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A Narrative Review of the Literature on Recovery From Intimate Partner Violence: Developmental Processes and Facilitating Elements

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The author utilized a narrative review to synthesize research on the recovery process of intimate partner violence (IPV) and introduced a continuum model that addressed developmental phases and specific elements. Developmental aspects of IPV recovery are summarized as (a) disentangling from the past, (b) coping with the present, and (c) moving toward the future. Recovery-facilitating elements are (a) informal and formal social supports and relationships; (b) psychological, emotional, and spiritual healing; (c) resources and education; and (d) social action and advocacy. Better understanding of IPV trauma and recovery may aid practitioners in assessment, conceptualization, and treatment. Further, it may aid survivors in better comprehending their unique recovery journeys

KEYWORDS: intimate partner violence; survivors; recovery; trauma; healing; posttraumatic growth

Intimate partner violence (IPV) is defined as "physical violence, sexual violence, stalking, and psychological aggression (including coercive tactics) by a current or former intimate partner" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p. 11). Researchers have estimated that 30% of women and 25% of men in the United States have experienced some form of physical or sexual abuse and/or stalking in an intimate relationship at some point in their lives (Black et al., 2011; Breiding et al., 2015). Though it is essential for clinicians to understand and recognize the abundance of negative outcomes and consequences associated with IPV victimization (e.g., physical health, psychological conditions, substance abuse; Black et al., 2011; Centers for Disease Control and Prevention [CDC], 2017), it is equally important to recognize survivors' strengths-based long-term journeys toward recovery; that is, survivors embark on long-term processes toward healing, and many do so successfully. Much of the extant literature focuses on understanding and addressing negative symptomatology

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and treating trauma, and many successful trauma-informed approaches have been created to assist survivors of IPV (e.g., Condino, Tanzilli, Speranza, & Lingiardi, 2016). However, a growing body of research on recovery has paid particular attention to the unfolding process of long-term recovery of survivors, including both growth-facilitating and challenging experiences. The purpose of this narrative review was to emphasize this research and synthesize the literature on the elements and processes that facilitate recovery and healing over time.

Though crisis and immediate interventions indeed play an important role in the support of victims and survivors (Steinus & Veysey, 2005), it is essential for practitioners to understand the recovery process that takes place post-IPV and offer clients support long-term. One obstacle to supporting victims and survivors is that traditional interventions are typically short-term, shelter/agency-based, and crisis-oriented, where *success* or *recovery* often lacks a clear definition (Ham-Rowbottom, Gordon, Jarvis, & Novaco, 2005). Further, despite the frequency of IPV, many therapists are unprepared to adequately assist victims and survivors, and many have been found to be incorrect in their knowledge of best-practice standards for treatment (Bozorg-Omid, 2007). This may result in contraindicated interventions and negative outcomes for recovery. Because of the prevalence and associated negative consequences of IPV, there is also a critical need for professionals who work with victims and survivors to understand survivors' processes toward healing and recovery. Practitioners' comprehension of the long-term process of IPV recovery may help inform long-term encompassing treatment, help survivors recover, and potentially minimize the risk of returning to IPV relationships and experiencing further victimization.

Most literature on the IPV recovery process is comprised of smaller qualitative studies (e.g., Abrahams, 2010; Allen & Wozniak, 2011; Author et al., in press; Farrell, 1996; Hou, Ko, & Shu, 2013; Humbert, Engleman, & Miller, 2014; Lewis, Henriksen, & Watts, 2015; Smith, 2003; Wuest & Merritt-Gray, 2001); however, not one article was identified that summarized extant research. The purpose of this article was therefore to introduce a narrative review of the literature (Ferrari, 2015) in order to synthesize current research on the IPV recovery process and healing, provide an overview of survivors' experiences after leaving abusive partners, and contextualize the IPV recovery process as a continuum.

DEFINING TRAUMA AND RECOVERY

In order to contextualize IPV recovery, it is important to understand the trauma that precedes it. Trauma denotes exposure to a disturbing event outside of the scope of regular life occurrences and involves a real or perceived threat of death or physical harm, such as IPV (American Psychiatric Association [APA], 2013). One of the most common negative responses to trauma is developing posttraumatic stress disorder (PTSD). Symptoms of PTSD often interfere with daily functioning and typically begin within three months of the traumatic event. For chronic exposure to trauma, such as long-term IPV, PTSD symptoms may persist for long periods of time. Though

PTSD may be the most frequently examined outcome of IPV, there are many negative consequences associated with abuse in intimate relationships, including physical health issues (Coker, et al. 2002), comorbidity for depression (Nixon, Resick, & Nishith, 2004), substance abuse (Kaysen et al., 2007), financial effects (Voth Schrag, 2015), and social stigma from friends and family, professionals in the court system, law enforcement officers, and mental health professionals (Black et al., 2011; Crowe & Murray, 2015). Thus, it is important for practitioners to assess for comorbidities and tailor comprehensive treatment efforts, especially when working with clients who have recently left IPV relationships or are in crisis. In sum, there are a myriad of negative effects associated with IPV that render survivors especially vulnerable to mental health issues, financial distress, and negative social consequences. These findings offer evidence for professionals' need to further understand the dynamics of IPV and the consequent recovery process so they can support their clients effectively.

