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ORIGINAL ARTICLE

Long-Term Recovery from Intimate Partner Violence: Definitions by Australian Women

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Abstract

This study explored the lived experience of Australian women affected by intimate partner violence (IPV) and determined whether and how recovery was part of that experience. An online survey of 665 Australian women in long-term recovery from IPV gathered qualitative information about their experiences and their definitions of recovery. The guiding methodology for data analysis was qualitative content analysis, as it provided a close analysis of the manifest meanings of the women's responses and an interpretation of the latent themes within the data. Outcomes included a thematic analysis and the numbers of women referring to each theme. The women's definitions focused on their lived experiences of recovery rather than on the psychological and academic constructs favoured by researchers. The five themes identified in the women's definitions were safety and survival, gaining freedom, moving on, enjoying a better life, and issues with children and parenting. These themes did not represent sequential stages but generally occurred concurrently. Relapses, digressions, and highs and lows were also common aspects of recovery. Thus, these themes were more like threads woven together in a multi-axial continuum or recovery journey, rather than sequential phases. Although many women considered they had recovered from IPV, most women found recovery to be ongoing. Some women struggled to make any progress in recovery at all. Overall, recovery from IPV is multidimensional and individualistic in nature. It is an arduous journey that evolves over a long period of time and requires a great deal of support.

Keywords Intimate partner violence · Recovery · Definition · Gender-based violence

Background

Since the inception of the Australian national research agenda in 2009, one of the research foci for the IPV sector is supporting women after leaving an abusive partner (Australia's National Research Organisation for Women's Safety [ANROWS], 2020). In 2016, the Victorian Royal Commission specifically nominated recovery as a desired outcome for support services (Neave et al., 2016). While research momentum on recovery has escalated in Australia since then, conceptual models of recovery are still in nascent form (Flasch, 2020; Laing & Humphreys, 2014; Sinko & Saint Arnault, 2020; Sullivan, 2018) and have yet to gain widespread national and global support. Further, it remains unclear whether all women can recover, as some researchers have presented varied findings (Bacci, 2014; Evans & Lindsay, 2008; Flasch et al., 2015; Miller, 2018; Smith, 2003).

Although recovery is often the stated or inferred goal of many interventions, researchers continue to debate what outcomes are important when measuring intervention effectiveness (Macy et al., 2015; Taft & Hegarty, 2010). Outcomes utilised have included: proxy measures for concepts related to recovery such as quality of life and absence of abuse (O'Doherty et al., 2014); measures for components of recovery such as social support, self-esteem, and mental

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health (MH) (O'Doherty et al., 2014); and measures for symptom reduction (Sinko et al., 2021). Recovery per se had not been used as an outcome measure at the time of survey design. To our knowledge, only one recovery measurement tool has since been developed for use in the context of IPV (Sinko et al., 2021). This tool (GBV-Heal) was based on dimensions defined in interviews with 56 women and a small homogenous sample of women from one American university (n = 236). The dimensions of this tool need to be tested for use with a broader range of socio-economically and culturally diverse women.

In our scoping review of the literature (435 items) from 1996–2018, studies on the period after leaving an abusive partner used the following frameworks in their research: coping strategies, resourcefulness, empowerment and strengths-based approaches, resilience strategies, post-traumatic growth and the 'self, others, society' framework. In the last few years some researchers have directly addressed recovery (Flasch, 2020; Sinko & Saint Arnault, 2020), but most researchers explored concepts not necessarily synonymous with recovery such as: healing (Draucker et al., 2009; Dutton, 1992), well-being (Sullivan, 2018), thriving (Anderson, 2010; Heywood et al., 2019), overcoming (Flasch et al., 2015), incorporation (Evans & Lindsay, 2008), citizenship (Franzway et al., 2015) and survivorship (Miller, 2018). Recovery therefore remains under-explored in the literature and this begs the question: What is meant by the term 'recovery'? We believe that women should define recovery for themselves as it is not clear which concepts would resonate with them most.

It should also be noted that many of the reported studies are small qualitative studies (Flasch, 2020) and more evidence is necessary to inform the design of measurement tools and interventions; (Sinko et al., 2021) including a definition of recovery that is acceptable to survivors, and relevant for operationalising into a measurement tool. Accordingly, this study sought to understand whether the concept of recovery had meaning to Australian women affected by IPV by addressing these research questions: 'Do women recover from IPV?' and 'How do women define recovery from IPV?'.

Methods

A pluralist ontology accepting the coexistence of multiple realities (Turner, 2010) and a pragmatic epistemology (Misak, 1999) informed the mixed methodological approaches chosen to answer the research questions (Cresswell, 2014). Befitting a concept that is poorly understood and not clearly defined in the literature, this study was designed as an anonymous online survey collecting both quantitative and qualitative data (Cresswell & Zhang, 2009) as part of a wider research design including four separate studies. Of relevance to the current study is the survey section inviting women to share in unlimited text, their experiences and definitions of recovery from IPV in response to the questions: '*What does recovery mean to you? What factors helped and what factors hindered your recovery? & Anything else*?'.

Participants

Participants consisted of 665 Australian women over 18 years of age, who self-identified as being in long-term recovery from IPV (defined as more than two years since leaving, to address a gap in the literature) and who had sufficient English skills to undertake the survey. There were slightly more older women (over 46 years) than younger women in the sample. Most participants self-identified as women with three women identifying their gender as being 'other', one woman as 'non-binary' and none chose 'prefer not to say' in the eligible sample. However, the representation of women of other gendered perspectives in the survey is not clear (Australian Bureau of Statistics [ABS], 2018) as there is currently no reliable statistic for the prevalence of gender diverse women in Australia, to compare to the sample (ABS, 2016).

