Healing After Gender-Based Violence: A Qualitative Metasynthesis Using Meta-Ethnography

Laura Sinko¹, Richard James², and Kathryn Hughesdon³

Abstract

Gender-based violence (GBV) is a significant violation of human rights, requiring specific understanding of how individuals heal and recover after these experiences. This article reports on findings of a qualitative metasynthesis that examined the nature of healing after GBV through the perspectives of female-identifying survivors. Empirical studies were identified by a search of peer-reviewed articles via electronic databases. Studies were included for review if they were available in the English language, reported on qualitative studies that directly engaged female-identifying survivors of GBV, and were aiming to understand the GBV healing journey, process, or goals. After our initial search, 1,107 articles were reviewed by title and abstract and 47 articles were reviewed for full text. Twenty-six peer-reviewed articles were included for the review and were analyzed using meta-ethnography. Key findings included the recovery journey as a nonlinear, iterative experience that requires active engagement and patience. Healing was composed of (1) trauma processing and reexamination, (2) managing negative states, (3) rebuilding the self, (4) connecting with others, and (5) regaining hope and power. “Shifts” or “turning points” are also mentioned which catalyzed healing prioritization. This article aggregates and examines the scientific literature to date on GBV healing and provides articulation of the limitations, gaps in evidence, and areas for intervention. The article considers implications for future research, policy, and practice and, in particular, focuses our attention on the need to expand our knowledge of alternative recovery pathways and mechanisms for healing.

Keywords
sexual assault, domestic violence, mental health and violence, support seeking

Gender-based violence (GBV) is a global health concern and human rights issue (World Health Organization, 2013). GBV is violence perpetrated against a person due to the power dynamics related to gender and can encompass such acts as intimate partner violence, sexual violence, child abuse, and stalking (Heise et al., 2002). While anyone can experience GBV, women face extremely high rates. For example, in the United States, it is estimated that one in four women has been exposed to GBV in some form throughout their lifetime (Walsh et al., 2015). These numbers highlight the epidemic of GBV, which disproportionately impacts women of color, lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) individuals, and women with disabilities (Abrahams et al., 2013).

The range of negative psychological and physical outcomes associated with GBV has been well-documented, including increased risk of depression, anxiety, substance use disorders, suicidality, chronic pain syndromes, gynecological disorders, gastrointestinal disorders, and sexually transmitted infections, among others (e.g., Bonomi et al., 2009; Heise et al., 2002). In particular, those who experience GBV at the hands of someone they know, for example, an intimate partner, may be at higher risk for these physical and mental health outcomes (Freyd et al., 2005). Less is known about the healing processes beyond the alleviation of symptom burden in GBV survivors, particularly from the perspective of survivors. Thus, the purpose of this review is to synthesize the current scientific literature to date to understand the recovery process after GBV through the eyes of women who have experienced it firsthand.

Recovery Concepts in the Literature to Date

Most research on recovery following GBV has focused on recognizing factors associated with distress or adverse outcomes (Draucker et al., 2009). Scientific interest is growing, however,
in understanding recovery beyond the alleviation of negative symptoms. For example, a 2009 qualitative metasynthesis described healing after sexual violence, revealing the importance of feeling safe, relating to others, and reevaluating the self as elements of the sexual violence healing process (Draucker et al., 2009). The authors noted, however, that only 12 of 51 reports synthesized focused on healing and recovery specifically, while others described the “lived experience” of survivors more generally (Draucker et al., 2009). Hence, many aspects of the healing process may have been missed due to the limited number of studies reviewed actually aiming to describe recovery directly. Additionally, this review was focused on evaluating healing after sexual trauma and did not focus on self-identified gender in its analysis. More recently, a narrative review was conducted to synthesize literature about recovery after intimate partner violence, which was published after the present review was conducted. This review revealed developmental aspects of recovery including disentangling from the past, coping with the present, and moving toward the future (Flasch, 2020). Greater understanding of recovery after GBV broadly is needed, however, to reveal how the dynamics of gender and violence interplay as individuals attempt to rebuild and make meaning after these experiences.

Other terms have been used to describe recovery in trauma-exposed populations, and have been applied to survivors of GBV. For example, resilience has been defined as “the ability of individuals facing adversity to utilize resources within psychological, social, and cultural domains that sustain their well-being and promote adaptive outcomes” (Schaefer et al., 2018; Ungar, 2012). This has often been compared with the concept of posttraumatic growth, which focuses on meaning making and positive changes in the perception of the self, relationships with others, and one’s general philosophy of life as the result of a traumatic event (Tedeschi & Calhoun, 1996). While the similarities and differences of resilience and posttraumatic growth have been discussed, both reflect positive psychological responses following traumatic events (Schaefer et al., 2018) and could contribute insight to how we conceptualize the process of recovering after GBV. Other terms used in the literature to describe GBV recovery include “thriving” (Heywood et al., 2019; Taylor, 2004), “remaking the self” (Oke, 2008), “transformation of identity” (Glumbiková & Gojová, 2019), and “overcoming” (Flasch et al., 2017), among others. Despite disagreement or lack of clarity over theoretical distinctions between recovery and related concepts, it remains an important endeavor to better understand how women cope with and move through their experiences of GBV. Hence, for the purpose of this review, our analysis included discussion of any of these topics, as long as it related to the recovery process. This ensured holistic understanding of important elements of recovery through the eyes of survivors regardless of the lens through which the investigators explored their experience.

The Present Review

Integrating qualitative findings on healing and recovery in survivors of GBV is essential to move the science forward in this domain. This will allow a clearer articulation of gaps in understanding as well as point to areas for holistic intervention based on survivor needs and desires. Therefore, our purpose in preparing this review is to examine the nature of healing after GBV through the perspectives of women-identifying survivors. While experts have theorized about recovery across many disciplines, our review focuses specifically on research evaluating GBV survivor perspectives to amplify their expertise in their own lived experience. This review focuses specifically on women survivors due to the disproportionate rate of women affected by GBV (European Institute for Gender Equality, 2020) and the differing lived experiences and challenges other genders who experience GBV may have. Qualitative metasynthesis (Sandelowski & Barroso, 2007) and meta-ethnography (Noblit & Hare, 1988) techniques were used to conduct the review and explore and integrate healing themes.

Method

Qualitative metasynthesis is an approach to synthesize qualitative findings on a specific topic. Sandelowski and Barroso (2007) created the guidelines for synthesizing the literature used for this project. The guidelines include (1) formulating the review question, (2) conducting a systematic literature search, (3) screening and selecting appropriate research articles, (4) analyzing and synthesizing qualitative findings, (5) maintaining quality control, and (6) presenting findings. The research team included two nurse researchers (first and senior authors), one with expertise in sexual violence and intimate partner violence and the other with expertise in child maltreatment, and a library scientist with expertise in the health care and support of LGBTQ+ youth as well as adverse childhood experiences, medical trauma, and toxic stress.

Data Sources

Three databases, PubMed, PsychINFO, and EBSCO violence abstracts/criminology/family studies, were searched in September 2019. Key words were created by the library scientist in consultation with the first and senior authors. Key words included combinations of GBV (e.g., sexual violence, intimate partner violence), recovery (e.g., healing, growth, flourishing), and qualitative research (e.g., ethnography, phenomenology). An additional search was completed in May 2020 to determine if any new articles matching our inclusion criteria had been published since the first search date. Additional relevant articles were found through references cited by included studies.

