social context. Next, we invite the participant to use *body mapping* to place their distress onto their body and focus on their internal process (Evans, 2010; Meiring & Müller, 2010; Meyburgh, 2007). Then, the participant completes a retrospective overview of triumphs and distress in their life in a *lifeline*, to find patterns and link past and subsequent events, emotions, and actions (Frank, 1984; Gramling & Carr, 2004; Shimomura, 2011). Finally, the participant completes a *card sort* referencing her most recent low point, to describe her distress and healing in detail on a focused event, creating a map of her symptom clusters (Borgatti, 1999; Canter, Brown, & Groat, 1985; Gordon, 2001; Saint Arnault & Shimabukuro, 2016). These four products are the basis for questions about interpretations of causes, perceived consequences, help-seeking actions, and the meaning of healing (Saint Arnault, 2017).

Analysis

After each interview, digital voice recordings and photocopied activities were uploaded to a secure, research drop box. Interviews were then transcribed, and the accuracy of the transcription was checked and finalized by the interviewer. We used a modified grounded theory analysis, which allowed us to examine exploratory and inductive research analyses simultaneously (Lofland, 1995). Transcripts were read and reread with main concepts identified. The text was then examined line by line, identifying grounded subcategories, and abstracting upward to main categories, allowing "systematic comparison" and "conceptualizing" (Strauss & Corbin, 1998). Codes were developed based on internal and contextual influences of healing, as well as participants' perspectives of components of healing. ATLAS.ti qualitative software was used for data management and analysis (Muhr, 2006). An audit trail using personal, theoretical, and analytic memos was maintained and was reviewed every other week by the second author, coding concepts were selected and discussed regularly by the research team, and emerging hypotheses were discussed at length in team meetings for verification of accuracy.

Results

Sample Characteristics

In total, 21 Midwestern women were included in the analysis. A total of 18 of the women identified as Caucasian, two women identified as African American, and one woman identified as Asian. The highest level of education varied in the sample:

Two women did not graduate high school, although one went on to get her GED, five women graduated from high school, 11 women graduated from college, and three women had achieved graduate degrees. Five women were current university students or had recently graduated the previous semester. In all, 12 women were actively working in the community, three women were retired, and one woman was receiving disability. Women were equally distributed in age range and had a variety of trauma and mental health histories. Specific information on participants' ages, trauma histories, and mental health histories are shown in Table 1.

Aim 1: Contextual and Internal Factors That Influence Healing From GBV

Women identified several contextual factors that influenced and interacted with their internal self-appraisal of their healing processes. Contextual influences included societal values and expectations, social responses to GBV, and the normalization of violence. The internal factors that influenced GBV healing included feelings of shame, self-blame, fear of judgment, and self-doubt. A diagram of these processes is shown in Figure 1.

Figure 1 shows the interrelationships among the external social influences on the internal self-appraisal the survivors in our sample. The social influences were those forces outside of the participant that influenced her self-appraisal and, ultimately, her recovery behaviors. Normalization of violence influenced both what society expected from them as women, as well as the social responses to self-disclosure about the violence experiences. These social values, expectations, beliefs, and behaviors were internalized by the survivors in varying degrees, and this internalization took the form of internal feelings of shame, self-blame, self-doubt, and fear of judgment.

Social context of recovery. The messages that one receives from their social environment combined with the experiences one has within this environment were found to greatly impact one's healing process. The first main influencing factor within one's environment was *societal values and expectations*. This manifested when reflecting on one's personal responsibility surrounding the GBV experience itself, as well as one's responsibility afterward. For example, one participant stated, "When you are deciding what to wear, you have to think about what does society believe that your responsibility is in what you wear" (Participant A005). Another reflected on her pressure to report by saying, "A lot of people in my head saying 'Hey, you should report him because he is around kids a lot and it's your responsibility to make sure this doesn't happen to anyone else'" (Participant A138). It appeared that the synchronicity between an individual's idea of her role both before and after her GBV experience, and how she believed she was meeting society's expectations of her role, directly impacted her satisfaction with her trauma recovery process as well as her resulting internal self-appraisal.

Table 1. Participant Age, Trauma History, and Mental Health History.

