Fostering Resilience and Posttraumatic Growth in Women Survivors of Intimate Partner Violence: A Holistic and Social Justice Framework for Healing

by

Bonnie Koehn

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APPROVED BY

Dr. Ron Manley, Capstone Advisor, Master of Counselling Faculty

Dr. Lynda Beveridge, Faculty Reader, Master of Counselling Faculty

School of Health and Social Sciences

Abstract

In this capstone project I discuss the therapeutic, social, and community supports that can foster resilience and posttraumatic growth in women survivors of intimate partner violence (IPV). I also examine our understanding and use of the concept of resilience, and considers how assumptions about IPV recovery may be contributing to inaccurate assessments or construal of resilience, strength, and fragility. Finally, I suggest ways to remove the individual emotional and psychological burden of resilience and PTG from women who experience IPV by proposing a social justice grounded holistic treatment approach that includes narrative, compassion-focused, and somatic therapies, combined with group therapy, Polyvagal theory, and social connection.

Keywords: domestic violence (DV); intimate partner violence (IPV); posttraumatic growth (PTG); resilience; social justice; women survivors.

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Dedication

This capstone is dedicated to the beautiful and bright sunshine of my life, DB, who has given me every reason to keep growing, and motivated me to keep climbing over every obstacle, no matter how steep. It is a joy and an honour to share life with such a miraculous and marvelous human being.

My project is also dedicated to the courageous women who survive intimate partner violence and walk steadfastly toward hope and renewal while navigating through the dark valleys of unacceptable systemic failures. We must do better for every one of these women and their children.

And finally, to my cherished sister-friend Raina, who was taken from us too soon, and left a legacy of light and strength that still shines brightly in all who loved her.

> I think the word 'resilient' was created to make it acceptable that people without means to cope or survive will be celebrated as an example instead of looking at what support systems could have helped them and how to make it better.
>
> - Stephanie Land (2021)

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Chapter One: Introduction

In this capstone project I discuss the therapeutic, social, and community supports that assist women with healing from the trauma of intimate partner violence (IPV). I consider the ways that these and other factors can bolster the development of resilience in the face of adversity, and lead some survivors to experiences of posttraumatic growth (PTG). I also address our understanding and use of the concept of resilience, and I ask: is resilience a concept that can harm survivors further by placing responsibility for the burden of trauma recovery internally rather than on the social, familial and community systems that either failed or supported them during their experiences of IPV and stages of recovery?

A study by Ashton et al. (2021) described resilience as "a developed characteristic of an individual which reflects their ability to transform potentially toxic stress into tolerable stress" (p. 2). While this is only one definition, it summarizes the common assumption underlying much of the literature reviewed for this capstone: that while the development and maintenance of resilience can be supported by external resources, it is an internal characteristic, an ability, and a measure of one's success and value relative to experiences of adversity.

This capstone project considers the ways in which the above assumption may be contributing to inaccurate assessments of resilience, fragility, or brokenness in IPV survivors. I examine ways to help lift the burden of resilience from those who have endured IPV and subsequently experience trauma or adverse experiences, by redefining recovery. In Chapter Three, I propose a holistic approach that uses Polyvagal theory, and a combination of narrative and compassion-focused individual counselling, combined with group therapy, somatic healing, and social connection, through a social justice lens.

Good-fit therapy and social connection are key elements of my proposed approach. These ideas are supported throughout the literature. As an example, Oppong (2019) identified that of the many "interpersonal factors necessary to foster resilience...having positive mentors and role models" was central to the development and functionality of resilience (p. 2). While social connection and therapeutic support are important in the initial development of resilience and PTG, I discuss in this capstone project the importance of providing such connections well after survivors have demonstrated an ability to adapt and overcome adversity, in order to nurture a deeper and ongoing healing and thriving process. I also examine the many ways we can work to relieve survivors of the burden of being deemed a relative success or failure at survival, healing, and recovery from trauma; and redistribute this responsibility onto the systems, such as social, familial, community, socioeconomic, and legal, that often abandon survivors to what I call "forced resilience".

The intended audience for this project is counsellors who work with women clients in recovery from IPV trauma, community services organizations who provide supports to this demographic, and clients who seek insight and guidance within their own healing processes. It may also be of use to those who love and support women survivors of IPV, since social support systems can be a tremendous recovery resource, particularly when they are sensitive, trauma-informed, and proactive.

Defining Intimate Partner Violence

Intimate partner violence (IPV) is defined by the World Health Organization (2021), in their online fact sheet, as "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (para. 2). Coercive control is an additional method of abusive

behaviour that is now included in many definitions of IPV. It is defined by Chambers et al. (2018) as a method of abuse enacted as a way “to dominate individual women by interweaving repeated physical abuse with three equally important tactics: intimidation, isolation, and control" (p. 671). Coercive control can be difficult for survivors to explain to those who have not experienced it, as its wounds become so deeply embedded in their psychology. It is a kind of control that is built incrementally over time and can have the effect of causing victims to live in constant fear, since it can be used intermittently with violence.

Purpose Statements

In this capstone project I will:

1. discuss the nature of IPV, and consider the personal strengths and community supports that can bolster resilience and posttraumatic growth after IPV;
2. discuss the roles of resilience and posttraumatic growth with respect to IPV, including possible harm associated with these concepts;
3. consider the ways in which assumptions about IPV recovery may be contributing to inaccurate assessments or naming of resilience, strength, fragility, or brokenness; and discuss ways to remove the individual emotional and psychological burden of resilience and PTG from those who experience IPV trauma by applying a social justice framework;
4. propose a holistic treatment approach, which suggests narrative, compassion-focused, and somatic approaches, combined with group therapy, and utilizing Polyvagal theory and social connection, through a social justice lens. Since the current literature already demonstrates the importance of social connection and support in healing from IPV trauma and overcoming adversity, I will also discuss the importance of maintaining such

connections well after survivors have demonstrated resilience, in order to nurture an authentic and lasting healing and thriving process.

Contributions to the Field

This research may benefit anyone who has an interest in the topics of IPV recovery, trauma, resilience, and posttraumatic growth, or anyone who works with populations affected by these in community-based, mental health, or therapeutic environments. It would be beneficial to survivors of IPV for those working in this field to reconsider how we tend to look at resilience and PTG as trophies of trauma, and to begin to recognize these as forced states of being that may in fact be exhausting, overwhelming, or even resented at times by those who have carried the burden of the traumatic experiences and disadvantages that IPV delivers.

A study by Luthar et al. (2019) discussed the way that over time, researchers of childhood trauma and resilience have learned that while personal or innate characteristics are relevant "they are only one part of three categories of major 'vulnerability or protective processes', with the other two encompassing aspects of the family and of the community" (p. 1814). Luthar et al. (2019) referred to the development of resilience in children, but these ideas can easily be applied to women survivors as well. Supports and protective processes should be accessible to women who have overcome IPV; even, or especially, to those who appear resilient but are perhaps lacking the internal or external resources that provide paths to resilience and PTG. Even the strongest and most persistent survivors can become overwhelmed or exhausted from the labour of bouncing back, only to find themselves being measured, often inaccurately, against their ability to perform the social, practical, and psychological dance of what we recognize as and label *resilience*.

It is my hope that this work provides some helpful suggestions for a holistic and social justice grounded approach to a type of trauma that affects every part of one's life and requires multifaceted care. The current systemic path for survivors' healing is limited. Therapies funded by crime victim assistance programs, domestic violence shelters, and other helping organizations are often brief in course and less holistic in focus. There may not be time to build the level of emotional safety needed to restore healthy nervous system function and move forward. If finances are strained, women may take whatever support they can get rather than being able to choose good-fit therapy. I hope that in time, the systems that are meant to support this population will see the benefits of ensuring that the whole woman is seen, heard, and nurtured.

Reflectivity and Positionality Statement

I have always been fascinated by the question of why some women survivors of IPV appear to be more resilient than others, and why some experience PTG while others do not. Despite starting on my life's path with a high Adverse Childhood Experiences (ACEs) score, and later becoming a survivor of IPV, I have been able to recover and grow beyond what I ever considered possible. Over time, I have been able to consider and recognize the therapeutic tools and social supports that nurtured my healing and fueled my ability to maintain hope and move forward. In reflecting on these, I have come to believe that without this specific combination of resources, my outcome could have been drastically different. For this reason, I felt compelled to research and write about why some women survivors of IPV are more or less resilient, why some land in a state of PTG, and how mental health practitioners and social service providers can help to foster recovery in this population.

I have an acute awareness of how being named resilient can be a point of frustration when there was perhaps no option for survival other than resilience, and when the environment

surrounding resilience can be highly stressful, difficult, limiting, and unsupportive. Even mental health clinicians trained in trauma sometimes seem to have an underlying belief that women are innately stronger, better, or more evolved when they are able to bounce back from adverse experiences. Being deemed a relative success or failure at survival, healing, and recovery from IPV can create further burden and pain, as it can place unwanted pressure or judgement on the shoulders of recovering women, no matter which label is presented. In this project, I consider ways to redistribute some of the responsibility for recovery onto the many systems, such as social, familial, community, socioeconomic, and legal, that relinquish some trauma survivors into lives of "forced resilience".

These ideas deeply inform my therapeutic process with clients who have lived through IPV. My proposal of a treatment approach is grounded in my personal experiences as both a client and a counsellor. It is also grounded in my work as a Research Coordinator for a child and youth advocacy organization, where I coordinated a participatory action research project that explored the effects of poverty on parents and children, some of whom were incidentally survivors of domestic violence. Additionally, I rely on my awareness of which supports are currently lacking for my counselling clients who are struggling, to varying degrees, with recovery from IPV. I hope to share my knowledge and research in a way that might cushion those women who feel that they have been left behind to manage with inadequate degrees of support.