Selection Criteria

The first and senior authors independently screened titles and abstracts for eligibility. The inclusion criteria were (1) studies that used qualitative research methods, (2) studies that focused on GBV or a type of GBV (e.g., intimate partner violence, sexual assault), (3) studies that discussed the healing/recovery
process, journey, or goals from women-identifying individuals’ perspectives, and (4) empirical articles in peer-reviewed journals. The exclusion criteria were (1) studies that only used quantitative data, (2) studies not published in English, (3) gray literature, (4) case studies, (5) interventions, (6) articles where the authors focused on biological or physical healing from injury, and (7) articles where the authors focused on influences of healing but not the healing process itself. Following title and abstract review, the first and senior authors assessed the full text of studies that met inclusion criteria for titles and abstracts. Uncertainty and disagreement were resolved by reconciliation meetings until a mutual decision was reached. An audit trail and journal containing analytic, theoretical, and personal notes was maintained by both the first and senior authors to promote awareness of reflexivity and potential bias.

Data Extraction and Quality Appraisal
Once all articles were reviewed and final articles chosen, the first and senior authors extracted data from each study into an evidence table. For the sake of parsimony, Table 1 is an abbreviated version of this table. To assess the quality of the articles, the Critical Appraisal Skills Programme (CASP; 2018) Qualitative Checklist was used. Since there is no consensus in regard to excluding articles based on the quality of the study (Daly et al., 2007; Dixon-Woods et al., 2006; Sandelowski, 2006), all articles were included in the analysis regardless of the CASP score, although the overall quality of articles synthesized was high. Detailed information on the quality appraisal of each article is available upon request.

Analysis
Our analytic methods are based on meta-ethnography (Noblit & Hare, 1988), though at present, there is varying theory and a lack of standardization for synthesizing qualitative research (Tacconelli, 2010). Meta-ethnography has been used in qualitative metasyntheses of similar nature in the past (see Trevil lion et al., 2014, for an example) and is one of the most widely used techniques for the synthesis of health research (Bondas & Hall, 2007; Campbell et al., 2011). This method uses primary studies explanations as “data” by applying the views of study participants as “first-order constructs” and the interpretations of study authors as “second-order constructs” (Noblit & Hare, 1988). These constructs are then compared and contrasted by reviewers before being translated to produce new insights or “third-order constructs” (Noblit & Hare, 1988). Some have argued, however, that the distinction between first- and second-order constructs are often murky due to authors selecting participant quotes to support their second order constructs (Toye et al., 2014). Others believe that first-order constructs can be analyzed and synthesized along with their corresponding second-order constructs but not in isolation due to the inability for reviewers to fully understand first-order constructs without having access to the full context of the primary studies (France et al., 2019). Thus, we analyzed first- and second-order constructs simultaneously, contributing to our development of third-level constructs.

Research studies that met our inclusion criteria were read and reread by both the first and senior authors to identify baseline concepts. Concepts were identified based on participant and researcher references to recovery (and related concepts) after experiencing GBV. The first and senior authors then identified and synthesized first- and second-order constructs simultaneously that were similar across studies (“reciprocal translation”; Noblit & Hare, 1988) by grouping common concepts and gathering similar themes into “piles” or categories of shared meaning (France et al., 2019). These constructs were then discussed by the first and senior authors at length, were defined, and served as a preliminary code list for synthesis. Articles were coded independently using the defined first- and second-level constructs in ATLAS.ti software (Muhr, 2006), with reconciliation meetings occurring to understand contradictory themes and concepts (refutational translation; Noblit & Hare, 1988) as well as additional areas of inquiry not initially recognized by the preliminary code list. Third-order constructs were then identified through systematic identification of first- and second-order constructs and abstracting upward to main categories, allowing “systematic comparison” and “conceptualizing” (Strauss & Corbin, 1997) which was the most common data translation method in a review of meta-ethnography studies (France et al., 2019). This was followed by a repeat coding process in ATLAS.ti based on third-order constructs and definitions to ensure each applied construct was represented across the majority of the studies reviewed. This created a “count” of articles that contributed to our understanding of each third-order construct (Feder et al., 2006; see Table 2 for details). The findings presented below are organized by third-order constructs identified, with supporting and conflicting first- and second-order constructs listed under each identified domain. We create a visual metaphor to link these concepts together in a line of argument to create a new “metaphor,” “story line,” or overarching explanation of the phenomena (France et al., 2019; Noblit & Hare, 1988).