Participants from regional areas constituted the largest group of women (38%), followed by urban areas (33%). Most significantly, 27% of the women came from rural and remote areas, which is representative of the national prevalence rate of 28% (Australian Institute of Health and Welfare [AIHW], 2020). The majority of women (80%) identified as being born in Australia. Three per cent of women identified as being of Aboriginal or Torres Strait Islander (ATSI) ethnicity, which is comparable to the national average (3.3%) (AIHW, 2019). Culturally and linguistically different (CALD) women included 15% of the sample. They were underrepresented in the survey, as 29.7% of the Australian population was born overseas (ABS, 2019). Language and other cultural barriers maybe be responsible for this lack of representation.

Most women had experienced long periods of abuse, with 45% of the sample enduring abuse for more than ten years. Of all the women, 81% had at least one mental health (MH) diagnosis, which was 1.8 times the national prevalence rate of 45% for any mental disorder in a lifetime (ABS, 2007). Co-occurrence of MH diagnoses was high and 45% of women also had multiple diagnoses.

In terms of time since abuse ended (TSAE), 37% of women had been more than 10 years since leaving the abusive relationship. Another 29% of women had between 5–10 years earlier, and 34% of women 2–5 years earlier. The sample therefore provided good representation of the spectrum of long-term recovery experiences.

Data Analysis

Qualitative content analysis was the methodology employed for the data analysis process as it is effective for analysing large volumes of qualitative data and provides a systematic methodology for doing so (Mayring, 2000). Qualitative content analysis remained close to the intended meanings of participants (the 'manifest' meanings), while accommodating the interpretation of findings to meet research objectives (the 'latent' meanings) (Roller & Lavrakas, 2015, p. 230). It also produced a thematic analysis retaining the individualistic and subjective nature of the material, while enumerating the frequencies of codes and themes in a cautious 'proxy for the significance' of responses (Vaismoradi et al., 2013, p. 404). Only a low-level thematic analysis was presented in the findings, and the women's words were used verbatim as the labels of the emergent themes (Sandelowski & Leeman, 2012).

After obtaining full human ethics approval from the University of Newcastle Ethics Committee (H-2018–0037), a paid social media campaign on Facebook promoted the anonymous online survey to Australian women from February to June 2019. Informed prior consent was obtained from participants before accessing the survey, and no record was kept of uncompleted surveys to ensure women had the right to revoke their consent at any stage of the survey. Women also had the opportunity to participate in the survey but withhold permission to share their qualitative responses and 59 women chose to do this.

All participant definitions of recovery were coded in NVivo, along with any succinct definitions provided in the open text narratives, the 'anything else' section, and the factors section of the survey. Data analysis was guided by the qualitative content analysis steps outlined by Schreier (2014) and Roller and Lavrakas (2015). After a first inductive coding pass, other deductive codes informed by a scoping review of the literature, the findings of the quantitative analysis, and an accompanying phenomenology (n = 22) were utilised where relevant (Graneheim et al., 2017). Axial coding organised codes into categories and categories into themes, in an iterative process based on related meanings within the data (Roller & Lavrakas, 2015). A second coding pass of the data ensured the comprehensive coding of all relevant material (Schreier, 2014). Code saturation occurred between 354–370 participants, depending on which codes were included in the estimation. This demonstrates the diversity of women's experiences and makes a case for much larger sample sizes in IPV studies. Together, all themes, categories and codes created the codebook that was exported from NVivo and forwarded to the senior researcher who also coded the data corpus and checked the coding framework (Roller & Lavrakas, 2015, p. 273). A consensus approach to coding agreement was adopted, instead of the more positivist approach of inter-rater reliability (Forman & Damschroder, 2008, p. 55). After discussing the codebook (Schreier, 2014), coding was modified in several ways. The various analogies for recovery used by the women were added to the codebook, and some categories and codes were reduced to simplify the coding structure. A final pass of the data ensured all relevant material was included and confirmed the coding frequencies (Schreier, 2014). As there will always be some variation between coders and even by the same coder at different times (Forman & Damschroder, 2008), particularly when coding such a large database, coding frequencies were used for comparison purposes only. They are generally not included with the findings except to report the number of women (not references) represented by each major theme.

According to Guba and Lincoln (1989), the trustworthiness of qualitative research depends on establishing the credibility, dependability, confirmability, and transferability of the data. The credibility and dependability of this study were enhanced by ensuring breadth and depth in study design, being transparent about the research process, coding the data corpus (not a selection), reporting positive and negative cases, and using verbatim quotes and vignettes. Involving multiple researchers in the analysis and performing multiple coding passes separated by time, helped to assure the dependability and credibility of the research process (Roller & Lavrakas, 2015). Triangulation with the findings of the phenomenology (n = 22) and quantitative data, as well as triangulation with the women's detailed narratives of recovery, supported the confirmability and transferability of the findings (Vaismoradi & Snelgrove, 2019). Limiting findings to low-level interpretation and confirming findings by a non-participating survivor, ensured the authenticity of results (Vaismoradi & Snelgrove, 2019).

Results

Data analysis of the women's responses identified common beliefs about recovery in four themes that the women worked on intermittently and concurrently throughout their recoveries. A fifth superordinate theme related to women with children and applied across the other themes. Staying close to the women's definitions, the themes described tasks or projects that the women worked on in their lived experiences, rather than the psychological or sociological constructs favoured by researchers. Together the five themes appeared as interwoven strands, or threads, woven throughout each woman's unique recovery journey.

Analogies of Recovery

Qualitative results revealed that women found talking about recovery important. One of the participants stated: 'Even someone with a language of recovery would have been helpful, it took me a few years to realise recovery was the journey I was on'. Women utilised many idiographic analogies to describe their recovery. However, the journey analogy was an exception, as it was used by 91 women. One example is the following quotation:

> The road to recovery has been a long, hard road that is still going almost 4 years later. I don't know if I will ever come to the end of this road, or if there will be a turn off at any point. But I can say that I have come a long way from where I have been. There have been so many hills to climb, hills that almost had me defeated on more occasions than I want to remember. But I had to dig so deep to find the strength and determination to keep going, to keep putting one foot in front of the other when I could and resting when I couldn't.