Defining Recovery and Posttraumatic Growth

The recovery movement in the mental health field highlights a relatively new shift in mental healthcare, as it emphasizes attaining wellness, fulfillment, and meaning rather than simply symptom management, which was historically the standard of practice (Smith, Hymen, Hymen, Ruiz, & Davidson, 2016). Further, trauma-informed approaches to healthcare have emerged in the past 20 years, paving the way for more holistic approaches to treating mental illness and trauma (U.S. Department of Health and Human Services, 2014). Recovery from trauma may be broadly contextualized as a multifaceted individual process that follows traumatic exposure and one which carries varying definitions and philosophical characteristics. Definitions of recovery vary widely and may differ based on the traumatic event, though there are some general features. In reference to recovery from mental illness, Deegan (1996) explained,

> Recovery does not mean cure. Rather recovery is an attitude, a stance, and a way of approaching the day's challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting and regrouping. Each person's journey of recovery is unique. Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again (pp. 96–97).

Though general recovery definitions may provide a basis for understanding recovery from IPV, unique elements exist in the recovery process following psychological and physical violence inflicted by an intimate partner. Researchers have attempted to formulate specific definitions of IPV recovery. Allen and Wozniak (2011) defined it as "a social, spiritual, cultural, and psychological process" (p. 37). Evans and Lindsay (2008) described it as *integration* rather than as *recovery*, contending that true recovery from IPV was neither likely nor desired. Farrell (1996) described the process as a "multidimensional phenomenon consisting of physical, mental, and spiritual components . . . [that involves] . . . reconnecting the fragments of the self by putting into perspective the past experiences of abuse" (p. 31). Similarly,

Kearney (1999) conceptualized it as "reassembling the shattered self" (p. 137). Wuest and Merritt-Gray (2001) described one aspect of recovery as "putting [the abuse experience] in its rightful place" to enable moving forward with one's life (p. 86).

Despite the myriad of challenges facing survivors, many go on to prosper and create meaningful lives. Increasingly, researchers and practitioners are also understanding more about resilience and the role it plays following traumatic exposure (Southwick, & Charney, 2012). Humphreys (2003) explained resilience as "a positive personality characteristic that enhances individual adaptation" (p. 142). Related to resilience, posttraumatic growth (PTG) may explain some of the variance in how survivors recover (Cobb, Tedeschi, Calhoun, & Cann, 2006). Calhoun and Tedeschi (2006) elucidated that PTG may be set in motion when an individual's worldview or assumptive reality is challenged by a traumatic event, which then opens up the opportunity for introspection, cognitive engagement, and rumination of the event. Specifically, researchers (e.g., Ai & Park, 2005; Burt & Katz, 1987; Senter & Caldwell, 2002) have found that survivors of IPV experienced more meaningful interpersonal relationships, enhanced ability to accept support, increased coping skills, increased probability of helping others in similar situations, enhanced religious and spiritual beliefs, enhanced introspection and awareness, and increased self-control. Indeed, in one study, researchers found that survivors' emotional health was better after the end of the IPV-relationship than it had been prior to the abusive relationship, possibly attributed to the PTG that occurred after the IPV experience (Follingstad, Brennan, Hause, Polek, & Rutledge, 1991). It is clear from the literature that some survivors who leave abusive relationships experience PTG. However, the factors related to how PTG comes about and the discrepancy in who experiences it necessitate further investigation. In the following sections, I explore two main areas of survivors' recovery experiences: (a) recovery as a developmental process, and (b) specific elements that facilitate recovery.

