Abstract

The current study sought to investigate the developmental and social characteristics of a group of victimised women to develop understanding into the factors which put local women at risk for victimisation and enhance the local support services for these women. Twelve women from local support services were interviewed about their experiences of violence. The aim of these interviews was to identify patterns within these women's narratives which can be explored and developed for future applications Interviews were analysed using thematic analysis which resulted in four themes: (1) childhood characteristics; (2) first sexual encounters; (3) quality of life; and (4) supporting services. The results provide an extraordinary opportunity to enhance the support services provided for vulnerable women and girls in the local community. These results have not only aided in advancing the current research but also developing current service-providers for this local population. More specifically, the results have indicated a number of characteristics which place women at risk of victimisation, more importantly, the results have demonstrated the importance of exploring other services that may be beneficial for the recovery of these woman. In essence, the woman taking part in this study highlighted areas which encourage future exploration for both researchers and service providers. Clearly, before definite conclusions can be drawn, more research evaluations need to be carried out to explore the characteristics that put women at risk of violence and the services which may aid in their recovery.

Key words: violence against women, sexual abuse, domestic violence, victimization

Violence against women is not a new phenomenon, yet the prevalence rates remain high. In the United Kingdom, one in five women have been a victim of abuse since the age of 16 (Women's Aid, 2013), and since violence against women is largely under-reported (Watts & Zimmerman, 2002), this may be a conservative estimate. Research has shown that only a minority of women who are victims of abuse are likely to seek support from social services and other agencies (e.g., Basile, 2008; Women's Aid, 2013). Since the majority of victims know their perpetrator and are likely to be victimized repeatedly (Women's Aid, 2013), it can be inferred that women do not seek support due to fear of repercussions. Therefore, the purpose of this study is to investigate the factors that put women at risk of victimization and re-victimization in light of the reasons why they may or may not seek support from formal agencies.

Gender-based violence incurs devastating costs to human life, animal life, and the economy. For example, Garcia-Moreno and colleagues (2005) found that such violence impacts on women's physical health and is a leading risk factor when compared to high blood pressure, obesity, and smoking. Researchers have also found that perpetrators of violence against women have used violence or threats of violence against animal pets to intimidate and exercise control over their victims (Allen, Gallagher, & Jones, Ascione, 1997, 2007; DeMello, 2012). In fact, there is a relationship between animal abusers and sexual violence, marital rape, emotional violence, and stalking (Simmons & Lehmann, 2007). The economic impact world-wide is far from negligible. Billions of dollars (US – Garcia-Moreno et al., 2005; Canada – Greaves, Hankivsky, & Kingston-Riechters, 1995) and billions of pound sterling (Great Britain, NPC, 2008) have been spent annually in response to violence against women. A significant portion has gone directly to medical and mental health care services resulting on a significant burden on these services (Garcia-Moreno et al., 2005). This

evidence demonstrates the human, animal and economic toll violence against women has, further exemplifying why agency support is in dire need.

The Socio-Psychological Risk Factors and Consequences of Violence Against Women

Along with the social and economic costs incurred by violence against women, the psychological, emotional and social impact of this violence is also substantial. More specifically, research has identified that these vulnerable women and girls face an increased risk of substance abuse (Kilpatrick et al., 1997), mental health problems (i.e., depression, posttraumatic stress disorder, and anxiety; Hossain et al., 2010), and suicide (Ullman & Brecklin, 2002). Similarly, according to a new report released by World Health Organisation in 2013, the impact of violence on the physical and mental health of women and girls ranges from broken bones to pregnancy-related complications, mental health problems and impaired social functioning. Many victims of violence may also experience emotional distress such as shock, disbelief, denial, fear, confusion, anxiety, and withdrawal (Herman, 1992). These negative reactions can impact on the on-going quality of life of many victims. For example, victims frequently report low self-esteem, self-blame (Littleton, Grills-Taquechel & Axsom, 2009), shame and insomnia (Christiansen, 2010). Moreover, the social impacts at a relationship level, such as victims having difficulty relating to others, developing new intimate relationships and returning to their social roles (e.g., mother, daughter student, etc.; Basile & Smith 2011). With that in mind, the social costs of being a victim of violence can also have a lasting impact, with victims having an increase chance of suffering isolation, the inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children (World Health Organisation, 2013). In essence, the impact of experiencing violence can greatly affect the quality of life of its victims at many levels.

