Original Research

Journal of Interpersonal Violence
1–26

DOI: 10.1177/0886260519829284
journals.sagepub.com/home/jiv
SAGE

Trauma Recovery Is Cultural: Understanding Shared and Different Healing Themes in Irish and American Survivors of Gender-based Violence

Laura Sinko, BSN, RN, CCTS-I, PhD(c),[1] Courtney Julia Burns,[1] Sharon O'Halloran,[1] and Denise Saint Arnault, PhD, RN, FAAN[1]

Abstract

Little research has focused on the trauma healing processes of survivors of gender-based violence (GBV) worldwide. Even less research has utilized cross-cultural comparison to understand shared or culturally-distinct healing goals, creating a gap in understanding how to provide adequate, culturally relevant, and trauma-informed care to survivors. The purpose of this study was to cross-culturally compare shared healing influences and themes of the trauma recovery process in samples of Irish and American female survivors of GBV. To gather healing data, an ethnographic narrative interview was used with 19 American and 12 Irish female survivors who self-identified as having experienced GBV. Thematic analysis was used to examine and compare desired healing outcomes, focusing on the definitions, influences, and meanings of healing experiences. Our analysis revealed shared healing objectives of reconnecting to the self, others, and the world. Within reconnecting with the self, shared themes included regaining control and feelings of competency. Within reconnecting to others, shared themes

[1]University of Michigan, Ann Arbor, USA

Corresponding Author:
Laura Sinko, Department of Health Behavior and Biological Sciences, School of Nursing, University of Michigan, 400 North Ingalls Street, Ann Arbor, MI 48109, USA.
Email: laurasin@umich.edu

included building and maintaining relationships, living one's life authentically, and feeling heard and understood. Within reconnecting to the world, shared themes included feelings of serenity, finding fulfillment, and having hope for a brighter future. Although these themes were shared, the way they manifested in each culture was often different. A vital component of the healing dynamic in the Irish sample was survivors' mothering responsibilities and feelings of unconditional devotion to their children. Conversely, the American sample focused on personal growth and resolving feelings of weakness. This information reveals shared as well as cultural nuances of important healing objectives following GBV. The present study's results can be used to create culturally sensitive and relevent healing spaces for survivors. These results can also inform intervention and messaging strategies aimed at promoting healing in these populations.

Keywords
support seeking, sexual assault, domestic violence, cultural contexts, battered women

Introduction

Gender-based violence (GBV) is a pervasive social and human rights issue, referring to "violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society" (Bloom, 2008, p. 14). GBV can encompass threats of violence and coercion and can be physical, emotional, psychological, or sexual. Due to its disproportionate impact on women, GBV is often used interchangeably with the term violence against women. Estimates of GBV suggest that 35% of women worldwide have experienced either physical or sexual violence by a partner or nonpartner at some point in their lives (García-Moreno, Pallitto, Devries, Stöckl, Watts, & Abrahams, 2013; World Health Organization, 2016).

GBV can have a lasting impact on women physically, emotionally, and spiritually, often leading to high utilization of health care and other services (Bonomi, Anderson, Rivara, & Thompson, 2009; Kapur & Windish, 2011). Because of survivors' frequent contact with services in a variety of helping professions, it is becoming increasingly important that clinicians understand and support survivor healing experiences and goals to enable them to engage in their care in a meaningful way. Additionally. it is important for clinicians' to understand the cultural nuances related to healing to provide adequate, culturally sensitive care and referrals.

Healing After GBV

Although most recovery literature to date is not centered around GBV populations specifically, there is some literature highlighting the idea of healing after traumatic events. For example, Judith Herman theorizes that there are three stages of trauma recovery: safety and stabilization, remembrance and mourning, and reconnection and reintegration (Herman, 1997). Relatedly, according to Taylor's (1983) theory of cognitive adaptation, successful adjustment to stressful life circumstances involves three phases: finding meaning in the experience, regaining mastery over the traumatic experience, and restoring one's self-worth. Taken together, although these influential theories, among others, provide some insight into how survivors of GBV may be able to heal after their experiences, building on these themes in this population is essential to further understand gendered and cultural nuances of healing for intervention going forward.

There is also a growing body of literature citing the idea of posttraumatic growth conceptualized as achieving positive change as a result of the survival of a highly stressful event (Tedeschi & Calhoun, 1996). Through this literature, it has been proposed that overcoming initially high levels of traumatic distress is possible through making meaning out of a traumatic event, resulting in positive changes within one's life (Tedeschi & Calhoun, 1996). This concept has been applied to a variety of physically and emotionally traumatic experiences, highlighting the importance of 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). Although the concept of posttraumatic growth is helpful as it represents growth after trauma, recovery experiences of survivors may differ depending on the type of trauma they have experienced. For example, interpersonal trauma recovery may differ from recovery after other forms of trauma (e.g., natural disasters, traumatic medical diagnoses) due to the intentionality of it being perpetrated by another person. Supporting this idea, 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 when compared with survivors of motor vehicle accidents and those in bereavement. The authors conclude that the direct threat to the personal physical integrity and the fact that sexual assault is a trauma that is interpersonal may add another dimension to the trauma experience (Shakespeare-Finch & de Dassel, 2009). This finding highlights the need to look further into interpersonal trauma such as GBV specifically, to identify pertinent barriers and facilitators to personal growth and healing.

Unfortunately, we know much more about adverse outcomes in survivors than we do about healing and recovery after GBV. For example, in a qualitative meta-synthesis of 51 reports discussing healing after sexual violence, one limitation identified by the authors was that only 12 synthesized reports stated their intended purpose was to describe how individuals heal, adapt, or recover from sexual violence (Draucker et al., 2009). This limitation could contribute to an inability to see the whole picture surrounding healing after GBV, with many ad hoc analyses potentially only capturing certain healing aspects relevant to their initial intended research questions. Reports that did discuss healing in this review revealed the importance of relating to others, feeling safe, and reevaluating the self as essential benchmarks in their trauma recovery process (Draucker et al., 2009). Additional research is needed, however, to explore the cultural nuances of healing after GBV beyond sexual violence, specifically as it relates to being a woman within society. Therefore, the purpose of this study is to understand shared and culturally-specific healing influences and goals in two samples of women recovering from GBV in different areas of the world, Ireland and the United States. This will begin to uncover what is cultural about healing, as well as how one's sociocultural environment can affect healing expectations and processes.