I overcame the obstacles created by IPV because I had no choice but to do so. I had some very well-timed help, a lot of luck, and several very knowledgeable and specifically-trained counsellors. Perhaps I had some internal resilience that was built and nurtured at various moments of my life. My posttraumatic growth was likely a product of many years of therapy and

a holistic approach to my own well-being, combined with some deeply meaningful and safe social supports that allowed my nervous system to reset and rewire. I hope to use these hypotheses alongside my academic learnings to advocate for women at all stages of IPV healing who might benefit from a more holistic and social justice grounded approach to recovery.

Definition of Key Terms

For the purposes of clarity and consistent use, the definitions below are offered.

Forced Resilience

My own term for a state of being cornered by adversity and by the failures of family, social, and other systems such that there is no option but to become resilient in order to survive.

Intimate Partner Violence (IPV)

"Behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (World Health Organization, 2023, para. 2). IPV is used interchangeably in this project with the terms "domestic violence" and "abuse".

Posttraumatic Growth (PTG)

PTG is a name for what occurs when a person is able to surpass the "level of adaptation, psychological functioning, or life awareness" at which they lived prior to a stressful life event or traumatic experience (Zoellner & Maercker, 2006, cited by Brosi et al., 2020, p. 3).

Resilience

Typically defined as a characteristic or ability of an individual whereby they are able to adapt to stressors or difficulties and overcome adversity in order to achieve a functional state of being. Brosi et al. (2020) define resilience as: "the ability to recover to previous functioning levels after a traumatic event" (p. 3).

Social Support

The presence of family, social, relational and community intervention, interaction, and help (my definition).

Protective Factors

Factors that can act as buffers against the consequences of IPV trauma. Some of these are healthy family support, therapy, community connections, mentorship, hope, optimism, rest and recovery, and socioeconomic security (my definition).

Woman/Women

These terms are used to include cisgender women, transgender women, and others who identify as women. Wherever the reference literature may have used the word "female", any discussion regarding such references refers to "women" in order to be inclusive.

Outline of Capstone Project Chapters

In chapter two, I will discuss the effects of IPV on women survivors, as reflected in current research. Then, I will examine resilience and PTG and the relationship between these two concepts. Next, I will discuss the literature on resilience and PTG in the context of women survivors of IPV, and present a critique of our current approaches to resilience. This will be followed by a discussion of common themes in the current literature on recovery in women IPV survivors, with some commentary. The chapter will conclude with a consideration of limitations in the research and suggestions for further study.

In chapter three, I will propose a holistic approach that, in consideration of the research reviewed in chapter two, would help to support women survivors of IPV to foster resilience and to move forward on their paths to recovery, and potentially, PTG. This holistic approach will

suggest narrative, compassion-focused, and somatic approaches, combined with group therapy, Polyvagal theory, and social supports/connection, through a social justice lens.

Chapter Two: Literature Review

For some time, as Žukauskienė et al. (2021) pointed out, "most of the research on the consequences resulting from IPV has focused on the victims' mental and physical health problems" (p. 7602). However, in recent years, the focus has shifted somewhat from a focus on negative outcomes to themes of recovery, resilience, and posttraumatic growth (PTG) following IPV. In order to understand the current literature on IPV, resilience, and PTG, I reviewed dozens of academic articles on these topics, and searched for common themes and ideas. While doing so, I maintained a focus on noticing which supports and therapeutic approaches researchers have most often identified as paths to resilience and PTG after IPV. I also carried an intention to notice the ways that survivors are labeled, mislabeled, or assigned what I view as excessive responsibility for their recovery.

In this chapter, I present a review of common themes within the current literature on women survivors of IPV, and consider ways to apply this research to best serve the mental health needs of this population. I identify gaps in the available studies, and implications for future research and treatment in this area. In addition to the academic research reviewed to support this capstone project, I also rely on the internal groundwork paved by my personal and academic readings done over the last decade. I include some of this literature as a supplementary reading list in Appendix A.

I will first consider the effects of IPV on women, as reflected in current research. Then, I will examine the literature on women survivors' resilience and PTG, and the relationship between these concepts. This will be followed by a discussion of common themes in current studies, and conclude with a consideration of limitations in the research and suggestions for further study.

The Effects of Intimate Partner Violence on Women

As Anderson et al. (2012) discussed, women in IPV recovery can experience barriers to healing and the recovery of their lives and selves, in that they are often focused entirely on difficulties like finding and keeping shelter, balancing work and parenting responsibilities, along with coming to terms with mental health challenges such as anxiety, depression, or posttraumatic stress disorder (PTSD). This can leave little time or capacity to focus on emotional, spiritual, and psychological well-being. Anderson et al. (2012) also identified that distraction from healing is worsened if there is additional lingering strain such as being stalked or harassed by an abusive ex-partner post-separation. Survivors' attempts to move forward and rebuild their lives are sometimes sabotaged by their abusers, who may not be able let go of a need to control their lives and punish them for leaving.

Choi et al. (2021) explained that "the adverse psychological outcomes of IPV for women, including heightened vulnerability to depression, anxiety, and posttraumatic stress disorder (PTSD)" are so prevalent that they are now a public health issue. (p. 2). The authors explained that IPV was "associated with an array of adverse physical and psychological health outcomes in women of all ages, including depressive episodes, PTSD, anxiety symptoms, somatization, self-harm, sleep disturbances, deteriorated functional health, chronic disorders, and pain" (p. 3). This was also detailed by Howell et al. (2018), who stated that "health consequences of IPV are substantial, with individuals exposed to violence endorsing depression, anxiety, suicidality, and worse overall health" (p. 2).

Also noted in current literature is that having lived with the trauma of intimate abuse, some survivors may develop a tendency to "experience fear (or anxiety) over the possibility of uncontrollable negative events occurring in future" (Choi et al., 2021, p. 4). This fear and anxiety

can cause some women to exist for a time in a state of hypervigilance, or to feel that they must be on high-alert, even if they may be surrounded by safety. In Chapter Three will discuss ways to help women to regulate and restore their nervous systems after abuse. Feeling safe is a key element of healing from IPV.

In addition to the mental health, physical, and financial consequences of IPV for women, there is also stigma attached to having experienced IPV. Questions such as "why didn't you just leave?", "why did you choose someone like that?", "didn't you notice any red flags?", or "why didn't you tell anyone?" are harmful to survivors. When asked (even in less offensive or more subtle ways) by mental health professionals, these questions carry the additional weight of having been asked by someone in a position of relative authority on mental health and relationships.

Women survivors of IPV are often looked down upon as having made bad choices, having been weak, or having chosen to experience ongoing abuse. These assumptions are deeply infused with shame, and freedom from shame is the real root of any meaningful healing. For all of the reasons above, therapists working with this population should have a specific skill set, including, but not limited to, a sincere empathy for clients who have suffered with IPV, and the ability to create a safe and non-judgemental space for curiosity, connection, and healing. In my view, there is also considerable benefit for survivors in seeing a counsellor who has lived experience with IPV, as the knowledge of this shared experience can bring forth incredible understanding and empathy in the therapeutic relationship.

Tutty et al. (2021) reiterated some of the previously noted consequences of IPV that can upend a woman's life: mental and physical health challenges, financial and social losses, and loss of work due to lasting mental health conditions and physical diseases that may develop due to

IPV. However, their research also showed that once women leave their abusers, "the women themselves not only generally do well, but statistically significantly improve their well-being over time" (p. 1138). This hopeful thread was woven through much of the reviewed literature. While IPV can push women to the edge of survival, those who do escape and recover, with the right supports, are highly motivated to move forward in their lives (Anderson et al., 2012; Brosi et al., 2020; D'Amore et al., 2021; Tutty, 2021).

Ethical Considerations for Disadvantaged Populations

As there are some populations that experience gendered violence and intimate partner violence more than others. It is important to acknowledge these groups and to understand that more focused and specific supports should be provided in such cases. I refer specifically to: transgender women; Black, Indigenous, and other people of colour (BIPOC); women immigrants; and women with disabilities. The additional stigma these populations face add complex layers of difficulty to recovery from IPV (Delker et al., 2020; West, 2021; Winiker et al., 2022). Mental health professionals have a responsibility to be knowledgeable and sensitive to their clients' individual challenges, as well as their strengths, and to advocate for better supports wherever possible. Additionally, in cases where two or more disadvantaged identities overlap, we must also consider the added levels of stigma, discrimination, and difficulty that may be present in clients' lives.

Another important consideration in this area is, as Delker et al. (2020) pointed out, that for those "who experience systemic oppression and marginalization on the basis of race, class, national origin, and gender and sexual identity, among other facets of identity, to tell a story of trauma can carry additional risk to safety" (p. 243). The tendency to underreport abuse due to fear of further harm was reiterated by West (2021) in regard to Black women survivors of IPV.

The prevalence of underreporting may also be one of the reasons that there are fewer studies available regarding the effects IPV has on these marginalized populations.

West (2021) shared this alarming statistic: the National Intimate Partner and Sexual Violence Survey (NISVS) found that "45.1% of Black women reported that they had experienced sexual violence, physical aggression, and/or stalking that had been perpetrated by an intimate partner" (p. 749). Tutty et al. (2021), in their longitudinal study of 419 Canadian women who had experienced IPV, pointed out that women with disabilities are often not included in studies about resilience. While Winiker et al. (2022) explain that there is now a growing body of research on the ways that transgender women experience IPV, this is only a start, and there is still so much to be done to explore the resilience and PTG of marginalized populations. Research about and treatment for women who face intersecting disadvantages should recognize the specific challenges, strengths, and unique pathways to recovery that these populations possess.