RECOVERY AS A DEVELOPMENTAL PROCESS

A narrative review of the research on IPV recovery illuminated the presence of developmental or process-like experiences. That is, numerous researchers have identified stage-like or process-like phases that survivors of IPV go through over time. Summarized modestly, survivors of IPV make sense of and separate from their abuse experiences, cope with and heal from the abuse, and grow and become empowered. In this article, I summarize these phases as (a) disentangling from the past, (b) coping with the present, and (c) moving toward the future. However, this oversimplification necessitates clarification: namely, these phases should be viewed as a continuum or cycle wherein individuals move back and forth depending on circumstances and triggers (e.g., Flasch, Murray, & Crowe, 2015) or as an integration of experiences over time (Evans & Lindsay, 2008). In fact, scholars (Anderson, Renner, & Danis, 2012; Humphreys, 2003) note that resilience and trauma symptoms often coexist. Anderson et al. (2012) explained, "Resilience and impairment are not necessarily opposites, but instead appear

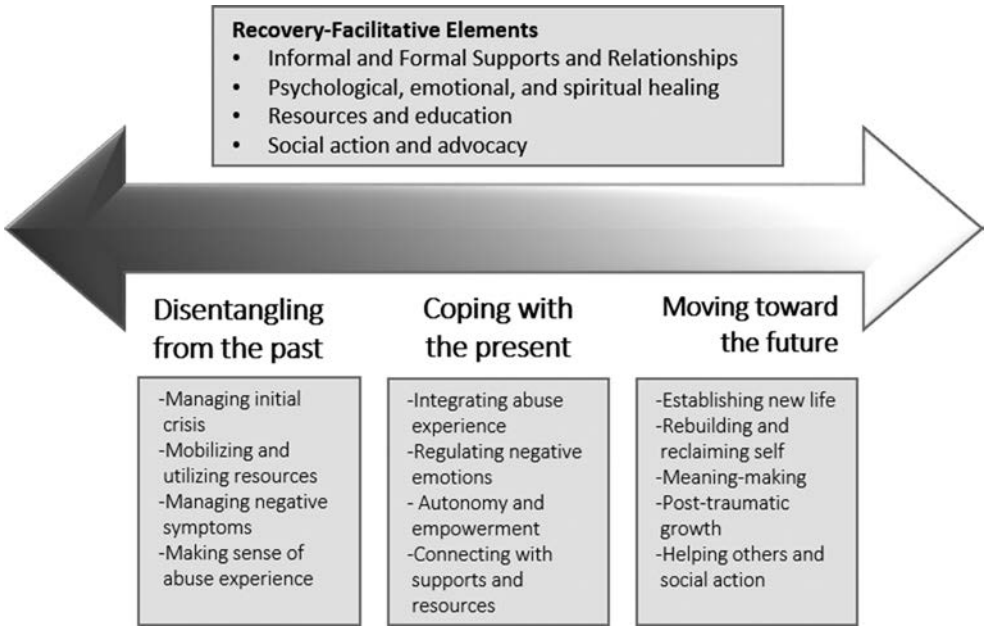

Figure 1. The continuum of recovery from intimate partner violence.

to be different aspects of the overall experience of coping and adjustment for survivors of domestic violence. In other words, demonstrating resilience may not necessarily infer absence of psychopathology" (p. 1294). The coexistence of resilience and impairment support the notion that survivors of IPV do not have to recover from their experiences fully prior to displaying resilience or wellness. Rather, they may vacillate on a continuum of recovery (see Figure 1.) where various aspects of their trauma experience (e.g., PTG, PTSD) may be dominant during different intervals. Additionally, it is important to note that some individuals never experience all phases of recovery as they are presented here. Finally, though an IPV relationship may be terminated, continuous abuse may take place due to, for example, shared custody or stalking; thus, some survivors may find themselves unable to embark on true recovery. It is critical to remember that each individual's experience and context of recovery is unique, and that many factors influence a person's process. Nevertheless, better conceptualizing IPV recovery as a continuous developmental process may serve as a foundation for clinical work with survivors as well as for future research.

Disentangling From the Past

Disentangling from the past refers to the initial emotional process of leaving or letting go of the abusive past, and may mirror the first stage of Kubler-Ross's (1969) bereavement process (Abrahams, 2007). In this initial stage, individuals may experience feelings typical when facing an initial loss, such as denial, shock, and numbness

(Abrahams, 2007), or shame related to have failed in a relationship and let down family (Hou et al., 2013) and God (Neustifter & Powell, 2015). Complicated grief may also explain some of the initial feelings of numbness, shock, bitterness, anger, and role confusion surrounding the loss of the relationship (Crunk, Burke, & Robinson, 2017). *Disentangling from the past* further involves survivors' experiences of acknowledging the past (Farrell, 1996), creating a safe place (Allen & Wozniak, 2011), and exploring and making sense of the abusive relationship (Abrahams, 2010; Wuest & Merritt-Gray, 2001).