Sociocultural Attitudes About Violence Against Women Globally

An understanding of the sociocultural attitudes toward violence against women is central to intervention and understanding trauma recovery goals. While we know that violence against women occurs in all countries, specific rates vary widely across the world, suggesting sociocultural factors may be at play. For example, a World Health Organization study found that 1-year prevalence for physical or sexual assault ranged from 4% to 54% (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). One study done in the Baltic region (Ismayilova, 2009) found that patriarchal gender beliefs and norms justified wife abuse, however, this study focused on these beliefs as risk factors for abuse. Another study by Nayak, Byrne, Martin, and Abraham (2003) used a researcher-developed scale to compare attitudes toward physical and sexual violence in four countries, finding that sociocultural differences were more important than gender differences, suggesting that cultural context shapes the beliefs of *both* men and women. Many studies operationalize beliefs related to violence (e.g., Dahlberg, Toal, & Behrens, 1998; Frese, Moya, & Megías, 2004; Worden & Carlson, 2005), and several studies have compared these between majority and minority communities in the United States. For example, a study of adherence to the culture of honor in Latinos found that high adherence may be associated with more tolerance

for violence against women, greater approval of the perpetrator, and less approval of seeking help to escape from violence (Dietrich & Schuett, 2013). However, few studies have used qualitative methods to compare culturally held beliefs about violence against women. One notable exception is a study that compared Somali, Vietnamese, and Latino communities (Pan et al., 2006). They found differences among the communities' definitions of violence, referencing the American definition of domestic violence as focused on domestic partners and encompassing verbal, physical, emotional, sexual, and financial abuse. In contrast, the communities' definitions of violence in the home included intergenerational as well as partner violence, and was focused primarily on physical violence.

Cultural Beliefs About Violence in the United States and Ireland

References to cultural beliefs about violence in the United States tend to focus on gender norms related to masculinity and power (Kilmartin & McDermott, 2016). For example, norms of male aggression include media portrayals of men having strong sexual needs and being obsessed with sex, whereas women are portrayed as seeing sex as part of love and commitment, and being generally sexually passive to protect their virtue (Byers, 1996). In Ireland, references to cultural beliefs about violence tend to focus on patriarchal institutions such as the Catholic Church and the law. In general, this focuses on the image of women in Ireland as the self-sacrificing Irish mother in which

> . . . women only exist as a function of their maternity in the dominant ideology. . . (And the) traditional feminine role, particularly as the Catholic Church defines it, is grounded in a deep loathing of femininity. . . and those women who identify with it are also expressing a form of self-hatred. . . The identification of the family (rather than the individual) as the basic building block of society is more than pious rhetoric in the Irish Constitution. (Meaney, 1991, p. 3)

For many, help-seeking actions are one of the key ways that one engages with their healing journey, equipping individuals with skills, support, and guidance while managing their recovery after GBV. Very little is known, however, about how culture affects help-seeking and subsequent healing, and we can find no studies that explicitly compare cultural views toward healing after GBV. However, some research about help-seeking focuses on cultural norms. For example, Fugate, Landis, Riordan, Naureckas, and Engel (2005) reported that personal perceptions affected American women's willingness to seek help after domestic violence. Primary reasons for not using services were perceptions that the violence was "not serious," and fears that

they would be forced to leave the relationship (Fugate et al., 2005). Similar findings were reported in a New Zealand study of a sample of 956 women who had ever in their lifetime experienced physical and sexual violence by an intimate partner (Fanslow & Robinson, 2010). Data on Irish women shows similar patterns. In a survey of women across the European Union, 1400 Irish women in the sample of 46,000 women were interviewed. When asked about the reasons for not contacting services other than the police, responses were similar to those reported in other studies, including believing that they should deal with it themselves or only involve a friend/family member; believing that they should keep it hidden because of shame and embarrassment; perceiving that the incident was too minor to seek help; believing it was their fault; fearing being blamed or not believed; and fearing the offender's reaction if they had told anyone (European Union Agency for Fundamental Rights, 2014).

These data suggest that fears of others' perceptions might be central to seeking help during the healing process. Again, the literature on the perceptions of, and impact of, cultural context on trauma recovery is limited. One systematic literature review identified three types of stigmatization and theorized how these could impair seeking help during the trauma recovery process (Westbrook, 2008). Westbrook found that internalization of negative beliefs about oneself or the world can increase psychological distress, reporting that women describe feeling weak, helpless, ashamed, or to blame for the abuse. Other research focused on how women worry about what others may think or say if women told others about the abuse. These studies found that women feared that people would be unsupportive, would expect them to leave, or would say that they were weak or "stupid" for staying. Finally, some research on cultural beliefs about violence examined how perceived ideologies within the broader community affect women's willingness to self-disclose their distress or recovery needs (Fugate et al., 2005; Murray, Crowe, & Overstreet, 2018; Saint Arnault & O'Halloran, 2016). These studies found that women faced judgmental attitudes from a variety of sources, including publicly stated beliefs that domestic violence is a private matter, should be kept secret, violence against women is normal, and abuse always involves physical injury (Westbrook, 2008). Unfortunately, cultural similarities and differences are not addressed in any of this critical research.

For this research, our definition of healing is consistent with Herman's final stage of the trauma recovery process, in which healing is the act of rebuilding the self through reconnecting to oneself and reintegrating to one's environment (Herman, 1997). Our study sought to understand the shared healing influences, goals, and objectives of Irish and American women recovering from GBV, as well as identify culturally specific healing goals and

influences. This comparison method can aid in retaining cultural integrity in future interventions intended for these populations.

Method

Study Design, Procedure, and Sample

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. We aimed to interview women who were accessing medical or social services. The Americans were recruited through a flyer distributed through a health system. The Irish recruitment was carried out with flyers at general, community-based GBV informational services, as well as at services for specific GBV types, such as domestic violence. In both sites, the flyer recruited women who identified as experiencing GBV at any time. The GBV experience was self-defined by the woman, and study staff did not impose any other criteria. For both staff and participant safety, women were screened for current GBV situation by phone before the interview. However, no participant endorsed this in either site.