Possibility of Recovery

Women's beliefs about the possibility of recovery varied widely. Opinions spanned a spectrum from not believing in recovery at all to feeling completely recovered. Recovery was possible and many women felt they had recovered: 'I got there' and 'I think I can say that I'm as recovered as I will ever be'. Other women believed recovery was possible and that they had recovered, despite their physical or psychological scars. According to one participant: 'I became whole again, with pieces of me together and scars smoothed, and I am better than before but different'. However, some women felt that the scars prevented complete recovery and other women found recovery to be ongoing: 'Let's say it's a continuous journey'.

Unfortunately, some women firmly believed that recovery was not possible for them, especially when there was ongoing exposure to the perpetrator. As one participant pointed out, 'You can never fully recover. Especially if you still have a connection through the children…it never stops". Another participant said, 'I've been free for 36 years and I still have flashbacks and nightmares'. The pernicious nature of the impacts of abuse was evident in responses such as: 'I don't think anyone ever fully recovers from the experience of domestic violence, it impacts every decision you make for the rest of your life, and sometimes triggers happen that you were completely unaware were even triggers until they occur'. Some women felt they would not be able to recover from the financial impacts, even in their lifetime.

Finally, some women were unsure about the possibility of recovery for them and expressed a desire to know more about recovery. Two comments that revealed this desire: 'I'd love to know what helps a woman recover' and 'I wish I knew how to be recovered'.

Definitions of Recovery

The women's definitions of recovery were succinct and summarised the main meaning of recovery for them. Responses varied from a few single words or a short phrase to a detailed paragraph when answering the research questions: 'What does recovery mean to you?' and 'Anything else?'. Four main themes—or strands to recovery—emerged from the women's definitions: Survival and Safety, Gaining Freedom, Moving On, and A Better Life. A superordinate theme—Children and Parenting–applied across each of the other themes for women who had children. These themes and their components have been included in Table 1.

Superordinate Theme: Children and Parenting

Being a good parent and raising healthy happy children is an important goal for most mothers, especially those recovering from IPV. As one mother put it, 'When you have 3 children to care for on your own. They are your priority, so you just have to get on with the job'. Many mothers were concerned about the impact of the abusive relationship on their children and went to great lengths to protect them: 'That is what I fought for. I fought for my children like a lioness. Whatever needed forgiving, reconciling, challenging. To divert them from bitterness… I battled and fought and loved my kids into healing and belonging'.

Some women allowed their children to have ongoing contact with their abusive partner either for the children to have a father or because they were afraid of losing their children if they did not provide this access. However, many women also felt the need to enforce 'no contact' due to its negative impact on their children. As one mother stated:

> Find a way to protect the children first…as the abuser will use them to hurt you as soon as they realise, you're not going back... Do whatever you can to protect your children from the abuser. ANY contact or sighting of the abuser by the children will bring about flashbacks, fear and take their recovery backwards.

Some mothers criticised the current preference of the judicial system to favour shared custody arrangements that prolonged exposure to abusive fathers: 'If the family court placed more emphasis on the safety of children rather than their need to know both parents'. Women objected to paternal access if the father was not paying his child support, was

Table 1 Components of Recovery from IPV

Parenting and Children 15% or 90/592 women *(Constant focus)* Being a good parent (emphasis on mother) Helping children to recover (emphasis on child)			
Safety and Survival 26% or 155/592	Gaining Freedom 64% or 378/592	Moving On 46% or 275/592	A Better Life 61% or 364/592
(Present focus)	*(Past focus)*	*(Future focus)*	*(Present focus)*
Physical safety and security	Accepting the past	Progress in healing and improved well-being	Happiness fun and joy incl. interests & hobbies
Housing—home and a safe place	Freedom from perpetrator and all forms of abuse	Regaining resources and reconciling losses	Self-identity, self-esteem, self-efficacy, self-worth
Financial survival -employment or welfare	Freedom from impacts of abuse incl. trauma and triggers	Returning to "normal"	Sense of belonging, relationships, and community
Psychological safety – mental health support	Freedom from fear	Reclaiming the narrative authority	Peace, sleep, and serenity
Emotional safety – at least some safe social support	Resolving troubled emotions eg shame, pain, grief, guilt, blame	Developing hope	Existential purpose and meaning

a threat to the child's health and safety or was using contact to continue abusing the mother.

Women were also concerned with helping children to recover from the impact of abuse, or as one participant called it, 'to work on patching the damage to the children'. Children were susceptible to MH issues and to repeating abusive behaviours later in life. One participant expressed her concerns thus: 'Unfortunately, I have been thru the anger/violence with my daughter…her learnt behaviour as a child thinks it is ok to smash everything…she is 20'. In conclusion, it is important to note that parenting responsibilities and managing the impacts of the abuse on children were an important strand of recovery for mothers, which complicated their progress in the other themes.

Theme 1: Survival and Safety

Attaining safety was the immediate reported goal of most women leaving an abusive relationship. One woman confirmed that, 'without having a safe and secure life recovery is almost impossible!' However, safety was not just an issue for short term period of recovery. One woman realised:

> There is a false assumption that once the 'crisis' phase is 'over' & an IVO has been granted, that the survivor is safe & can get on with her life. Unfortunately, this is not the case…The recovery phase is fraught with many obstacles and challenges and is often ignored by the sector which is more focussed on the crisis stage.

Safety formed the crux of survival and was fundamental to surviving without the perpetrator. Even decades after the abusive relationship had ended, safety remained an ongoing concern for some women. One participant described the continued threat to her safety: '16 years later, I'm in a loving and very supportive marriage… He still tries to contact me. I moved countries and he has still traced me and attempted contact. I am filled with fear every time he tries'.