Results

Description of Sample/Articles
The study selection process for retrieving and screening studies is found in Figure 1 (Moher et al., 2009). After screening abstracts, a total of 47 articles were identified for potential inclusion. After screening full-text articles and hand-searching references, a total of 25 studies were included for our synthesis. Details of these studies and sample characteristics can be viewed in Table 1. Authors used a variety of words to describe the concept of healing, including resilience ($n = 6$), healing ($n = 5$), recovery ($n = 14$), growth ($n = 3$), identity transformation/reconstruction/remaking self/reclaiming self ($n = 4$), and thrivership/survivorship thriving ($n = 2$). Some authors used multiple healing descriptors, so these are not mutually exclusive.
<table>
<thead>
<tr>
<th>Title/Authors</th>
<th>Country</th>
<th>Sample Characteristics</th>
<th>Methodology</th>
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<tbody>
<tr>
<td>Allen, K. N., &amp; Wozniak, D. F. (2010). The language of healing: Women’s voices in healing and recovering from domestic violence. <em>Social Work in Mental Health, 9</em>(1), 37–55.</td>
<td>United States Survivors of domestic violence (DV). Mean age was 35 years. Majority of women had completed some college. About half of the women were working and the other half were receiving state assistance.</td>
<td>Thematic analysis</td>
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<td>Barnes, R. (2013). “I’m over it”: Survivor narratives after woman-to-woman partner abuse. <em>Partner Abuse, 4</em>(3), 380–398.</td>
<td>England and Wales Survivors of women-to-women partner abuse. All but four participants were White (n = 40). Most participants self-defined as gay or lesbian.</td>
<td>Thematic analysis</td>
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<tr>
<td>Cram, S. E., &amp; Barata, P. C. (2016). The experience of resilience for adult female survivors of intimate partner violence: A phenomenological inquiry. <em>Violence Against Women, 22</em>(7), 853–875.</td>
<td>Canada Survivors of IPV. 50% White/European sample, 12.5% Caribbean, 12.5% South Asian, 6.25% Latin American, 6.25% First Nations/ Native, and 12.5% biracial. Level of education ranged from some elementary education to having a graduate degree.</td>
<td>Phenomenology</td>
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<tr>
<td>Farrell, M. L. (1996). Healing: A qualitative study of women recovering from abusive relationships with men. <em>Perspectives in Psychiatric Care, 32</em>(3), 23–32.</td>
<td>United States Survivors of physical, sexual, or psychological abuse. Race or ethnicity not discussed. Women were high school graduates or had a GED. Over half were supported by welfare.</td>
<td>Phenomenology</td>
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<tr>
<td>Flasch, P., Murray, C. E., &amp; Crowe, A. (2017). Overcoming abuse: A phenomenological investigation of the journey to recovery from past intimate partner violence. <em>Journal of Intimate Partner Violence, 32</em>(22), 3373–3401.</td>
<td>United States, Australia, Europe, and Other Survivors of IPV. 83.7% White, 8.9% Hispanic/Latino/Latina, 4.1% African American/Black, 2.4% Native American, and 3.3% “Other.” Mean age was 41 years. About 83% of sample was from the United States, and 42.3% of sample had an income less than US$30,000.</td>
<td>Phenomenology</td>
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<th>Title/Authors</th>
<th>Country</th>
<th>Sample Characteristics</th>
<th>Methodology</th>
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</thead>
<tbody>
<tr>
<td>Lewis, S. D., Henriksen, R. C., Jr., &amp; Watts, R. E. (2015). Intimate partner violence: The recovery experience.</td>
<td>United States</td>
<td>Survivors of IPV. Mean age was 39.6 years. Sample was 66.7% African American/Black, 16.7% White, 16.7% Black/White, and multiple heritage background. All participants employed.</td>
<td>Phenomenology</td>
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<tr>
<td>Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., &amp; O’Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence.</td>
<td>Canada</td>
<td>Survivors of IPV. Sample was 54% White, 15% Black, and the remainder is a mix of ethnic groups. Majority unemployed (3%) or on disability (42%).</td>
<td>Grounded theory</td>
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<tr>
<td>Oke, M. (2008). Remaking self after domestic violence: Mongolian and Australian women’s narratives of recovery.</td>
<td>Mongolia and Australia</td>
<td>Survivors of IPV. All of the Mongolians were ethnic Mongolian. The Australian women were 45% Anglo-Celtic, 9% Indigenous Australian, 9% Italian, 9% Dutch, 9% Maltese, 9% Indian, and 9% African.</td>
<td>Feminist, narrative approach</td>
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<tr>
<td>Ranjar, V., &amp; Speer, S. (2013). Revictimization and recovery from sexual assault: Implications for health professionals.</td>
<td>United Kingdom</td>
<td>Survivors of sexual assault. Mean age was 31.59 years.</td>
<td>Essentialist, inductive thematic analysis</td>
</tr>
<tr>
<td>Sinko, L., Burns, C. J., O’Halloran, S., &amp; Arnault, D. S. (2019). Trauma recovery is cultural: Understanding shared and different healing themes in Irish and American survivors of gender-based violence.</td>
<td>United States and Ireland</td>
<td>Survivors of GBV. American women were from Southeast Michigan. The American sample was 84.21% White, 10.53% African American, and 5.26% Asian. The Irish women were from rural areas of Ireland. The Irish sample was 92% White and 8% Black.</td>
<td>Ethnography and thematic analysis</td>
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<td>Sinko, L., Munro-Kramer, M., Conley, T., Burns, C. J., &amp; Saint Arnault, D. (2019). Healing is not linear: Understanding the day-to-day healing processes of female survivors of undergraduate unwanted sexual experiences.</td>
<td>United States</td>
<td>Survivors of sexual violence. Sample was 68.4% White, 15.79% African American/Black, and 15.79% Asian. Sample was current undergraduate students or alumni of a 4-year institution.</td>
<td>Holistic and cross-sectional data analyses</td>
</tr>
<tr>
<td>Sinko, L., &amp; Saint Arnault, D. (2019). Finding the strength to heal: Understanding recovery after gender-based violence.</td>
<td>United States</td>
<td>Survivors of gender-based violence. Sample was 85.71% White, 9.5% African American, and 4.76% Asian.</td>
<td>Modified grounded theory analysis</td>
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<td>Smith, M. E. (2003). Recovery from intimate partner violence: A difficult journey.</td>
<td>United States</td>
<td>Survivors of IPV. Sample was 93.3% White and 7.1% African American.</td>
<td>Phenomenology analyzed using a hermeneutic process</td>
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<tr>
<td>Smith, M. E., &amp; Kelly, L. M. (2001). The journey of recovery after a rape experience.</td>
<td>United States</td>
<td>Survivors of sexual assault. Sample was 100% White.</td>
<td>Hermeneutic process</td>
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<td>Taylor, J. Y. (2004). Moving from surviving to thriving: African American women recovering from intimate male partner abuse.</td>
<td>United States</td>
<td>Survivors of IPV by an African American male or male partner of color. Sample was 100% African American. Mean age was 39 years. Median income was US$20,500.</td>
<td>Womanist ethnographic investigation</td>
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<td>Title/Authors</td>
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<td>Zraly, M., &amp; Nyirazinyoye, L. (2010). Don’t let the suffering make you fade away: An ethnographic study of resilience among survivors of genocide-rape in southern Rwanda. Social Science &amp; Medicine, 70(10), 1656–1664.</td>
<td>Rwanda</td>
<td>Survivors of genocide rape. All participants were members of Abasa or Association des Veuves du Génocide (AVEGA). Mean age was 39.75 years.</td>
<td>Grounded theory and content analysis</td>
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<tr>
<td>Subtheme</td>
<td>Definition</td>
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<tr>
<td><strong>Trauma processing and reexamination</strong></td>
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<td><strong>Managing negative states</strong></td>
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<tr>
<td>Trauma symptoms and reactions</td>
<td>Physical, mental, social, and behavioral responses to GBV that interfered with one's ability to function in society or connect with others.</td>
<td>17</td>
<td>Barnes (2013), dos Reis et al. (2016), Flasch et al. (2017), Glumbiková and Gojová (2019), Heywood et al. (2019), Lewis et al. (2015), Matheson et al. (2015), Oke (2008), Ranjbar and Speer (2013), Sinko, Burns, et al. (2019), Smith (2003), Wuest and Merrit-Gray (2001), Thompson (2000), Sinko and Saint Arnault (2019), Sinko, Munro-Kramer, et al. (2019), Anderson et al. (2012), and Hou et al. (2013)</td>
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<td><strong>Rebuilding the self</strong></td>
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<td>Identity construction</td>
<td>Creating an identity that one is proud of either by returning to who they were before their experience or incorporating new aspects into a creation of a “new” self.</td>
<td>18</td>
<td>Barnes (2013), Crann and Barata (2016), Duma et al. (2007), Flasch et al. (2017), Glumbiková and Gojová (2019), Heywood et al. (2019), Matheson et al. (2015), Oke (2008), Sinko, Burns, et al. (2019), Smith (2003), Smith and Kelly (2001), Taylor (2004), Thompson (2000), Wuest and Merrit-Gray (2001), Sinko and Saint Arnault (2019), Farrell (1996), Allan and Wozniak (2010), and Hou et al. (2013)</td>
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<td><strong>Connecting with others</strong></td>
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<td>Subtheme</td>
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<td><strong>Regaining hope and power</strong></td>
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The Healing Process: A Journey of Patience and Active Engagement

Healing was found to be a multidimensional \((n = 2)\), nonlinear \((n = 10)\), and iterative \((n = 4)\) journey requiring courage \((n = 7)\), active engagement \((n = 12)\), and patience \((n = 4)\) when setbacks arose. We identified five main third-order constructs that described the healing process. This included (1) trauma processing and reexamination, (2) managing negative states, (3) rebuilding the self, (4) connecting with others, and (5) regaining hope and power. While some studies postulated the order of these objectives, there was not enough consistency to create a hierarchy or order to these themes, as many appeared to develop simultaneously. It is important to note that these themes do appear to build on crisis stabilization and establishing safety and autonomy (Allen & Wozniak, 2010).