Women who responded to the research call were contacted via phone by study staff to schedule an interview. Interviews were held at a location of the participants' choosing, ranging from their homes to secure locations at the service agencies or private office spaces. Each interview was 1 hr to 90 minutes in length and were recorded with consent. Interviewers at both sites were research staff with a baccalaureate degree (or higher) in a human service field and had training in the interview methodology, trauma-informed interviewing, and human subjects protection. After the interview, local psychological support resources were given, and materials were photocopied and returned to the participant.

Demographics of the samples are included in Table 1. The American sample included 19 women from Southeastern Michigan ranging from 20 years to 81 years in age, and about one half had children. Eighteen of the women identified as Caucasian, two women identified as African American, and one woman identified as Asian, and all of the women were born in the United States. Half of the sample had experienced more than one type of GBV; five had experienced child abuse, 10 had experienced sexual abuse, and nine had experienced domestic abuse. The Irish sample included 12 women from primarily rural areas of Ireland, ranging from 20 years to 64 years in age, and all of them had children. Eleven women identified as Caucasian and one identified as Black. All but one of the women was born in Ireland; however, several had lived abroad, primarily in England. All 12 participants reported instances

Table 1. American and Irish Demographics.

	American (*n* = 19)	Irish (*n* = 12)
Age (years)		
20-30	8	—
31-40	4	1
41-50	3	6
50+	6	5
Children	10	12
Education		
Baccalaureate or higher	14	4
Trauma history		
Sexual assault	10	6
Domestic/dating violence	9	12
Complex trauma	8	9

of abuse (emotional, physical, or sexual) in childhood, as well as domestic abuse. Seven of the nine participants who identified abuse in childhood stated that their abuser was their father. One identified an older brother as the abuser, and one did not state who the abuser was.

Measures

The Clinical Ethnographic Narrative Interview (CENI) was used to collect data in both the Irish and American samples (Saint Arnault, 2017). The CENI is a semistructured interview developed by the senior author for a National Institutes of Mental Health (NIMH)-funded research study examining the interactions between distress experiences, cultural interpretations, social structures, and help seeking (Saint Arnault & Fetters, 2011; Saint Arnault & Shimabukuro, 2012). Since its development, the CENI has been adapted to study trauma recovery and has currently been utilized in over 100 survivors of trauma in seven different countries to identify sociocultural themes of help-seeking and the trauma recovery journey after GBV.

The theoretical background and detailed procedures of the CENI are described elsewhere (Saint Arnault, 2017). The interview lasts about 90 minutes and utilizes four activities (social network, body map, lifeline, and card sort). Each part of the CENI relates to the others, and each activity's product remains in view throughout the interview, with the opportunity for the individual to have a copy of her activities at the end. The interview begins with open questions asking about oneself. The first activity in the interview is a *social network map* that frames social support and conflict within one's social

context. When describing her social map, a woman is also asked who provides support and if there is conflict in any of her relationships. Next, the participant uses *body mapping* to move her focus from her social world into her personal experience within her body. She is asked how she feels in her mind, body, and spirit, and how life has left its mark on her body. Then, she completes and reviews her *lifeline* to facilitate a retrospective overview of her high and low points in life, and to identify linkages between experiences and subsequent actions. During the description of her rendering, she is asked about how she recovered from low points, as well as factors that might have contributed to the low points and high points. Next, she uses a *card sort* to focus on a recent low point, regardless of its trauma content, to facilitate contemplation about her current situation. The cards include 46 empirically derived physical and emotional feelings. During this activity, she is asked about the meanings of these experiences, and beliefs about how others saw her then. Finally, the participant answers questions reflecting on her recovery and things that she believes aided in her "healing process."

Analysis

Qualitative analysis was carried out to identify participants' healing goals, and the meaning of healing for them. Study staff in both samples transcribed their data, with the accuracy of the transcription finalized by the interviewers at both sites. Grounded theory analysis consisted of systematic identification of grounded and axial codes, identified in line-by-line constant comparison (Strauss & Corbin, 1998). 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 reviewed alternating weeks by the senior author, with coding concepts being regularly discussed by the research team for verification of accuracy.

Comparative Ethnographic Narrative Analysis Method (CENAM) was used to identify shared and culturally-distinct healing meanings and goals (Saint Arnault & Sinko, under review). CENAM is an analysis method that involves independent analysis of each cultural sample, followed by "reconciliation meetings" to discuss possible similarities and differences. Reconciliation meetings for this project were mediated by the senior author, and were comprised of the entire research team. In the reconciliation meetings, the team affirmed the phenomena that were shared, and also determined the themes that were distinct between the two groups. Next, each data set was reanalyzed using the culturally distinct from the *other* group to determine whether that phenomenon was present or if it was truly absent. Upon understanding the shared and the culturally-distinct healing meanings and goals, we examined the shared phenomena in light of the culturally distinct phenomena. This final analysis was called the

"metanarrative" analysis; wherein we define metanarrative as the overarching interpretation of cultural circumstances that provides the structure and meaning for people's beliefs, actions, and goals. This ultimate metanarrative analysis allowed us to understand the cultural nuances of each cultural group's experiences, being true to the meanings for the women of each cultural group.

Results

Shared Themes

Reconnecting to the self. The women in both of our samples described how their GBV resulted in a disconnection within themselves, often referring to an experience of themselves "before the violence" and "after the violence." For example, one American woman said, "I didn't know who I was anymore, so I had to rebuild from scratch" (Participant A013). Similar sentiments were shared by Irish women, illustrated by one woman reflecting on feeling like she "wasn't there herself" after her experience (Participant 2D12). This disconnection caused great pain and confusion in our participants. In order to reconnect with oneself, shared themes for the Irish and the American women included regaining control and feelings of competency.

Regaining control was described as essential in our samples because many struggled with feeling "out of control" of their symptoms as well as their resulting decision-making processes after their GBV experiences. This feeling of being out of control seemed to cause particular frustration and anxiety in our samples, because coercion and forced control was often an attribute of their GBV experience. For example, one American woman expressed her feelings in the following way:

> I am frustrated that I don't have as much control over my situation as I would like, and I feel like every way I try to problem solve, there is some sort of roadblock that is not possible to overcome or is a feat to overcome. (Participant A041)

An Irish woman elaborated on this topic, explaining,

> I was saying [to myself] do I want to be here or do I want to be elsewhere? And, by god, I kept coming up with "No, I have to do this; I have to take charge of this." (Participant 5DD)

Regaining control manifested in a variety of ways in both samples, including managing symptoms, autonomous decision making, choosing whether or not to report, as well as participating in activities and tasks that made them feel in control.