Most recently, the academic interest invested in further understanding violence against women has led to a greater exploration into the risk factors associated with women who experience violence. In particular, research has identified specific individual factors associated with a woman's increased likelihood of experiencing violence included; low level of education, exposure to previous violence or abuse and acceptance of violence (Abramsky et al., 2001; Heise & Moreno, 2002). Community and societal factors have also been found to increase the risk of women experiencing violence. For example, women living in lower socio-economic neighbourhoods or environments that endorse gender-inequitable social norms (Heise & Moreno). Additionally, lack of social support has also been identified as highly associated with potential victimisation (Ozer et al., 2003; Ullman, 1995).

Types of Violence

The risk factors and consequences of violence against women comes in various forms. Although not exhaustive, we will discuss two prominent forms, domestic, sexual violence, and trafficking of women and girls. Domestic violence is, in fact, the most common form of violence experienced by women globally. According to World Bank data, women aged 15 to 44 are more at risk of domestic violence than from cancer, motor accidents, war and malaria, with one in every four women worldwide experiencing domestic violence within their lifetime (United Nations, 2006). Similarly, research has found that this type of violence is also the most prevalent in terms of physical injuries to women, women suffering domestic abuse incur injuries such as; bruises, broken bones, genital injuries and bodily burns (Grisso, Schwarz, Miles, & Holmes, 1996). Several surveys conducted globally have further suggested that half of all women who die from homicide are killed by their current or former spouses. For example, research has found that in Australia, Canada, Israel, South Africa and the United States, 40%-70% of female murder victims were killed by their partners (United

Nations, 2006). Within the UK, the Women's Aid Charity estimated that in 2012/2013, more than 1.2 million women experienced domestic violence. The Charity further stated that on one day in 2013, 155 women and 103 children were turned away from refuges in England. Furthermore, according to the British Crime Survey in 2004, 45% of women aged 16 to 59 had experienced at least one incident of domestic violence in their lifetimes (Walby & Allen, 2004).

Another common form of violence is sexual violence. Sexual violence includes rape and sexual assault, sexual abuse of girls, trafficking and sexual exploitation, and sexual harassment (Kelly, 2005). In essence, the critical defining point of sexual violence is when the survivor does not consent to the sexual activity, or when the survivor is unable to consent (e.g, due to age, the influence of alcohol or drugs) or unable to refuse (e.g, due to physical violence or threats; Basile & Smith, 2011). To date, global research has indicated that as many as one in five women have experienced sexual violence in their lifetime (Koss & Harvey, 1991; Fisher, Cullen, & Turner, 2000; Synovitz & Byrne, 1998). Further research has revealed that 25-35% of adult women have been sexually abused when they were children (Briere & Elliott, 2003; Finkelhor, Hotalling, Lewis, & Smith, 1990).

Whilst these numbers are staggering, one of the most recognised forms of sexual violence in the world is sex trafficking (Zimmerman et al., 2008). Researchers in the UK have found that as many as 80% of people trafficked across international borders are women and girls. That being said, as both the police and Home Office have acknowledged, there are no reliable estimates for the number of women being trafficked in the UK. The Solicitor General however suggested that more than 1,000 women were trafficked into the UK annually, although this is believed to be a substantial underrepresentation (Craig et al., 2007), as other Western nations estimate this number to be considerably more. For instance, according to the US Department of State, it was estimated in 2003 that 45,000 to 50,000

people, primarily believed to be female, were trafficked across the US border (Makkai 2003). Furthermore, the International Organization for Migration has stated that as many as 800 000 people are trafficked across international borders annually (The Centres for Disease Control and Prevention, 2003).

Women's access to support services

There are a number of ways in which victims of violence can access help, from informal sources such as friends and family, to more formal services, such as support services, social services or the criminal justice system (Dunbar & Jeannechild, 1996; Kaukinen, 2002; Lempert, 1997). Whilst there are a variety of support services available to victims of violence, this help is not always consistent or easy to access. Many victims, especially those form minority populations and smaller communities, are less likely to access formal services (Batsleer, 2002), rather, these women often turn to informal service providers (Bent-Goodley, 2004; Bent-Goodley, 2006; Sokoloff, 2005). Accordingly, decisions to seek help vary along a number of social dimensions, including; social isolation, beliefs, culture and feelings of inaccessibility.