Farrell's (1996) model termed this initial phase of recovery *flexibility*, in that female participants in her phenomenological study ($N = 7$) acknowledged their past IPV experiences, explored and adjusted boundaries in relationships with others, and increased resiliency and self-awareness. Allen and Wozniak (2011) described it as *creating a safe place,* wherein priorities of recent survivors' centered around safety and an initial need for freedom. The participants ($N = 11$) in Allen and Wozniak's grounded theory study, recruited from domestic violence agencies, noted the importance of "home as sanctuary" (p. 46) where they were able to exercise some form of freedom and control (e.g., decorating, organizing). In a longitudinal participatory action research study that took place over nearly a decade, Abrahams (2010) interviewed female survivors ($N = 12$) in England about their experiences. She found that the initial phase consisted of making sense of the effects of the IPV, dealing with an emotional roller coaster, urgency to locate a home and settling in, and exploring hopes and expectations. She named these initial phases *a new journey with old baggage* and *the transformation of home*, emphasizing the immediate psychological and practical needs. As a result of their feminist grounded theory study, Wuest and Merritt-Gray (2001) called this initial phase of recovery *figuring it out*, emphasizing White female survivors' ($N = 15$) search for reasons as to why the abuse happened and why they stayed. Further, this stage was characterized by a focus on assignment of blame, wherein individuals tried to make sense of who's fault the abuse was and whether they themselves were to blame. The researchers described the phase as a "conscious and proactive process, often driven by a desire to prevent abuse from happening in future relationships" (p. 84).

Smith (2003) used a phenomenological methodology to interview 15 women in a mid-sized southern U.S. city. Out of the 15 women, 14 were White and 1 was African American. Findings indicated that the initial recovery phase centered around the *abusive past*, characterized by survivors leaving behind their past abusive relationship and letting go of it. Abrahams (2007) used a participatory research methodology interviewing 23 women who had left abusive relationships. The participants were all volunteers who were either currently living in or had previously lived in a domestic violence shelter. Participants ranged in socioeconomic status, sexual orientation, age, and ethnic backgrounds. Based on her findings, Abrahams identified the initial phases of recovery as *reception* and *recognition*. In the *reception* stage, Abrahams (2007) described survivors as feeling numbed, confused, and dazed, with no clear recollection of their actions. The *recognition* phase marked a transition period that involved recognition of the abuse experience, a period of mourning,

disorganization, and adjustment, with accompanying feelings of anger, loss, depression, lack of confidence, and intense waves of emotional feelings.

To summarize, *disentangling from the past* refers to the initial stage of IPV recovery and is characterized by survivors being on a sort of autopilot, dealing with negative emotions and symptoms of abuse, working to secure housing and practical resources, and trying to make sense of their abuse experiences. For practitioners, the implication of this phase may be that they help survivors manage the initial crisis of post-IPV recovery by functioning in more of a case management role. For example, professionals may connect survivors to community resources that help them meet basic needs (e.g., housing, transportation, employment, medical, food, and childcare assistance) and engage in safety planning. Further, practitioners should help their clients process their negative emotions, validate their fears, and help them make sense of their IPV experiences and new reality.

Coping With the Present

Coping with the present can be described as the middle phase on the recovery continuum and includes survivors embarking on the healing process, seeking supports, becoming empowered and autonomous, and integrating the abuse experience into their new lives. This phase is described as *coping with the present* because it is present-focused, in that survivors have begun leaving the past behind and are concerned with creating a new everyday reality and heal. Long-term planning, PTG, focus on social action, and advocacy are not the focus of this phase. Rather, this phase can be viewed as more of an urgency to *get back to normal* and put resources and supports in place so that growth can eventually occur. Smith (2003) defined this phase as *struggles* in that survivors learned to cope with struggles as they embarked on a violence-free live. Farrell (1996) described this middle phase as *awakening* and *the relationship* and found that participants experienced a realization of their inner strengths and freedom, were able to begin reestablishing relationships, and began integrating themselves into the social context. In Allen and Wozniak's (2011) study, themes related to the middle phase of recovery included establishing autonomy, taking pride in appearance, reclaiming the self, developing inner peace and serenity, and rejoining the community. This phase also included an integration of the past with the present, becoming more forward thinking, creating a new life with new memories, recovering skills and talents, an emerging sense of calmness, improved mood, and less reactivity, improved coping skills and confidence in their ability to set goals and achieve them, and reconnecting with family and friends. It was also characterized by a sense of calmness, improved mood, less reactivity, and improved coping skills. Establishing this foundation activated elements needed for growth and healing.