Age	*N*	Trauma history	*N*	Complex trauma history	*N*	Psychiatric history	*N*	Mental health services utilized	*N*
20-30	8	Sexual assault	10	More than one type of GBV experience	8	Depression	7	Individual therapy	15
31-40	4	Domestic/Dating violence	9	Past history of ongoing GBV	9	Anxiety	7	Psychiatrist	4
41-50	3	Child abuse	2	One GBV experience	4	PTSD	7	Group therapy or other support groups	3
50+	6	Sexual harassment	3			Therapy without formal diagnosis	7	No mental health services utilized	4

Note. GBV = gender-based violence; PTSD = post-traumatic stress disorder.

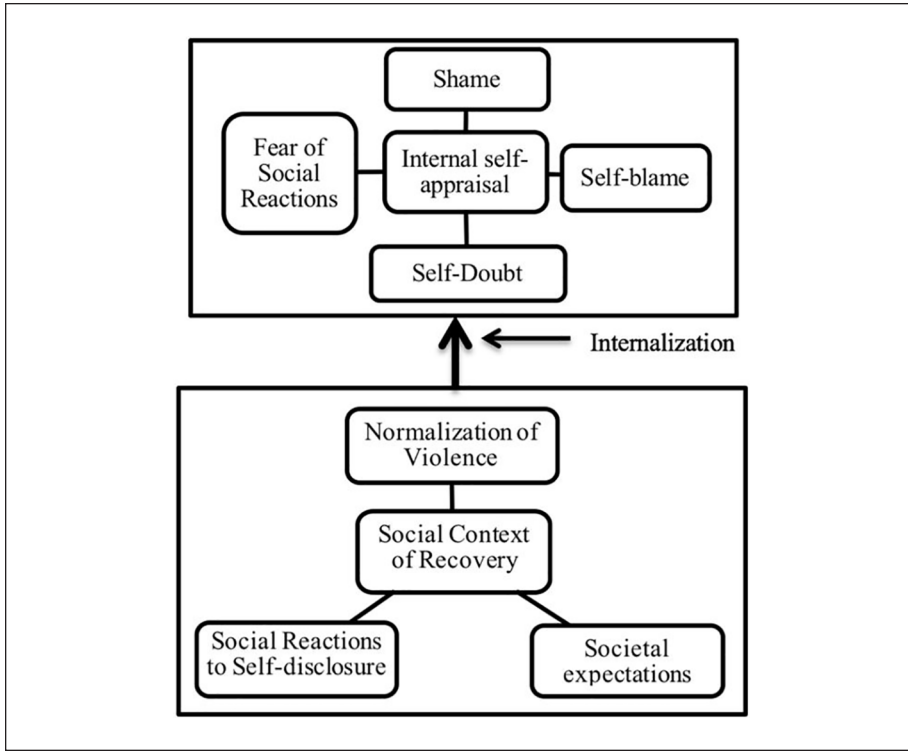

Figure 1. Individual and contextual influences of GBV healing.
Note. GBV = gender-based violence.

Importantly, the societal value of needing to be "strong" and "independent" was a repeated theme in our sample. Often, this caused women to try to force "getting over" their GBV experience quickly or try to heal "all on their own," while giving the "appearance of being normal" (Participant A079). For example, one participant stated, "So, I didn't really ask anybody [for help] . . . I was Superwoman. I didn't mention that before, I grew up to be Superwoman" (Participant A036). Another said, "So it's like, well they know, but I try to minimize it so they don't think, like, now she is like this teacup . . . because I want to be treated like I am strong" (Participant A005). The need and expectation to be strong often caused the women to grow frustrated when they were emotionally affected by their GBV, manifesting in shame that they "could not get past this," self-blame that they were not "doing enough," and self-doubt that they were "not as strong as [they] wanted to believe [they were]" (Participant A105).

Another influencing factor was the *normalization of violence.* Often, this influenced women to either think that their experience was "no big deal" or that they were to blame. For example, one American participant reflected, "I thought it was my fault, because like no, I shouldn't have denied his friend, I should have just went along with

it and they would take me home sooner" (Participant A035). Another woman commented, "You know, like one in three women have been sexually assaulted, right . . . like everybody has. Of course I have, no big deal" (Participant A005). The normalization of violence noticed in this sample often seemed to cause women to minimize their experiences, believe their experience was "not serious enough" to report, or not initially recognize that violence was happening, resulting in denial and repression of their resulting emotions.