Resilience

Heard-Garris et al. (2018) described resilience as "the ability to withstand difficulties" (p. 204). Graham (2013) defined resilience as "the capacity to respond to pressures and tragedies quickly, adaptively, and effectively" (p. xxv). Graham asserted that resilience is developed based on early experiences of neurobiological safety and secure attachment to caregivers, and that when these factors are in place we can develop "stable and flexible coping" mechanisms (p. 8). She described how when we develop the neural pathways to resilience as infants, and then subsequently experience the modeling of resilience by family and loved ones, we solidify our ability to cope with challenges, stressors, and difficult situations, and we develop a functional level of innate resilience that can last through the lifespan.

Howell et al. (2018) focused on resilience in adulthood, and cited Ungar (2013), who proposed a social-ecological model for resilience. The Unger model identified the importance of layered systems of support and resources for those in difficult situations. It highlighted the need for people to be able to "navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being" (p. 2). This aligned with Howell et al.'s (2018) overall findings that women survivors of IPV gain resilience when they exist within a socially supportive environment. This model supports the approach that I will present in Chapter Three, as it clearly identifies the importance of ensuring that survivors are connected with both internal and external resources to foster their healing processes.

Posttraumatic Growth

The term *posttraumatic growth* was coined by Richard Tedeschi and Lawrence Calhoun in the mid 1990s. The definition provided here relies on the concept as described in their research. They described PTG as neither a process nor an outcome, but both. PTG is marked by an ability to make positive changes after a trauma or crisis, over time. Unlike resilience, it is not a personality trait or an ability to withstand stress and struggle in the moment it occurs. Rather, it is a process of moving forward and building a more positive world for oneself after a traumatic experience. This is not a process devoid of strain or difficulty. It is not a focus on the concept of happiness. It is a pushing through difficulty toward something better, where, as Tedeschi et al. (2020) described, people "recognize that they have developed capacities for relating to others, trusting themselves, and appreciating life", and have "a confidence that life is not only fulfilling, but manageable" (p. 7).

According to Tedeschi et al. (2020), PTG is indicated by growth in one or more of the following five areas: personal strength, relationship with others, new possibilities, appreciation

for life, and spiritual and existential change. Those who experience these elements of PTG have come to a realization that struggle is not permanent, nor will it be entirely absent. They have the ability and capacity to rebuild their lives in better ways that can become more fulfilling and rewarding than what they experienced prior to the experience(s) of trauma. This does not mean that the new path is free of stress or problems, but that it can be walked with the knowledge that there is meaning in struggle. Those who experience PTG understand that they can have positive and valuable connections and lives, even when there is difficulty. There is an internal grounding that allows for graceful acceptance of challenges and continued perseverance.

The Relationship Between Resilience and PTG

The relationship between resilience and PTG can be confusing at times. Brosi et al. (2020) specifically explained the differences between resilience and PTG in IPV survivors. They first defined resilience as "'rebounding' or returning to a normal state following a stressor event or situation dictating change" (p. 2). They then described PTG as what occurs beyond this rebounding: some women surpass their previous normal and grow far beyond survival in spite of terrible trauma. D'Amore et al. (2021) observed, in their study of women IPV survivors, that those who demonstrated PTG "spoke about their personal changes in a manner that seemed to indicate they were building themselves up in ways that were totally new to them, rather than restoring their previous self" (p. 12).

Tedeschi et al. (2020) explained that resilience is an ability to bounce back during difficult times, and that because resilient people are quite able to manage the challenges of stress and hardship, they are in fact less likely to experience PTG. The authors described PTG as resulting from "'psychological earthquakes' that challenge or shatter the core belief system" (p. 31). The authors explained that since people who are more resilient are less likely to have their

core beliefs significantly altered after trauma, they are also less prone to PTG. However, Tedeschi et al. (2020) also discussed that when someone has experienced PTG for some time, they develop a stronger ability to manage additional trauma that may arise and as a result can actually grow more resilient. I believe that longitudinal studies of women survivors of IPV might demonstrate that women who were exceptionally resilient prior to IPV may in fact be primed for the development of PTG afterward, if surrounded by the right supports. This is an area for further research.

Resilience in the Context of IPV

Given the above discussion of resilience, one might assume that a woman's innate level of resilience will be reflected in her access to resilience after IPV. Those women who began life with secure caregiver attachments and strong neural pathways to resilience will likely fare better at recovering from the challenges of coping with the aftermath of IPV. Women who were less fortunate in their early relational development are more likely to struggle to get through the layered difficulties imposed by IPV recovery. Graham (2013) suggested that there is hope for the development of resilience due to our ability to activate neuroplasticity and rewire our thinking around difficult situations.

Brosi et al. (2020) cited Anderson et al. (2012) and Humphreys and Thiara (2003), who studied battered women living in shelters, and found some common factors amongst the more resilient survivors. They discovered that "women who demonstrate a sense of determination, pride in self and accomplishments, a lack of dependency on other's opinions, had support systems, and were able to mobilize resources, were more resilient than those who did not" (p.2). Brosi et al. (2020) also identified that "the ability of women to build upon unique outcomes, despite the negativity of the dominant narrative, influenced the decision-making process" (p. 2).

These observations provide some evidence that survivors' levels of resilience can be dependent on both internal and external factors, and that both areas should be considered by those who work to support women survivors.

Another key finding in Howell et al. (2018) is that it is important to acknowledge and study the positive aspects of their resilience that survivors can identify in themselves while in the midst of both difficulty and recovery. Some of these were described as: "taking pride in their achievements, relying on God for help, and believing that things happen for a reason" (p. 3). The authors also included "confidence in their personal strength, as well as their ability to: adapt to change, deal with whatever comes their way, bounce back from hardship, and achieve despite obstacles" (p. 3).

Similarly, Schaefer et al. (2021) noticed the ways that women who had been exposed to IPV were able to identify their own transformation via the identification of their strengths and coping skills. In their study of pregnant mothers who had experienced IPV, the mothers "spoke to a set of fundamental shifts that women experience through this process with respect to their outlook, the way they view themselves and others, and the way they lead their lives" (p. 10). However, the authors specifically highlighted the discrepancy between the survivors' ability to identify their own strengths versus service providers' abilities to notice the strengths of their clients. While the women identified their own strengths via a coding process 74% of the time, service providers' strength coding only noted transformation in the women survivors 34% of the time. Service providers should be aware of the importance of centring survivors in their own assessments of resilience.

The presence of children in women's lives can make a difference to whether they are able to access resilience after IPV. Schaefer et al. (2021) identified that children can be a significant

factor in the enactment of resilience, since they provide "motivation and a purpose to keep going, as well as providing a source of joy and love" (p. 14). Similarly, D'Amore et al. (2021) noted that the women in their study "discussed how they drew hope and strength from their children and their pursuit to provide them with better lives" (p. 14). The idea of children being a motivator of resilience is a common thread throughout the literature, and will be discussed further in Chapter Three.

Resilience in the context of IPV is complex and multifaceted. Since individual women have varied levels of innate resilience prior to IPV, and live in varied social, emotional, and economic environments, it can be difficult to predict how this population will respond to the challenges and trauma of abuse. However, the literature identifies some common themes and protective factors for resilience that can help practitioners to nurture women's recovery. In Chapter Three I will discuss ways to apply these to treatment for survivors.

PTG in the Context of IPV

What does PTG look like in the context of IPV? Tedeschi and Calhoun (2004), cited in Brosi et al. (2020), suggested that "the conceptualization of posttraumatic growth (PTG) indicates that women survivors do not simply return to normal, they grow beyond their previous state as a result of their experience" (p. 3). Brosi et al. (2020) considered four central themes that contributed to PTG in the women IPV survivors they studied: "deliberateness of action, ending the cycle for the children, a changed perspective on life, and alternative perceptions of social support" (p. 1). The authors described the PTG process of one research participant this way: "this woman describes how she has grown from viewing herself in a negative light to being happy, self-reliant, and thankful. By feeling self-sufficient and shaping her life based on this belief, this woman has been able to transform her life from being 'a piece of trash' to being

happy with herself". They explained that because the woman, a survivor of IPV, "demonstrates second-order change, or a changed perspective, that leads her toward posttraumatic growth" (p. 10).

Bakaitytė et al. (2022) reviewed studies that examined the connection between sociodemographic and violence-related factors and PTG in women survivors of IPV. They discovered that older age and employment were positively related to PTG. They found that education showed both a negative and positive relationship with PTG across the reviewed studies. They also learned that PTG occurs more commonly when more time has passed since the last episode of violence, which supports the idea that PTG is a process that can take some time to occur. Notably, they discovered that "professional psychological help may be crucial for successful cognitive processing leading to PTG" (p. 5).

Brosi et al. (2020) also found that there were some common traits that more forward-moving women displayed. These were: "a sense of determination, pride in self and accomplishments, a lack of dependency on other's opinions, had support systems, and were able to mobilize resources" (p. 2). When considering this, it becomes clear that the ability to access these elements of PTG depends, to some extent, on having access to both internal and external resources. Chapter Three considers ways to connect women survivors of IPV with resources in order to optimize opportunities for PTG.

