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"Survive, learn to live with it … or not": A narrative analysis of women's repeat victimization using a lifecourse perspective

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ABSTRACT

Violence against women is a global public health concern, with high levels of prevalence and debilitating consequences for victims, including a higher risk of revictimization. Quantitative evidence shows a strong association between previous experiences of sexual victimization, particularly in childhood, and future victimization. However, there is limited rigorous qualitative scholarship that advances understanding about revictimization experienced from childhood into adulthood. In this study, we address this gap offering a novel contribution to qualitative insights on revictimization using a life-course perspective. We conducted a rigorous qualitative secondary analysis, adopting a feminist narrative approach, to explore how individuals make sense of their experiences of abuse. Findings showed five main themes about survivors' experiences of repeat victimization across the life-course including: abuse experiences in childhood and adolescence; mental health and 'risky' coping mechanisms; naming abuse in early adulthood; seeking support in adulthood; surviving and a life beyond abuse. Most participants experienced multiple incidents of sexual abuse in childhood, which led to helplessness, shame, blame, and normalization of their experiences, creating a vulnerability to repeat victimization. Childhood abuse had later mental health impacts. Many participants used risky coping mechanisms, such as substance use. Survivors tended to be seen through the lens of their mental health diagnosis and addiction rather than through the lens of how abuse caused complex trauma. To address the impacts of revictimization and complex trauma affecting women across the globe, healthcare policy and services need a narrative and trauma-informed approach, over the short-, medium- or longer-term, enabling survivors to make sense of the connected nature of their experiences and accumulated vulnerability resulting from the abuse by others, rather than factors associated with the individual (their mental ill health, for example, or substance use). This is important as women's individual understanding is critical to processing trauma and abuse, and to longer-term recovery.

1. Introduction

Globally, violence against women is a major public health and human rights issue (Alhabib et al., 2010). Whilst prevalence measurement is problematic (due to under-reporting, data recording difficulties and diverse methodologies), the World Health Organization (WHO) report that globally almost one third of women, aged 15–49, have experienced some form of physical and/or sexual violence by their intimate partner (WHO, 2021) and many will experience repeat victimization. Repeat, or revictimization, refers to repetitive patterns of interpersonal violence experienced by an individual. There is a well-documented link between previous and future experiences of victimization albeit research has not determined the mechanisms that link these revictimization events (for overview, see Walklate and Clay-Warner, 2016). Specifically, repeat victimization has been linked to previous experiences of sexual assault, domestic violence, and abuse (DVA) and child sexual abuse (CSA) (Papalia et al., 2021). CSA refers to the involvement of a child under the age of consent in contact and non-contact sexual activity with, or without, force.

This paper examines revictimization through the narratives of women and, for most women in this study, their first experience of interpersonal violence was CSA. Our focus on women reflects that girls

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are more likely to be victims of CSA than boys. The WHO (2014) estimates the global lifetime prevalence of CSA to be 7.8% for boys and 18% for girls. CSA is a risk factor for a wide range of physical, mental, and sexual health problems (Finkelhor and Browne, 1985; Krahé and Berger, 2017; Sharratt et al., 2023). CSA survivors are consistently reported to have increased vulnerability to sexual revictimization than those without a history of sexual abuse (Finkelhor et al., 2015; Walker et al., 2019). Exact prevalence rates are unknown, but a meta-analysis of 80 studies reported a mean prevalence of lifetime sexual revictimization to be 47.9%; nearly three times higher than the reported sexual victimization rate among women without a history of CSA (Walker et al., 2019).

Several negative outcomes are linked to women's experience of sexual revictimization and these include mood and affective disorders; anxiety-related disorders; post-traumatic stress disorder (PTSD); disassociation; alcohol/drug abuse; risky sexual behaviors; fertility problems; sexually transmitted diseases; somatic complaints; and dysfunctional family environments (Papalia, et al., 2021; Scoglio et al., 2021; Sharratt et al., 2023; Walsh et al., 2021). Certain demographic variables are also associated with sexual revictimization: e.g., sexual minorities (Edwards et al., 2015) and ethnic minorities (Pitterger et al. (2019) are at increased risk of sexual revictimization However, the full extent of the issue is not known due to under-reporting (Pittenger et al., 2018) and barriers to help-seeking such as lack of recognition of abuse, shame or embarrassment, fear of repercussions or no action as a result of disclosure, previous poor experiences when disclosures have been made (Alaggia et al., 2019). There is limited, but significant, evidence suggesting that victims of sexual revictimization do not seek professional help and thus do not benefit from protective and preventative efforts from social, health and welfare services (Schramm, 2016).