Safety and independent survival issues, featured in 26% of the women's definitions. Factors identified by the women as necessary for survival included: financial independence (meaning an income stream via employment or social welfare), financial recovery, safe housing, safe social support, and effective MH support. Finding independent income was one of the greatest challenges that women had to overcome to begin recovery and to live safely. Employment was the most obvious way to sustain financial independence and women were very motivated to obtain and maintain employment. Women also identified secure housing as equally important to their recovery as an independent source of income. One woman summarised this need: 'Living a full rich and independent life with secure housing and employment'. Another stated that 'Recovery involved rebuilding life from scratch—finding a new home, ensuring my own income'.

Where women were unable to work, social welfare was essential to survival, especially for paying the rent. However, some women had difficulty accessing social welfare payments. As one mother put it, 'Life was tough for a while I had no income for a very long time. It took months for Centrelink [the social welfare office] to approve my payments and child support took longer again'. Another commented on the link to homelessness: 'Faster processing of financial assistance from Centrelink and child support agency would have meant not becoming homeless'. Women had to face mandatory waiting periods and means tests for eligibility thresholds to gain access to welfare payments. This was

particularly problematic for women who shared assets with the perpetrator or were members of family businesses or trusts, as in many family farms or small businesses.

Women needed more than just an income to survive; they also needed financial security, 'being financially stable enough to live a good life with my kids…not just existing week to week. Financial strain has turned out to be the hardest thing to live with'. Many women also struggled to pay off the financial burdens imposed on them by the perpetrator. According to one participant, 'Being free of the debts that he left me with which was over 30 grand that I paid off'. Further, shared custody issues, the cost of prolonged legal battles and ongoing contact with the perpetrator, impacted many women's abilities to ensure their safety over the long term. The following vignette illustrates some of the difficulties faced by one woman who had more resources and resilience than many others:

> I dated ex for 3 years. I was educated, had property and a good job. When I left after the first physical attack, I was LUCKY. I had friends who got my kids and I out safely. I had resources for a lawyer and housing. I had knowledge about restraining orders and counselling from volunteering as Victim Witness. None of this helped when dealing with lawyers, police and courts as a victim. Police asked if I'd aggravated/incited him. Despite bruising and lacerations, forced mediation, pushed for shared custody. I refused. Courts deemed me obstructive to access visits in the face of handwritten death threats. Twice he got 18 months' probation for bashing me in parking lots. (The first day I left was a freebie for him 'previous good character'). He lost his government job due to drug use. That escalated attacks on my house car parents and pets. I kept going to court for 11 years. Finally, the court did a blanket 'no contact' order for me, kids, parents, my siblings, my workplace, kids' school. Attacks got sneakier, as he got the only job possible, taxi driver. I could see him 20 times while shopping. Finally, when the kids were in uni I moved 10,000 km away. It has been peaceful since.

Dealing with MH symptoms was also an important aspect of some women's definitions of recovery, especially in helping them to sustain employment. The availability of MH support was a problem for many women due to lack of access to services or to the costs involved. As one participant stated, 'I can barely afford the basics, never mind have the money for things like psychological treatment'. The quality of MH services also varied with some MH support being helpful, as one participant related, 'Support services helped me a lot, I don't think I would have survived without them'. However, not believing or listening to the woman, and reinforcing the 'victim' status of the survivor, were unhelpful aspects of service support identified by other women in the survey.

In conclusion, safety and survival form a crucial part of the recovery process. As one participant stated, 'it is very difficult if not impossible to recover when I was just trying to stay alive—bare basic survival mode doesn't promote recovery and healing'. Therefore, it is more helpful to view attaining safety and surviving independently as one of the threads woven through the recovery journey, rather than as a distinct stage in a sequential process.

Theme 2: Gaining Freedom

The most common theme identified in the definitions provided by the women was that of gaining freedom, with 64% of women referring to this theme. While women acknowledged the need to survive and attain safety, they were more interested in acquiring freedom. One woman commented, 'Recovery doesn't mean I've forgotten but it does mean that I am finally free at last'. Acceptance was a precursor to freedom, particularly acceptance of the past, the IPV and the need to face the reality of the situation. One participant stated, 'Realising that although I could not control what happened to me, I can control how I think about it, and what I think about it'.

The foremost freedom that women sought was freedom from the perpetrator, his abuse and his coercive control over their lives or the lives of their children: 'Being able to completely separate yourself physically, emotionally and financially from the abusive relationship'. Being free from him also included being free from the fear he induced: 'Freedom from stalking & harassment, ability to go out in public without panicking or searching for his car, ability to not panic when a hidden number calls my phone'. Fear was particularly toxic as it prevented women from being able to move forward in their recovery and enjoy their lives.

Women also needed freedom to make their own choices and determine their own futures: 'Freedom from the fear and anxiety. In control of my future and my life'. 'Re-learning, rebuilding, baby steps, out from under excessive & abusive control & manipulation, FREEDOM!' To regain control of their lives, women had to learn to establish healthy boundaries in their relationships not just with the perpetrator but also in other relationships: 'as the abuse escalated, the allowable boundaries expanded… So, part of recovery is setting new boundaries, pulling back the acceptable limits, knowing what your "rock bottom" is, and resolving to never allow anyone to ever push your boundaries back again'. Women's freedom to make their own choices did not just apply to major life decisions, but also to the small and ephemeral things in daily life: 'It means I can truly be myself, I can laugh, breath, cry, get angry, tell jokes, show compassion, have friends, socialize, dream, plan, be independent, spend

money, be creative, without ridicule, without being in trouble and frightened of the outcome'.