Finally, *social responses to GBV* influenced the recovery process, often leading to patterns of self-doubt, withdrawal, and secrecy among participants. Common negative social responses included not believing the survivor, blaming the survivor in some way for her GBV experience, or passing judgment on the survivor for prolonged distress or her actions following her GBV experience. For example, one participant noted,

> It was a very difficult time for me and instead of having anyone in my family just say "Do you want to talk about it? We are here for you," they just were like, "Can't you just put this behind you?" (Participant A079)

Another woman reflected,

> There were many people who really thought I was making the wrong decision, because what a charming man I was with; and even some of my friends thought that. . . . The hard thing was is that it just threw me back into feeling like I was stuck here. (Participant A036)

It is important to note, however, that not all of our participants experienced negative social responses to GBV. In these many examples, surrounding oneself with "good people" or realizing that "people are willing to help" encouraged others to continue making strides toward healing. Often, quality support enabled survivors to engage in their healing process more effectively by providing help with competing demands when needed, holding survivors accountable for engaging in their treatment, and by encouraging them to seek professional guidance. For example, one participant reflected on how being surrounded by others who encouraged her to utilize mental health services led her to seek help by saying, "the only reason why I was open to going to therapy is because . . . you can talk about going to therapy here [at this university]" (Participant A035). Another woman described how her daughter "got her moving,"

> So until [daughter name] moved back in June this year, I did everything in the basement. I knew that I should be moving upstairs, but you know how the inertia of all that . . . how am I going to do this? (Participant A017)

These narratives, among others, emphasized the importance of supportive responses to GBV to empower survivors to take control of their healing process by dismantling internalized barriers that can cause them to "feel stuck" and unable to move forward.

Internal self-appraisal. In the women's social context, common internal themes of shame, self-blame, fear of judgment, and self-doubt seemed to be directly influenced by their interaction with their environment, creating meta-barriers to their trauma recovery process. *Shame* was described by the participants as feelings of embarrassment surrounding their perceived role in their GBV experience or their reaction to it. For example, one woman stated, "[I felt] shame for sure, because you know, you always hear about it takes two people to be involved in sexual assault" (Participant A138). *Self-blame* was often fueled by shame and was understood as feeling as though one is responsible for their GBV experience or resulting negative feelings surrounding it. For example, another woman reflected, "I thought it was my fault because . . . I shouldn't have got in and gone with them in the first place, like, I was blaming it on myself" (Participant A035). *Fear of judgment* was understood as being afraid of how others may perceive or respond to one's GBV experience or resulting actions. For example, a third participant commented, "I didn't really tell anybody, because . . . I didn't really want that to be what they thought about when they saw me" (Participant A102). Finally, self-doubt was understood as questioning the reality of one's GBV experience or one's abilities to recover from it. These themes were revealed in the participants' narratives of their lifeline as well as unintentionally during the interview itself. For example, one woman revealed self-doubt by telling the interviewer, "Okay. So can we make a deal? If I am sharing too much, can you just tell me to stop?" (Participant A039). It was later revealed that this participant had many negative reactions to her disclosure of her emotions surrounding her assault in the past, which caused her to "get anxious when [she thinks] about sharing things, because [she is] not sure how it will be accepted."

Aim 2: The Nature of Healing After GBV

The nature of healing was described by women as three interacting healing objectives: reconnecting with the self, reconnecting with others, and reconnecting with the world. Below, we will present each component separately. A diagram of these categories and subcategories can be seen in Figure 2.

Reconnecting with the self. Women often described the experience of GBV as "changing how [they] saw themselves" (Participant A005). Changes in one's view of themselves manifested in many ways including questioning one's strength, value, and worth as well as feeling out of control of one's emotions, physical symptoms, memories, and their future. In general, self-disconnect was described as feeling "less than," questioning "if [she] should even be alive," "blocking off" certain parts of the body, and "not knowing who [she] was anymore." Healing self-disconnect was composed of three subcategories: reclaiming identity, managing symptoms, and regaining control.