Theoretical explanations have been offered to account for the impact of CSA in revictimization throughout the life-course; for example, Finkelhor and Browne's (1985) traumagenic dynamics model illustrates the short and long-term effects of CSA. Finkelhor and Browne argued that the event of CSA leads to the view of self and that of the world becoming altered in the mind of the child. The ability to experience and express emotions is troubled. The model suggests a long-term impact to the survivors' self-esteem and sexual behaviour in adolescence and adulthood. More recently, Felitti et al.'s (1998) work on Adverse Childhood Experiences (ACEs) has been highly influential globally. The large body of ACEs literature evidence substantially overlaps between different forms of abuse and neglect (for example, CSA and DVA) along with harmful non-victimization experiences such as parental divorce or incarceration (Sharratt et al., 2023). This work suggests that ACEs have potential consequences for future violence, victimization, perpetration and lifelong development and health. ACEs frameworks have limitations. For instance, diverse exposures, often considered cumulatively, can be identified using prospective and retrospective approaches, but their multidimensional nature may lead to greater measurement error (Kelly-Irving and Delpierre, 2019). As a population-level tool, ACEs frameworks are not adapted to diagnose individual-level vulnerabilities, an approach which could ultimately exacerbate inequalities. Alternative theories proposed to explain gender-based violence especially the intergenerational transmission of violence, feminist perspectives (e.g., learned helplessness, effects of patriarchy) and attachment theories, for example, suggest a relationship between past exposure to abuse and revictimization although some revictimization experiences are not always explained well (Rogers and Ali, 2023).

While the literature gives an insight into the potential prevalence, impacts and risks of experiencing sexual revictimization, and there is an identified link between CSA and revictimization, research into interpersonal violence is often conducted in silos (Williams, 2003). Specifically, studies exploring abuse experiences tend to focus on specific incidents or types of abuse at one point in a time and are largely cross-sectional, though indicating revictimization trajectories among survivors (Papalia et al., 2021; Walklate and Clay-Warner, 2016). As argued in recently published evidence reviews, there is a yawning gap of qualitative research examining the experiences and life trajectories of women experiencing revictimization and of how trauma and abuse affects their agency and sense of what is normal and what is not (Corbett et al., 2023). Therefore, we took a qualitative life-course approach enabling an analysis of survivors' narratives over time to improve qualitative understanding of the accumulated experiences of women, the cyclical nature of revictimization and factors which might help or hinder help-seeking (Williams, 2003). We have achieved this using secondary data analysis of survivor interviews from the Justice Inequalities and Gender Based Violence Project (hereafter 'the Justice Project)' (Williamson et al., 2021).

The research question for the study was: what is the impact of repeat victimization on survivors' perspectives of abuse over time? Specifically, we wanted to explore how survivors talk about their aggregated experiences of repeat victimization across the life-course to understand how women interpret their abuse experiences, if they view them as connected and in terms of how such experiences have shaped their agency and trajectories. In doing so, this work offers novel insights through a life-course perspective rather than focusing on one experience in a particular relationship type. We attempted to address the gap that research has yet to fully explore to understand if survivors make sense of their experience by talking about the mechanisms that link these victimization events over their life-course.

2. Methodology

For the present study, a qualitative secondary analysis (QSA) was conducted of the data from the Justice Project. We obtained transcripts from the UK Data Service (SN853338) where data from the original study are publicly available. QSA is a now widely recognised methodology which facilitates an extension of the analytical depth of the original work (Rogers et al., 2019). QSA enables greater analytical depth by returning to key themes within the context of new or contemporary theoretical frameworks; in this instance, integrating the concept of revictimization and by using a life-course perspective. QSA enables alternative understandings of the original data. A feminist narrative approach to the QSA was used which highlights how individuals construct meaning and experiences through narratives (Riessman, 1993; Woodiwiss et al., 2017). A narrative approach is common in feminist research because it gives voices to those who have been silenced through experiences of violence and abuse (Woodiwiss et al., 2017). Similar to QSA, adopting narrative analysis not only extends the initial analysis but enables greater analytical depth (Elliot et al., 2015). It enables survivors to tell their stories which generates a sequence of events within the narrative to reflect the ordering of a story that survivors wish to emphasize in-line with their re-constructed identity as a survivor, not victim. The analysis of narrative in this case is enhanced through a life-course perspective.