Another way women reconnected with themselves was through building feelings of competency. The women in both cultures described feelings of competency as feeling as though one can function productively and adequately in the home and within society. There were variations in the emphasis of their functioning activities (described below), however, the restoration of *being* competent was shared by the women in both groups. Women explained that, after the violence, they felt that they had lost their way, feeling that they felt their ability of capability or capacity had been destroyed. However, during their healing process, they described slowly resuming their roles, or expanding their abilities through engagement in school, work, or the home. Women also reported rebuilding their confidence that they could effectively manage and navigate their external worlds on their own. An American described her journey to feeling competent by saying,

> I want to go back to work, but I want to do something really significant that will carry me. I don't ever want to stop working. I am not really designed to retire. I am looking at going back to school. . . (Participant A079)

An Irish woman also noted the importance of feeling capable, saying,

> . . . everything disappears when I'm in the garden. I look at this little flower growing and I think I'm going to nourish you and you're going to grow big and strong, and I look at the flower and I look at me. . . (Participant 6TK)

Reconnecting to others. Although often difficult, reconnection to others was something that women strived for, achieved through building and maintaining relationships, interacting with others authentically, and feeling heard and understood. Building and maintaining relationships was described by both samples as a feeling of community engagement and mutual support. Although this was voiced as a goal for participants, many struggled to regain trust in others and hence had difficulties engaging in close relationships. For example, one American woman reflected, "I think the disconnect was fear to let anybody get close to me, because oh, they would hurt me" (Participant A012). Irish women also struggled with this feeling, with one woman saying, "I am disconnected from everyone because I don't trust people . . . I'm disconnected because I was alienated and I'm angry about that" (Participant 4DWA).

Women in both cultures described authentic interaction as another goal, describing a desire to allow others to see their true self. Women struggled through their fears, knowing that the pathway to healing was living fully as themselves, and this required letting people in even after being so hurt. An American woman said, "I am [now] completely open about everything I have

done and everything that has been done to me . . . I am becoming closer to people" (Participant A105). An Irish woman echoed this statement, saying,

> I still love from my heart, but the love is different now because the love has been expanded over different strands of people and different areas than I had before. . . . enabling me to look at life in a different way. (Participant 4DWA)

Feeling heard and understood included feelings of validation through supportive social reactions. Although closely related to being authentic, this theme related to their perceptions of how others responded to them. Sometimes, it was an awareness that people *do* care, and will respond positively and with support, even though there were fears to the contrary. For example, an American woman said, "there are people there who I know I could call five years from now, and they would still (be there for me)" (Participant A039). An Irish woman discussed her feelings for her friends, explaining, "They know where I am, they've been there and you know the nice thing is when speaking to them. . . . somebody kind of understands" (Participant 3MWS).

Reconnecting to the world. Reconnecting with the world often brought a feeling of connection with something more substantial than themselves, bringing not only peace but also perspective during their recovery journeys. Shared healing themes included attaining moments of serenity, finding fulfillment, and maintaining hope for a brighter future. These themes were important and relevant to both samples as they reevaluated and rebuilt their world.

Women from both cultures described feelings of serenity as feelings of lightness, calm, and peace. This feeling was often described as something that was lost or tainted after abuse. Women searched for times when they could regain this sense, often remarking that it was a moment-to-moment feeling, and that they were aiming to make those moments more prolonged and more profound. For example, one American woman reflected, "That's what I really lost, that person who felt mothered and connected, and part of the world" (Participant A036). An Irish woman reflected,

> I love nature; I learned how to use the camera so I could photograph nature in my back garden. . . . I don't give myself enough praise for some of the things I do. So, I've opened my mind to be more aware of what I can do against the background of being told I can't do. (Participant 4DWA)

Finding fulfillment was described by women as pursuing interests that aided others and brought a sense of purpose. This fulfillment was a goal-oriented set of activities that resulted in a sense that their life, and even their

past, had meaning. It also set the course of their time, their energies, and their goals, creating a roadmap for the future. An American woman discussed her process by saying, "It's funny, because like in the last year I have started to have long-term 30-year goals, which I never had before . . . it is giving more motivation to preserve relationships, and work towards real conversations" (Participant A005). An Irish woman said, "Lots of nights I sit here with my kids, and I think of the alternative, and I'm really happy and blessed that things have turned out. We have got money, and we've got a house" (Participant 3MWS).

Hope for a brighter future was an openness and longing for a new life of healing and recovery. Hope had less to do with what they did in the day to day, instead having more emphasis on the impact they had on the broader world. This hope was not generally abstract but connected the dots between who they were now, how they were in their relationships with others, and how these, together with their focused activity, could affect change and positivity in the world. An American woman reflected,

> That would be my long-term hope for society in general . . . that the emotional intelligence part can kick in, that the person can have empathy and compassion towards themselves, love themselves enough to do whatever it takes. That's the commitment I had to give myself. (Participant A079)

An Irish woman explored the causes for newfound optimism in her worldview, stating, "It was the light and the truth that came with it that I could make a difference for myself, but more importantly I've made the difference for my kids" (Participant 4DWA).

Culturally Distinct Themes

Reconnecting With the Self

Irish women found motherhood central. The Irish women's perception of strength and competency often manifested as an internal, selfless process. The Irish women described extreme pride in their role as a mother, which was often shattered by their GBV due to their low residual confidence in themselves and their ability to mother on their own without their partner. For example, one woman expressed feeling like a "failure as a mother" after her abuse (Participant 3MWS). Low confidence and feelings of failure were not uncommon in this sample and seemed to stem from the control and manipulation of their perpetrator, in addition to the internalized cultural messages of the woman being responsible for keeping the family together. Finding one's internal strength to persevere was, therefore,

essential and required "courage" due to the risk of familial and societal judgment that often accompanied leaving one's partner and creating a new life. This courage was motivated by one's love for her children, illustrated by one woman saying, "The children probably were the best motivation. They deserved a mother to be functioning proper. Courage, strength, but, possibly, the children were the main thing" (Participant 2MWSS). Another woman said, ". . . my kids are my world; I would move hell or high water for my kids" (Participant 1D12). And, even though raising children was often perceived as stressful, one woman said, "(Yes). . . that's more stress, I have to say, on an everyday basis but he's your child, and I do everything I possibly can for them" (Participant 3CW).