Reclaiming identity was an important aspect of reconnecting with oneself once a woman separated herself from her GBV experience. For example, one woman reflected, "So, now I had to reinvent myself. I had no identity. My name did not even match my social security number" (Participant A006). Important subcategories of

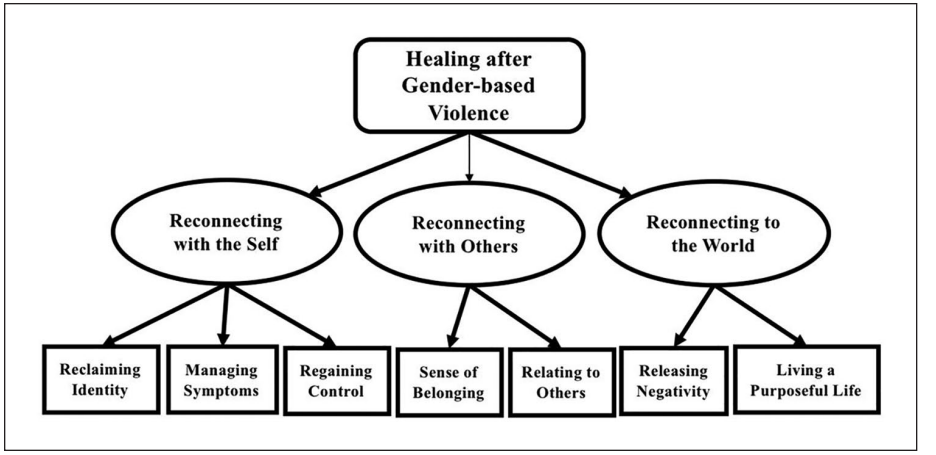

Figure 2. The nature of healing after GBV.
Note. GBV = gender-based violence.

regaining one's identity included rebuilding self-worth, reclaiming strength, and overcoming self-doubt. For example, one woman reflected,

> You are never going to be the same person you were before it happened, but you can find yourself in there, and you can see new things grow out of the place that you are in, that could never have been there before. (Participant A079)

Another woman suggested, "just really focus on trying to figure out what strength is, where there is good, and what things still hold value to you" (Participant A011). The previous narratives highlighted the importance of rediscovering one's identity through one's inner strength. It seemed particularly important to the women in our study, despite often having different definitions of what strength is, to incorporate strength into their new identity and understand that "vulnerability isn't necessarily a bad thing" (Participant A105).

Managing symptoms consisted of a need to manage emotions, physical symptoms, and memories related to their traumatic event. For example, one participant described the importance of "fighting" her symptoms by saying "if you fight anything, don't fight your attacker. Fight the depression. You have to fight that" (Participant A005). To decrease symptomology, survivors listed many strategies including escaping through reading or exercise, experiencing the beauty of nature, using mental health resources, receiving psychoeducation, and practicing self-care.

Survivors also expressed some survival strategies that, although they acknowledged were "unhealthy," helped manage symptoms. Some of these strategies included disconnecting from their body and emotions, disordered eating, denial of abuse, substance use, and promiscuity. For example, one woman explained that by abusing substances, the negative events in her life "just did not exist" (Participant A012). Despite

this being initially helpful, this woman reflected that she "never grieved" the negative events in her life, causing further problems for herself as she aged. Her story and others revealed that although often helpful, maladaptive coping strategies often led to difficult habits to break, creating further barriers to recovery.

Regaining control consisted of participants expressing a need to have power over their lives through improved self-efficacy and autonomous decision-making as well as achieving feelings of personal mastery. One woman reflected on regaining control of her life by saying, "I am taking some responsibility for not polluting my relationships . . . because I have that power to do that and just shut it out, to give me more" (Participant A005). Another reflected, "I am in a better mindset than I was before, because I am recognizing the signs [of distress]. I accept them, and I am taking the steps to try to circumvent the effects, and just advocating for myself" (Participant A035). Narratives related to regaining control suggested feeling as though others had been "controlling" their lives, finances, and decisions leading to a longing for independence.

Reconnecting with others. Women described feeling emotionally and physically disconnected from their families and communities through either personal withdrawal or intentional isolation facilitated by survivors' family and friends. One woman summarized withdrawal by saying, "I think the disconnect was fear to let anybody get close to me, because, oh, they would hurt me" (Participant A012). Another woman expressed feeling distance from loved ones: "I didn't lose many friends, but a lot of my friends distanced themselves because they just didn't understand. Nobody said they thought I was crazy, but it was sort of that" (Participant A036). Healing this disconnect from others consisted of two subcategories: relating to others and feeling a sense of belonging.

Relating to others consisted of survivors feeling able to build and maintain relationships as well as reestablish trust. One woman discussed her journey by saying, "I am becoming closer to people . . . [I'm] even doing social activities . . . I never had any social life" (Participant A012). Another woman expressed wanting to relate to other survivors by saying, "I want to . . . get women to understand; One, there is help out there, and Two, your situation is not normal, nor is it isolated" (Participant A045). One final woman reflected on what she learned through this process by saying, ". . . just reach out, don't try to deal with it on your own, because you will always be surprised by who is ready and willing to help, and maybe just doesn't know how to help" (Participant A100). By relating to others, survivors were better able to find support and get their needs met, have authentic interactions, as well as feel common humanity with other survivors.