More specifically, a number of women may feel too frightened or isolated to seek help. Abusers commonly make threats to inflict harm on victims if they seek help, this fear often isolates victims from any support. As a result, many victims are unaware of services or people that can help (Dobash, 1979). Nabila and colleagues (2001) explored the availability and use of support services among women who reported partner violence. The results indicated that male dominance and control function to isolate and prevent women from accessing support; participants further felt that they had few people to turn to for support.

Furthermore, many victims believe the abuse is their fault and thus do not want their family or friends to know they are abused. These actions are often deepened at times by societies belief that the victim provoked the violence, the shame of being criticised by society often renders many victims helpless. The cultural hurdles of some victims can lead to further shame or guilt from the victim. The lack of culturally sensitive and appropriate services for minority populations pose additional barriers for seeking assistance. In particular, problems faced by women from minority culture populations may include; fear of isolation, fear of relocation, fear of immigration authorities (Lees, 2000) fear of poverty, shame, cultural insensitivity, child custody issues, lack of information about available services and language barriers (Dasgupta, 2005; Warrier, 2000).

The perceived accessibility of support services may also hinder many women from accessing help. Research has consistently indicated that much of the violence against women is not reported to the police (Home Office, 2002) and those that do report crimes to the police are not always satisfied with the level and types of services provided. Hutchinson and Hirschel (1998) examined the help seeking strategies used by 419 battered women. The results indicated that the victim's level of education was connected to seeking formal help from services and those with higher level of education had an increased likelihood of seeking help through professional services. Support services therefore can be inaccessible to women with lower levels of education, thus, more investigation into creating services which are more encompassing for these types of woman is essential. Overall, it is clear that there are barriers and issues which make access to support services difficult for many women. There are few programs focusing on specifically on overcoming these barriers and therefore an area for further exploration.

Our Study

Given the literature reviewed above, we are still not clear about the link between the factors that put women at risk of victimization and re-victimization and the reasons why they may or may not seek support from formal agencies. The social learning theory, one of the most popular explanatory frameworks for violence against women, suggests that individuals learn how to behave through both experience of and exposure to violence (Jasinski, 2001). Accordingly, women at risk of re-victimisation are most likely to have been victimised in the past. Therefore, based on this theory, if women learn to be victimised through the reinforcement of certain risk factors, they can equally learn to become empowered through formal support. Furthermore, based on this theory, women may not seek formal support because they have learned not to seek assistance in prior abusive experiences.

Whilst this study cannot specify specific learned behaviours which may place these women at risk for victimization, nor can it establish the causal relationship, as a qualitative study, we can elucidate, from a group of women in a local community, the common factors that bind their experiences beginning at childhood and progressing to the time of their interviews. Thus, the interviews covered developmental, social, and psychological factors common amongst this group of women. Most importantly, these interviews examined the needs of this sample and whether they accessed support from formal agencies. The overall aim of the project was therefore to develop understanding into the factors which put a local group of women at risk of victimization and more importantly, the aim was to highlight the factors that explain why women are reticent when accessing the local support services. Further understanding into these factors will enable practitioners and support services a better understanding into some of the learned behaviours that may place women at risk for abuse.

METHOD

Participants

Twelve women with a history of being victimized were recruited from a local Probation service (n = 6) and local support centres (n = 6) within South East England. All participants that were recruited from Probation had been convicted of a crime and were part of a corresponding support service for past abuse. Participants recruited from local support services may not have had a previous criminal conviction and were attending a support group for past abuse.

Data Collection

Data were collected via a semi-structured interview created by the authors to ensure that questions presented were adapted for the local population. The interviews covered the following themes: childhood experiences (i.e., family and school life, experiences of childhood abuse, intimate relationships, etc.), general adult experiences (relationships, employment, housing, etc.), the context of the year/days leading up to most prominent experiences of abuse, and the description of the abusive experience. Throughout the interviews, participants were encouraged to express any thoughts and feelings about how they managed their experiences. These could include any coping mechanisms they employed when they encountered stressful situations (e.g., substance abuse, seeking help from friends/family, etc.). Since this interview was semi-structured, the interviewer, at times, asked additional questions to probe prominent topics that the interviewees brought up during the interview. Interviews varied in length depending on the depth that each participant went into during the interview process; accordingly, interviews ranged from15 to 45 minutes.