American women wanted independence. In the American sample, strength, control, and competency often looked different. This seemed to relate to women believing that their violence was influenced by "gender norms" in society, typically painting women as being the "weaker" gender. Relatedly, violence often made women question their strength and ability to stand on their own, causing them to long for the independence and control that they once thought that they had. For example, one American woman recalled, "I always considered myself, you know, the strong independent woman kind of idea, and I just wasn't that. . . I just wasn't. It just made me totally reconsider how I thought of myself as a person" (Participant A105).

As a result of the experiences listed above, women's self-worth was often determined by counteracting these feelings of weakness through feeling able to "take care of themselves" and "do things on their own." For example, one woman said, "So, I didn't really ask anybody for help. . . I grew up to be Superwoman" (Participant A036). Another recalled, "I guess this all comes back to this independence idea, I really didn't want to be a burden on other people" (Participant A105). Feeling independent gave women a sense of control over their surroundings, enabling them to see the value of themselves within their greater society. For example, one woman recalled, "I got a Presidential Scholarship, so I went back for another degree (laughing). More school and that was fabulous. . . I could do whatever I wanted it seemed like" (Participant A006).

Personal achievement in education and work life was often the vehicle in which women felt able to take care of themselves, pushing against common gender traditions that limited them to the home. For example, one woman said, "I find it very [interesting]. . . If I look at like the positive stuff, a lot of what I wrote has to do with school" (Participant A011). That same woman went on to say,

> I had for the first time like a really good stable year. . . I had a job, I had stability, and it was great. Yeah, and there [were] challenges. . . but at the same time, it felt manageable because it was counteracted by other positives. (Participant A011)

Similarly, another woman recalled, "I had four job offers. . . when I left, I mean, I held my head up high because I knew this" (Participant A006). Demonstrating that one was doing well often gave women a sense of control over their life and validated their sense of competence, challenging their doubt in their abilities to succeed after violence's impact.

Reconnecting With Others

Irish women feared judgment and scorn. The women in the Irish sample explained that many of the barriers to healing that the women faced involved their own family's judgment and community scorn. For example, one Irish woman reflected that by leaving her marriage, she felt "the embarrassment of failure" (Participant 3CW), whereas another disclosed that she could not tell anyone because of the, "whole fear and anxiety of what other people think about you" (Participant 1D12). The previous examples illustrate how fearing judgment often impeded women from leaving their abuser, disclosing their experiences, and utilizing supportive services, causing women to hide themselves and their experiences from the outside world. This further isolated women from their communities, affecting their ability to reach out for support throughout their healing journeys. This sense of secrecy is highlighted in the following quotation, with one participant saying, "yeah, we all put masks on to hide ourselves, because we're told no-one would believe us" (Participant 4DWA).

Knowing that the world is judging her, women felt the eyes of the community on them all the time. This scrutiny and scorn even extended to those helping them. One woman said, "That's the type of thing when you're trying to deal with social work, they think you're nuts, you're being judged, you can't cry because you're being judged" (Participant 5DWA). Another said,

> And, knowing that the social (workers) are looking down your back the whole time. . . just waiting for you to slip up, waiting for you to forget something and she would be down on you like a ton of bricks. (Participant 1MWSS)

Situations such as these often made women feel as if they had nowhere to turn, especially when the individuals supposed to be helping them often further reinforced the scorn the women were receiving from their communities.

This ultimately resulted in distrust for the systems put in place to help these women, creating further barriers to reconnecting with those around them after their abuse.

As a result of this perception of judgment, to fully reconnect with others, women described needing to "live her truth" despite her awareness that some would judge her. By being able to live her truth, women were able to reach a state in which they "weren't ashamed to ask for help" and were better able to authentically interact with those around them, building meaningful connections to support their healing journey. One woman said, "since I left him, the greatest thing I feel for myself is to be true to myself. I'm no longer living a lie. . . " (Participant 2MWSS). Bravery to express one's needs despite the environment rich in judgment was central to healing, as expressed by this woman,

> I would advise them to get help and definitely to talk to somebody or a service, just a support system. That doesn't mean they may be able to get out of it; they may not. It's not an easy thing to do but to get help anyway, not suffer alone. That's probably the best advice I can give. (Participant 2MWSS)

American women feared vulnerability. In the American sample, however, the most significant barrier to connecting with others seemed to be allowing oneself to be vulnerable with people, despite societal and familial messages putting pressure on these women to "get over it." For example, one woman reflected on her family's responses to her persistent low mood by saying, ". . . 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, you know, 'Can't you just put this behind you'" (Participant A079). Feeling as though others were pushing the participant to "get over" their GBV experience quickly was not uncommon in our sample, often causing women to internalize these beliefs and get frustrated when they were not "healing fast enough."

As a result of the messages that they received in their social world, American women often felt that vulnerability was a sign of "weakness" causing them to resist disclosure of their distress to trusted others. For example, one woman commented on minimizing her experiences so that others would not "think she is a teacup" (Participant A005). Another commented that she did not tell her support network when she was struggling in fear of "being a burden" (Participant A013). Relatedly, to push back against this feeling of weakness, some women resulted in fits of anger or aggression when they were feeling vulnerable rather than addressing their vulnerable feelings. For example, one woman stated, "I don't think I had allowed myself any feeling except anger, and actually rage" (Participant A012). Another disclosed,

> I remember walking down the hallway at school, and all of the sudden a bunch of boys would be pushing me against the locker and feeling me up, over and over, and over, and over. What am I supposed to do about it? I got assertive. I started hitting. (Participant A013)

Redefining what strength means was particularly crucial for the women in this American sample to be able to accept help, acknowledge the impact violence had on them, and adequately address it. For example, one woman said, ". . . so that was the biggest thing, probably just really focus on trying to figure out what strength actually is, where there is good and what things still hold value to you" (Participant A011). Another recalled, "I now understand that vulnerability isn't necessarily always a bad thing, which is something that I probably didn't experience before this" (Participant A105).