Recovery for many women also involved freedom from the past and persistent memories. One of the biggest hurdles women dealt with were sudden 'flashbacks' that could be strong enough to 'trigger' PTSD symptoms. Recovery entailed freedom from these triggers and flashbacks: 'Recovery means I can go by most days and not be triggered by events or words. Not think about my past and look towards the future'.

While an experience of victimhood was common within the abusive relationship, some women expressed a need to overcome the role of 'victim' after leaving. A few women were comfortable using the term 'victim' in relation to themselves: 'I'm a successful professional woman who was a victim of IPV'. However, other women did not identify with the term: 'Once I was out of the crisis zone, I had to want to recover. I didn't want to live my life as a victim, for the rest of my life'. Women needed resolve to escape a victim mentality upon leaving: 'An important decision for recovery after leaving was not to be a "victim"'. Further, some women learned about a victim mentality in their family of origin, which created additional complications in their recovery journeys. According to one participant, 'Being a victim of abuse is a pattern learnt from childhood'. Another woman noted that: 'abusers, sense, or in some cases know, when a woman has been abused in childhood and is therefore a more vulnerable victim'.

Apart from freedom from trauma symptoms, bad memories, triggers and enforced victimhood, women also needed freedom from a variety of troubling emotions to recover. These emotions included anger, blame, depression, grief and loss, guilt, pain, self-loathing, and shame. Of these emotions, freedom from pain (94 references) and freedom from shame (79 references) were the most cited emotions troubling the women. In overcoming the impact of negative emotions, some women noted that they had to accept their emotions as valid, acknowledge the emotion, reflect on it and eventually dismiss it: 'It's an ongoing journey of reflection and acknowledging emotions'. Not all women were able to overcome their troubled emotions, especially if the emotion was pain. Nevertheless, most women eventually learned to overcome the emotion and move on in their recovery. One woman advised other women:

> Let the emotions come—the grief, pain, sadness, self-pity and anger will come in waves as you remember and reprocess it all—just face it, feel it, cry, let it fade away. Every time you feel a wave of pain, let it be there, remember it will never hit you as hard again. It will be smaller next time. Eventually the waves are smaller and less often. Don't act out during these waves, just let them hurt and pass like a wave in the ocean.

Women also employed other strategies to help them deal with their emotions including seeking support from other survivors, MH services and self-education: 'I learned that I could get past the feelings of shame, blame, guilt, anger, sadness, regret, through talking to other survivors, counsellors, psychologists, psychiatrists, and just my own research with many sources that are available'. Women who were unable to reconcile troubling emotions ran the risk of becoming 'stuck' and unable to move on in their recovery journeys: 'This is a massive turning point in your life—you can end up better or bitter'.

Freedom to be themselves was just as important to the women as freedom from the perpetrator, his control, and the negative impacts of his abuse: 'Freedom to exist as I am, who I am, without restriction, fear, freedom to live in my own home as a safe haven from the world and not a place of anxiety and fear'. The phrase, 'Free to be me', implies a knowledge of myself, interests, and goals. Many women had been so conformed to the perpetrators' control over them that they were no longer sure of their identity and what they liked or disliked: 'Freedom, being me, no more walking on eggshells, peace, discovery of me'.

Theme 3: Moving On

Many women articulated the concept of recovery as moving on or moving forward in their definitions (46% of women). This forward movement occurred through healing, personal growth and developing well-being: 'Recovery means a process of healing'. Knowledge and information about recovery helped women to move on: 'the greatest tool for recovery is knowledge and understanding'. 'I don't think there is enough education regarding this topic'. Family and friends were also identified as needing education on recovery.

Healing was often linked to trauma and its repercussions: 'Healing from the trauma and functioning in a healthy way in all areas of life'. Women also described healing from the loss of their sense of self—a common response to trauma (O'Doherty et al., 2016; Van der Kolk, 2015). For one participant, 'the ability to heal' was to 'find the part of you that was lost'. Healing occurred with time, or support from services: 'This process can be consciously pursued, with professional advice and assistance, or healing can come with the passing of time, as your brain gets used to the memory of that trauma and loss'. However, some women did not find that time healed them: 'It is not true that time heals everything. Time helps you move on and to dull the pain. It helps you learn to forgive, but you never forget'.

For some women being able to move on also involved a return to normal functioning: 'To be able to function

normally and not re-live the trauma all the time'. However, other women noted that what was normal differed for everyone: 'Any sense of normality improves recovery—whatever that looks like to each person'. The biggest impediment to functioning normally cited by the women was the impact of MH issues especially trauma symptomology: 'My view of recovery was that I would be able to lead a normal productive life. But this has not been the case due to my ongoing mental issues'.

Another conception of 'moving on' provided by some women was a regaining of things that had been lost. Things regained by the women included their perspective, the person they were before the abuse, a positive future, self-esteem, self-confidence and the life they felt they should have had: 'Recovery to me means undoing all the negatives he put me in. In recovery l have dealt with each issue one by one & come out on top in all areas of my life'. For many women, this process of regaining multiple losses, involved a renewed self. As one woman said… 'regaining my sense of self, being strong, independent and happy within myself'. However, some women questioned the possibility of regaining their previous state due to intrusive flashbacks and nightmares, difficulty trusting others, difficulty feeling loved and the need for a new identity incorporating the abusive experiences:

> It doesn't mean being the same as before—it means being able to live without intrusive thoughts, to be able to deal with a situation and not become super vigilant or intimidated, to have confidence in myself, to trust again, to feel love and loved (not by a partner, just for my children), to feel normal, balanced, to feel okay.

Finally, some women moved on by regaining the 'narrative authority' over their lives (Hossain, 2020). They did this by rejecting and replacing the perpetrator's negative words and narrative with their own narratives, thereby integrating their negative experiences. Two responses illustrated this: 'Regaining my own identity outside of what happened to me. Looking to the future. Integrating my experience of IPV as a part of my life story that is significant but not all-defining' and 'achieving everything I was told I couldn't'.