For the Justice Project 152 semi-structured interviews with survivors were conducted between 2015 and 2018. Participants were recruited via specialist domestic abuse and sexual violence services. Information was distributed through online forums, email, posters, and flyers handed to potential participants by key workers. Participants were eligible for the study if they had experienced some form of interpersonal violence and were aged over 18. Informed consent was obtained, and all interviews were anonymized. Further details about the processes of recruitment and ethical concerns are outlined in Williamson et al. (2021). Ethics approval was gained from the Faculty of Social Science and Law Research Ethics Committee, University of Bristol. Ethics approval was not required for this secondary analysis.

3. Participants

In the Justice Project, survivor characteristics were collated into a table, including demographics, abuse experiences and additional needs (e.g., mental health, substance use). This table was used to identify

survivors who had reported experiences of revictimization (childhood abuse, adulthood sexual violence and/or domestic violence and abuse experiences) alongside mental health needs. The latter was part of the inclusion criteria as this secondary analysis was undertaken as part of a larger project on DVA and mental health impacts. This narrowed the pool from 152 to 21 transcripts. To ensure rigor, a first reading of transcripts was undertaken by three members of the research team to select a sub-group of relevant cases to proceed with analysis that contained sufficient narrative and best addressed our research question (n = 10). Table 1 presents the ten redacted case histories. All participants identified as heterosexual women aged 33–63. Seven were white British, one British Bangladeshi, one British Indian and one British Pakistani. All reported mental health needs, three physical disability, and four substance use issues. At the time of interview survivors were safe and were all living separately from their abusers.

4. Data analysis

A narrative thematic approach was adopted (Reissman, 2008). Taking a systematic and rigorous approach, instead of a singular thematic analysis, we created two outputs: individual case summaries to contextualize the narratives, and a cross-case thematic analysis. First, one researcher undertook multiple readings of the transcripts to gain an overview and then created individual case summaries outlining revictimization experiences. Notes taken began to inform the structure of the coding frame for the cross-case comparison around our key enquiry: abuse experiences over-time. These initial codes were mapped sequentially across a coding frame to represent the different stages of the life-course: childhood; adolescence; young adulthood; and adulthood. This enabled the analysis to keep intact the sequence of events according to incidents of abuse and help-seeking/involvement from agencies. Second, two members of the team did multiple readings conducting a second coding of the data and developing second generation codes and themes. Data were annotated within MS Word and, at step two, Nvivo 12 was used to organize and code the cross-case analysis.

With regards to rigor, the primary study used robust techniques such as member checking, description of context, peer briefing and triangulation. The secondary analysis reported here has also followed a rigorous process of peer briefing, discussion and consultation within research team and with the team members of original study. Ample information is provided about participants and the context in which the study has been conducted to demonstrate rigor in the secondary analysis.

Table 1
Case studies.

Participants
Mia (40–49): experienced extensive CSA, by her father, a neighbour and his son, then a pedophile ring. She was forced to marry one of her abusers at 18 and had two children. During her marriage, Mia experienced high levels of DVA from her husband and sexual violence from other men, facilitated by her husband. She made multiple suicide attempts throughout her life, facing many barriers to help-seeking.
Yvaine (40–49): witnessed DVA and experienced CSA. She was in an extremely violent relationship as a young person which ended with the perpetrator attempting to kill her by strangulation. Most of her adult life has been spent in and out of mental health and substance use services. At the age of 30 she found a therapist who helped her to make the connection between her mental health, substance use and the early trauma experiences. At 36 she entered a relationship with a man and had a child. The now ex-partner was extremely controlling and emotionally abusive.
Shelly (50–59): experienced CSA and neglect. When she was 17 Shelly was sexually assaulted and raped by her employer, on multiple occasions. She has suffered mental health issues because of these abuse experiences. She experienced DVA from her ex-husband during their 12-year marriage.
Niamah (30–39): witnessed DVA between her parents, and experienced physical and sexual abuse and neglect. At 15 she was forced to marry a man twice her age. She experienced DVA by her husband, her in-laws and subsequent partners. She has also experienced sexual harassment on multiple occasions as an adult from strangers.
Fatima (40–49): witnessed DVA as a child and control/physical abuse from father. She has experienced forced marriage and sexual violence and coercive control from her husband and subsequent partners. She experienced sexual violence from extended family members and strangers in her early 20's.
Alice (age unknown): was sexually abused by her father from the age of 2–12. She reported to police when she was 12 and he was convicted. Alice was a sex worker in early adulthood and experienced assault, drug and alcohol misuse, homelessness, prison, and probation. She was in two relationships which involved DVA, sexual violence and rape.
Hannah (50–59): As a child, Hannah experienced neglect and physical and psychological abuse. She experienced DVA for 25 years which started when she was 17 years old. She has four children. She was gang raped as a teenager and her husband used this knowledge to taunt her during their marriage.
Marie (late 40s): experienced CSA followed by DVA from two long-term partners. The first abusive relationship was extremely violent including threats to kill. The perpetrator went unpunished. The second abusive relationship involved a lot of emotional abuse and control over 12 years.
Ellen (60s): experienced CSA. As an adult, Ellen has been in four abusive relationships including with her abusive husband for 23yrs. She separated from him 8 months ago and described her ex-husband as a Jekyll and Hyde character who would be very physically violent towards her when he had used alcohol. He was emotionally/psychologically abusive and controlling when he had not used alcohol.