Feeling a sense of belonging consisted of survivors perceiving support by their social networks as well as becoming engaged in their communities. Types of community activities women involved themselves in included volunteering, participating in their faith, and joining leisure, educational, or support groups. One woman discussed how her community supported her by saying, "I was carried by somebody from AA and from my religious community. They stayed with me for two weeks and [told me] 'It's

time to take a shower', 'Do you need to pay your bills,' just carried me" (Participant A012). Another woman reflected on how she strove to expand her social network and community after GBV by saying, "I decided to kind of get more involved and do things . . . and just move towards something sustainable and positive that I could apply in the future" (Participant A105). By getting involved and feeling cared for, women were able to dismantle their often paralyzing, negative, internal self-appraisal after GBV.

Reconnecting with the world. The importance of reconnecting with the world was described in a number of ways. One participant reflected, "That's what I really lost, that person who felt mothered and connected, and part of the world" (Participant A036). Another participant said, "It is difficult to believe that there is good in this world when another person unleashes their pent up aggression onto you over a period of time" (Participant A079). According to survivor narratives, overcoming world disconnection was established by releasing bottled-up negativity as well as creating a purposeful life for oneself.

Releasing negativity consisted of establishing a positive world view and believing in a higher power, or something "greater than yourself." Women described their process in numerous ways. For example, one woman commented,

> There are so many people who just hold horrible grudges and they just carry this angst and heaviness. It is like, to me, a prickly wool blanket that is wet and heavy, and burdensome . . . like a ball and chain. (Participant A006)

Another discussed how religion was helpful in releasing her negativity by saying, "I have been really focused on renewing my mind . . . I don't have a positive family so I have to find positive voices . . . letting the things that have been painful die, and just let myself go" (Participant A079). Religion was a prominent vehicle to connect with the world for many women in their healing process, with seven of the 21 participants mentioning the significance of God in their journey to reconnection. It is important to note, however, that while some found support and comfort in religion, others found that it created additional barriers to their recovery, especially when it coincided with survivor blame. For example, one woman recalled, "My mom, she thinks it is very shameful that I got a divorce . . . even for years after . . . she would still be like 'Oh can't you work things out, can't you go back to him'" (Participant A009). Familial reactions like these were also not uncommon, often causing additional negativity and resentment to build up, requiring other avenues for release.

Living a purposeful life was highlighted by two main themes: finding fulfillment and personal growth. Women discussed finding fulfillment in a number of ways, including raising their children into kind and loving adults, taking care of family, volunteering within their community, and going into helping professions. As one woman said, "I think we all have to go through hard times, but it just makes you better able to be compassionate, to be less judgmental" (Participant A017). Another woman reflected, "being useful is important to me . . . and being compassionate to people. I was fortunate; I got to do that in my job" (Participant A013).

Personal growth and achievement was another way women found purpose in their lives. This was made apparent by the great pride our participants took in their educational, professional, and financial endeavors after their GBV experience, often using it as evidence of worth and proper societal functioning. For example, one woman reflected with pride, "I went back to school. That was fabulous. I got a Presidential Scholarship, so I went back for another degree [laughing] . . . I could do whatever I wanted it seemed like" (Participant A006). Interestingly, however, our cohort seemed to be split between women who attempted to create a new, purposeful life for themselves, such as in the narrative mentioned above, and those who attempted to continue to "go on with normal life." Women who talked more about "pushing through" and "focusing on work" seemed to have greater difficulties in healing from their trauma, compared with those in the other group. Influencing factors of this disconnect seemed to be economic insecurity or caretaking responsibilities as well as a fear of vulnerability, resulting in a lack of acknowledgment of one's feelings. For example, one woman reflected,

> I had to work 12-hour weekends . . . but I knew [my daughter's] dad wouldn't step up to the plate . . . and will all of that, I never took time to heal . . . I never had time to stop and think about what was going on in my body. (Participant A079)

Another woman discussed her suppression of her negative feelings by saying, "Boy is that a dumb thought. Get up, put your clothes on, get moving. You just get out of bed . . . and you go do whatever you were gonna do. You just do it" (Participant A012). These narratives revealed not only the potential inequities between those who can afford to make lifestyle changes and those who cannot, but also the importance of accepting and making meaning out of one's feelings as a means of healing.