Abrahams (2010) found that the middle phase included a focus on building supports, becoming part of the community, focus on work and finances, and embarking on mental and physical healing. It was also characterized by a focus on children and parenting. Further, Hou et al. (2013), based on their phenomenological study of eight Taiwanese female IPV survivors, named their middle phases *creating mastery* and

recognizing the imperfect self, during which individuals readjusted their attitudes, became more flexible and comfortable with themselves, became more self-aware and able to seek support, and acquired autonomy in their daily lives. Further, they began to utilize their skills and abilities and worked to gain financial independence. Wuest and Merritt-Gray (2001) called their middle phases *putting it in its rightful place* and *launching new relationships.* During this time, the women in their study stopped defining themselves in relation to their abusive experiences (e.g., victim, survivor), and instead began defining their own existence. This period was also marked as a time of softening of anger and a reinvestment in the future. *Launching new relationships* related to participants' experiences with new romantic partners, difficulty of trusting new partners, and hypervigilance and being on guard. The researchers found the women in their study made protective rules, such as "I'll never marry again, I'll always keep control of own money, and I'll always have an exit" (p. 88). Though embarking on new relationships carried with it struggles, new non-violent relationships often served as a healing element (e.g., Author et al., in press).

To summarize, the middle phase of recovery, or *coping with the present* included survivors' experiences of coping with the present circumstances, integrating their abuse experience into their new life, regulating negative emotions, recognizing their strengths, and connecting with social supports and resources to become more financially and emotionally autonomous and empowered. For practitioners working with survivors in this phase, particular emphasis needs to be placed on helping clients establish social supports and connect with their communities through work or education. Focus should also be on aiding clients in beginning to rediscover their new identities, building their self-esteem and efficacy (e.g., exploring likes and dislikes, exploring strengths, making autonomous decisions), and finding new routines and rituals in daily life. In this phase, it may be appropriate to start more comprehensive trauma treatment, as opposed to crisis counseling.

Moving Toward the Future

Moving toward the future describes the final phase in the recovery process, and includes a deeper sense of connection, healing, advocacy, meaning, and empowerment. It is more future-oriented than the previous phases, in that participants in this phase emerge from the more crisis-focused phases and manage to create a stable environment where they are able to focus on meaning-making and the future. Smith (2003) named it *healing and growth.* Hou et al. (2013) defined it as *embodying the self by helping others*, signifying the ultimate positive use of one's abuse experiences. Further, this phase recognized the need to create a significant life, to feel self-worth, and to gain meaning of existence. Participants explained that they embodied the self through the process of helping others. Further, Wuest and Merritt-Gray (2001) named the final phase *taking on a new image* in which individuals experienced increased feelings of strength, bravery, capability, security, and pride in themselves. Additionally, there was a greater awareness of personal power and control and a curiosity about the future.

To summarize, *moving toward the future* may be defined as the *final layer of healing* or, for some, PTG, where individuals move forward and have begun incorporating their abuse experience into their new life, possibly even grown from it, though not being defined by it. Further, survivors in this phase may use their IPV history to help others and engage in social advocacy (Author et al., 2015). Practitioners working with survivors in this phase may still need to help them process past trauma and how it manifests in their present; however, focus of treatment may be more existential in this phase. That is, practitioners may support survivors in exploring meaning and purpose and work with them to integrate their abuse experiences into their new identities. Further, practitioners may also consider broaching the topic of considering volunteering to help others (e.g., domestic violence shelters).

The developmental continuum model presented here may provide a foundation for understanding and conceptualizing phases of recovery, as identified in the research. Nonetheless, it is important to remember that even though survivors may reach great levels of recovery, healing, and growth, IPV recovery is a non-linear process and should not be treated as a stage model. Additionally, many elements and factors interplay in and may affect the developmental phases. These factors are explored in the following section.

SPECIFIC ELEMENTS THAT FACILITATE RECOVERY

In addition to developmental or process-like models, researchers have investigated specific elements that facilitate healing in survivors' recovery experiences. These occur at varying points and to varying degrees during the recovery process and are broadly summarized as (a) informal and formal social supports and relationships; (b) psychological, emotional, and spiritual healing; (c) resources and education; and (d) social action and advocacy.

Informal and Formal Social Supports and Relationships

Perhaps the most widely supported factor related to positive recovery and healing experiences from trauma is social support (e.g., Beeble, Bybee, Sullivan, & Adams, 2009). Social support includes both formal (e.g., therapy, support groups) and informal (e.g., friends, family, other survivors) networks. Several researchers have identified informal social support and reconnecting with friends and family as an essential factor in IPV recovery (e.g., Abrahams, 2010; Davis & Taylor, 2006; McDonald & Dickerson, 2013; Neustifter & Powell, 2015). In one study, Anderson et al. (2012) used a mixed-methods approach to identify women's perceptions of their recovery process and adaptation after IPV experiences. One statistically significant finding was that participants who recovered well and had lower levels of PTSD symptomatology tended to have at least one close and secure relationship which they experienced as helpful during stress. This was supported by qualitative data from the participants in that support systems were viewed as essential, especially during the first two years after leaving the abusive relationship. Some of the contributions