5. Findings

Participants of the study talked about their experiences of abuse at various stages of their life. We present five main themes about survivor's experiences of repeat victimization across the life-course which are: i) abuse experiences in childhood and adolescence; ii) 'risky' coping mechanisms; iii) naming abuse in early adulthood; iv) seeking support in adulthood; v) surviving and a life beyond abuse. Sub-themes featured in survivors' abuse narratives from their childhood and adolescence include: a sense of helplessness and shame; and normalized practices. Sub-themes that featured in survivors' narratives of help-seeking in their adulthood related to**:** mental health services; substance use services; and voluntary sector domestic and sexual violence services.

6. Abuse experiences in childhood and adolescence

There were several recurring themes in narratives of childhood abuse including: feelings of helplessness, shame and self-blame; and normalization.

6.1. CSA experiences: A sense of shame, helplessness, and acceptance

Talking about childhood sexual abuse perpetrated by her father, Mia spoke about how her formative years had conditioned her to expect abuse in adulthood. Her father had introduced her to a pedophile ring at the age of seven and at 18 she was forced to marry one of the perpetrators. Throughout their marriage of over twenty-years he continued to abuse Mia physically and traffic her to other men.

> "Your formative years … your kind of … and not that I had a choice … it's not like I picked my husband out. But yes, you know, conditioned into that way of life that … and I think that's why I never looked to get out of it, because it was just, all I've known".

Mia's narrative highlighted the transition of childhood feelings of helplessness and acceptance about the domestic abuse in her marriage as she described it as "just typical domestic violence, [and] you just take them back again, having not known any other kind of life." Across time, the acceptance of abuse had a detrimental and enduring impact on survivors' sense of agency which created a vulnerability to harm. This vulnerability was most evident in Fatima's narrative who described how the acceptance of abuse prevented her from disclosing sexual assault perpetrated by a male cousin in adolescence. She stated: "He would climb into my bed every night and just literally force his body over me and then I couldn't do anything … What else could I do, 'cos nobody would believe me."

Niamah described the acceptance of male power and female subordination in her everyday world. She had been forced to marry a man and at the time of interview, she experienced workplace-based sexual harassment. She described the barriers to reporting: *"[…] because you're*

working in a man's world, you know, and it's fire or police service and they're not going to believe it". The sense of helplessness in Niamah's narrative was identified in relation to her experiences of abuse, but it also reflected systems failure in that she thought that statutory services would not believe or help her. Survivors who had experienced childhood abuse in the UK in the 1960s and 1970s also described barriers related to norms explaining how even if family or friends knew what was going on, nobody talked about it because *"it's always been a stigma, really" (Ellen) and "you didn't get involved in other people's families"* (Shelly).

Many survivors internalized their emotional responses to abuse resulting in shame and self-blame. Shelly experienced CSA perpetrated by her older brother and this made her feel ashamed of the situation. For all survivors, feelings of guilt, shame and blame represented a mechanism for acceptance, but these emotions also highlight the contradictions of abuse. Marie described how much confusion she felt about her experiences of CSA from her mother's partner, and how this led to the genuine belief that it was her fault. She said:

> "You can't understand, all you are is scared that it's your fault … Is it right? Is this what you do? Is it a part of growing up? You think it's part of it because nobody has ever walked in the room and said, "what the hell are you doing to her?""