Theme 4: A Better Life

This theme was almost as common as the 'gaining freedom' theme, having been referred to by 61% of participants. Women enjoyed aspects of a better life from the first days of separation from the perpetrator, even as they were surviving and finding safety. The word 'better' connotes improvement and refers to an increasing quality of life: 'Recovery means working through a problem/s to create a better life'. Aspects of a better life identified by the women included happiness, enjoyment, fun, homemaking, sleep, peace, calm, self-confidence, self-esteem, social support, a sense of purpose, hope and a future. The three most frequently nominated aspects of a better life in order were: 1) identity and a sense of self-worth 2) social support and a sense of belonging and 3) happiness, enjoyment, and fun.

A restored sense of self was the most nominated category code in the women's definitions of a better life. Women needed a positive sense of self to be happy and engaged in life: 'Regaining a sense of self, feeling heard, seen and believed'. In being free of the perpetrator's toxic attitudes towards them and in finding themselves, the women were able to restore their sense of self-worth and rebuild their inner core value. Two women described this change: 'Believing in my own worth' and 'Recovery is physical and emotional. It's a journey of picking up pieces of yourself and reconnecting them back together to find yourself again'. Some women found this difficult, as they struggled to believe in themselves, manage their memories of verbal abuse, and curb their negative self-talk: 'Finding myself again and not listening to his negative voice in my head'.

In finding themselves again and developing their self-worth, some women were able to think about opening themselves to new relationships with others: 'Finding yourself again. Rebuilding your dreams. Rebuilding your self-worth. Finding a tribe'. Developing a strong sense of self was an important step in being able to interact with others and to developing a sense of belonging: 'Discovering who is living in my body and finding ME and most importantly accepting and loving who I am with all my imperfections and strengths. Walking out my front door without fear, meeting and forming friendships based on trust'.

Developing a sense of belonging, and enjoying relating to others, was the second most nominated aspect of a better life. One participant wrote, 'Recovery means that I am living my best life. One that I choose. One of belonging and meaning where I am not treated badly. Or scared. Or have toxic relationships, with myself or others…My relationships are healthy'. However, many women struggled with maintaining friendships and establishing new intimate and platonic relationships after leaving their abusive partners: 'Being wary of all people, no matter who you think they might be'. The betrayal of the perpetrator and the betrayal of unsupportive family and friends affected women deeply, often reinforcing feelings of worthlessness and low self-esteem. Many of the women found their feelings of distrust in others were the last and most significant barrier to overcome in their recovery. 'Recovery for me will be when I am able to trust again. I am doing OK in every other aspect I just don't trust either friends or potential partners'. Being able to identify what is a healthy relationship and being able to distinguish that from an unhealthy relationship was an important aspect of healing for many. As one participant put it:

> For me full recovery means being able to fully function in all areas of life, including having a healthy relationship. I am unsure I would be able to maintain a healthy relationship. I fear being drawn to someone similar to the children's father and going through something of that nature again. When in a relationship I find I am analysing the relationship for signs of abuse and being very reactive to any sort of controlling or manipulative behaviour. I am mostly unsure of my relationships and need to get professional advice about whether they are healthy or not.

Women with a history of multiple abusive relationships, including abuse within the family of origin, had a particular need for professional services support and education in negotiating healthy relationships, but often struggled to find it. One participant stated: 'I needed more direct support a long time ago that I'd reached out for and always received emotional band aids, not helpful healing'. Without significant support these women risk becoming serial victims.

Happiness and enjoyment were aspects of recovery that many women were able to experience after leaving: 'Living life on my terms with as little suffering as possible and as much joy as possible'. Women also referred to the ability to laugh and enjoy humour in their lives again. Factors associated with happiness varied between women and encompassed a wide diversity of experiences: 'Fun is important. Adventures are important. Dancing. Love. Beauty. Joy'. Activities such as enjoying nature, music and hobbies were commonly associated with recovery. Eating well, exercising, and maintaining a healthy lifestyle were also valued: 'Recovery happens when there have been enough good times to be able to look back and they overshadow the bad. It is very important to allow the person to have those good times'.

In summary, recovery from IPV is a long personal journey that involves maintaining safety, surviving independently, and gaining freedom from the perpetrator, while healing from the impacts of abuse, trauma and loss, and enjoying a better life. This healing does not occur in a defined sequence or chronology; rather, it depends on the unique circumstances of each woman's life. For women who are mothers, parenting responsibilities and their children's recoveries are of primary concern. According to one woman: 'Recovery means slowing down. Daring to sit in stillness. As all the threads come together and are reabsorbed in healing'.

Discussion

The findings of this study produced a conceptualisation of recovery illustrated in Fig. 1 as five themes, like threads woven together in a multi-axial continuum (Warshaw & Brashler, 2009, p. 347) that represents the recovery journey. Although the concept of a continuum in recovery was also identified by Flasch (2020), our data supports the concept of a multi-axial continuum where different threads are worked on concurrently by survivors, rather than as a developmental continuum only. Women varied in terms of which theme/s they focused on at any given point in time. Themes arose and fell in order of priority to the women as their life circumstances changed. Eventually, all the threads merge and are absorbed in healing.

Themes of Recovery as Threads Woven in a Multi-axial Continuum

The following discussion addresses each theme presented in the findings, with implications for service support. Suggestions for future research are noted where relevant in the discussion section. Limitations of the study conclude the discussion.