Procedure

This study was first approved by the University of Kent's School of Psychology Ethics Committee. Subsequent to this approval, potential participants were provided with a full verbal briefing regarding the purpose of the research. However, to avoid response bias, participants were not told that the aim of the research was to investigate the psychological, social and behavioural characteristics of vulnerable women and girls. Instead, they were told that the questionnaires were investigating the attitudes and beliefs of women in order to better improve the available support and services for them. If participants agreed to engage in the study, they were asked to read and sign a consent form, at which point they were also allocated a participant number to ensure anonymity. While the Consent Form made clear all the briefing information that was necessary for the participants to consider prior to giving consent, the researcher also verbally explained to all participants that their responses were completely confidential and anonymous. This was particularly significant to emphasise, as it was important to ensure that participants provided truthful answers on all the questionnaires (Leonhard, Gastfriend, Tuffy & Neill, 1997). Following this briefing, the interview began.

Data Analysis

The technique used to identify themes within the interviews was thematic analysis. This specific method was chosen as the main aim of thematic analysis is to identify, analyse, and report patterns within qualitative data (Braun & Clarke, 2006). Two researchers independently analysed all 12 interviews using a specific thematic method, Luborsky's (1994) technique, suitable for analysing qualitative data obtained from semi-structured interviews as the classification of themes provides insight into the beliefs, motivations, planning, interpretation, and responses to events (Kelley, Swanson, Maas & Tripp-Reimer, 1999). The overall aim of thematic analysis is to look for patterns of meaning and issues of interest in

data (Ryan & Bernard, 2000), as such the current study sought to use this technique to aid in further understanding factors associated with the victimisation of women.

RESULTS

The purpose of the data analysis was to identify the characteristics associated with women and girls who have experienced abuse. Several themes emerged from the transcribed interviews; themes were all associated with the developmental and social characteristics of the sample. Once initial themes were highlighted, they were refined with sub-themes to ensure the detailed nature of the sample was identified. Table 1 provides a summary of the overarching themes and subset themes. Each of the four themes is further presented below with supporting verbatim patterns from the interviews.

→Insert Table 1 ←

Childhood Characteristics

Childhood characteristics refer to the general patterns which emerged in relation to participants' childhood. 'Childhood' refers to younger than 18 years of age. Participants were asked a number of questions about their childhood generally (e.g., home life, school, family relationships, and discipline), their perceptions of their childhood (e.g., positive or negative childhood, significant events, etc.) and specific questions about any sexual encounters as a child (e.g., forced sexual acts). This theme encompassed two sub-themes which developed from participants answers to the above questions; (1) childhood maltreatment and (2) disordered childhood.

Childhood maltreatment

This pattern constitutes all forms of child abuse, such as; physical, emotional and sexual abuse, along with childhood neglect, including negligent treatment,

exploitation during childhood and traumatic childhood events. When participants were asked about their childhood, n = 10 (83%) participants discussed some form of maltreatment during their childhood. Although the severity and length of these maltreatment encounters varied by participant, all encounters were categorized within either childhood abuse/trauma or childhood neglect. For example, one participant explained the years of childhood abuse she had suffered by her father:

> *Basically, I did have quite a hard childhood…. Between the age of 6 and 8 I was sexually abused… My dad, he would tell me, that was my punishment.* Hmmm, so my relationship with him was totally different than with my mum. But my mum started drinking, taking drugs so my relationship with her had *changed as well… (P1).*

Another interviewee talked about the childhood neglect she endured growing up:

> At home with my mum and dad. My dad was an alcoholic until I was 12; my mum left us when I was about 15. I grew up in [county name] from 12 to 15 and got a prison sentence at 15 (P2).

Whilst n = 8 (67%) recalled long standing maltreatment, n = 2 (17%) described their childhood as nothing negative but recalled specific incidences which stayed with them as they developed. For example, one interviewee talked about a childhood trauma that had occurred where she had a miscarriage at 15 years old. Similarly, another participant discussed how she enjoyed her childhood in general, but recalls one specific incident where she had an argument with her mother and was violently attacked by her mother, leaving her face with scars and unable to return home.