This lack of validation from family, friends and professionals compounded feelings of self-blame which often prevented survivors from help-seeking until much later in their life-course. Due to their young age, many survivors struggled to make sense of their experience and felt that this was normal and usual part of life.

6.2. CSA leading to normalized thinking and practices

As stated earlier, the process of normalization occurred particularly for those survivors when abuse started early in childhood as Shelley indicated: *"the thing to remember is that when you had [abuse] since you were born, you think that it's normal"*. Normalized practices were underpinned by two sets of norms in relation to gender and culture. Survivors seemed aware that gender norms and attitudes had diminished their opportunities to be heard and hindered their understanding of what had happened to them. Talking about her experience of CSA, Alice said *"… my first experience with my dad, [I] was 2 [years old] … My father firmly believed that [CSA] was okay and expected thing for a father to have from his daughter*." Similarly, Niamah linked being a girl with an inability to disclose CSA from her uncle and she said:

> "He would just always, whenever he got a chance, he would grope me but I just couldn't do anything because obviously being a girl you couldn't tell your parents or anything … you know, like back then how we were brought up as girls".

For other survivors, gender and cultural norms combined resulting in their abuse experiences; for example, two survivors described being forced to marry. Niamah had witnessed domestic violence and abuse (DVA) between her parents as a child and at 15, she was taken from the UK to Bangladesh and forced to marry an older man. The *"man she was forced to marry"* – Niamah did not use the term husband at any point – was physically and sexually violent. She managed to escape him and fled to the UK, where she experienced DVA from a new partner.

Similarly, having experienced honor-based violence and forced marriage at the age of 16, Fatima described how her female cousins (of the same age) were supportive of the forced marriage telling her: *"You just need to do this. They were trying to make me aware of what the consequences were … if you don't do this, this will happen"*. After leaving her abusive husband, Fatima talked about how she was seen as 'damaged goods' by her community, linking this to experiences of sexual harassment as a punishment for 'being the bad one'. This was explicitly connected with gendered social and cultural attitudes about the role of girls and women, which had created further vulnerability to harm. *"I was further targeted as somehow not doing what I should do as a dutiful daughter, wife or whatever it might be"* (Fatima).

7. Adolescent 'risky' coping mechanisms

Throughout the life-course the mental health consequences of early CSA became visible in adolescence and early adulthood. All survivors described symptoms of complex PTSD (including disassociation, depression, anxiety, and flashbacks) which persisted into adulthood. Mia talked about how the ongoing abuse within the pedophile ring had grown too much for her at the age of 17 and she had attempted suicide: *"I took all the medicines that were in the medicine cupboard, but I hadn't taken sufficient. And I still look back at that and kind of regret not dying that day"*. For Mia, contemplating suicide was a recognition that death was the only place *she "could get to where it was all over"*. For a survivor for whom revictimization had destroyed much of her sense of self as an agentic being, the extreme outcome of mental ill-health, suicide, was positioned as a way of re-establishing control and agency.

Substance use was also common as a coping mechanism for early abuse experiences. Alcohol use was central to Yvaine's narrative, after the gang rape at age 14 she described a pattern of *"binge drinking, drinking very destructively, sometimes taking drugs"* at a young age to manage what she now recognizes as trauma symptoms. Yvaine made a direct connection between the substance use and the series of sexual assaults she had experienced in early-adolescence:

> "… I was raped again when I was 14. Again, I was very drunk … There's two others … Another time somebody threatened to rape me if I didn't give them a blow job, and then somebody else got me stoned and coerced me. Another time I just woke up with somebody trying to … all this before the age of 16".

In her mid-40s she was starting to see the connection between PTSD from sexual assault and substance use, although her narrative often reverted to self-blame. Both Yvaine and Alice were experiencing regular flashbacks and their memories of early abuse experiences had been repressed. Alice's experiences of CSA from her father re-surfaced in her mid-30s. His death had triggered her abuse memories and she was struggling to process the trauma because there was no resolution or justice for her father's actions: "*It's fine I'm used to it, I survive it … but I'm living with it. I don't feel like there's anywhere to put it, there's nowhere for it to be acknowledged"*.