Ultimately, going against this ingrained belief and allowing one to be vulnerable and honest about the impact of violence on their feelings seemed to help foster genuine, lasting relationships that lead them to feel heard and understood. For example, one woman recalled, "I felt this hostility, and I just kind of channeled that energy into survivorship" (Participant A006). Another woman reflected on her journey of authentic vulnerability by saying,

> At least for me, it was kind of like going out on a limb and sharing little bits and letting people in. . . so, I think that recognizing that people are generally good and want to be there and help if you are willing to let them. I think that's one thing. (Participant A039)

Reconnecting to the World

Irish women will end the cycle of abuse. The woman in our Irish sample seemed motivated by the hope that the cycle of abuse would end with her generation, and this hope often facilitated her healing processes by motivating her to teach her children how to live in a world that does not tolerate violence. This belief was often referred to as "wanting something different" for her kids or by "breaking the chain of events" (Participant 4DWA). Although this belief was important to her healing journey, the practice of enforcing this goal with her children was often difficult, as many were acutely aware of how witnessing the violence had affected their children's behavior even at a young age. One woman illustrated this by discussing a conversation she had with her son after a violent episode,

> It was very, very bad, I have to say. I then brought him off for a walk, I always walk with the kids, and I said it to him, "where did you see that behavior?," "daddy" he said. So, he was picking up on what daddy was doing which is really sad. (Participant 3CW)

Addressing their children's aggressive behavior, and reinforcing that violence was unacceptable throughout their development, was important for women in our sample. This goal enabled them to give their children the tools necessary to choose not to perpetuate or tolerate violence in the future. For example, one woman focused on making sure her children feel pride and self-love as she never had, saying, "They love being praised. If (my son) gets the champ in school, 'mammy, are you proud?,' I say 'you have no idea how proud I am of you.' That would be that part of (breaking the cycle)" (Participant 3CW).

The belief that her children's future could be different from her past seemed to motivate women to see their world differently, filled with new possibilities. One woman elaborated on this idea, saying,

> If I don't come forward then my kids can't follow. . . I don't want them following in his steps. . . So, if I'm independent and can do what I want by myself, the kids can do it and yet know when to ask for help. (Participant 1D12)

This example illustrates the belief that being a good role model for one's children was an important aspect of the role of a mother, especially because many children could not look toward their father as an example of appropriate behavior. This gave the women a sense of purpose and importance going forward, with one saying, "I want a change and embraced the changes that are coming because. . . I'm going to make a difference for myself and for my children" (Participant 4DWA).

American women will release anger and negativity. As noted earlier, many American women harbored anger and negativity toward the greater world as a result of their GBV experience. For example, one woman recalled, ". . . for me primarily what I felt was like swamped and not sure what to do with the amount of anger I felt" (Participant A011). Another noted her daughter referred to her as the "Incredible Hulk" due to the "hair trigger anger" that she had, resulting in "a totally overblown reaction. . . A child throws a ball that hits me in the head accidentally, and I explode in vicious yelling" (Participant A012). Anger and negativity often caused stressful environments for those around survivors, creating barriers to connection.

To reconnect and find hope again, American women described a strong need to release or resolve pent-up negativity and anger that seemed to follow them, allowing them to look at their world through a new lens. This release was often accomplished by letting go individuals who influenced their negative thinking or avoiding stimuli that contributed to their negative thinking patterns. For example, one woman reflected, "I have just been trying to avoid

anything that is negative" (Participant A079). Another said, "I realized that I didn't need those kinds of negative people in my life. So, I was able to cut the ties" (Participant A100).

Ultimately, women who were able to decrease some of the negativity in their thinking felt a tremendous emotional release. One American woman recalled,

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

Another woman had similar thoughts, saying "Don't look in the rearview mirror, move forward. . . I don't like negativity or dark. . . I don't have time for it" (Participant A006). Releasing anger and hate and replacing those feelings with gratitude and hope enabled women to realize that "there is good in this world" and that "life is worth living."

Metanarrative

The overarching concept of disconnection was pertinent to women in both cultures. This disconnection manifested in many ways, often causing significant difficulties for our participants, including feelings of self-doubt and self-blame, withdrawal and isolation, as well as negativity and fear about the world and their future. However, the cultural emphasis of *how* to reconnect, *what* needed reconnection, and what *connection* felt like or meant, was culturally nuanced. In the area of the self, reconnection to strength, competence, and control were the central goals for the women in both samples. However, as we have seen, for the Irish women, the road to achieving this surrounded the idea of being a good, functioning mother despite her circumstances. In contrast, the American women seemed to strive to prove and demonstrate their worth through personal achievement and healing "on their own." The American women who were mothers seemed to keep motherhood separate from their healing process, often citing it as a reason why they had trouble devoting time to their healing or as a reason why they suppressed their distress. For example, one woman mentioned, "I don't get any time for myself. Like, if I want to take a shower, it has to cut into my sleep. . . I don't get time to just relax" (Participant A009). Another questioned, "Why do I always have to be the one of taking care of people, why won't somebody take care of me" (Participant A012)? Overall, identification with, or experiences of motherhood did not seem to provide the same feelings of competency for the American women in or sample compared with the Irish, taking the form of a role in her life rather than a critical healing piece.

In the area of connecting with others, again we see shared goals of building relationships, being authentic in those relationships, and receiving social validation. Women shared the idea that rebuilding their sense of connection was essential to enable them to "not look in the rear-view mirror and look forward," while accepting and learning from their past experiences (Participant A006). However, the experience of disconnection and the meaning of reaching out were different for the women from the two groups. Because personal achievement and worries about being perceived as weak or vulnerable were such a cultural concern for American women, the disconnection from others was sometimes experienced as a self-protective survival strategy, keeping them away from questions about their abuse or their struggles.

For the Irish women, there was also a self-protective aspect to disconnection, but the emphasis was avoiding public scorn or abandonment by others in their family and within their community. Of course, American women did experience stigma and judgment within the larger society, but their experiences within their personal social network of trusted others seemed to be more positive and understanding compared with those reported by the Irish sample. In contrast, the American women described a voluntary withdrawal due to fear of judgment that they would appear weak, rather than perceiving community scorn for breaking the norms of marriage and womanhood noted in the Irish sample. For example, one American woman reflected,

> I remember being so scared to share anything, but if I understood that people weren't nearly as judgmental. . . I think that recognizing that people are generally good and want to be there and help [is helpful] if you are willing to let them. (Participant A039)

These feelings were not uncommon once women reached out to trusted people in their inner circle, enabling them to feel supported as they continued to engage in their healing process.