Brosi et al.'s (2020) discussion of the deliberateness of action required for PTG referred to the way it reflects a change in beliefs about the self and one's "determination to act on those changed beliefs" (p. 6). In the case of one woman in the study, her final determination to leave her abuser was based on a desperate need to survive, and not social support. What may have happened for such a woman if she had been supported by her community, mental health care

providers, and other resources during the course of her abuse? Would she have left the abusive environment sooner? Would her deliberateness of action have taken a leap forward from leaving and landing in an emergency shelter to seeking higher education, a new career, or other life improvements? These questions apply to the other aspects of PTG identified in the Brosi et al. (2020) study as well. As an example, in ending the cycle of abuse for children, the gateway to PTG is not only internal. Women require ways to leave an abusive home with the children while still ensuring their safety, access to shelter and food, and an ability to protect themselves and the children from further abuse.

Throughout my review of the literature, I viewed all aspects of resilience and PTG through a lens of social justice and holistic care for survivors. I believe that PTG cannot exist for women survivors of IPV without at least basic social supports, and that social supports are unlikely to be accessed without the internal presence of some elements of PTG. Specifically, deliberateness of action and changed perspective, as referenced above by Brosi et al. (2020), are two elements of PTG that are imperative in order for survivors to have the emotional capacity to reach for supports to aid their growth. Further, those supports must exist, and be within reach, during the development of PTG.

Critique of Current Approaches to Resilience

In thinking about the ideas discussed in the previous sections, I question whether all resilience is an innate neurological and behavioural ability, or whether it is in part a social construct. The latter aspect of our current conceptualization of resilience can result in a forced emotional and practical labour for women survivors, in response to the failures of familial and/or social and mental health systems to support adequately during and after experiences of IPV.

Hamby et al. (2021) described the way that "some view resilience through a social-ecological framework and define it as one's capacity to individually and collectively navigate social, psychological, physical, and cultural resources that sustain well-being" (p. 235). However, it is important to recognize that one's capacity to navigate resources is directly related to the availability of these resources at a specific time and place. Capacity is the sum of many factors in the seeking and obtaining of resources. These factors include freedom (for example, physical, emotional, religious), physical or mental ability, geography, financial access, social guidance, community assistance, and the ability to reach a point of functioning where one can push through a survival state into the momentum of seeking of resources.

Delker et al. (2020) conveyed our failures with assumptions about recovery and resilience very well. They noted that "cultural values around individualism, stoicism, personal "grit," and "pulling yourself up by your bootstraps" can convey that victimization and emotional vulnerability are personal weaknesses, which should be overcome promptly by force of personal will" (p. 243). No woman is an island, and it can be difficult for survivors to thrive in an environment devoid of care and support.

Another consideration is that while some survivors may be high-functioning and appear resilient outwardly, assessments of resilience may not accurately assess the complexities of IPV trauma. Outcome, in this situation, can only be correctly measured when it considers each individual woman's complicated and unique path to recovery, what healing looks like from day-to-day, how trauma continues to affect women who seem to have it all together, and the unidentifiable damage IPV has done, even in the lives of particularly resilient women. This damage can manifest as anxiety, depression, PTSD, hypervigilance, financial instability, relational discomfort, and the absence of connections to which women in secure and healthy

relationships may have had access, such as family support, money, property, and social and professional networks. As Smith (2006) asserted: “resilience is not a fixed trait; it is instead a dynamic, contextual process developed as a result of the interactions between individuals and their environments” (p. 32). Its measurement, then, must be equally dynamic.

The term *resilient* is so often the way we describe those who have had to rely on themselves in order to overcome social, emotional, psychological, financial, and other types of adversity in the absence of protective factors and supports. I do not suggest that we cease using the term resilient, but that we take thoughtful care to first consider the environmental and systemic factors that each individual client has worked with or without in times of trauma. Only after doing so can we try to accurately assess resilience.

Those who experience IPV did not ask to have harmful experiences. Similarly, they do not ask to be measured or evaluated (unless voluntarily, by way of a study or similar measurement) based on their emotional and psychological recovery from such adversity, their level of resilience, or what society defines as external markers of success. Resilience is typically judged by observations of external indicators like financial, social, or professional success, as well as internal characteristics such as fortitude, courage, patience, and resourcefulness. It is important for future research and current treatment practices to consider whether these typical indicators provide a complete picture that can be summarized by the label “resilient” and assessed as “outcome” or whether outcome, for resilient individuals, can even be defined accurately by anyone but the survivor herself.

Common Factors in the Literature

The Need for Safety and Trust in Therapy

D'Amore et al. (2021) explained the way that the "the therapeutic relationship offers an opportunity for corrective relational connection", and that this is of particular importance to survivors of IPV, since they have often been disconnected socially and emotionally during the abuse (p. 20). Survivors are also subjected to stigma and judgement within their circles of family and friends, their wider social networks, and in society generally. D'Amore et al. (2021) asserted that in the practice of "adopting a caring, empathic, nonjudgmental stance, the therapist creates a safe environment in which the survivor can work toward reconnecting with the self through a connection with another" and that the therapeutic relationship itself can be a significant path to healing from IPV (p. 20).

Geller and Porges (2014) explained how clients can benefit from therapy only when they feel safe and secure in both the therapeutic relationship and the therapy environment. Porges (2017) noted that this "precursor of treatment is not well-integrated into educational, medical, and mental health treatment models" (p. 24). He suggested that it would be beneficial for practitioners to assess therapeutic environments for sounds that may activate a defensive nervous system in clients. A safe, quiet location, gentle lighting, comfortable furniture, and checking in with the client as to their comfort level in the therapy space may all be helpful in this regard.

It is important not to make assumptions as to what kind of environment each client needs. For example, some may find a sound machine that plays the sound of a running brook soothing, while others may become dysregulated by the addition of nature sounds in the therapy room. Allowing clients some choice in their physical environment can also offer a sense of control, which may be calming in and of itself, as long as the choices are not overwhelming.

The combination of safe therapeutic connection and a safe therapeutic environment is key to recovery for this population. Levine (2010) discussed the need for "relative safety" in the

healing of trauma. He described safe and calm support as "a *critical* element that trauma therapists must provide for their unsettled and troubled clients" (p. 75). Levine (2020) expanded on his concept of relative safety as "an atmosphere that conveys refuge, hope, and possibility" (p. 75). When a therapist can convey, with facial expression, tone of voice, body language, and sincere empathy that the client is safe, this provides fertile ground for healing.

Levine (2020) noted that a therapist must also ensure that the emotional and physical safety of the counselling space does not create a dependency on the therapy such that the client becomes dysregulated in between sessions, or after the course of treatment. He suggested working on assisting clients to build autonomy and "capacity for mastering self-soothing and feelings of empowerment and self-regulation" (p. 76). Providing a secure base can allow clients the mental space to explore their own limits and skills in between sessions, so that the building blocks of resilience and PTG can be cemented with the mortar of both internal and external safety and grounding.

The Benefits of Polyvagal Theory When Working with IPV Survivors

Porges' Polyvagal Theory asserts that our nervous systems are always scanning for safety, and that when we feel safe, we can relax and rest in a physiological state that supports healing and positive social engagement. Porges asserts that in this safe state, therapeutic relationships become stronger, neural pathways related to attachment and relational safety are repaired or formed, and the therapeutic process can be productive (p. 179). Geller and Porges (2014) similarly discussed the importance of safety for healing. They asserted that "in the presence of someone with whom an individual feels safe, a person experiences the sequelae of positive social engagement behaviors consistent with a neuroception of safety" (p. 187). Neuroception, according to Flores and Porges (2017), is an unconscious neurological process

that humans use to scan for safety. This process "optimizes secure attachment" (p. 203), which in turn supports the development of social connection and resilience. Geller and Porges (2014) explained that when the physical body is relaxed, we lose our sense of defensiveness, and in such a state of mind and body, we begin to lean toward positive relational engagement.

Geller and Porges (2014) also considered the way that neuroscience, biobehavioural mechanisms, and use of Polyvagal Theory contribute to a feeling of safety in therapy. Porges (2017) further discussed the importance of co-regulation as a pathway to feeling safe. He described co-regulation as the "mutual regulation of physiological state between individuals" (p. 9). Where there are feelings of connection and safety, the nervous system can calm, and clients can relax into therapy and engage fully. Porges asserted that "the neural pathways of social support and social behavior are shared with the neural pathways that support health, growth, and restoration" (p. 100). This is one of the reasons that safe-feeling therapy can be a core element of recovery from IPV. Therapy can provide a safe home base from which a survivor can access resilience and explore healing and PTG.

Women who experience IPV have highly activated internal safety scanning systems. This is another reason a safe therapeutic relationship and environment are so needed and beneficial for survivors. Their nervous system must be relaxed in order to receive the empathy, care, and safe emotional connection offered in therapy. A highly attuned therapist who understands a survivor's need for a safe emotional harbour can more effectively nurture healing by being knowledgeable about Polyvagal theory, co-regulation, and the neurological building blocks for resilience and PTG.

Also important to consider is that the systems through which women IPV survivors are funneled (for example, legal, justice, medical, mental health, and social services) can sometimes

be dehumanizing, triggering, and retraumatizing. This can set off internal alarm systems so that even if survivors do become connected with a trauma-informed professional within those systems, they may require some time to regulate and accurately assess for safety. The literature reflects that the systems and helpers who work with survivors can benefit from knowledge of Polyvagal theory, co-regulation, and the time, skills, and effort it can take to earn the trust and neurobiological acceptance of a traumatized survivor.