Conversely, women who were financially able to "[take] time to work on themselves" or, with support, women who were able to acknowledge their unhappiness and attempted to work through it seemed to live happier, more productive lives in the present. For example, one woman reflected on her life changes after her abuse, saying it

> made me feel more comfortable with kind of being on my own . . . I think that is a huge step from where I was, where I was like afraid to do anything . . . he wasn't holding me back anymore, so I could do the stuff that I wanted to. (Participant A039)

Being intentional about one's healing appeared to be essential in our sample, although often uncomfortable at first.

Discussion

This study sought to understand the nature of healing from GBV through survivors' narratives as well as internal and contextual influences of trauma recovery. Internal influences included shame, self-blame, fear of judgment, and self-doubt adding to the emerging body of literature highlighting the importance of one's inner dialogue on

healing and help-seeking after GBV (Fugate et al., 2005; McCleary-Sills, Namy, Nyoni, Rweyemamu, Salvatory, & Steven, 2015; Saint Arnault & O'Halloran, 2016). In addition, findings revealed social and contextual influences including societal values and expectations, the normalization of violence, and social responses to GBV. The previous themes identified support data from international studies emphasizing the highly prevalent attitudes and norms tolerating GBV as well as the powerful influence of one's social context in impacting help-seeking agency in survivors' lives (McCleary-Sills et al, 2015; Saint Arnault & O'Halloran, 2016).

The present study highlighted the complex interaction between one's internal self-appraisal and women's perspectives of and experiences within their social context. The data showed synchronicity between an individual's idea of her role in society as a GBV survivor and how she believed she was meeting society's expectations of her role, directly impacting her satisfaction with her trauma recovery process. In addition, the degree to which one's beliefs about her social context matched up with what she actually experienced within her social world was shown to either facilitate or create further barriers to her healing process. This finding revealed the importance of supportive social responses when one does seek help, a concept frequently highlighted in disclosure literature for sexual assault survivors (Campbell, Greeson, Fehler-Cabral, & Kennedy, 2015; Ullman & Peter-Hagene, 2014).

The nature of healing consisted of the interacting processes of reconnecting with oneself, reconnecting with others, and reconnecting with the world. The idea of disconnection is not uncommon in trauma literature. For example, the feeling of "disconnect" survivors describe upon reflection on their trauma experiences is sometimes explained by the survival strategy of creating psychological distance from overwhelming events, often causing challenges in rebuilding an individual's sense of identity and meaning (Crossley, 2000). The present study has revealed, however, the importance of reconnecting identity and meaning, which heretofore had been severed by the need to survive. This reconnection can facilitate healing goals and personal satisfaction with one's trauma recovery process. A qualitative metasynthesis supported some of the present study's findings, as themes of relating to others, feeling safe, and reevaluating the self were found within the review (Draucker et al., 2009).

Interestingly, we found a difference between women who were attempting to "go on with normal life" or "survive" and women who made personal decisions to create a new life for themselves separate from their pasts. Women who talked more about "pushing through" described difficulties in healing from their trauma, and women reported that taking time to reflect and create a new identity separate from their GBV was healing. The present studys' results are consistent with current posttraumatic growth literature, arguing that while some women go on to "survive" their trauma, between 30 and 70% of individuals actually report positive change and growth coming out of the traumatic experience (Joseph & Linley, 2006). In the posttraumatic growth literature, similar to the "creating a new life" cohort, the individual has not only survived, but has experienced changes perceived as important to the individual, influencing their view of relationships, themselves, and their philosophy of life (Joseph & Linley, 2006; Tedeschi & Calhoun, 2004). The previous themes are similar to the

themes discovered in the participants' healing narratives, indicating the importance of perceived growth in one's healing journey. However, the act of "survival" itself carries with it its own meaning and represents strength, perseverance, overcoming, and resilience for some women. It is important to continue to examine these differences to intervene for women in a way that meets their cultural world view as well as their personal trauma recovery goals.