8. Naming abuse in early adulthood

As survivors reached early adulthood, many began to recognize the abuse they experienced "as abuse". While all had experienced multiple forms of abuse, one incident or relationship typically dominated the narrative. Survivors who talked mostly about their experiences of childhood abuse highlighted how being young and not knowing what abuse was prevented them from accessing help. Priya described being sexually assaulted at the age of 7 by a Sikh priest at the temple, after he made her undress, she said *"I knew it wasn't right, but because I was so young, I didn't know what to do"*. This issue of "unknowing" had contributed to her awareness of another abuse experience in early adulthood when she was assaulted by a doctor. "He felt my breasts and, you know, so afterwards it sunk in that I was actually abused by this doctor".

Survivors were at different stages of processing their trauma narratives, and repression of childhood abuse memories had prevented disclosure and help-seeking many years after assaults had occurred. Niamah's memories of the CSA she had experienced from her uncle came back to her while she was studying at college. She described how *"… subconsciously I repressed it, and when I was doing my psychology, it came back to me that "Oh my god that was abuse". He was luring me into having sex with him. He was grooming me."*

Survivors who talked about their adult experiences of DVA described how awareness of their childhood abuse had been utilized as a

mechanism for control. For instance, Hannah was gang-raped as a teenager and had been in a physically and sexually abusive relationship with her ex-husband for 25 years. She noted that telling her husband about the abuse was the worst thing she ever did "He used that for the whole of the 25 years that we were together". Similarly, Fatima talked about how her abusive ex-partner used knowledge of her previous forced marriage to emotionally abuse and control her. *"Well, I'm nice to you. I let you go out. I let you do things … I'm not like when you were in that forced marriage …"* In these examples, abusers reinforced survivors' core beliefs that they were to blame for earlier abuse experiences, calling them to question their awareness/understanding of the abuse and contributed to feelings of entrapment.

Alice was sexually abused by her father between the ages of two and twelve. As an adolescent she used substances to cope with the trauma, resulting in addiction, homelessness, and sex work in early adulthood. Reflecting on abuse from an ex-partner Alice demonstrates the immobilizing effect of repeat victimization. She shared: *"I wasn't sure if I could call it rape. You know he assaulted me when I was asleep … At the time I didn't think 'this wasn't quite right'. I thought this guys' going to fucking kill me actually. There was not 'this isn't a good idea', it's that 'I'm stuck, and I'm trapped"*.

Feelings of entrapment and lack of agency were also found within Hannah's narrative.

> "For some reason I know that people say you have a lightbulb moment, and I didn't because when we got to it – the crux of the matter is that he raped me on my daughter's wedding day, and this was the first time he had done this, and a few weeks later he did it again. But it got to the stage where I thought 'there's not much more he can do to me, there's only one more thing he can do to me – and that was to be dead'".

Hannah's narrative demonstrates almost a form of nihilism in response to awareness of the abuse, this was her way of coping with the knowledge of what was happening to her.

9. Seeking support in adulthood

Help-seeking took place in adulthood and service engagement was central to survivors' growing recognition of their abuse experiences *and* their ability to process it. Across narratives, the majority had disclosed to informal sources of support in late adolescence or early adulthood (e.g., to mothers or friends). No survivors had received formal support or intervention in childhood at the point of crisis and formal help-seeking was delayed until adulthood. This illustrated the limits to girls' and women from naming their experiences and abusers, as well as the effects of abuse upon girl's and women's diminished agency. In addition, for some survivors, rather than help-seeking, service involvement was mandatory because of ongoing high-risk situations within domestic abuse relationships. Survivors described a range of experiences with statutory and voluntary services with most impact from mental health services, substance use services, and specialist DVA services.

9.1. Accessing mental health services in adulthood

When appropriate and timely mental health support was accessed, it was described as beneficial. For example, Alice had received Eye Movement Desensitization and Reprocessing therapy (EMDR) to address the effects of CSA and the multiple sexual assaults she had experienced while sex working. She said: *"this year I had EMDR therapy, and it's the first time I've been able to talk about it … I've been able to talk about him and some of the events that happened and taken the trauma away. It's moving the trauma symptoms and reprocessing them into forming memories"*. Yet, others demonstrated a lack of joined-up, specialist care for complex trauma within mental health services. Yvaine had accessed multiple therapies and had struggled with the inconsistency and availability of appropriate care. "*I went to trauma focused CBT [cognitive behavioral therapy] … but it was only twelve weeks … I felt quite pushed into being well."* In the year of her interview, she had taken an overdose while on the waiting list for CBT and had to be referred to crisis care which she described as an ongoing occurrence. She felt that she "didn't have any support". Similarly, Marie had accessed 14 different therapists over the course of 12 years and felt very let down by what she described as "generic mental health services". Marie felt that these services saw her "as" her mental health diagnosis rather than attributing her complex PTSD as a symptom of revictimization.