The connection with the world was a significant goal for the women and was experienced by feelings of serenity, fulfillment, and hope. However, the pathway to this purpose, or how women can contribute to the future, was culturally nuanced. For an Irish woman, her resounding and compelling contribution to the world was that the cycle of abuse would *end with her*. She was empowered, through her competent care of her children, to teach values of respect, and to foster a new world literally. To the American women, hope and peace for themselves and the world could only be achieved when they changed their way of being in the world, approaching life with gratitude and positivity. This expansive sense of fulfillment and purpose, then, shaped how women were in life, affecting those around them.

Discussion

This study aimed to understand how GBV survivors perceived healing, and to recognize shared and culturally-distinct healing themes for samples of Irish and American GBV survivors. We did find shared reconnection goals in the areas of the self, others, and the world. Our method also revealed that there are healing goals that are rooted explicitly in cultural values, the role of women in society, and sociocultural pressures. Moreover, these cultural values helped us understand the cultural nuances of the shared goals. Importantly, this cross-cultural comparison study is the first of its kind to compare Irish and American healing influences, goals, and objectives.

Generally, data about the needs of survivors related to housing, financial security, legal support, and trauma recovery have been cast in terms of PTSD or depression. These are critically important aspects of recovery, and we applaud the research in this area. Our contribution aims to illuminate a perhaps more elusive aspect of recovery, which is the socially situated set of desires, needs, and goals, especially those that become apparent after the survivor has achieved some sense of safety and stability. Because these arise from and relate to the sociocultural world where the women find themselves, the cultural aspects of them are essential to comprehend. This research begins to arm us with that perspective of trauma recovery as a meaning-oriented, sociocultural enterprise, helping us provide culturally sensitive assistance. This method can be used with any two cultures to help us discern what is universal and what is particular. The value of these data is that we can understand, perhaps, the transcultural influences and goals of survivors, as well as to recognize sociocultural specific needs. These cultural differences can also be used to provide targeted public health messaging for survivors, containing culturally relevant strategies promoting help seeking and healing, as well as treatment for women on their recovery journey.

The overarching concept of disconnection was pertinent to women in both cultures. However, the cultural emphasis of *how* to reconnect, *what* needed reconnection, and what *connection* felt like or meant, was culturally nuanced. The idea of reconnection is not new in the trauma recovery literature (See Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Herman, 1997; Sinko & Saint Arnault, in press). For example, Herman (1997) described reconnection and integration as her third and final phase of trauma treatment. Our findings, however, break this phase down into concrete goals and objectives through the eyes of survivors, creating an opportunity for multiple points of culturally relevant intervention and public health messaging strategies for those in a variety of fields and disciplines with whom these women interact.

Other research that has highlighted the importance of reconnection is the posttraumatic growth literature. While encompassing a wide variety of traumatic experiences (e.g., natural disasters, community violence, medical diagnoses), this research highlightes 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). Although the posttraumatic concept highlights similar ideas to our core findings, we suspect that the definition of these categories may be problematic for survivors of GBV. The concept of posttraumatic growth states that one experiences such positive changes as a result *of their crisis* (Tedeschi & Calhoun, 1996), rather than as a result *of their healing* or personal efforts. The emphasis on healing can empower survivors and be easier to relate to. For example, many women in our American sample expressed feeling pressure to give off the impression of growth and strength without giving themselves the time and space to heal. Relatedly, many women in Ireland consistently referred to the immense "courage" it took to go against the violence within their household, often leaving them without a home, ostracized from friends and family, and without financial security. This awareness of public scrutiny makes the language attributing the crisis to producing growth rather than one's own courage off-putting. Relatedly, in Ireland, many of these women just longed for a "normal family" and may not resonate with this American idea of self-actualization and growth as a result of their experience. Ultimately, our research highlights the caution that needs to be taken when discussing delicate topics such as GBV and the vital influence of cultural messaging strategies on one's expectations and resulting actions after a traumatic event.

There are several limitations to this study, including differing sample sizes, recruitment sites (despite the shared procedures), the specific Midwestern and Ireland locations of the participants, and a primarily Caucasian American sample. It is important to note that while the Irish sample had experienced domestic violence, over half of our American sample had domestic or dating violence experience, and there was also a large proportion of complex trauma in both samples. The women in both groups faced numerous sources of GBV experiences, and our analysis does not try to compare healing based on violence type. However, future research may be needed to explore the similarities and difference of healing by various types of GBV. Despite these limitations, this study is the first of its kind to inquire about the similarities and differences in healing influences, goals, and aspirations in Irish and American GBV samples. We aimed to uncover culturally relevant nuances to healing to help us as we begin to address the

need of explicitly incorporating the interaction between one's nationality and gender into our support for survivors, to create better infrastructure to support survivor's healing needs. Continued understanding of national and ethnic differences is essential to better understand the influence of culture as it relates to the treatment of women, the normalization of violence, stigma, power dynamics, and access to treatment. Further cross-cultural comparison work is needed in this area, to discover what about healing may be universal, and what is culturally specific.

The present study has the potential to improve clinician interactions with survivors of GBV, by understanding potential primary healing objectives as well as the impact of disconnection and how it can relate to their engagement in care. In addition, this may provide a supportive framework for survivors who are just starting their healing process to engage with, to help them better understand what others in their culture have found integral to their healing. Finally, the understanding of culture's impact on violence and healing is incredibly important to make system-level changes in the way GBV is presented and discussed on a national level. Understanding and addressing the cultural nuances of healing are essential to ensure that we are catering to diversity and are keeping our interventions survivor-centered. This can further encourage survivor help-seeking and begin to dismantle the cultural infrastructure that often keeps them silent.

Acknowledgments

The authors acknowledge the participants whose brave decision to disclose their beliefs about this sensitive topic enabled the authors to draw conclusions about our phenomena of interest.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The author(s) received funding from the University of Michigan Institute for Research on Women and Gender (IRWG) to support this research.

ORCID iD

Laura Sinko https://orcid.org/0000-0002-6021-4727

References

Bloom, S. S. (2008). *Violence against women and girls: A compendium of monitoring and evaluation indicators*. Chapel Hill, NC: MEASURE Evaluation.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2009). Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Services Research*, *44*, 1052-1067.

Byers, T. B. (1996). History re-membered: Forrest gump, postfeminist masculinity and the burial of the counterculture. *MFS: Modern Fiction Studies*, *42*, 419-444.