The Benefits of Social Supports and Co-Regulation for IPV Survivors

The effects of trauma are mitigated, and resilience developed, in the presence of certain social resources. According to Ashton et al. (2021), "a range of protective factors can help individuals develop resilience, which can include: characteristics of the individual, nurturing relationships with their family and adult caregivers, and cohesive social networks and communities" (p. 2). These factors, as well as a focus on the future (Oshri et al., 2018), maternal support (Hatch et al., 2020), trusted adult support or mentorship (Bellis et al., 2017), belonging (Scarf et al., 2016), optimism (LaNoue et al., 2020; Smith, 2006), and others, are discussed in the literature as key elements in the early development of resilience. This framework for the development of resilience in children can be easily applied to the activation of resilience in women after IPV. It is no surprise that most of these core factors in resilience development are anchored in social connection. The benefits of safe social and community supports for women survivors of IPV are strongly represented in the current literature.

While the research addresses the importance of safety for IPV survivors in therapy, it is equally important to ensure that they find safety and secure attachment within social and systemic supports. Flores and Porges (2017) asserted that "secure attachment not only translates into a greater capacity for emotional regulation and resilience, it also influences our bias to react

to challenges using neuroception" (p. 203). Similar to the therapeutic environment, social connections after IPV should be grounded in safety, and allow for nervous system regulation and co-regulation, in order for them to contribute to resilience and PTG.

Flores and Porges (2017) explained that "without the appropriate contextual cues of safety and without the body shifting into a physiological state of calmness, attempts to support health will be challenging and often ineffective" (p. 204). In other words, we cannot heal unless we feel safe. This is especially relevant for women who have experienced IPV, who may at times be in a heightened state of alert and defensiveness after experiencing abuse. The availability of social co-regulation and safety is as imperative to healing as any therapy.

Anderson et al. (2012) shared their study participants' views that reaching out for social and community support helped them not only to manage day-to-day life, but to heal their emotional wounds. These supports are referred to in their study as "informal networks" (family, friends, employers, and coworkers) and "formal networks", for example, therapy, shelters, domestic violence service providers, crisis lines, support groups, and Alanon (p. 1292-1293). In addition to the emotional healing aspects of social supports, they can also bolster positive changes and forward motion. Nnawulezi et al. (2019) asserted that "survivors gain power by building social networks, and having the knowledge, skills and supports needed to make the life changes they desire" (p. 261).

Suvak et al. (2013) provided further evidence that survivors benefit from interventions that build belonging and social connection. They defined belonging as the "perceived availability of people one can do things with", and indicated that survivors benefit from participating in social activities such as groups and clubs, as these "represent an important component of a comprehensive approach to increasing the health and well being of this socially isolated and

oppressed group" (p.14). Dahlgren et al. (2020) provided evidence to support this as well, by discussing the ways that connection and closeness within relationships can help to reinforce the idea that another human is trustworthy. In building such trust and closeness, a feeling of belonging can develop.

Choi et al. (2021) defined social support as "information from others that one is loved and cared for, esteemed and valued, and part of a network of communication obligations", and reiterated that this is one protective factor that can assist survivors of IPV to heal from the painful consequences of abuse. Since much of IPV can occur behind closed doors, and typically involves women being isolated from friends, family, and community supports, it makes sense that reconnecting to social networks can provide such a meaningful element of recovery.

Because social connections add positive elements to survivor's lives, they can also draw attention away from negative connections. Anderson et al. (2012) explained that "professionals may assist each survivor in figuring out who is supportive in one's environment and strengthen those connections while allowing for disengagement from negative support" (p 1295). Further to this, Brosi et al. (2020) cited Burr, Day, and Bahr (1993), who identified that "maintaining emotional distance from those creating problems" was a contributor to PTG (p. 3). One of the ways a social network can contribute to a survivor's resilience and PTG is by helping her to obtain and maintain a safe distance from her abuser whenever possible. This can be through attending court with her, filtering an abuser's communications for her, being present for child visitation exchanges, or assisting her with procuring a restraining order or protection order, if needed.

The research makes clear that having access to safe, secure social supports is necessary to healing for woman survivors of IPV. But what of those who have none, or few, of these

protective social factors, and still somehow manage to become resilient? Often, these women have survived and thrived through their own grit and determination, with hard work, and possibly with some luck and good timing. They may not feel they have bounced back from adversity at all, but that they have had to carry a heavy load, through social and systemic failures, to a place that feels relatively safe. Flasch et al. (2020) explained that "sourcing practical, legal, and financial support for individuals as they leave relationships is essential" (p. 31). They also note that these community resources can be very difficult to find. In Chapter Three I will further discuss the need for counsellors to advocate for ongoing access to social supports for even the most resilient survivors.

The Problem of Post-IPV Legal Conflict

A growing body of research is beginning to reflect the damage done when women are taken to family court by an abusive partner after separation. In these cases, victims are subjected to the ex-partner's continued emotional and financial grip on their lives via the family court system. This can sometimes last for the duration of their offspring's remaining childhood years.

The problem of post-IPV legal conflict is pervasive, and is often either minimized, or only peripherally addressed, by the systems that are meant to support the recovery of women and children from IPV. The prevailing view of many social services and IPV programs is that legal and custody issues are separate from mental health care, but this is simply not the case. There is often an assumption that the lawyers and judges involved are trained to recognize power-and-control-motivated abusive behaviours in the courts, and that the safety and best interests of women and children will be protected in family court. Unfortunately for women and children, this is not always true.

In such situations, women face more challenges to recovery and healing than they otherwise would, such as having to spend time and energy seeking affordable or free legal counsel, writing response affidavits, documenting past and/or ongoing abuse, being subjected to custody or mental health assessments (where the psychological or socioeconomic effects of IPV may be used against them), and being forced to attend family counselling with the abuser, which can be retraumatizing or dangerous. They also must cope with missed employment due to legal paperwork obligations and court dates set by abusers (Hrymak & Hawkins, 2021). An IPV survivor may be forced, at any moment, to respond to her abuser's court applications, even if they are frivolous, misleading, or repetitive.

All of this can disrupt healing, access to services, parenting, and employment. Forced entanglement in legal conflict takes a serious toll on every area of a victim's life. In addition to the above barriers to healing and recovery, it also has power to worsen and extend the trauma by repeatedly revictimizing, keeping the survivor under chronic toxic stress, and causing long-term financial instability for women and their children.

Davina and Holt (2021) wrote a study on post-separation contact and domestic violence and abuse (DVA) that examines the problems described above. They asserted that "empirical evidence identifies the significant role that positive mother-child relationships play in supporting children's recovery from living with DVA and indeed the role that responsive mothering plays in promoting children's resilience" (p. 991). Legal conflict, especially for the purposes of maintaining control or abuse, may detract significantly from a mother's ability to be fully responsive, functional, and forward-focused at a critical time in her, and her children's, recovery processes. Davina and Holt (2021) also pointed out evidence that family court professionals "virtually ignore the issue of DVA when considering contact or residence applications" (p. 992).

This places both mothers and their children at ongoing, and often worse, risk of further family violence and other forms of abuse.

The emerging literature on this aspect of IPV makes clear that the assumption that courts serve justice and protect women and children from abusers is far from accurate. In fact, there is increasing evidence available that demonstrates how family courts are used as a vehicle for abusers' enactment of coercive control after IPV. Once a woman leaves an abuser, court is a direct access point for continued coercive and financial control over her. As Davina and Holt (2021) and Hrymak and Hawkins (2021) illustrated, this can have devastating effects on mental health for women and children, particularly because courts rarely recognize what is happening. This is now beginning to change, with some courts limiting or even preventing legal action by perpetrators of IPV when abuse of the legal system is detected.

In a report by Rise Women's Legal Clinic, Hrymak and Hawkins (2021) took a more in-depth look at the difficulties that custody litigation can create for survivors of abuse and their children. The authors reported that 80 percent of the women they interviewed had negative impacts on their health during the family court process, and that "there were a number of women whose mental health had such a decline that it rendered them permanently disabled and unable to continue working" (p. 63). For these reasons, counsellors and other mental health professionals should engage in ongoing education about the specific struggles women face during the court process after IPV, and how being trapped in this system by an abuser presents a very real barrier to recovery and healing.

There is a need for specialized counselling for women in these situations. Ongoing legal conflict can result in worsened anxiety, complex posttraumatic stress disorder (C-PTSD), sleeplessness, chronic stress, and other conditions. The strain it places on survivors is disruptive

to the maintenance of happy family homes, and can be severely damaging to children, who are often placed in the middle of conflict in order to fuel an abuser's legal strategy. Practitioners should be prepared to offer a social justice approach to therapy, as well as referrals to community and legal supports, where these exist. Social services and counselling professionals have an ethical responsibility to acknowledge the major mental and physical health consequences of legal conflict, and to advocate for systemic change that protects the well-being and stabilization of women survivors and their children. This will be further elaborated on in the next chapter.

Limitations of Existing Studies

There is an extensive body of literature on IPV, trauma, resilience, and PTG. As such, it is difficult to narrow down gaps in the research. However, there is a need for further study on the ways that the label *resilient* places uninvited weight on the shoulders of survivors. The idea that survivors are somehow stronger, better, or more evolved when they are able to bounce back from the adverse experiences of IPV is one that makes me uncomfortable from a social justice perspective. There is a need for additional long-term studies of survivors that examine resilience, PTG, and longitudinal outcomes for women based on the availability (or lack of availability) of a combination of specialized IPV therapy, community supports, legal supports, and educational opportunities.

IPV damages every part of a woman's life: mind, body, spirit, finances, parenting, employment, social life, and family stability. The idea that women who can bounce back from IPV are just naturally more resilient is disproven simply by observing support groups where IPV survivors gather. Those who receive the care and support of their communities, helping organizations, and well-trained therapists have a far lighter road to recovery than those who have been left to their own devices, or to rely on internal resilience while battling posttraumatic stress,

physical ailments, litigation, coparenting, and making ends meet. There is a need for a holistic, social justice grounded approach to both research and treatment in regard to this population. In Chapter Three I will outline ideas for an approach that, in consideration of the research reviewed in Chapter Two, may help to support women survivors of IPV on their paths to recovery, resilience, and PTG.