In essence, the range and severity of maltreatment within childhood varied by participant. Childhood maltreatment ranged from n = 2 (17%) interviewees who reported no form of maltreatment but also reported no positive memories from their childhood, to the more extreme levels of maltreatment described above. In fact, one of the participants who reported no form of maltreatment did further explain how they enjoyed their childhood most of the time but also wished they could have been someone else.

Disordered childhood

This theme encompassed a variety of patterns which relate to the disruption of the participants' childhood. More specifically, this type of disruption included events involving frequent change in caregivers (e.g., foster care, family separation) or unstable home life (e.g., constantly moving), resulting in a chaotic household. Along with incidences involving a chaotic lifestyle, such as caregivers' lack of organized parental skills (e.g., parents are disordered or unorganised, parents with mental health issues) or participants' general lifestyle as children (e.g., participants partook in antisocial behaviour). Within these patterns and sub themes, all but one participant, n = 11 (92%), had features of a disordered childhood.

For example, one of the participants explained her chaotic household and how she grew up:

> *…with my mum, dad, and a few sisters. I can't remember how many there were at the time, and one brother… We all had the same mom and some of us had different dads…It's a bit confusing to go through all of them… but yeah… (P3).*

The same participant talked further about her parents' separation and how her father beat her mother up until one day it got quite bad *'…and my mum was on the floor hurt and obviously I* was scared, I was only 10 at the time and we went into an ambulance and got my mum

checked out… we never came back…' Similarly, when another participant was asked a similar question about her chaotic lifestyle as a child, she discussed her mental health problems and having to care for her mother for a few years during her childhood, due to her mother's chronic health issues. Whilst the one participant who did not describe any disordered childhood encounters also did not disclose any forms of childhood maltreatment. She was the same participant who could think of nothing positive about her childhood and at times wished she could have been someone else.

First sexual encounter

All participants engaged in their first sexual experience before the age of 15 years old. First sexual encounter was further broken down into themes based on participants' experiences; (1) negative encounter and (2) positive encounter.

Negative encounter

Words such as "abusive", and "violent" were often used to describe participants' experiences within this theme. The majority of participants (n = 8, 67%) described these first experiences as abusive sexual encounters. When one participant was asked to describe her first sexual encounter, she simply responded with *'Violent!'* Other participants talked at length about the abuse they suffered during these early sexual encounters, for instance, one interviewee stated:

> *'…it was a domestic violence relationship, I was beaten up on a regular basis… there* were things I wanted to do *but I wasn't allowed to* do, such as see family members and stuff like that and he *tried to stop me yeah …' (P4).*

A further pattern that developed within this theme was the number of first sexual encounters which resulted in pregnancy, with six participants (50%) becoming pregnant. Of these six, all but one participant's first sexual experience was also an abusive sexual encounter:

> '…within 5 years I had 2 children with him and it was just violent throughout, by the *time I was 19 I had 2 children with him…' (P2).*

One participant talked not only about the abuse she suffered but also the loss of her baby: '*Oh I miscarried. When I was 15 and obviously young enough. So… (P6).*

Positive experience

The remaining participants (n = 4, 33%) described their first sexual encounter as a relationship which came to a mutual end. Of these participants, only one saw the experience as generally positive. For instance, one participant described the experience as a positive relationship which simply *'ran its course'*:

> Quite funny actually I was with him for about 2 and a half years and he was lovely, he *was really nice… It was love and everything else which obviously was my first love* but yeah no it was good (P11).

These positive patterns were not echoed by other participants. More specifically, when the remaining three participants (25%) were asked to describe their first intimate encounter, they did not perceive it as a positive or negative experience, rather they were ambivalent about the end of the relationship using phrases such as *'we just fell apart'* or *'That sort of age isn't it?',* to depict their views on the events.

Quality of Life

This theme referred to the general well-being of the participants leading up to their most prominent incident of abuse. The term encompasses the participants' perceptions of their emotional well-being (e.g., depressed, happy, etc.), their social situation (e.g., relationships, employment) and their overall views on life on the year, months and weeks leading up to their abuse. The patterns which emerged within this theme were subsequently broken down into two sub-themes: (1) overall well-being and (2) social situation.