made by supportive others (e.g., friends, family, employers) included affirmation, encouragement, stability, and resources (e.g., financial, housing). The authors concluded that developing support systems and mobilizing resources were central to participants' resilience and ultimately to their recovery from domestic violence. Though informal social support generally serves as a protective factor (Kemp, Green, Hovanitz, & Rawlings, 1995), Beeble et al. (2009) found that intensity of abuse was related to social support as a mediator for well-being. That is, the buffering effects of social support were most significant when the abuse levels were lower, suggesting that in more severe cases of IPV, informal social support may be less effective in moderating negative effects. Therefore, it is critical that practitioners assess for the severity of their clients' IPV history and recognize that unique experiences demand tailored treatment approaches. Further, Beeble's et al. (2009) findings also serve as a reminder that, because of the varying characteristics for each survivor, recovery may require additional work and patience on the part of both client and practitioner.

Finally, a source of informal support that has been less explored in the literature is that of new non-violent partners. Several researchers have established that there is a connection between overall wellness and healthy romantic relationships (Liu & Umberson, 2006; Mastekaasa, 1994). That is, in relationships where the quality of the relationship is high, research findings suggest that the supportive nature of the partnership may buffer from psychological distress (Mastekaasa, 1994), physical health problems, and mortality (Rendall, Weden, Favreault, & Waldron, 2011). Individuals in healthy intimate relationships are likely to experience positive physical health, increased coping skills, report better life satisfaction, and report decreased symptoms of depression, stress, and anxiety (e.g., Granello, 2012). Though limited studies exist that examine post-IPV relationships, there is support for both challenging and helpful aspects (Flasch, Boote, & Robinson, 2019; Lewis et al., 2015) of dating post-IPV. Survivors of IPV who embark on new relationships may fear revictimization, experience difficulty trusting men, and find themselves hypervigilant of abuse signs (e.g., Lewis et al., 2015). On the other hand, healthy new relationships may facilitate recovery. Author et al. (in press) found that in the process of dating, survivors learned to trust themselves and discern between healthy and unhealthy behaviors. As participants' self-trust and efficacy increased, they felt stronger and more empowered and were able to soften rigid boundaries that allowed emotional connections to emerge. Additionally, participants in Neustifter's and Powell (2015) study found they were able to process and explore the change between the two types of relationships (i.e., healthy and abusive), how their own relational roles changed between relationships, and the ways in which the new relationship thrived or struggled.

Practitioners may be reticent to encourage their clients to embark on intimate relationships post-IPV for a variety of legitimate reasons. Rates of revictimization by the same partner remain high, with estimates ranging from 19% to 44% (Alexander, 2009). Revictimization by multiple partners has received less emphasis in the literature, but is estimated to range from 27% to 56% (Alexander, 2009; Orke, Vatnar, & Bjorkly, 2018). That is, researchers estimate that nearly a third to almost a half of IPV victims have had more than one abusive partner in their lifetime. Orke et al. (2018)

conducted a systematic review of the research on revictimization by multiple partners to investigate whether there was a difference between women who experienced victimization by a single partner and those who experienced victimization by multiple partners. They found only one conclusive correlation: women who had been victimized by multiple partners, as opposed to one single partner, were more likely to have been experienced various forms of lifetime victimization, including exposure to childhood victimization (violence and sexual abuse). Thus, IPV survivors who have lifetime experiences of abuse, including childhood victimization, may be at higher risk for revictimization by multiple partners, as opposed to survivors who have not had lifetime victimization experiences. Though it is important to assess for risk factors and prepare survivors for potential pitfalls (e.g., warning signs of abuse), there may also be room for exploring the process of navigating new relationships in therapy for clients who choose to do so. That is, practitioners may serve as a sounding board for clients' growth, insight, and empowerment as they explore dating post-IPV and learn about themselves in the process.

In addition to informal support, mental healthcare is consistently cited as a facilitative factor in IPV recovery (e.g., Abrahams, 2010; Anderson et al., 2012; Davis & Taylor, 2006) and is viewed as a type of formal support. Other formal supports may include law enforcement, medical personnel, domestic violence advocates, and community speakers. As with informal support, survivors distinguished between helpful and unhelpful others, noting that though some helped them process their experiences and heal, others were unsupportive and even hurtful (e.g., Author et al., 2015; Lewis et al., 2015). Generally, mental healthcare often serves as a helpful experience, in that individuals are able to talk about the abuse, process their trauma, and manage PTSD symptoms (Anderson et al., 2012). Further, they may help in providing safety, support, education (e.g., safety strategies), and connection to other helping systems, like legal, financial, and health networks. Thus, mental health practitioners serve an important role for survivors, many of whom seek professional help after leaving abusive relationships and long-term.