Chapter Three: Best Practices within a Social Justice Framework

In this final chapter, I will propose a holistic social justice framework that, in consideration of the research reviewed in chapter two, can help to support women survivors of IPV on their paths to recovery, resilience, and PTG. This approach suggests using Polyvagal theory, and a combination of narrative and compassion-focused individual counselling, combined with group therapy, somatic healing, and social connection. This framework must be firmly grounded in a social justice approach in order to accurately support the healing of women survivors of IPV. When practitioners acknowledge the many disadvantages that this population faces post-IPV, and they integrate this awareness into treatment plans, they foster a more lasting recovery and thriving process for clients.

Discussion

Women in an Emotional and Physical State of Trauma

One of the deepest wounds of IPV is the damage it can do to a woman's sense of trust in her own judgement. There can be a loss of self and identity, as domestic abuse can cause women to detach from self in order to survive or to protect themselves and/or children in the home. A woman living with IPV can become externally focused on trying to create safety, which can cause a partial or complete loss of the internal self. The abuser may isolate her from friends and family and limit her ability to participate in the work or leisure activities she enjoyed prior to the relationship. This results in a need, once she is no longer living with the abuser, to rebuild a new self in recovery: one that can integrate with the former self in a compassionate way.

Some survivors are able to bounce back with resilience and find some combined form of previous and former identities. Others forge a path to PTG, forming a new sense of self that is grounded in healthy relationships, improved external supports, and forward motion. I have

discussed the factors that foster resilience and PTG. I will now consider how service providers and therapists can best support women survivors of IPV in the development and maintenance of these.

As Anderson et al. (2012) asserted, "practically every aspect of a domestic abuser survivor's life is altered in the aftermath of domestic violence. Leaving an abusive relationship involves transitioning from being controlled to being in control while coping with the costs of a domestic life filled with fear, terror, and devastation" (p. 1279). Anderson et al. (2012) spoke to the fact that this process requires an incredible level of strength and energy. However, strength and energy can be difficult to access for women who are in a state of post-IPV trauma. They may experience PTSD, anxiety, or depression, while also going through the required motions of work, parenting, earning a living, and other responsibilities.

There should be no assumption that once a woman leaves her abuser, she is free. Whether she has children with her abuser or not, they may still have control over her home, her finances, her health care, her vehicle, and her social connections. They may stalk or harass her, monitor her personal and/or professional life, or intimidate her friends and family. If they share children, it may be many years until she and the children are out of danger. The abuser may use visitation with children as a sanctioned access point for stalking, excessive or intrusive communication, and coercive control. They may use parenting time as a way to sabotage her work, education, and relationships by being unreliable or absent for parenting commitments. They may avoid financial or practical responsibility for the children in order to destabilize her or punish her for leaving the relationship. There is a myriad of ways that an abusive partner can maintain abuse and control after separation. All of these can limit and slow the pace of both internal and external recovery for women survivors.

Supporting this population's mental health means having an awareness of the lengthy process of disentanglement from the abuser, and knowing that in many cases women may be working hard to recover despite indefinite exposure to more abuse and control, whether physical, emotional, financial, or legal. Fortunately, as Tutty et al. (2021) explained, studies of this population "remind us that women are not necessarily depressed or traumatized and that many remain resilient despite living with and through adverse circumstances" (p. 1139). Current research shows that it is possible to increase resilience and experience PTG while amid ongoing difficulty. This, however, depends on the presence and accessibility of the many protective factors discussed in Chapter Two.

Applied Practices/Recommendations

The Necessity of Good-Fit Therapy

It is imperative that survivors of IPV have access to a counsellor and process to which they can relate. Anderson et al. (2012) looked at factors in IPV recovery. They noted that within their subject group, some women "found therapeutic services not helpful due to the provider's lack of expertise in the area of domestic violence resulting in blaming them for the abuse" (p. 1293). They shared the view of one of their participants, who suggested that incompatible therapy can harm survivors, particularly if it is their first counselling experience.

Tutty et al. (2021) expressed concern that advocates and counsellors may incorrectly assume that IPV clients "necessarily suffer from mental health problems" (p. 1139). In my experience as an IPV survivor, an advocate, and a counsellor, I have observed that women survivors may present as clinically depressed or having an anxiety disorder when in fact they are having a very normal, healthy reaction to being oppressed by the consequences of IPV and the inadequacies of the systems that are meant to support them. Women survivors of IPV are some

of the most resourceful and hopeful clients I have seen, and they often surpass their own expectations for recovery.

Good-fit therapy for this population must be grounded in a strengths-based and hope-focused view of clients. Women in recovery from IPV can have a longer and more difficult recovery period when in treatment with therapists who are not trained in trauma, or where there is some incompatibility, disconnect, or a lack of understanding regarding the specific social, emotional, and practical barriers to healing. In such cases, survivors can find it difficult to feel safe, share openly, or be vulnerable enough to push toward recovery and growth. More government and non-profit funding for long-term, specialized trauma therapy is needed to best support this population.

My own recovery experience was facilitated with the help of skilled and empathic trauma counsellors. These therapeutic relationships were grounded in empathy, deep listening, compassion, validation, a social justice lens, and a good dose of humour. It was a key element of my healing to be able to try a few counsellors until I found a fit that worked best for my needs and personality. Counsellors can encourage clients to share openly and not feel badly about it if they wish to try seeing another practitioner who may be better suited to them.

While therapists do not need to have a personal history of IPV to be authentically empathic, compassionate, and supportive, it can be beneficial to have lived experience in this area. For a counsellor to have overcome IPV, and the specific kinds of trauma and barriers that clients experience both during and after the abuse, can provide a powerful sense of therapeutic connection. A counsellor need not disclose very specific or personal information about their own experiences. Their ability to hear, see, and understand from a place of experiential understanding can be deeply healing for the client. In such a therapeutic environment, and in the knowledge of

shared experience, there is authentic empathy that can encourage the client to feel safe to release and externalize their pain without fear of judgement.

Most importantly, therapists can understand and acknowledge that resilience is not a gift survivors ask for, and that their ability to experience PTG is a reward that does not come easily. A non-judgmental stance and steady respect can build a secure base that allows IPV clients to keep reaching toward growth, hope, and forward motion. It can anchor survivors in a sense of safety that permits them to take the steps needed to push through and out of trauma, even if they may still be amid efforts by their abuser to sabotage their recovery and stability. Dahlgren et al. (2020) explained that "therapeutic presence requires the practitioner to be open to oneself as well as to the other and, importantly, to the relational space between the two" and that "this attunement or resonance in the intersubjective space between two people (e.g., therapist/client, mother/infant) serves to coregulate emotion through empathic responsiveness" (p. 41). This kind of grounded energy, connection, and unconditional positive regard in therapy is highly beneficial to women in IPV recovery.

Individual Therapy

Because each IPV client is a unique individual with unique ways of relating, I believe that a holistic, person-centred approach is most effective. My recommendations for individual counselling for women IPV survivors focuses on narrative therapy, Polyvagal theory, and compassion-focused therapy, through a social justice lens. This population requires approaches that consider their past, present, and hopes for the future, as well as consideration of what systems are either supporting or oppressing them. Narrative, Polyvagal, and compassion-focused approaches allow space for all of these considerations.

Narrative Approach. Narrative therapy provides opportunity for survivors to externalize the pain, shame, stigma, and destruction that IPV brings to their lives. It offers the freedom and space for survivors to share the story of the abuse in their own unfiltered words and to be heard by a compassionate and non-judgemental listener. This can provide tremendous relief, especially if a woman has been silenced by her abuser or by the patriarchal systems that contribute to the oppression of women.

The narrative therapy processes of noticing strengths, identifying values, and re-storying are empowering for survivors, and can help them to take back ownership of their lives and selves. Anderson et al. (2012) explained that "helping women reformulate life stories that feature their strengths and resourcefulness does refute that people who endure such hardships are lacking in resilience or are unable to achieve their aspirations" (p. 1295). Learning to notice their own strengths and acts of courage within their story of IPV can lay the groundwork for resilience and PTG for survivors, as it focuses on internal resources that can be accessed and relied on well beyond the therapeutic environment.

Dolman (2020) discussed how to use the narrative technique of "double listening", which is listening to clients' stories of their difficulties while also listening to identify how they responded to their difficulties (p. 7). Doing this can help clients to see both the problem and the self differently, as they notice what they may have done to care for themselves or improve the outcome of a situation. This can be useful with IPV survivors, since they may be looping through a narrative of the fear or violence they experienced, and sometimes may internalize negative views of self after being mistreated. Listening for the ways they coped with struggle, protected their lives, and made positive changes can empower survivors and ground them in a more true and meaningful identity of strength and courage.

There is power in collaboratively identifying and naming the acts of resistance in a woman's narrative. As Delker et al. (2020) asserted, "in a cultural climate that tends to silence survivors from speaking out about interpersonal violence, even naming one's experiences can represent a form of resistance" (p. 7). In naming her acts of resistance, a woman can begin to understand herself as someone who fought back, left the abuse, and survived. She can centre herself as the heroine in her life as she begins to look toward a better future. These are the seeds of PTG.