Survivors talked about how their experiences of the criminal justice system (CJS) had worsened their mental health issues and affected their ability to access essential mental health services for complex trauma. Mia described the lengthy CJS process against her husband and the other perpetrators who had trafficked her as an adult which was incredible stressful as she said "I couldn't handle it … so there was another suicide attempt". Mia was told that this process could take up to four years and she could not access any mental health services until the CJS cases had been heard. She explained *"NHS [National Health Service] were like 'can't touch you, we're not prepared to give you any* support *whatsoever', not even the crisis team were prepared even after two suicide attempts."* This demonstrated the lack of joined-up, collaborative support for survivors despite acknowledgement that a multiagency approach is the most appropriate one.

9.2. Substance use services

For many survivors, substance use services played a central role in recovery; unsurprising given the close connection between trauma symptoms and alcohol/drug use as a coping mechanism. Yvaine had struggled with substance use since her experience of gang rape as a teenager. Throughout adulthood she had accessed many substances use services and different interventions including group work and residential care. Yvaine said: *"In group therapy [the therapist] would go around and almost shame people. And I remember this one time she came to me and I was saying something about being pathetic … and she said "I don't know, if I was your mother, I'd slap you"*. Her narrative highlights the need for trauma-informed care being embedded within substance services.

Yvaine's trauma symptoms were recognised as "alcohol addiction" and this had been central to her understanding of the abuse she experienced.

> "It's very dogmatic and the way that I interpreted or understood things was all the things that had happened to me was because I was an alcoholic, that they were a consequence of my drinking …. the steps are very much about admitting what you did wrong, saying that you're powerless, that you've got to hand over your power."

This treatment had compounded her feelings of guilt, shame, and blame. This example also suggests a disconnect between professional's capacity to recognize long-term trauma as the root cause of other behaviors (such as problematic alcohol or drug use).

9.3. Domestic and sexual violence services

Most survivors had accessed domestic and sexual violence services for adulthood experiences of domestic abuse. Marie was supported by an Independent Sexual Violence Advocate (ISVA) following a second abusive relationship. She felt empowered by the ISVA and described her advocate as an *"… absolute godsend […] I have been with her about a year, and that girl knows I hold onto her. I tell her everything. She is a married lady who is independent, and she empowers me"*.

Mia's court case had been supported by an Independent Domestic Violence Advisor (IDVA) and, similarly, the support was invaluable as Mia said *"She accompanied me at that time. I couldn't have done it without her ….my IDVA told me that she believed me … you need people not directly involved in the system telling you yeah we believe you, we believe these things"*.

Evidently, this specialist support played a significant role in validating survivors' experiences, by 'believing' them and by advocating for their needs. This validation helped survivors to understand the abuse they had experienced and begin taking steps towards processing the trauma. They described how advocates had helped them to access other services and the right care for their needs. At 63 years old, Ellen had accessed DVA services for the first time. She had been in four abusive relationships, including her husband of 23 years who had been extremely physically violent, emotionally abusive, and controlling. She had also been sexually abused as a child and had never told anyone:

> "I was sexually abused as a kid. It was a family friend's son. I mean, I've lived with it for years and years, but I buried it deep. I mean it's only been these last few months that I have been able to speak about it".

Access to these services had been challenging, particularly for those with complex trauma as Alice explained:

> "I had substance misuse issues, so none of the refuges [safe accommodation] would help me, no one would take me … There was no way of offering me any support to access a script or get me stable or anything … for someone presenting with complex trauma".

Mia described how support ended quite abruptly for her once the case was over and she had been relocated away from the perpetrator/s:

> "The services kept saying to me 'Oh you're free, you're free, fantastic, go and do whatever it is that you want to do', and I found that incredibly traumatizing […] My life has been controlled from being a baby to at age 43, and I have had no concept of how to live my life really, so for me that was even more terrifying […] I think it's just trying to be realistic and kind of, you know […] trying to pace the recovery process."