Recovery was viewed as an active process, specifically mentioned in 14 of our included articles, underpinned by “recognition that they have been adversely affected by their abuse experiences, and that they need to take measures to work towards a successful recovery” (Barnes, 2013, p. 392). Ultimately, while healing does take time, the articles counter that time alone is not enough, and active engagement and support from your environment is essential to make meaningful strides forward. See Table 2 for critical findings and Table 3 for refutational translations or contradictions noticed in the literature. Healing objectives did not appear to differ by the type of violence as evidenced by the diversity of studies contributing to each theme, however, individualized nuances based on trauma history characteristics, individual identity, and culture are important to consider as we attempt to create interventions under each domain listed.

**Trauma processing and reexamination**. An important element of healing consisted of processing one’s trauma and reexamining one’s experience, recognizing broader contextual factors that reinforce negative states and uphold social and cultural norms.

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**Figure 1.** Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) for article review (Moher et al., 2009).
of violence against women (Crann & Barata, 2016). While social and cultural norms differed by study context, trauma processing and reexamination generally consisted of two second-order constructs: meaning making and self-evaluation. Through making sense of her violent encounter, putting it in context, and looking inward to understand one’s responses and needs, individuals were able to let go of self-blame and envision a path forward.

Meaning making. Nineteen articles discussed meaning making as we defined it with a specific focus on first-/second-order constructs of accepting reality and reexamination. In the domain of accepting reality, five studies alluded to the idea that “overcoming denial is the first step” (Ranjbar & Speer, 2013, p. 278) and that accepting what had happened, by acknowledging the experience and one’s resulting emotions, was a significant part of their definition of recovery (dos Reis

### Table 3. Refutational Translation.

<table>
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<th>Concept</th>
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<td>Role of forgiveness in meaning-making process</td>
<td>Most studies that mentioned forgiveness in their findings ($n = 9$) were in agreement that forgiveness of the self is essential to allow individuals to “stop punishing themselves for what happened” and “discontinue trying to change the past” (Flasch et al., 2017; Ranjbar &amp; Speer, 2013). Heywood et al. (2019) countered that some participants viewed “self-forgiveness as irrelevant” due to the fact that the perpetrator “chose you, you did not choose him.” This was mentioned with the caveat that individuals had to recognize the abuse was never their fault. It was unclear whether forgiving your perpetrator was essential to move forward. Flasch et al. (2017; IPV) and Smith and Kelly (2001; rape) explicitly mentioned forgiving ones’ perpetrator as a core healing theme. Despite this, Flasch et al. (2017) said “many but not all” of their participants agreed with this idea while Smith and Kelly (2001) said “some” saw it as part of the healing process. The only article ($N = 37$) that explicitly stated that they asked survivors about forgiveness was Heywood et al. (2019). This study revealed that “all except three participants said that they could never forgive their abuser.”</td>
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<td>Identity: A return to old self or the building of a new self?</td>
<td>There was a slight tension about whether or not healing is a process of “identity lost and found” (Oke, 2008) or rather a process of “recreation” (Flasch et al., 2017). Eight articles used verbiage referring to a “return” to the self (e.g., “regaining a sense of true self” [Crann &amp; Barata, 2016], “reestablishing one’s identity” [Matheson et al., 2015], and “connecting aspects . . . fragmented by abuse” [Farrell, 1996, p. 30]). Five articles referenced the self as a new self (e.g., “change of identity”; Glumbiková &amp; Gojová, 2019) or a self “before and after the violence” (Sinko, Burns, et al., 2019), with one article stating that the word recovery itself “may not be right because it implies a complete return to what once was” (Ranjbar &amp; Speer, 2013). Two articles referred to both processes happening differently depending on the individual (Oke, 2008) or potentially at different times in the healing process (Flasch et al., 2017). Flasch et al. (2017) shares that perhaps survivors must first find a way back to their old selves prior to creating a new identity post abuse.</td>
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<td>The role of spirituality and religion</td>
<td>While spirituality was found to be an important support to healing, there was a discrepancy surrounding its tie to religious institutions. Heywood et al. (2019) mentioned that religion provided more “practical support” from people within the community, while Anderson et al. (2012) mentioned that religious communities offered “emotional support, a sense of belonging and security.” Other studies refuted that religion was not necessary for recovery (Heywood et al., 2019), with two studies citing some harm religious institutions can incite. For example participants from Sinko, Burns, et al. (2019) and Anderson et al. (2012) mentioned that familial values tied to religion (e.g., divorce) caused some survivors to feel shame for ending their violent relationships.</td>
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<tr>
<td>Do you need to leave a gender-based violence (GBV) relationship to begin healing?</td>
<td>Some articles discussed a low point of being in imminent danger and thus leaving their relationship as a significant turning point (e.g., Lewis et al., 2015). Contrastingly, other women discussed how they started to heal while they were still in the abusive relationship (e.g., Crann &amp; Barata, 2016; Farrell, 1996), while others did not believe they engaged in their healing until long after the abuse was over. Thus, it is unclear if women need to leave GBV relationships to begin their healing process or even if leaving an abusive relationship truly starts one’s healing. We synthesize that perhaps leaving the relationship is an important part of the healing journey but is not always the catalyst to initiating the healing process.</td>
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et al., 2016; Flasch et al., 2017; Ranjbar & Speer, 2013; Sinko, Burns, et al., 2019; Sinko & Saint Arnault, 2019; Zraly & Nyirazinyoye, 2010). This acceptance was not to be confused with complacency. For example, one participant mentioned in Flasch et al. (2017), “First I had to recognize it as abuse, which was very difficult for me. From there, it became easier to overcome” (p. 3388).

Another important construct as someone made meaning of their experience was reexamining their situation and their role in their experience objectively in context to allow them to forgive themselves and potentially those around them. One article described this process as shifting toward resistance to allow women to “push back against the abuse and its negative effects, the abuser and abusive relationships, and the broader social environment that upholds social and cultural norms of violence against women” (Crann & Barata, 2016, p. 860). Reexamination often involved education consisting of (1) learning about the dynamics of abusive relationships and (2) using that knowledge to examine past experiences with abuse (Flasch et al., 2017). Ultimately, reexamination often catalyzed a process of grieving and letting go of negative internal dialogues, allowing the individuals to “give up the painful feelings about the past” and allow it to not control them (Smith, 2003, p. 562).