Overall well-being

An emerging pattern within the overarching quality of life theme related to participants' perceived overall well-being. In particular, when participants were asked about their life around the time of victimization, there was a noteworthy emergence of discussion on mental health issues, with half of the participants (n = 6, 50%) reporting some type of problem within this area. For example, as one interviewee explained:

> 'I have suffered with mental health problems; I have bi-polar disorder, so I had like a *mental break down at the time'. (P10).*

Another participant stated a similar sense of well-being when asked about her general lifestyle:

> '*I have suffered from depression and I've got mental health problems, I am a vicious* self-*harmer…' (P4).*

Whilst half of the participants accounted for their mental health problems, eight participants (67%) disclosed that there had been stressful circumstances leading up to their victimization. For example, one participant explained how she was going through problems created by her separation from her ex-husband. One participant in particular explained the circumstances of her mother which had a massive impact on her well-being:

'My mum died last year for the last 5 years I had been looking after her until last year when she died, I have had a lot of stress worrying about my mum, she had chronic *kidney disease' (P10).*

These types of stressful incidences were echoed throughout the interviews, many of which, participants perceived as direct triggers to their circumstances.

Social situation

A further pattern that developed within the quality of life theme was the participants' social situation. More specifically, it emerged that certain activities, such as a antisocial/chaotic lifestyle and/or relationship difficulties influenced individuals' perceived quality of life around the time of victimisation. Those who exhibited an antisocial/chaotic lifestyle had experiences such as engaging in reckless behaviour (e.g., sexual promiscuity, substance misuse, etc), disorganized lifestyle and/or general behaviour which constitutes self-evident health risks. Half of the participants (n = 6, 50%) revealed aspects of an antisocial/chaotic lifestyle leading up to their victimization. As one participant explained:

'Yes, so I was drinking with people and then the next thing you know I would be waking up in some *man's bedroom wondering how the fuck did that happen!' (P2).*

This antisocial pattern was also evident in several other participants, for example, as some interviewee explained:

'I smoked, I drank before I got pregnant, and I *drank every night or the next…' (*P9);

'Well 15 simple, sleeping around, sort of wildlife but I was really good in school still, *just weekends, I was out of control…' (P2).*

Some participants (n = 4, 33%) revealed signs of both an antisocial nature and a chaotic lifestyle, as shown below:

> He went to prison so, I had stopped working because I was alone and basically pregnant. I had done it all on my own, my sister was with me for the birth. It was quite scary for a 16 year old being pregnant and then like you know, not knowing if I was safe to go to work (P2).

Participants describing relationship difficulties discussed problems with their family members, friends and/or partners. The majority of participants (n = 9, 75%) indicated some type of relationship difficulty, and of these nine participants, four (n = 4, 33%) of them also indicated an antisocial/chaotic lifestyle. With participants disclosing issues such as separation from partners, troubles with caregivers, dissatisfaction with relationships and struggles with friends and family. As participant 11 explained:

> *I wasn't talking to my family at the time and they were all in Ireland anyway, all three* of them now live in Ireland, I had no one around here, the partner I was with had *cheated on me with someone else…. It was just me.*

These types of issues were echoed within other associated relationships, for instance, another participant revealed, *'…my mum was ill… my neighbour committed suicide…' (P10),* whilst another explained, *'…my mum started drinking, taking drugs so my relations*hip with her had *changed as well' (P1).*

A few of the participants (n = 3, 25%) had specific problems within their romantic relationships, with phrases such as *'he cheated on me'* and *'he became violent'* and *'separating from my ex-husband'*, being used to describe their romantic relationships at the time of their victimization.

Supporting services The final theme which emerged involved the support that the participants were currently receiving within their support group and also the support they felt they needed and/or would have liked to receive within the support group. Whilst the preceding themes developed from the frequency within each theme reported, the current theme reflected its explanatory significance. This theme was developed differently as not all participants were asked about the support they received or would have liked to receive in the future, however there were a number of individuals who disclosed the support which aided in their recovery, along with the support they felt would be significant. More specifically, as not all participants were asked about supporting services, it was noted that all those participants which were queried, disclosed important information that maybe beneficial for future supporting services. Accordingly, based on these participants' experiences, this theme was further divided into two subthemes which became evident through participant responses: (1) *support received*, and (2) *future support*.