We uncovered two main reasons for the difference in approaches to recovery ("going on with normal life" vs. "creating a new life"). These data suggest the hypothesis that there may be differences related to (a) being unable to take time to heal due to financial instability or caretaking responsibilities, or (b) a fear of vulnerability resulting in a lack of acknowledgment of one's feelings. These differences may be supported by, or are in interaction with, one's internal self-appraisal and one's social context. Evidence of this complex interaction was found in a meta-narrative in which women fought the image of being weak within their social context and longed to regain a feeling of independence and competence. This finding adds to the posttraumatic growth literature because, although researchers have linked socioeconomic status with positive change after traumatic events, most research primarily associates personal characteristics with posttraumatic growth (see Joseph & Butler, 2010, for review). In addition, this hypothesis that there are divergent meanings of strength, survival, and recovery needs to be examined more closely in future research and can be useful in tailoring survivor recovery interventions.

The finding about the critical role of social responses on one's healing process further emphasizes the responsibility of professionals to understand and properly execute trauma-informed care to avoid unintentionally derailing survivors' trauma recovery processes. The emphasis on professional responses has been the focus of GBV policies by the WHO in recent years, with the goal to provide evidence-based guidance to health care providers on appropriate clinical interventions and emotional responses to GBV (WHO, 2013). Future research is needed, however, to expand and educate other helping professions on proper responses to GBV, as a review of interventions to improve responses of helping professionals to intimate partner violence only found eight studies conducted in non-health care settings and 10 studies in general classified as "good quality" (Choi & An, 2016).

Finally, the findings from this study add to scientific theory about survivors' trauma recovery processes. By identifying the interaction between internal and contextual influences, we can more fully examine why women may take many years before leaving their abusive situation or before fully engaging in their trauma healing. For example, we found that internal forces can be systematically undone with support from others, both personally and professionally, and that this process interacted with becoming engaged in economic and social security. Both of these processes interacted together, facilitating the healing process by helping the survivor reconcile the "paralyzing" internal and economic barriers. The present study's results are consistent with the large existing body of literature highlighting the importance of social support in mitigating adverse mental health outcomes, as well as the importance of economic security when trying to disconnect from one's

perpetrator (Anderson & Saunders, 2003; Kim & Gray, 2008). However, it adds the focus on the internal and cultural messages that interact with these external realities. We hope to expand upon these healing themes by adding the voices of additional survivors in the United States and abroad, with the goal of reevaluating existing trauma recovery measures to ensure trauma recovery is being captured through a holistic, survivor-centered lens.

Although not in the initial aims, interview evaluations provided evidence that women found the CENI helpful in organizing traumatic experiences and articulating the meaning of low points. Several other studies using the CENI have reported similar findings (Saint Arnault & Fetters, 2011; Saint Arnault & Roels, 2012; Saint Arnault & Shimabukuro, 2012, 2016). It appears that by promoting self-awareness and meaning-making through empowerment and narrative self-disclosure, participants can gain insight to enable self-mastery and help-seeking decision-making. Future research into the healing mechanisms of the CENI is needed to discover if any improvement in recovery-related actions occurred after participation in the interview.

This study has several limitations, including the Midwestern location of our participants, small sample size, our focus on only female survivors, and our primarily Caucasian sample. Therefore, caution should be used when generalizing to individuals of other cultures, genders, and sociodemographic characteristics. Future research should expand on these findings to other social and cultural groups to better understand how cultural and socioeconomic differences can influence a survivor's healing process. Future research should also attempt to understand the recovery process of men and transgender survivors, as their healing goals and desires may be very different from our female population. Despite the present study's limitations, results provided data about the critical components of the trauma healing process, and a framework to describe survivors' healing patterns, grounded in the voices of female participants. The diversity of recovery experiences and ages lends trustworthiness to the findings. The new knowledge created by this study has the potential to impact how we interact with survivors in their social worlds to better promote empowerment and strength within survivors of GBV.

The present study has the potential to improve personal and professional interactions with survivors. Encouraging professionals to become trained in appropriate therapeutic responses and to focus on survivor healing goals, rather than solely focusing on negative responses to GBV, can help empower survivors to move forward in their healing process. These findings also encourage future GBV research to diversify outcome measures beyond mental illness symptoms, to more accurately target healing. Finally, future research is needed to further expand upon the themes identified in this analysis, with the goal to reevaluate existing trauma recovery measures to ensure this outcome is being captured through a holistic, survivor-centered lens. By changing the narrative and focusing on healing rather than deficit, we can begin to empower women to recognize their strength, lifting the veil of silence caused by the interaction of their internal self-appraisal and their social context.

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