Self-evaluation. Fourteen of our articles discussed self-evaluation as we defined it, with a specific focus on first-/second-order constructs of self-awareness and recognizing one’s potential. Self-awareness included recognition of the physical and/or mental health consequences stemming from the abuse they experienced (Flasch et al., 2017) as well as recognizing one’s tendencies and healing needs going forward. Self-awareness was often facilitated by self-reflection, enabling survivors to “connect with their emotions, appreciate themselves and the things around them, and identify what was working for them and what their needs were going forward” (Sinko, Munro-Kramer, et al., 2019, p.12). Through an honest assessment of self, others, and events, survivors learned to discover the realities of the self (Farrell, 1996), enabling them to discover the areas they would like to grow and improve upon as they journeyed toward healing. By growing self-aware, participants were able to chart negative and positive changes in their lives (Barnes, 2013), define their own landmarks (Duma et al., 2007), gradually recognize their imperfections, and feel comfortable in different situations (Hou et al., 2013). This laid the foundation to enable people to recognize their potential and visualize a path toward healing.

Self-evaluation also consisted of recognizing one’s own potential, which often catalyzed feelings of self-efficacy and hope. As Farrell (1996) reflected, “increased self-awareness provided the fuel for flexibility, enhancing the individual’s capabilities to be self-sustaining and resulting in a broader perspective of life as a whole beyond the limited view of life created by the abuse” (p. 28). Some found their potential through reflecting back on what was lost. This could motivate individuals to engage in active strategies in reclaiming those aspects of themselves (Duma et al., 2007). Others found potential through looking forward. This process allowed individuals to find flexibility “enhancing the individual’s capabilities to be self-sustaining and resulting in a broader perspective of life as a whole beyond the limited view of life created by the abuse” (Farrell, 1996, p. 28).

Managing negative states. While managing one’s negative internal dialogue, emotions, and trauma reactions were not considered to be a survivor’s sole recovery goal, it was important to their functioning to understand the origins of and learn strategies to manage negative states. Most frequently, women described “enduring emotional or psychological impacts such as anxieties about future relationships or struggles with their self-concepts” (Barnes, 2013, p. 389). Negative states that were important for survivors to manage included three second-order constructs: negative internal dialogue, distressing emotions, and trauma reactions and symptoms. Developing perceptions of increased agency and control over negative states, influenced the control women felt they had over specific aspects or overall outcomes of their lives, relationships, and other experiences.

Negative internal dialogue. GBV caused many survivors to ruminative about their experiences, creating patterns of negative internal dialogue that made it difficult for them to make meaning of their situations. Eleven articles discussed the impact of one’s internal dialogue as we defined it. Common internal reactions survivors had to their experiences included self-blame, feelings of failure, feelings of weakness, and blaming God. As mentioned above, by processing their trauma and reexamining their experience, survivors were able to start the process of letting go of this dialogue.

Distressing emotions. Emotions that were important to survivors to manage focused on cumulative negative feelings experienced after the abuse, impacting one’s ability to function in society or connect with others. Fourteen articles discussed managing distressing emotions as we defined it. Common emotions included feelings of shame, fear, worry, anger, sadness, hopelessness, guilt, confusion, and self-doubt. Interestingly, for some participants, recognizing that it was okay to have these feelings and that allowing themselves to feel negative emotions aided in their recovery. For example, one woman stated, “...And I saw my friend being angry and somehow I felt it was okay for me to be angry...recovery for me...staring down my assailant and expressing my anger” (Smith & Kelly, 2001, p. 345). Thus, although these emotions were typically viewed as challenging, expressing these feelings also aided in the healing process.

Trauma reactions and symptoms. Sixteen articles addressed the impact of trauma reactions and symptoms on survivor well-being. These reactions and symptoms included isolation, negative self-concept, powerlessness, lack of trust, hypervigilance, and flashbacks. Others experienced more clinical post-traumatic stress, depression, or anxiety symptoms that
interfered with their day-to-day life. As one article reflected: “for most participants, recovery also meant being free from the trauma symptoms associated with the experience and being able to ‘move on with [their] life without having anxiety attacks, nightmares, flashbacks’” (Ranjbar & Speer, 2013, p. 279). Living a life not dominated by mental health struggles allowed survivors to feel more optimistic about their healing moving forward.

Some studies addressed trauma reactions that we termed “survival strategies” that survivors engaged in as they attempted to survive and cope with their GBV experience. In 11 articles, authors discussed survival strategies as we defined it. For example, some women utilized substance use and self-injury to help manage their pain (e.g., Glumbíková & Gojová, 2019; Matheson et al., 2015; Sinko, Munro-Kramer, et al., 2019; Sinko & Saint Arnault, 2019). Others discussed disconnecting from their body and/or emotions as a means of protection (disembodiment; e.g., Matheson et al., 2015; Sinko & Saint Arnault, 2019). While survival strategies such as these may have been necessary for a period of time, letting go of these habits and replacing them with more sustainable outlets was important for survivors for long-term recovery.

**Rebuilding the self.** Rebuilding the self consisted of three second-order constructs: identity construction, improving self-concept, and renewing the spirit. Regaining a sense of their “true selves” was an important goal to survivors, as many reflected that their GBV experiences caused them to need to “start from scratch” (Sinko, Burns, et al., 2019) due to their symptom burden, complex trauma, and shifts in worldviews. In order to rebuild, survivors needed to both accept the things about themselves they could not change, while also embracing curiosity to learn more about themselves and their needs.

**Identity construction.** Eighteen of our articles addressed rebuilding the self as we defined it, with a specific focus on first-/second-order constructs of self-discovery, self-acceptance, and recognition of potential. One of the participants in the Matheson et al. (2015) article described it this way, “I was like a sponge just soaking every knowledge and information that I could. Now I have so much self-respect for myself. Self-morals. Self-values. Dignity. Pride. Self-confidence” (p. 565).

**Improving self-concept.** Seventeen articles addressed this construct as we defined it, with a specific focus on the first-/second-order constructs mentioned in the definition. Six articles included mentions of improving self-worth (Flasch et al., 2017; Heywood et al., 2019; Hou et al., 2013; Matheson et al., 2015; Sinko & Saint Arnault, 2019; Sinko, Burns, et al., 2019), improving self-esteem was mentioned in five articles (Ahmad et al., 2013; Crann & Barata, 2016; dos Reis et al., 2016; Flasch et al., 2017; Glumbíková & Gojová, 2019; Hou et al., 2013; Matheson et al., 2015; Smith, 2003; Thompson, 2000), and five articles addressed building competence and/or mastery (Glumbíková & Gojová, 2019; Hou et al., 2013; Sinko, Burns, et al., 2019; Sinko, Munro-Kramer, et al., 2019; Sinko & Saint Arnault, 2019). In order to do this, survivors needed to “recognise one’s own positive aspects and strengths” (Glumbíková & Gojová, 2019, p. 7). This often involved consultations with professionals to ensure they were “doing the right thing” (Hou et al., 2013, p. 164), however, some were able to do it on their own.

**Renewing the spirit.** Sixteen articles addressed this construct as we defined it, with a specific focus on first-/second-order constructs listed in the definition. In order to do this, survivors identified “refocusing their energy, time, and thoughts” (Crann & Barata, 2016, p. 864) to build feelings of “lightness, serenity, peace, and calm” (Sinko, Burns, et al., 2019, p. 12). Survivors of the genocide in Rwanda, in which GBV played a significant role, used the phrase “Kwongera kubahonow” to describe this process, which allowed survivors to “feel there is peace in you, on your body and inside in your heart you feel there is peace and you have means to develop yourself in order to live” (Zraly & Nyirazinyoye, 2010, p. 1660). Survivors engaged in a variety of activities to renew their spirit including reading, exercise, gardening, writing, spending time with their children, and religion.