As identified in previous research, safety and survival were of primary concerns for survivors (Draucker et al., 2009; Warshaw & Brashler, 2009) and a prerequisite for

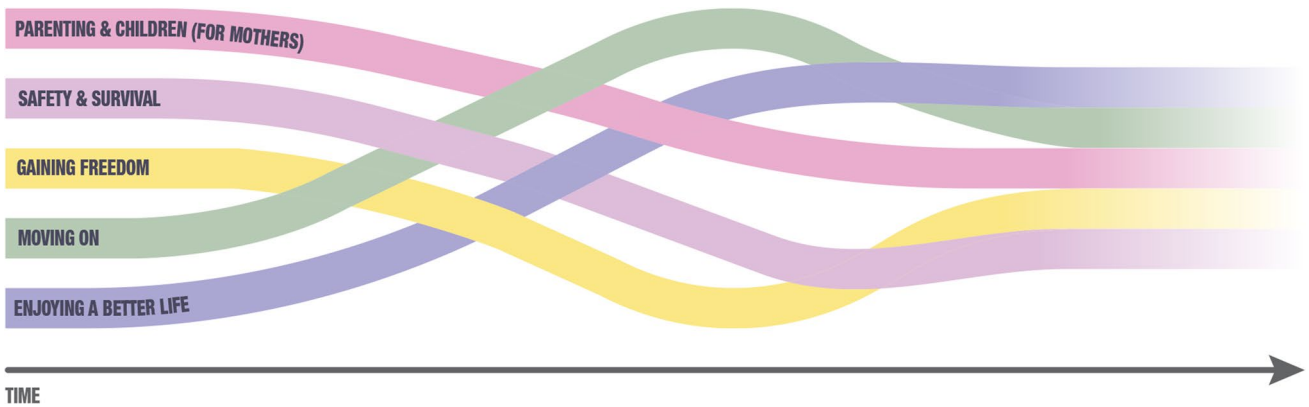

Fig. 1 Themes of Recovery as Threads Woven in a Multi-axial Continuum.

women's recovery (Laing & Humphreys, 2014; Sullivan, 2018). Without safety, progress in recovery is limited (Dutton, 1992; Rodgers et al., 2016). Therefore, ongoing safety should be an important feature of any definition of recovery, recovery program and measure of recovery (Draucker et al., 2009). Ensuring safety and survival required an independent source of income (employment or social welfare), secure accommodation and effective MH support and safe social support, consistent with prior evidence (Abrahams, 2010; Miller, 2018). Perpetrator's efforts to coercively control women through financial and legal avenues needs to be addressed by legal and support services. Confirming the literature, this study supports the need for programs for women recovering from IPV to have access to financial management training in budgeting, debt management, career development and wealth creation (Chronister & McWhirter, 2003; Macdonald, 2012).

As well as ensuring their safety and survival, women focused on gaining their freedom from the perpetrator, the effects of abuse—including trauma—and the effects of troubling emotions such as fear, shame, grief, anger, and blame. Recovery services could assist women in gaining freedom by helping them to identify the many tactics employed by perpetrators to abuse or control them (even after leaving), manage trauma symptomology, maintain healthy boundaries, and reconcile the past, which involves dealing with troubling memories and emotions (Alexander, 2015; Draucker et al., 2009; Herman, 1997). A strong case has already been made for trauma-informed care training for staff working in the IPV sector (Fallott & Harris, 2009; Quadara, 2015; Taft et al., 2016). However, training in an awareness of MH issues (Howard et al., 2013) and the nature of sub-threshold symptomology (especially of anxiety, depression, and PTSD) could also be helpful (Macy et al., 2019; Sullivan, 2018). As evident in this survey, dealing with ubiquitous emotional responses (such as those listed above) should also be a feature of any recovery program (Baker, 2013; Sinko & Saint Arnault, 2020) and a component of professional training courses for the sector. A common long-lasting problem for women in recovery was dealing with the all-pervasive fear or 'ontological insecurity' created by IPV (Moulding et al., 2020), indicating the centrality of dealing with trauma symptomology during recovery (Herman, 1997; Van der Kolk, 2015).

While women were gaining their freedom, they were also progressing with their lives on their recovery journey. This theme is supported by Laing and Humphrey's model (2014, p. 59) and Sullivan's model (2018, p. 127), and other researchers who have understood the importance of moving on (Abrahams, 2010; Ochocka et al., 2005; Wuest & Merritt-Gray, 1999) for recovery. While time helped with healing, many women still needed support adapted to their individual circumstances (Macy et al., 2019; Sinko & Saint Arnault, 2020; Sullivan, 2018) to make recovery progress. Some women were not sure if recovery was possible for them; however, recovery was possible and women could benefit from hearing the long-term recovery stories of others (Tutty et al., 2006) and developing resilience (Anderson, 2010). While it may not be possible to be completely free of trauma and other symptoms, recovery is possible and lives can improve despite the symptoms associated with MH issues because 'grief and relief are not mutually exclusive' (Miller, 2018, p. 204). This is an important message for many women. Using the journey analogy is also helpful here (Miller, 2018). Services should help women to seek progress in their lives, even if the goal of a complete recovery seems unattainable to them.

While recovery has previously been described as an outcome and a process (Davidson et al., 2010) and our findings support both views, it is less suited to stage-based theory (Laing & Humphreys, 2014). The women's responses in this study have illustrated that recovery is unique to each woman's circumstances and is nonlinear in nature (Flasch et al., 2015; Sullivan, 2018). Unlike Laing and Humphrey's model (2014, p. 59), women addressed the different strands of recovery both concurrently and non-sequentially. Further, progress gained did not always remain, and relapses and digressions in recovery were common. These findings suggest that the use of the Stages of Change theory (based on the trans-theoretical model of change) (Prochaska et al., 2009) may not be helpful to recovery models, even though it may be helpful when considering women's decision-making in relation to leaving an abusive relationship (Khaw & Hardesty, 2007; Liang et al., 2005).