Psychological, Emotional, and Spiritual Healing

Psychological healing is an essential element in survivors' recovery. Psychological healing refers to a reclaiming of the self through empowerment and fostering self-esteem, self-love, and self-control. As a result of IPV, many survivors experience a loss of self and note the importance of rebuilding themselves psychologically and emotionally. Participants in Humbert's et al. (2014) study expressed this as *tending to one's needs, experiencing comfort with one's self*, and *self-love through self-nurturing*. Other studies echo the theme of survivors' need to learn to know and love themselves again. McDonald and Dickerson (2013) defined this experience as *nurturing the self* through the challenging of negative reflections, believing in one's self again, and self-exploration and self-discovery. Author et al. (2015) found that participants experienced psychological healing through exercising power and freedom to direct their own lives and by recreating themselves as a unique individual, not defined by their abuser.

Participants in various studies (e.g., Author et al., 2015; Wuest & Merritt-Gray, 2001) stated that psychological healing came from reestablishing themselves, recognizing that they had power and freedom, and taking control of small aspects of their lives, such as decorating their homes or starting a hobby. In fact, Anderson et al. (2012) found that survivors of IPV who experienced pride in their achievements had higher scores on resilience and exhibited fewer PTSD symptoms. Participants in Hou's et al. (2013) study experienced empowerment and psychological healing as *creating mastery*, which referred to survivors "increasing their abilities, readjusting their attitudes, being flexible, and acquiring autonomy in their daily lives" (p. 163). Further, an important element of psychological healing for many survivors was to remember and accept recovery as a journey and long-term process, rather than a *quick fix*; patience and self-compassion with oneself was essential for this (e.g., Author et al., under review; Author et al., 2015). In sum, survivors experienced psychological and emotional healing as becoming empowered, secure, and rebuilding their identities. Practitioners can work with survivors by helping them take steps toward autonomy and independence as to highlight their freedom, power, and capabilities. Practitioners may also utilize self-compassion approaches to help clients develop self-esteem, self-love, and self-forgiveness. Finally, practitioners may need to educate their clients about the long-term process of healing in order to establish realistic expectations and goals.

In addition to psychological healing and perhaps an element of it, many studies support spiritual healing in the aftermath of IPV as an element in recovery for individuals who experience some level of connection to religious or spiritual traditions. However, religious sources were also experienced as negative by some participants who felt unsupported in their decisions to leave their abusive partners. Nevertheless, spiritual healing is frequently noted as a theme in survivors' experiences of recovery. In Anderson's et al. (2012) study, participants found that having a spiritual relationship helped them view their trauma in a more positive and meaningful way. That is, they focused on the increased strength, wisdom, and compassion they had come to embody as a result of their struggles and found meaning and purpose in that. They also found that their faith communities offered emotional comfort and a sense of belonging, security, and practical assistance. Further, Lewis et al. (2015) found that participants in their study emphasized how fundamental their spiritual beliefs and connection to God was to their sustained recovery from IPV. Participants in Author's et al. (under review) study also suggested God was central to their healing, noting that with God, they were never along, always loved, and always supported. Findings support the role that spirituality or religion is an element in the recovery experiences for some survivors; thus, practitioners should assess whether clients want to utilize religion or spirituality in their counseling experiences. Further, practitioners may encourage clients to seek support from, and help connect them to, suitable religious/spiritual resources.

Resources and Education

Another specific element in IPV recovery includes practical resources (e.g., housing, childcare, medical, employment, transportation, and financial resources) and education about IPV. Though emotional and psychological healing is essential for sustained recovery, new survivors who leave IPV relationships are often in crisis and need to meet basic needs quickly. Further, there are often safety concerns that need to be addressed. Though domestic violence shelters may serve as an initial refuge for some, these are often short-term and not all survivors are able or willing to use them. Abrahams (2010) found that some immediate aspects of recovery included finding housing, employment, childcare, and financial assistance. Another important resource for survivors may be medical care due to potential physical injuries and other associated physical consequences of IPV (e.g., asthma, fibromyalgia, gastrointestinal issues, sleep disturbances, and migraines). Related to financial abuse or otherwise lack of resources, it is essential for survivors to meet basic needs prior to being able to process and heal from the abuse experience. Thus, practitioners are tasked to advocate for and connect their clients with community resources to address these initial needs.