**Connecting with others.** Connecting with others consisted of two second-order constructs: letting people in and building support networks. By relating and being authentic with others, individuals were better able to find support, build, and maintain important relationships in their life and feel less alone.

**Letting people in.** Seventeen articles addressed this construct as we defined it. While this did not always mean being open to everyone about their abuse experiences, it did recognize that survivors should not need to face their recovery alone (Sinko & Saint Arnault, 2019). Talking about the experience, particularly with people who “wants to know her story and the person behind the story” was found to be exceptionally validating on the journey to recovery (Matheson et al., 2015, p. 566). Letting people in may also have other benefits, including learning about others survivorship experiences and hearing views which may cause the survivor to look at their experience in a different way (Thompson, 2000). While some participants stayed silent about their experiences, we identified a consensus in the body of articles reviewed that disclosure to at least one supportive personal or professional relationship can encourage the survivor during difficult stages of the process and combat feelings of self-blame.

Foundational to letting people in is the development of trust, discussed specifically in 10 of the articles reviewed (indicated by * in Table 2). As Farrell (1996) said, “trust involved belief in the self and others, allowing the women to let go of the protective walls that isolated them from others” (p. 30). Rebuilding trust for themselves and others allowed survivors to be better able to connect with them and form new lasting relationships, requiring patience, compassion, and understanding (Flasch et al., 2017).
Building support networks. Twenty articles addressed this construct as we defined it, with a specific focus on second-order constructs of validation, belonging, and community. As mentioned previously, survivors often needed a balance of personal and professional support, providing education to allow them to see their experience differently, while also helping them recognize that they do not need to do it alone (Sinko, Burns, et al., 2019).

Specific elements of belonging and community as one builds their support network were discussed in nine articles (indicated by * in Table 2). Like letting people in, finding belonging was often intertwined with the actions and responses of others, creating supportive environments which allowed survivors to feel accepted or, if nothing else, distracted from their trauma responses. People found belonging in their personal relationships, through meeting others who had similar experiences, and engaging in community activities (e.g., volunteering, activism, faith, leisure groups, school events). While not all individuals became connected with other GBV survivors, those who did seemed to greatly benefit from it, with one article calling those connections “perhaps the most important informal network” survivors engaged in (Lewis et al., 2015, p. 389). No matter where survivors ended up finding their place within the community, establishing an environment that fosters connections with others allowed survivors to escape from their trauma, develop empathy, help others, and find purpose (Crann et al., 2019).

Regaining hope and power. Regaining hope and power consisted of embracing freedom, finding purpose, and building hope. This required a critical awareness of the survivor’s individual autonomy and potential, allowing survivors to develop increasingly positive perspectives about their future by focusing on what they wanted to achieve for themselves (Ahmad et al., 2013). By looking toward the future and finding meaningful fulfillment in their lives, survivors were able to build a future that works for them separate from their abuse experiences.

Embracing freedom. Eighteen articles addressed this construct as we defined it. Particularly in situations with ongoing abuse that exerted power and control over survivors, embracing freedom was an important step of regaining hope and power by illuminating a new reality for them and reminding survivors that they have the choice to direct their own lives (Flasch et al., 2017). Survivors of genocide in Rwanda used the phrase guko-mezu ubuzima to describe this concept, conveying a sense of willingness, effort making, or participation in one’s own life, despite one’s experiences (Zraly & Nyirazinyoye, 2010). New-found freedom and empowerment yielded a powerful journey of self-discovery, allowing survivors to figure out who they would be happy as and how they could reinvent themselves (Heywood et al., 2019).

One way survivors embraced their freedom was through engaging in daily activities (e.g., keeping oneself busy, spending time with friends, learning a language, learning job skills, volunteering, engaging in hobbies; Ahmad et al., 2013). Survivors felt that these activities distracted them from ruminating about their problems and helped them regain feelings of confidence and competence. Reinforcing feelings of competency was important to survivors, as it allowed them to prevent the violence from “destroying their lives” (dos Reis et al., 2016, p. 2357) and instilled beliefs that they could effectively manage their external world on their own (Sinko, Burns, et al., 2019). Outside of personal activities, survivors were also able to embrace freedom through “refocusing their energy, time, and thoughts” (Crann & Barata, 2016, p. 864). Some women did this through using their freedom to focus on caring for themselves and their children, while others simply tried to focus on the present and enjoy each day (Crann & Barata, 2016). Education was also another way women enabled a new life course, by pursuing knowledge, reconnection with the world, and a strengthened and empowered identity (Oke, 2008). Ultimately, feeling able to embrace freedom without fear allowed survivors to take risks and make mistakes in pursuit of their goals and aspirations.

Finding purpose. Seventeen articles addressed this construct as we defined it, with a specific focus on second-order constructs of achievement, helping others, and advocacy. Personal achievement in education and work life was often a vehicle in which women felt able to take care of themselves and push against the gender norms of their societies (Sinko, Burns, et al., 2019; Sinko & Saint Arnault, 2019). Additionally, being engaged in paid or voluntary work, particularly in spaces that helped others, enabled a sense of purpose, connection with others, and potentially income (Oke, 2008). Directly interfacing with other survivors was another way purpose was found. For example, in one study, nearly half of the women shared a feeling of reciprocity through “helping other women in similar situations by providing emotional support and/or assisting others with finding employment or training to enhance work skills” (Ahmad et al., 2013, p. 1061). Another study described this as “cohesion tension” which involved a sense of duty to the greater good of the community either through volunteering or advocacy (Crann & Barata, 2016). In families with transgenerational abuse, some women expressed a desire to channel their desires to help the community through raising their children (particularly boys) with a norm of gender equality to stop the cycle of violence (Ahmad et al., 2013; Sinko, Burns, et al., 2019). While not all women directly engaged in the survivor space, those who did expressed a sense of justice through being a part of a movement to end violence and oppression (Crann & Barata, 2016).

Building hope. Fourteen articles addressed this construct as we defined it. Building hope allowed survivors to envision themselves actively in the world and in their lives (Taylor, 2004). This frequently co-occurred with the idea of future orientation (Glumbiková & Gojová, 2019) and challenged survivors to approach opportunities with a commitment to oneself. By anticipating new relationships, the possibility of furthering their education or career, among other things, survivors felt better able to overcome suffering (dos Reis et al., 2016). One article described a “shift to positivity” allowing survivors to
acknowledge progress in their lives (Crann & Barata, 2016). Hope as a motivator for survivors to continue on the path of healing despite hardship (Farrell, 1996) was essential to recovery (Lewis et al., 2015). Hope of healing or of a safer world allowed survivors to propel forward when they felt stuck in their recovery process (Sinko, Burns, et al., 2019). One survivor described it in this way:

Well, I'd say someone who's thriving... they've got more of a positive outlook or not even just positive, but being able to see further into the future and have a long-term plan whereas when you're not thriving, you are just surviving, you're not looking long-term you're just looking to get through the here and now. (Heywood et al., 2019, p. 6)

**Turning points.** An important element discussed in the articles were turning points or things that contributed to turning points. Turning points were defined as moments that propelled survivor healing forward and for many, encouraged them to begin working toward recovery. While some turning points overlapped with healing themes, the examples mentioned below were specifically mentioned by survivors in the studies synthesized as critical moments that promoted recovery engagement. Turning points consisted of significant low points, trauma recognition and speaking out, external motivations, and social support/pressure.