Dahlberg, L. L., Toal, S. B., & Behrens, C. B. (Eds.). (1998). *Measuring violence-related attitudes, beliefs, and behaviors among youths: A compendium of assessment tools*. Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Dietrich, D. M., & Schuett, J. M. (2013). Culture of honor and attitudes toward intimate partner violence in Latinos. *SAGE Open*, *3*(2), 1-11. doi:10.1177/2158244013489685

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: A qualitative metasynthesis. *Research in Nursing & Health*, *32*, 366-378.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*, 319-345.

European Union Agency for Fundamental Rights. (2014). *Violence against women: An EU-wide survey—Main results report*. Luxembourg: Author.

Fanslow, J. L., & Robinson, E. M. (2010). Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. *Journal of Interpersonal Violence*, *25*, 929-951.

Foa, E. B., & Rothbaum, B. O. (1998). *Treatment manuals for practitioners: Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York, NY: Guilford Press.

Frese, B., Moya, M., & Megías, J. L. (2004). Social perception of rape: How rape myth acceptance modulates the influence of situational factors. *Journal of Interpersonal Violence*, *19*, 143-161.

Fugate, M., Landis, L., Riordan, K., Naureckas, S., & Engel, B. (2005). Barriers to domestic violence help seeking: Implications for intervention. *Violence Against Women*, *11*, 290-310.

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. H. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*, 1260-1269.

García-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C., & Abrahams, N. (2013). *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Retrieved from https://www.who.int/reproductivehealth/publications/violence/9789241564625/en/

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York, NY: Basic Books.

Ismayilova, L. (2009). *Intimate partner violence in three former Soviet Union countries (Azerbaijan, Moldova, and Ukraine): Prevalence, risk factors, and women's reproductive health*. New York, NY: Columbia University.

Kapur, N. A., & Windish, D. M. (2011). Health care utilization and unhealthy behaviors among victims of sexual assault in Connecticut: Results from a population-based sample. *Journal of General Internal Medicine*, *26*, 524-530.

Kilmartin, C., & McDermott, R. C. (2016). Violence and masculinities. In Y. J. Wong & S. R. Wester (Eds.), *APA Handbooks in Psychology Series: APA handbook of men and masculinities* (pp. 615-636). Washington, DC: American Psychological Association.

Meaney, G. (1991). *Sex and nation: Women in Irish culture and politics*. Dublin, Ireland: Attic Press.

Muhr, T. (2006). *ATLAS.ti (Version 5.0)*. Berlin, Germany: Scientific Software Development.

Murray, C. E., Crowe, A., & Overstreet, N. M. (2018). Sources and components of stigma experienced by survivors of intimate partner violence. *Journal of Interpersonal Violence*, *33*, 515-536. doi:10.1177/0886260515609565

Nayak, M. B., Byrne, C. A., Martin, M. K., & Abraham, A. G. (2003). Attitudes toward violence against women: A cross-nation study. *Sex Roles*, *49*, 333-342.

Pan, A., Daley, S., Rivera, L. M., Williams, K., Lingle, D., & Reznik, V. (2006). Understanding the role of culture in domestic violence: The Ahimsa Project for Safe Families. *Journal of Immigrant and Minority Health*, *8*, 35-43.

Saint Arnault, D. M. (2017). The use of the clinical ethnographic narrative interview to understand and support help seeking after gender-based violence. *Testing, Psychometrics, Methodology in Applied Psychology*, *24*, 423-436.

Saint Arnault, D. M., & Fetters, M. D. (2011). RO1 funding for mixed methods research: Lessons learned from the mixed-method analysis of Japanese depression project. *Journal of Mixed Methods Research*, *5*, 309-329.

Saint Arnault, D. M., & O'Halloran, S. (2016). Using mixed methods to understand the healing trajectory for rural Irish women years after leaving abuse. *Journal of Research in Nursing*, *21*, 369-383.

Saint Arnault, D. M., & Shimabukuro, S. (2012). The clinical ethnographic interview: A user-friendly guide to the cultural formulation of distress and help seeking. *Transcultural Psychiatry*, *49*, 302-322.

Saint Arnault, D. M., & Sinko, L. (under review). Comparative narrative ethnographic analysis: A lens to discover the importance of sociocultural contexts. *Qualitative Health Research*.

Shakespeare-Finch, J., & de Dassel, T. (2009). Exploring posttraumatic outcomes as a function of childhood sexual abuse. *Journal of Child Sexual Abuse*, *18*, 623-640.

Sinko, L., & Saint Arnault, D. M. (in press). Finding the strength to heal: Reconnecting the self back to others and the world. *Violence Against Women*.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Taylor, S. E. (1983). Adjustment to threatening events: A theory of cognitive adaptation. *American Psychologist*, *38*, 1161-1173.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*, 455-471.
Westbrook, L. (2008). Progressive information engagement model: Using, losing, and rejecting information in crisis situations. *Proceedings of the American Society for Information Science and Technology*, *45*, 1-10.
Worden, A. P., & Carlson, B. E. (2005). Attitudes and beliefs about domestic violence: Results of a public opinion survey: II. Beliefs about causes. *Journal of Interpersonal Violence*, *20*, 1219-1243.
World Health Organization. (2016). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. *World Health Organization*.

Author Biographies

Laura Sinko, BSN, RN, CCTS-I, is a PhD candidate and Hillman Scholar at the University of Michigan School of Nursing. She is a mental health nurse by training whose research focuses on trauma-informed care and gender-based violence (GBV) help-seeking and recovery. Long-term interests include using survivor's stories to improve culturally sensitive care, survivor-messaging strategies, violence policies, clinician training, and survivor education.

Courtney Julia Burns is an undergraduate student at the University of Michigan Department of Biomedical Engineering. She is on the premedical track with a passion for feminism and social justice advocacy. Her research interests include women's health disparities, trauma-informed care, and sexual violence prevention and treatment.

Sharon O'Halloran is the CEO of Safe Ireland. Her work center-stages women's voices and Safe Ireland carries out research and development that advocates for policy and service level improvements for Irish women and families.

Denise Saint Arnault, PhD, RN, FAAN, is an associate professor at the University of Michigan School of Nursing. Her research centers on gender, cultural and social influences on mental health, trauma recovery, and help seeking. She is the PI of an international GBV consortium called MiStory aimed at using cross-cultural comparison to determine cultural influences of violence and recovery.