Additionally, learning about IPV served as a healing element for many survivors. In Author's et al. (2015) study, survivors emphasized the importance better understanding the dynamics of IPV, which helped them integrate their experience and make sense of it. One participant in their study stated, "First I had to recognize it as abuse, which was very difficult for me. From there, it became easier to overcome. I needed to understand what happened, view it realistically, and forgive myself for being a participant" (p. 16). In Murray's et al. (2015) study, survivors identified *education about IPV* as a critical turning point in helping them leave and stay away from their abusive partners. Reading books about IPV and gaining resources explaining the dynamics of power and control often served as validating and aiding in this process (e.g., Author et al., under review; Author et al., 2015; Murray et al., 2015). Further, better understanding the effects of IPV on children and how to move forward with parenting served as a helpful element for many survivors (Abrahams, 2010). In sum, mobilizing practical resources and learning about IPV dynamics has been found to be an element in survivors' recovery process. This evidences the need for practitioners to be knowledgeable in community resources, have an established network of referrals, and serve, in part, as case managers. Further, it is essential that practitioners are educated in IPV dynamics so that they can provide psychoeducation to their clients and help them understand key elements of IPV perpetration.

Social Action and Advocacy

Many studies have found that aspects of *giving back* served as healing for many survivors. That is, survivors used their trauma experiences as a way to help others, and they experienced meaning and purpose as a result. Hou's et al. (2013) theme of *embodying the self by helping others* referred to participants' desire to find meaning in their lives, and that a significant source of meaning was to help others in their

community who were going through similar experiences. Moreover, Authors (2015) investigated how survivors of IPV (N = 123) viewed themselves as social advocates and found that many engaged in both small scale (e.g., being there for a friend, posting articles on social media) and large scale (e.g., speaking engagements, professional or volunteer work related to IPV) advocacy efforts. The researchers concluded that even though advocacy work had the potential to be healing for many survivors, it was important that each individual chose their own path about whether and how to engage in it. Further, they highlighted the risk of retraumatization as a result of premature social advocacy. Practitioners may choose to explore the idea of social advocacy involvement with clients who may be open to it, though it is important that practitioners discuss and process potential risks.

CONCLUSION

Healing from IPV is a complex and multifaceted process that exists on a continuum and involves numerous specific elements, all of which affect individual journeys. Using a narrative review of the literature, I synthesized survivors' experiences of recovery into a developmental continuum model of (a) disentangling from the past, (b) coping with the present, and (c) moving toward the future. *Disentangling from the past* was characterized by the initial crisis after leaving an abusive relationship where survivors dealt with negative symptoms, tried to make sense of their abuse experiences, and mobilized to acquire resources, such as housing. *Coping with the present* was the middle phase and included survivors' experiences of beginning to integrate their abuse experience into their new life, regulating negative emotions, becoming more autonomous and empowered, and connecting with social supports and resources. *Toward the future* was characterized as the final phase, in which survivors established new life and rebuilt or reclaimed themselves. Elements of PTG were experienced in this phase of the continuum. The specific elements facilitating the recovery of many survivors were found in the literature, and synthesized here, to include (a) informal and formal social supports and relationships; (b) psychological, emotional, and spiritual healing; (c) resources and education; and (d) social action and advocacy.

Though the narrative review utilized research on the recovery experiences of survivors of IPV, it is important to acknowledge that such a method of synthesis carried limitations. It is possible that I missed articles that were not registered in the databases by the key search terms I used. Additionally, the studies I reviewed were qualitative in nature and utilized varied rigor in methodology. Further, the vast majority of the examined research studies used samples of predominately White heterosexual women who were victimized by male partners, which limits transferability to other populations. It was not the purpose of this review to present a conclusive model of the recovery process of IPV or to conduct a systematic review. Rather, the hope is that this review grounds the current research and provides a springboard for survivors and clinicians alike to better understand recovery experiences and utilize the various developmental and specific factors in their work.

Practitioners may use the processes and elements outlined in this article to examine the experiences of their clients and assess for both developmental and specific elements of their recovery journeys. Though, it is essential to recognize that not all survivors experience developmental phases, nor are the phases meant to represent a linear process. IPV recovery is a highly individualized process that is contextualized in abuse-specific and lifetime experiences, cultural factors, and social and psychological elements (e.g., social support, education about IPV, resilience, substance abuse, mental illness). Thus, individuals recovering from IPV may vacillate between the developmental phases, may only experience one or two of them, or may not experience any of them. Further, certain specific elements may be helpful for some survivors and not others. Future research may explore processes examined by more diverse groups of survivors (e.g., ethnic and sexual minorities, male victims). Additionally, researchers may investigate aspects of IPV recovery utilizing quantitative methods that can control for various variables (e.g., revictimization experiences, culture, abuse-specific characteristics, supports), and are generalizable to a larger population. In sum, IPV recovery may be described as existing on a developmental continuum that is affected and influenced by specific factors over time. Using this model may help practitioners better understand survivors' experiences and may serve as a starting point for assessment and conversation.

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