**Significant low points.** Significant low points occurred when women could no longer avoid their pain and thus began thinking about how they might relieve their suffering. Glumbiková and Gojová (2019) describe it as “hitting rock bottom.” “Hitting rock bottom is characterised as a moment when nothing seems to make any sense. It is a moment of total disempowerment and maximum hurt. Hitting rock bottom is the moment when one cannot get any further down” (p. 5). There were many examples of significant low points women experienced that catalyzed their healing throughout the five articles that highlighted this. For some women, the low point was when the participant was in imminent danger (Lewis et al., 2015; Oke, 2008). Recognizing this imminent danger also was often the motivating factor for women to leave the relationship. For other women, the significant low point was recognizing the impact the experience was having on their everyday lives (Smith & Kelly, 2001) or realizing they do not deserve to be treated that way (Smith, 2003). While the low point may be different person to person, these experiences encouraged survivors to reach out and seek help, starting their healing journey.

**Recognition and speaking out.** Recognition and speaking out was defined as acknowledging and labeling experiences as abuse and/or sharing secrets of abuse with selected, trusted family or friends. Five articles addressed this as we defined it. A participant in the study by Flasch et al. (2017) stated, “The biggest hurdle (and most rewarding triumph) was when I ‘came out’ as a survivor... I no longer have to hold my secrets and let them distill into shame” (p. 3386). Ranjbar and Speer (2013) and Thompson (2000) discussed the importance of recognizing and labeling the abuse in the healing process. Other articles included discussion of the importance of sharing the secret abuse with trusted family and friends as an important start to the healing process (Duma et al., 2007; Flasch et al., 2017; Taylor, 2004).

**External motivations.** External motivations were defined as recognizing others in a survivor’s life who were impacted by their “lack of” recovery, and using that as motivation to start their process. Four articles addressed external motivations as we defined it. In all of these articles, external motivation was discussed in the context of protection for one’s children (Ahmad et al., 2013; Matheson et al., 2015; Smith, 2003; Taylor, 2004), however, other external motivations were also mentioned. For example, Taylor (2004) also discussed external motivations related to how their silence was harming their community. While external motivators helped survivors recognize that a change needed to be made, it is important to also recognize the continued internal perseverance that was necessary to continue the healing process when these motivators were no longer relevant.

**Social support/pressure.** Social support/pressure was defined as encouragement and support from others to make decisions to benefit themselves and/or others. Eight articles addressed social support/pressure as we defined it. Many women discussed how having supportive family and friends pushed them to heal (Duma et al., 2007; Smith, 2003; Smith & Kelly, 2001), allowing participants to let go of self-blame (Crann & Barata, 2016) or encouraging participants to seek help (Sinko & Saint Arnault, 2019). Social support and pressure held survivors accountable for their actions and encouraged them to begin engaging in help-seeking behavior.

**A Metaphor for Healing: Weaving Life’s Tapestry With Knotted Silk**

We use the image of weaving a tapestry with knotted silk to describe what healing may look and feel like for survivors based on our synthesis results. The creation of a metaphor is typical in qualitative meta-ethnography, although we take a more visual approach (see Figure 2).

We visualize survivors as a spool of silk thread, weaving the tapestry that is their life. When a GBV event happens, it can have a great impact on the integrity of their thread, unraveling it and creating kinks and knots along the once smooth strands. At first, the survivor may think they can continue using this thread to build the tapestry they envisioned. The survivor has in their mind what they have woven before and what they want their tapestry to eventually look like and become. They may therefore try to continue on weaving despite the knots, but eventually smaller knots may become bigger knots and it feels impossible to move forward without addressing them. While the survivor may recognize this, false starts can occur, and frustration may push them to put their tapestry away for a while because starting over is just too hard. Then, a shift happens, where the survivor recognizes that untangling the knots is...
unavoidable and necessary in order to move forward. For some, this turning point happens sooner than others. This causes the survivor to refocus on starting anew.

Whether it is alone or with the help of a loved one or professional, the survivor begins to address each knot, and as they do the knots grow smaller. Some even disappear completely. This process requires active engagement and patience. Sometimes as the survivor attempts to untangle, they uncover even bigger knots. These knots may be too big to untangle on their own, and they may need the help of trusted others or professionals to get through that section of thread. They may also need others to work side by side with them as they untangle or may need encouragement as they continue to do it on their own. Other times, they may just need a distraction from the untangling so that they have the strength to rest to go back to it. Through this process, the survivor is eventually able to look inward, recognizing they have all the tools necessary to rebuild, but just have lost sight of the path and where they left off. Ultimately, regaining their vision for what their tapestry will look like and actualizing that vision allows them to create something beautiful and new, inspiring others they encounter to continue their own weaving. Our tapestries tell a story. It depicts all that we are: strengths, triumphs, and traumas.

**Discussion**

In this review, we synthesized qualitative literature to date describing the healing process after GBV from the perspectives of women-identifying survivors. While the relationships between these themes will need to be tested in future research, healing was found to be composed of (1) trauma processing and reexamination, (2) managing negative states, (3) rebuilding the self, (4) connecting with others, and (5) regaining hope and power. “Shifts” or “turning points” were also explored which catalyzed healing prioritization. These results have built a framework for discussing GBV healing with women survivors as well as revealed important discrepancies and gaps in the literature on this topic.

While our findings have some overlap with concepts in the resilience and posttraumatic growth literature, our analysis reveals important nuances related to GBV trauma recovery that may warrant specific attention. For example, important sub-concepts of posttraumatic growth include relating to others, new possibilities, personal strength, and appreciation of life (Tedeschi & Calhoun, 1996). While some of our synthesized themes overlap with these concepts, particularly with relating to others and new possibilities, this concept is missing important facets of GBV recovery: processing one’s trauma experiences and reexamining the GBV situation, managing negative states, rebuilding one’s relationship with themselves, and developing feelings of freedom and power. Similarly, while resilience has been measured in different ways throughout the scientific literature, it conceptually focuses more on evaluating one’s ability to bounce back from adversity, rather than how one might bounce back. For example, the Connor-Davidson (2003) Resilience Scale captures the domains of personal competence, trust/tolerance/strengthening effects of stress, acceptance of change and secure relationships, control, and spiritual influences. The inability of these measures to capture the full domain of healing after GBV is not surprising, as these concepts were initially created to understand healing from trauma and adversity generally. Interpersonal traumas (i.e., trauma that occurs as a result of actions by another person), particularly GBV, may require additional healing considerations due to the fact that their experience of violence was an intentional violation of bodily autonomy perpetrated by another person. These nuances can be demonstrated by quantitative evaluations comparing these outcomes by trauma type. For example, Shakespeare-Finch and Armstrong (2010) found that survivors of sexual assault had greater difficulty relating to others, appreciating life, and higher rates of post-traumatic stress disorder compared to survivors of motor-vehicle accidents and those in bereavement. Outside of these growth concepts, the majority of quantitative studies to date have used mental health outcomes and symptom checklists as a proxy for recovery (see Linhorst & Beadnell, 2011; Ahrens et al., 2010, for examples). Our review reveals the need for more survivor-centered and holistic outcome measurements to better evaluate the efficacy of interventions in this population as well as expand survivor-driven recovery ideas to future quantitative studies.