Support received

There were seven participants who talked about the support they received after their victimization. Of these individuals, four (57%) acknowledged that family and friends were vital in their recovery process. For example, one participant expressed her gratitude towards her partner and friends:

> I have spoken to my partner all about it, my best friend, couple of other friends and they have all being really supportive. They have offered advice where they can, helped where they can, even if you just go down and crawl on their shoulders! I had a lot of support yeah (P9).

Similarly, another participant talked about the support she received from her partner, *'...he has been, he is been my support, he really has. If I have an issue or I feel down or anything, he is there 100%...' (P1).* Whilst some participants conveyed their gratitude towards family support, some participants (n = 5, 71%) expressed their appreciation towards professional support, such as *'*the doctors and the mental health team*' (P10)*, all of whom provided help and advice. Another participant talked about the medical help they had received for their mental health issues stating, *'*I see my psychiatrist on a regular basis and *my GP…so I am getting a lot of support at the moment' (P4).* Of particular note was one participant's disclosure about the counselling she had received after years of being sexually abused by her father:

> *Yeah, I did…hmm… It's…it hurt me a lot through my life. It affected me in a lot of ways, in ways I wouldn't even imagine it would... I've got a counsellor <inaudible>* like that to help me with my past (P1).

Future Support

Although a number of women expressed the support that helped during their time of victimization, three of these women (25%) also spoke about the support they thought would have been beneficial. One participant explained how she did not feel the support she received at the centre she was attending was adequate and talked about the occupational assistance she would have liked to have received:

> *I don't know really, I suppose I want something different* from what they got. I would like to just come out of it with a job which is what I would like. I was doing

community service but I finished it now I stayed …… shop as a volunteer (P8).

These requests for further occupational assistance were echoed by another participant, who stated that *'a bigger* concern is trying to find a job, *I don't want to be out of* work, and I *don't like not working' (P9).* With that, the theme of assistance with education, was another pattern which emerged when three of the participants were asked about future support, of these three participants, two (67%) stated that they had plans to return to education:

> Oh yeah I want to get my mentoring qualification and would like to work in the probation service either as a mentor or something to do with domestic violence helping women or man (P11).

Overall, these patterns of future support emerged from participants' responses and the emphasis that certain participants placed on the need for future support services focusing on educational and occupational assistance.

DISCUSSION

Following the evaluation of 12 interviews with women who have experienced some form of abuse, findings indicate that there are key themes representative of these women's experiences. These themes relate to both the factors which put them at risk of victimization and also the factors which reflect their feelings of support.

The patterns which emerged in relation to childhood characteristics concurred with the conclusions drawn from similar studies (e.g., Desai, Arias, Thompson & Basile, 2002; Heise, Ellsberg & Gottemoeller, 1999; Heise & Garcia-Moreno, 2002). More specifically, themes relating to childhood maltreatment and a chaotic upbringing were heavily prevalent. These patterns are not unique for the local population which was explored, as there is a growing body of research which indicates that childhood exposure to violence and a chaotic

childhood (e.g., juvenile delinquency) are risk factors for future victimization (Desai et al., 2002).

In terms of participants' first sexual encounters, the general age this occurred, among all participants, was under the age of 16. Whilst this overall pattern of early sexual encounters is similar to previous research, which has found that women who experience violence were more likely to have had their first sexual experience before the age of 15 (Silverman, Raj & Mucci, 2001), the unique nature of the population was highlighted within the emotional experience of the encounter. In particular, the majority of participants noted that their first sexual experiences were negative, with subthemes such as the experience being abusive and resulting in pregnancy as particularly prevalent. The remaining participants indicated a positive first sexual experience, with the relationship coming to a mutual end. In essence, consensus was partially divided on overall experience of first sexual encounters, these patterns are unique for this specific population as, to date, there has been no empirical evidence establishing that the experience of a woman's fist sexual experience may present as a risk factor for future victimization. It could therefore be argued that a negative first sexual encounter may be a risk factor for future violence. Whilst research has indicated that being exposed to prior violence is a risk factor for future violence (e.g., World Health Organisation, 2007) there is no research within developed counties to indicate whether a negative first sexual encounter is a risk factor for future violence. According to the social learning theory, individuals learn how to behave through both experience and exposure to violence, accordingly, victims of violence learn to be helpless (Jasinski, 2001). This theory could help to explain how a first negative sexual encounter transcends into future violence through the notion of 'learned helplessness'.