Some women experienced moving on as a 'return to normal' or a 'regaining of what had been lost' (Sauber & O'Brien, 2017), but other women rejected any possibility of recovery when defined in these terms. Services should remain flexible (Sorrentino et al., 2020) and adapt to the terminology that each woman prefers. Enforcing the usage of terms when women are not receptive may risk re-traumatisation (Substance abuse and MH services administration (SAMHSA), 2014). Other women articulated the need to reclaim the narrative authority (Hossain, 2020) over their lives, by redefining their reality from the perpetrators' negative interpretations of events or hurtful words about them. This finding reinforces the importance of including narrative work (Alexander, 2015; Denborough, 2014) and journaling techniques (Denborough, 2014; Tetterton & Farnsworth, 2011) in recovery programs. Assisting women with reframing their experiences (Goodfriend & Arriaga, 2018) from a strengths-based and resilience-based perspective (Abrahams, 2010; Anderson et al., 2012), and helping them to identify an alternative narrative viewpoint, could be effective strategies for recovery programs (Alexander, 2015; Anderson, 2010).

A better life was something women enjoyed from the first days of escape. Women experienced different aspects of a better life (e.g., sleep, peace, purpose, enjoyment of hobbies and appreciation of nature) from separation, and in increasing measure throughout the recovery process. Participation in aspects of a better life was not dependent on mastering a series of previous stages. Women were able to experience aspects of a better life even while there was potential threat to their safety, inadequate finances, or uncertain housing and not as a nebulous goal achieved in the future. In fact, it was participating in aspects of a better life that helped women to endure the stress generated by their difficulties and to find solutions. Aspects of a better life motivated the hope and inspiration needed for further recovery progress and to harness the 'resource caravans'—including internal and external resources—identified by Hobfoll (1989).

Supporting the literature, the impact of IPV was often devastating to women's sense of self including their self-esteem, self-confidence, and self-identity (Anderson et al., 2012; Childress, 2013). Finding or returning to a healthy sense of 'self' was a major task associated with recovery and healing (Matheson et al., 2015; O'Doherty et al., 2016). Addressing issues related to self-identity and self-worth should be an important component of any recovery program (Sinko & Saint Arnault, 2020). All social support, services support and spiritual support provided to survivors should principally aim to impute self-worth to survivors and to help women identify safe and trusted social supports who value them (Draucker, 1999). Our findings also confirm that positive alliances with service professionals can help women with impoverished social support networks (Alexander, 2015; Miller, 2018). Psychoeducation about healthy relationships, boundary work and dealing with trust issues should be an important part of any recovery program (Alexander, 2015; Draucker et al., 2009).

Since mothers were concerned with protecting their children and being a good parent (Burnett et al., 2016), children's recoveries complicated their mother's recovery. However, being a good parent required progress across all the other themes and was often difficult in shared custody situations. Given that shared custody created an opportunity for abusers to inflict ongoing coercive control over women and their children (Broughton & Ford-Gilboe, 2017), it should be acknowledged as a form of abuse in any legislation addressing coercive control. Supporting women in their parenting and considering children's recoveries alongside their mother's recovery should be integral aspects of any recovery program (Abrahams, 2010; Austin et al., 2019).

As it is still unclear which service model should be used for providing recovery support (Signorellie et al., 2012) a number of different programs over time may be needed (Macy et al., 2019) due to the heterogenous nature of survivor's recoveries. As 'no single treatment modality will meet the needs of all survivors' (Warshaw & Brashler, 2009, p. 336), the themes of recovery identified in this study and their subcategories could be used as a basis on which to develop recovery programs composed of relevant targeted units. Although this definition was intended to be operationalised into a measure of recovery that could be used to evaluate interventions aiming to promote recovery, it also provides evidence to support the sub-scales of the recently published GBV-Heal Scale (Sinko et al., 2021). However, our findings also identify that the themes of parenting and the importance of ongoing safety and financial independence and survival, that do not appear to be included in their scale.

This study also lends support to the notion that survivors desire education and information on the subject, and that psychoeducation can be effective in assisting MH recovery (Sarkhel et al., 2020). There is a need for reliable and accessible internet information on the topic of recovery from IPV (Dutton et al., 2005; Simmons et al., 2016), particularly as few survivors seek professional support services (McClennen, 2010). Finally, the development of e-intervention supports for recovery from IPV could be effective in helping women to recover, especially women located in regional, rural, and remote areas.

Limitations and Directions for Future Research

While the large number of qualitative responses, the broad geographic spread of participants and the representation of ATSIS and rural/remote perspectives were strengths of this survey: some limitations need to be noted. Firstly, findings are relevant to an Australian cultural setting and may not be relevant in other countries. More research is needed to explore the recovery experiences of women from diverse cultural, ethnic, and gendered perspectives (including men), who were under-represented in the study. Women without computer access or literacy, or who prefer a written format, may have benefitted from alternative ways to report experiences. Women with disabilities were not differentiated in the study and it is unclear whether their views are represented in these findings. Although the unique difficulties of rural and remote women featured in the women's survey responses, it is important to consider that some of the reported findings may not be applicable in these social contexts, which lack services and resources. Lastly, the retrospective nature of the self-reported data has limitations due to the nature of memory recall over long periods of time.

Conclusion

Long-term recovery from IPV is a personal, evolving, and multidimensional experience that is often described as a long and arduous journey by survivors. It is best conceptualised

as a multi-axial continuum. While some women felt fully recovered from their experiences of IPV, most women continued to progress in their recoveries. However, a small number of women did not make any progress in recovery and struggled to accept the concept. Psychoeducation about recovery and common MH and emotional issues could be helpful to women in recovery from experiences of IPV (Macy et al., 2019).

For the women in this survey, recovery meant ensuring their safety and surviving independently of the perpetrator, while gaining freedom from his control; healing and moving on from the effects of the abuse, while enjoying a better life. Children's well-being was of primary importance to their mothers and parenting responsibilities complicated their journeys to recovery.

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