Our finding that healing goals did not substantially differ qualitatively by GBV type or severity may seem surprising on the surface but has been verified by some quantitative studies (e.g., Abrahams et al., 2013). This could be explained by the importance of the centrality of one’s GBV event, defined as “the degree to which an individual believes a [GBV] event has become a core part of their identity” (Boals, 2010, p. 107), which may be a better predictor of psychological distress and healing than the actual GBV event itself in this population. The centrality of one’s event has been found to be a unique
Table 4. Implications for Practice, Policy, and Research.

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<thead>
<tr>
<th>Practice implications</th>
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<tr>
<td>Understand and promote recovery beyond the alleviation</td>
<td>Laws that take away voice and choice from survivors (i.e., mandatory reporting of violent crimes in</td>
<td>Exploration of contexts that promote and inhibit healing are important to understand</td>
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<td>of mental and physical health symptoms</td>
<td>health care depending on state mandates) may inhibit recovery by taking away autonomy, control, and</td>
<td>how to create environments where survivors can flourish</td>
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<td>Interventions to promote key ingredients of the process:</td>
<td>choice</td>
<td>Alternative trauma recovery pathways and mechanisms of healing</td>
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<td>active recovery</td>
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<td>Need for better gender-based violence (GBV) recovery measurement for quantitative</td>
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<td>Engagement, patience with setbacks</td>
<td>Trauma and violence informed care to ensure therapeutic interactions with survivors</td>
<td>studies</td>
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<td>Infrastructure to promote trauma recognition and disclosure,</td>
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<td>GBV healing in men, transgender, and nonbinary individuals</td>
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<td>key turning points found</td>
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<td>Importance of finding purpose and fulfillment in survivors</td>
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<td>could call for more tailored career and volunteer</td>
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Implications for Practice, Policy, and Research

Implications for practice, policy, and research can be seen in Table 4. To summarize, it is important for those who work with survivors of GBV to understand and promote recovery beyond the alleviation of adverse mental and physical health symptoms, as managing negative states was mentioned as only one facet of survivor’s recovery desires. Additionally, interventions to promote active recovery, reexamination and self-evaluation, and patience when setbacks arise may be important for GBV survivors, particularly at the start of one’s healing journey. In the policy realm, it is interesting to note that no survivors mentioned the concept of justice as a part of their recovery journey. While this could be for a number of reasons, it may because the needs and wishes of survivors have often been found to be “diametrically opposed to the requirements of formal legal proceedings” (Herman, 2005) and many who have gone through the process have been disappointed by their lack of control or voice in the process (Jülich, 2006; McGlynn et al., 2012). While this may or may not be the reason justice was not mentioned, it does warrant questioning of many current state policies mandating certain professions (i.e., health care providers) to report violent crimes despite survivor wishes (Jacoby et al., 2018). This directly takes power and control from survivors, an important aspect of the process mentioned by those interviewed through the studies reviewed. There are also many implications of this review that can be expanded to future research studies. First, given the importance of identity and the “self” in these findings, intersectional exploration of the role of identity in healing is needed, particularly for communities that have experienced compounded historical trauma or face unique challenges to accessing services. Additionally, healing does not occur in a vacuum and exploring the relationship of culture and context in relation to reaching one’s healing goals will be important to understand how structural violence and social norms may impact this process. In particular, individuals who experience GBV at the hands of someone they know more intimately, or those who experience institutional betrayal in the aftermath of their experiences, may face unique challenges to recovery which warrant further exploration (see betrayal trauma theory; Freyd, 1996, 2008; Freyd et al., 2005). While some authors of the articles reviewed noted that there may be differing pathways to recovery (e.g., Crann & Barata, 2016),

predictor of posttraumatic growth above and beyond one’s trauma history and mental health burden in quantitative studies (Boals & Schuettler, 2010; Groleau et al., 2013; Sinko et al., under review). Hence, assessing for the centrality of one’s GBV experience in the service setting may promote greater understanding of one’s healing trajectory than current assessments alone, which tend to focus solely on the number or type of trauma events experienced (e.g., Felitti et al., 1998; Hooper et al., 2011).

Turning points that promoted recovery engagement revealed in this study consisted of significant low points, trauma recognition and speaking out, external motivations, and social support/pressure. These findings were verified by a recent review on recovery after intimate partner violence (Flasch, 2020) in which the authors discovered similar recovery-facilitating elements of informal and formal social support and relationships, resources and education, and social action and advocacy. The influencing role of significant low points has been discussed at length in the intimate partner violence literature related to reasons for leaving relationships (e.g., Enander & Holmberg, 2008) and help-seeking (Oyewuwo-Gassikia, 2020), however few studies have described its relationship with recovery engagement. Finally, the most significant external motivation found in this study that catalyzed recovery was a desire to protect one’s children or serve as a better caretaker for one’s children. While this has been referenced in GBV studies (i.e., Katz et al., 2015; Rasool, 2016), one’s children may also influence one’s desire to stay in an abusive relationship or to not seek help for their feelings and symptoms (Rasool, 2016; Williams et al., 2020). This reveals the potential importance of incorporating children or other relevant family members into healing interventions to allow for a more survivor-centered approach, leveraging the trusted bonds that already exist within their social network.
these pathways have not been well described. Further investigation is needed to understand contributing factors of these healing differences as well as mechanisms of recovery. Finally, as stated above, improved measurement to evaluate recovery is needed to provide a better baseline and subsequent follow-up as survivors engage in treatment.

Limitations
There are limitations to this review that are important to keep in mind when interpreting our findings. Only articles written in English were included, so healing processes discussed in other languages may have been missed. Additionally, despite working with a library scientist, there is a chance some studies that met our inclusion criteria were not picked up by our search strategy. Thus, some relevant aspects of GBV survivors’ lived experience may not be fully captured through this review. We additionally did not include males in our study and no articles came up in our review processes that discussed healing in transgender and gender nonconforming individuals. Therefore, future research is needed to understand the unique healing journeys and challenges of these communities. Healing may also vary across cultures, although we did include English studies from all countries that met our inclusion criteria. Finally, although we sought to describe the recovery process for those who experienced GBV, the included articles did not always provide context to a specific order for the healing themes experienced. Therefore, we could not expand on the potential order the themes may occur in. Future research would benefit from examining if there is a specific, chronological order of the healing process. Despite these limitations, this review provides an important foundation to understand and promote recovery in women survivors of GBV. Understanding recovery from the survivor perspective is important to ensure our research, policy, and practice is survivor-centered and promotes recovery for all survivors.

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