Delker et al. (2020) explained that "during acts of coercion and violence, an individual's agency, choice, and control are taken from them. Part of the power of narrative reconstruction is to regain a sense of personal agency and control that was violated by the violence" (p. 7). Narrative therapy provides an opportunity for women survivors to shed the sense of self as victim, and reconstruct a new narrative on their own terms. This empowered narrative can be carried forward to fortify clients against the stigma they inevitably face as women who have lived with abuse, and as mothers raising children alone or within difficult or unsafe coparenting circumstances. Being grounded in a narrative of strength and self-respect can be a powerful antidote to the judgements and disadvantages this population faces during and after IPV recovery.

Polyvagal Approach. The use of Polyvagal theory in therapy with women IPV survivors was discussed at length in chapter two. It provides a useful theoretical groundwork when working with this population because safety and nervous system regulation are essential to survivors' ability to relax, connect, and engage in productive emotional work. Flores and Porges (2017) explained this very concisely: "the active engagement of one person's social engagement system with another person's social engagement system lies at the heart of all psychotherapy,

interpersonal learning, exploration, discovery, change, emotional regulation, and the maintenance of mutually gratifying relationships" (p. 213). The social engagement system becomes confused and can go offline during and after IPV. When a therapist can effectively bring it back online using Polyvagal theory, they support the client's optimal healing potential.

Dana (2018) provided a therapeutic tool called the Polyvagal Ladder in order to illustrate the three states of the nervous system, and the way the vagus nerve helps to regulate nervous system response. She explained that we are always in one of three states: ventral vagal (calm, feeling safe, and able to connect socially), sympathetic (nervous system has triggered a perceived threat alarm and our fight or flight signals are active), or dorsal vagal (shut down, non-communicative, detached from self and others). Dana (2018) illustrated these three states using the analogy of a ladder, with the top rung being ventral, the middle being sympathetic, and the bottom rung being a state of dorsal vagal activation.

Dana (2018) explained that clients can use the imagery of the ladder to practice Polyvagal exercises, such as writing, visualization, and awareness in order to expand their understanding of their feelings and behaviours at each level of nervous system function. This expanded knowledge and familiarity with each vagal state (or rung on the ladder) can help clients recognize when they are in transition and to move from a low, dorsal state up through the middle sympathetic state, and back into a top rung ventral vagal state. Dana's (2018) tool can be helpful for IPV survivors as it can support them in learning to return to, and spend more time in, a calm and safe state of mind and body.

A Compassion-Focused Approach. Compassion and self-compassion are powerful tools in the healing of IPV and the fostering of resilience and PTG. Lander (2019) explains how receiving and observing compassion helps clients to develop self-compassion, and that "self-

compassion may contribute to coping and resilience especially in those who are struggling with issues of guilt, shame and self worth related to painful life experiences" (p. 1). IPV can cause a loss of self worth. It can also cause feelings of shame, guilt, and self-criticism in survivors, as they may have internalized the abuser's views of them, along with the stigma and judgements they receive from those who may not understand what they have experienced.

Gilbert and Procter's (2006) Compassionate Mind Training (CMT) can be used with IPV clients to help increase feelings of safety. CMT trains the mind to seek empathy for self and acceptance of discomfort when faced with situations that would normally elicit self-criticism or distress reactions. Counsellors practicing CMT demonstrate compassionate behaviours in their reactions to clients' upsetting situations, and this guides clients in learning to offer themselves similar understanding and compassion. For clients who have never learned to respond compassionately to their own fear and distress, or have been forced to unlearn self-compassion in order to survive IPV, this therapy can help them learn or rediscover how to react mindfully and compassionately to distress, and to find feelings of safety in self-soothing thoughts and behaviours.

One CMT intervention that works well for women IPV survivors is compassionate imagery. According to Gilbert and Procter (2006), compassionate imagery can be used to visualize an object, being, or place that the client imagines as having a compassionate and empathic mind that can communicate warmth and care toward them. One way to do this, as described by Gilbert and Procter (2016) is to ask clients to imagine their "perfect nurturer" (p. 12). This can be a real or imagined person or creature who has capacity to express care and compassion toward the client. Survivors can call this perfect nurturer forward mentally in times of distress in order to soothe fear or internal criticism. Therapists can also use this intervention in

session by alternating between ideas of threat and visualizations of the perfect nurturer. The feeling of receiving compassion from an internal nurturer can help clients to develop the ability to lean into self-compassion in difficult times.

Compassion-focused therapy can also support the social connections that are so necessary to IPV healing. Lander (2019) explained that "compassion appears to give rise to powerful motivation for prosocial behaviors towards others, including care taking, support giving, and generosity, that may also facilitate positive social connectedness and relationship building" (p. 656). The next section discusses the need for social connection in IPV recovery. Compassion-focused therapy can help clients prepare to give and receive social care and connection. However, counsellors using compassion-focused therapy with this population should take a patient approach, as it can take some time for IPV clients to be able to receive compassion and to feel it toward themselves.

Group Therapy

Research shows that group therapy can be an efficient way to use Polyvagal theory and Attachment theory together to support IPV recovery. Flores and Porges (2017) argued that group therapy is a neural exercise that can create safety and attachment for participants. They shared that "if the group leader provides safety and predictability, especially at the beginning of a new group, it will be virtually impossible for group members not to become attached to each other and for the group to become a secure base for its members" (p. 212). They explained that this safe social connection shuts down the fight/flight/freeze system, and the nervous system can engage in socially productive ways.

Since social connection is a key part of IPV healing, group therapy is an effective way to combine therapeutic interventions with the creation of safe connections to others who have had

similar experiences. A group environment where participants feel safe to discuss shared experiences with IPV can be a powerful vehicle for building emotional, social, and neurological resources. The freedom to speak openly and without shame about experiences of IPV can be healing. Delker et al. (2020) explained that "without needing to keep painful experiences a 'secret' hidden from others, people who have experienced interpersonal violence may feel greater self-acceptance and re-alignment" (p.7). Tutty et al. (2021) also discussed the effectiveness of group therapy for this population, and described the way this treatment can improve mental health for IPV clients "significantly and relatively quickly" (p. 1138).

Another aspect of group therapy for IPV clients is that it provides opportunities to be mentored and to mentor. The mentor/mentee relationships that can occur in IPV therapy and/or support groups can last for years and provide a meaningful sense of belonging, compassion, and hope. The mentorship women receive in group environments can be life-altering and essential to their recovery. In addition to the emotional and spiritual care and guidance they offer, mentors have a wealth of knowledge about the practical resources that may be available to support restabilizing of the survivor's external environment. When clients eventually reach the point where they are ready become a mentor to others, that role provides a full-circle healing experience.

Community and Social Supports

Žukauskienė et al. (2021) identified that "for 40% of women who disclosed that they were abused by an intimate partner, no one in their social network tried to help them" (p. 7605). This is an alarming statistic that illustrates the isolation that women survivors can feel during and after IPV. The reasons for this lack of support are varied (for example, isolation or triangulation of social relationships by the abuser, shame, fear of making things worse for the victim), but in

all cases, repairing and/or rebuilding the social circles of survivors is imperative to their recovery and their access to resilience and PTG.

Social and community connection can build webs of support infused with friendship, shared experience, networking possibilities, nervous system regulation, access to advice or guidance, skills building, and simple human functions like laughter, storytelling, sharing food, and the enjoyment of time. When children are included in such activities, these connections can affect their well-being and help them to not only build their own social-emotional skills, but to observe their mothers in environments of friendship, positivity, and care. It can provide some relief to children who have observed their mothers in fear, stress, or danger at home with an abuser to see them surrounded by support, nurturing, and positive social behaviours.

In addition to ensuring that IPV clients are connected to social supports, counsellors can also refer them to community organizations, government agencies, and non-profits that specialize in supporting this population. Speaking with clients about needed supports, or providing resource guides they can access out of session can help them to make these necessary connections. Counsellors can also advocate for clients by making initial contact on a client's behalf if this is a barrier for them.

Somatic and Physical Healing Practices

IPV can cause women to detach or dissociate from the body. There may be physical pain or body memory, or there may be a resistance to connecting with the body at all. Somatic healing can be a tool used in therapy or between sessions, depending on the client's needs. Whether it is trauma-sensitive yoga (TSY), massage therapy, energy healing, sound baths, osteopathy, acupuncture, or other healing modalities, IPV survivors benefit from healing touch and movement when they are ready and feel safe to explore these.

TSY is an example of an effective healing practice for IPV clients. It meets needs for movement, physical release, safe sharing of space with others, energetic connection, quiet, and spiritual guidance. TSY can provide an opportunity to be in a low-stakes safe space with a group of people who are present for an exchange of positive connection and the movement and release of physiological energy. For women emerging from a state of trauma, this kind of space can be reassuring and healing.

Ong (2021) discussed the way that trauma lives in the body, and described how one must reconnect with the body before they can effectively process trauma cognitively. They described TSY as a gentle, body-centred form of yoga that works with self-awareness and being present in the body within an external guided environment. There is a focus on safety in the environment as well as in instructor language, tone, and energy. Ong (2021) recommended using TSY interventions alongside psychotherapy with trauma clients.

According to Ong (2021), one of the elements of TSY that differentiates it from more commonly practiced forms of yoga is that the focus is on safe and positive connections with the body. Instructors encourage students to work within their physical limits and not to push past pain or discomfort, but to honour their inner knowledge of what feels safe and good for them. This allows students to lean into a compassionate and loving relationship with their physical selves, which they may not have been able to do post-trauma. It also provides them with a sense of choice and bodily autonomy. All of these practices can restore feelings of control and safety within survivors.

Ong (2021) noted that the same principles and signals of safety used in TSY (safe environment, non-judgement, gentle tone, careful wording, choice, compassion) can also be used by therapists in the counselling environment to foster healing. Somatic exercises like mindful

breathing, sensory connection (aromatherapy, holding stones or other natural objects) can also be used to bring the principles of TSY into therapy. The underlying TSY themes of safety, autonomy, gentleness, and honouring each person's limits and needs are easily transferable to the counselling environment.