In terms of participants' perceptions of their quality of life leading up to their incident of victimization, the majority of participants disclosed either having mental health issues or

enduring stressful circumstances around the time, which affected their overall well-being. Whilst prior research has identified some life risk factors associated with women who experience violence, for instance, low level of education, exposure to previous violence, acceptance of violence (Abramsky et al., 2001; Heise & Moreno, 2002), lower socio-economic environments that endorse gender-inequitable social norms (Heise & Moreno) and lack of social support (Ozer et al., 2003; Ullman, 2005), research has yet to identify the specific quality of life factors that may be associated with victimization. More specifically, there has been no research, to date, which explores the specific quality of life factors that may impact on the risk of victimization of women. Accordingly, this study has identified potential protective and/or risk factors that could be associated with the quality of life of women. Similarly, this study also found that specific social factors, such as a chaotic lifestyle and relationship difficulties, are lifestyle characteristics associated with victimization of women. These patterns however are not unique to the population, as previous research has indicated that social factors such as prior relationship difficulties (Basile & Smith, 2011) and aspects of an antisocial lifestyle, in particular, alcohol and drug use, can present as risk indicators for the victimization of women (Tesa, 2004).

Finally, most participants acknowledged that the help they received from family and friends, and professional support was vital in their recovery process. With these positive views it could be argued that for women victimized, enabling family and friends to provide support could be an essential protective factor from future victimization and their recovery. Prior research supports these conclusions as studies have indicated that creating an environment where victims of abuse feel comfortable and supported both personally (Davis, 1991; Husso et al., 2012) and professionally (Claudia Garcia-Moreno, 2005) plays an important role in their recovery outcomes.

When participants were asked about additional support that they would have found beneficial, the overall view was that future support should focus on educational and occupational assistance. Whilst research has found that most support services offer some assistance with educational and employment opportunities (Saunders, 2012), the vast majority of care offered within these types of services can be categorized as a form of emotional support, with service-providers referring those interested in vocational and education assistance to local community services. Previous studies have shown that for many victims, violence is a private family matter, making it difficult for victims to access initial help (e.g., Husso et al., 2012; Lutenbacher, Cohen & Mitzel, 2003; Straus & Gelles, 1990). It could, therefore, be argued that providing victims with information for referring services may impact on their motivation to ask for further help. Accordingly, the results of this study, along with the findings from previous research, would suggest that support services need to offer more internal support for vocational and educational services.

Overall, the results of this research have not only aided in advancing the current research but also developing current service-providers for this local population. More specifically, the results have indicated a number of characteristics which place women at risk of victimisation, more importantly, the results have demonstrated the importance of exploring other services that may be beneficial for the recovery of these woman. Despite these contributions, there are a few identifiable limitations that necessitate further discussion. The patterns found within this study were developed with qualitative accounts from twelve women who have been abused in the past, this number accounts for a small representation of the wider group which they embody. Furthermore, the interviews were conducted within a local community. Therefore, the results, however interesting, are limited to a specific geographical area. Limitations aside, the aim of this research, using thematic analysis, was to identify patterns within these women's narratives which can be explored and developed for

future applications. In essence, the woman taking part in this study highlighted areas which encourage future exploration for both researchers and service providers. Clearly, before definite conclusions can be drawn, more research evaluations need to be carried out to explore the characteristics that put women at risk of violence and the services which may aid in their recovery.

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Table1. A summary of the coding frame

Main Theme	Sub-Themes	Sub-Themes
1. Childhood Characteristics	Childhood maltreatment	Childhood trauma/abuse Childhood neglect
	Disordered childhood	Chaotic household Chaotic lifestyle
2. First Sexual Encounter	Negative encounter	Abusive sexual encounter Resulted in pregnancy
	Positive encounter	Mutual end to the relationship
3. Quality of Life	Overall well-being	Mental health issues Stressful circumstances
	Social situation	Antisocial/chaotic lifestyle Relationship difficulties
4. Supporting Services	Support received	Professional support Family and friends
	Future support	Occupational assistance Assistance with education