In addition to the internal healing that can occur with yoga, Graham (2013) explained that there are positive social benefits to it as well. For example, Graham (2013) suggested that there are often people who exhibit prosocial behaviours in yoga classes, and that "being in connection with people who are emotionally healthy can shift our emotional state and reprogram our circuitry" (p. 280). She also explained that the breathing practiced in a yoga class "activates the calming branch of our autonomic nervous system, the parasympathetic branch" (p. 215). This can supplement and reinforce any Polyvagal work that is being done in therapy.

Graham (2013) elaborated on this further by explaining that breathing positive energy into the heart in a yoga class allows for a process whereby "neural pathways from the heart to the brain signal the brain directly to release oxytocin, which evokes a sense of safe connection with others" (p. 215). All of this lowers stress and promotes feelings of calm, safety, and positive social connection for women survivors of IPV. The practice of TSY, and adapting the principles of TSY to therapy, can help IPV clients to reconnect with and feel safe in the physical body again.

Parenting and Coparenting Support

Women who have been victims of IPV where children are involved require an additional level of support from community and mental health service providers while they support their children's well-being, and in many cases, try to facilitate a safe relationship between children and their other parent. Coparenting with an abusive ex-partner, particularly if they can continue

the abuse post-separation (for example, through harm to the children, intimidation, financial control, coercive control via parenting, stalking, harassment, and/or legal abuse), can be a minefield of setbacks to healing. There is also a need for safety planning in such situations, as women who coparent with abusers may be at risk of violence during child exchanges. Clients in such situations need counsellors who are trauma-informed, have knowledge about the psychology and behaviours of people who abuse women, and are ready and willing to advocate for the women and children they serve.

A study by Scrafford et al. (2022) identified that "service providers may be conceptualizing parenting in the context of IPV from a deficit model that underestimates the resilience demonstrated by these women" (p. 2). This is the opposite of the strengths-based approach to parenting that is most needed by survivors. Counsellors and other service providers can best serve this population by focusing on women's parenting strengths and love for their children throughout the healing process. As Scrafford et al. (2022) asserted, "failing to recognize the scope of challenges and strengths in parenting may result in programs and policies that do not fully meet women's needs and perpetuate stigma associated with women's exposure to IPV, potentially ostracizing them from critical resource system" (p. 2).

The mental health support available to mothers after IPV is often short-term counselling provided by non-profits or social services, where staff may have minimal or mainly academic knowledge of IPV, parenting dynamics between an abuser and their victim, and control tactics used during coparenting and legal processes. According to Davina and Holt (2021) abusers often use coparenting and court proceedings as ways maintain control and to harass their ex-partners. Abusive coparenting and legal conflict are also powerful ways to "undermine and damage the mother-child relationship" (p. 994). The Rise Legal Women's Centre's (2021) report discussed

in Chapter Two details the safety risks family courts can create for abused women and their children. It would benefit women survivors of IPV for this report to be read by every judge, mental health professional, counsellor, and social service provider who works with this population and their children.

There is a need for more counsellors who have in-depth training regarding survivors' experiences of coparenting with abusive ex-partners. The current models are reactive as opposed to preventive in terms of providing parenting and coparenting support for women survivors. A separate, safe, strengths-based, nurturing, and compassionate space for this population of mothers to share the challenges of parenting and coparenting after IPV can go a long way in reinforcing the mother-child bond and building confidence in a mother's abilities to navigate her child's recovery alongside her own. A focus on secure attachment, positive parenting skills, and self-care in difficult parenting moments can help to ground mothers and allow them to rebuild their unique identities as parents.

Attachment-based parenting support can be beneficial for this population and their children. According to Dansby Olufowote et al. (2020), if secure attachment is not fostered in the early developmental years, it can still be earned by practicing secure, positive attachment behaviours later on. In order to do this, secure attachment must be modeled, and there must be an internal change that includes improving self-worth and "taking small risks with trust" (p. 8). When survivors are guided and supported in using secure attachment behaviours such as warmth, comforting, reciprocity, and connected responding, they can deepen their bond with their children and bolster feelings of safety both internally and within the family. Promoting secure attachment in their children also helps to develop the groundwork for secure relating skills that

will serve as a guide for choosing healthy, safe friendships and romantic relationships later in life.

Social Justice Considerations

The need for a social justice approach to IPV recovery for women is clear when we consider the many disadvantages abuse can create for this population. I have weaved these throughout this capstone in order to keep them at the forefront. However, here I will highlight some specific areas of disadvantage about which counsellors can and should advocate for IPV clients whenever possible.

Financial Need. Howell et al. (2018) explained that "higher income levels tend to be associated with increased access to resources, more perceived control, and higher levels of resilience", as opposed to lower income, which "is associated with an insecure sense of the future, passive coping, heightened stress, and poor health" (p. 6). Žukauskienė et al. (2021) shared that "higher levels of financial independence may improve the chance of building a new life after experiencing IPV" (p. 7616). Despite this knowledge, counselling remains out of financial range for some IPV survivors. As discussed previously, government or non-profit counselling can be brief in course and sometimes lacking in trauma sensitivity. To ensure that this population receives quality good-fit therapy, counsellors can consider offering sliding scale or pro bono services until clients are financially stabilized.

Safety at Home. Schaefer et al. (2021) explained that for IPV survivors, physical safety is "a precondition for coping" and successful engagement in therapy (p. 14). Practitioners should check in with clients to assess whether they are safe and secure at home, and whether they are adequately housed. Another factor to consider is that it can be more difficult for survivors to heal if they are still living in the home in which they were abused, as memories of the abuse may be

triggered by environmental factors. Finances or logistical difficulties may prevent them from moving to a new space, but this should be encouraged and advocated for whenever possible.

Resources. Counsellors can stay apprised of legal, educational, employment, housing, community supports, and other resources for women survivors of IPV. It can be useful to create a resource document that can be easily updated and shared with clients.

Limitations

The limitations of this capstone are many, given the complexities of the lives of women affected by IPV. There are so many aspects of healing and recovery for this population that are impacted by the disadvantages IPV causes. Resilience and PTG can both exist to some degree with minimal external protective factors, but they are far more likely to be fostered in an environment of support, therapeutic safety, and social connection.

The major limitation of this project is that it cannot possibly consider all IPV survivors and the specific and unique struggles they face. My recommendations for treating this population are both informed and biased by my own perspectives, experiences, identities, and sociocultural locations. While this brings forth some knowledge that I hope is useful, it also means that there will be gaps and blind spots in my research and my perspectives. I am grateful for the extensive research that continues on this topic.

Reflections on Personal Learning

This capstone project was informed by reflecting on the process of my own journey of recovery from IPV, my own experiences of resilience and PTG, and the stories that courageous and empowered women have shared with me in support groups, sharing circles, and therapy sessions. In all of these narratives, good-fit therapy, a holistic approach, somatic release of trauma, social support, and a social justice framework were core aspects of healing.

It is my hope that my experiences make me an empathic and compassionate counsellor to other women who survive IPV. I find it deeply rewarding, humbling, and moving to walk alongside clients as they work through the scars of this trauma and begin to see themselves as whole women again. I aim to use elements of this capstone research to help guide survivors toward a nurturing and holistic path to healing, where they can feel seen and heard, where they can see their value and strengths, where they can feel safe in their bodies and in the world again, and where they can find a lasting sense of support and community that will bolster their ability to bounce back, and to continue growing beyond trauma.

Summary: The Value of a Holistic Approach

If mental health professionals and service providers could begin to reconsider the ways in which they measure and think about resilience, and how they convey this term or bestow it upon those who have moved through the trauma of IPV, they would be of greater service to women IPV clients. While it is admirable to overcome the adversity of IPV and to thrive in social, emotional, interpersonal, career, or other endeavours, we cannot overlook the weight that this journey places on those who are less supported, less protected, fall through systemic cracks, and are forced to forge their own path to a healthier life and mental state.

Resilience and PTG are not end points after IPV trauma. They are only the survival mechanisms and starting places for healing the wounds incurred by carrying such heavy things. They are places where we can sit in respectful compassion with our clients, to assess, and ideally, to help repair, the failings of systems that are meant to protect and guide those who have been harmed by an intimate partner emotionally, physically, financially, or psychologically, or so often, some combination of these. Anderson et al. (2012) asserted that “the goal of the helping process should not be for professionals to impose a resiliency framework onto survivors’ life

experiences" (p. 1295). Rather, the true goal of the helping process with women survivors of IPV is to provide women with a safe and compassionate space where they can, at their own pace and in their own unique ways, reclaim ownership of their bodies, minds, lives, and identities.

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Appendix A

Recommended Readings

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Heller, Diane Poole (2019). *The power of attachment: How to create deep and lasting intimate relationships*. Sounds True Publishing.

Land, S. (2019). *Maid: Hard work, low pay, and a mother's will to survive.* First edition. Hachette Books.

Maté Gabor. (2003). *When the body says no: The cost of hidden stress*. A.A. Knopf Canada.

Miller, C. (2019). *Know my name: a memoir.* Viking.

Perry, B. D., & Winfrey, O. (2021). *What happened to you?: Conversations on trauma, resilience, and healing*. First edition. Flatiron Books.

Rendon. (2015). *Upside: The new science of post-traumatic growth.* Touchstone.

Smith, Ilene (2020). *Moving beyond trauma: The roadmap to healing from your past and living with ease and vitality.* Lioncrest Publishing.

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin Books.