Mia's narrative highlighted the need that many survivors had - for longer-term care.

9.4. Surviving and life beyond abuse

Survivor's experiences of accessing services (specialist domestic abuse and sexual violence services in particular) had shaped the ways in which they understood the abuse and described it. There were several instances of "professional/agency" language throughout the narratives. As Ellen noted "*from the moment I started getting housed and started engaging with things again […] I'm a survivor. Not a victim. Survivor.*" Survivors were more likely to talk about their experiences of DVA with an increased sense of agency compared to their narratives of childhood abuse. Their narratives demonstrated moments of resistance and strength which were core to their understanding of who they were, then and now. Shelly said: "*there had been other times, but I hadn't called the police the other times throughout the marriage, I just dealt with it*".

Many survivors were engaged in an ongoing process of understanding the abuse and constructing or re-constructing a sense of identity. This was not easy as abuse experiences and the normalization of that abuse had eroded survivors' sense esteem and identity (Finkelhor and Browne, 1985). They described wrestling simultaneously with guilt, shame, and self-blame alongside the realization that they could at last begin to look forward. Ellie described this by stating: "*I'm a victim again last year, you know … I don't understand how that happened again … and the shame and the guilt and the self-blame that comes up from that happening again. I think with the sexual violence stuff, you don't get over it. You survive it, you learn to live with it … or not.*"

Survivors talked about how they had come to realize that processing trauma was not linear, and that there was a lot of moving back and forward during the recovery journey. Recovering was enhanced by actively learning about early abuse experiences and why it happens, for Marie this had been helpful but also destabilizing at times:

> "I see myself as a victim. I see myself as a survivor. I see myself as a broken woman, and I don't know how to fix myself. I must have 500 self-help books, there's nothing in the books."

She described herself as lost in this process. In contrast, Alice recognised that it had taken a long time to achieve a sense of identity outside of her abuse experiences, but that being an advocate for others was now a central part of who she was. She said:

> "I was stuck into the whole victim blaming and rape culture, you know, as a woman. I am a feminist. And I call it when I see the subtleties, and it intrinsically makes me who I am […] I am not going to be the one that shuts up and puts up. I will be the whistleblower; I won't shut up about this. I will fiercely protect anyone who I think is vulnerable."

Some survivors felt a sense of accountability in needing or wanting to protect others against the perpetrators. This motivated them to campaign in the sector or work frontline within the voluntary DVA/SV sector; this was central to what was described as the "process of empowerment" (Niamah).

10. Discussion

This rigorous qualitative secondary analysis of women's narratives of revictimization offers a novel contribution to scholarship through a feminist narrative and life-course analytical strategy. Our findings align with existing quantitative research which suggests that survivors of CSA are at significantly greater risk of experiencing sexual revictimization than those without a history of sexual abuse (Walker-Williams and Fouche, 2017; Papalia et al., 2021). However, as the majority of this scholarship is rooted to quantitative research, our project draws sharply into focus the value of qualitative methods that progress rich insights about revictimization. In addition, adopting narrative methodology has value when examining women's revictimization over time as the process of narrating enables women to connect such events across their life-course to demonstrate their sense-making of linked experiences. This is important as women's individual understanding is critical to the processing of their trauma and abuse histories and to recovery (Sánchez and Lopez-Zafra, 2019).

A life-course analysis of revictimization has value in illuminating the intersections of negative emotions (e.g., shame, self-blame) and social processes (e.g., normalization, learned helplessness). Combining a life-course perspective with Finklehor and Browne's (1985) traumagenic dynamics model enables a theoretical understanding of the impact of CSA to women's sense of self as adolescents and in early adulthood and the ways in which this sense of sense has longer-term impacts to women's agency and self-determination through different stages of their life. Agency in adolescence and adulthood was frequently depicted in the narratives through decision-making around 'risky' behaviors (e.g., substance misuse, suicide attempts, or sex working) and while these can be positioned as adverse or, additionally harmful, behaviors and choices, conversely, these are examples of women reclaiming control and power over the ways in which they coped, or survived, to neutralize the effects of trauma. Women's behaviour and choices in the study are not unusual, substance use is a commonly reported coping mechanism for people who have experienced abuse and trauma (Boppre and Boyer, 2021). Moreover, the adoption of coping mechanisms is critical to women surviving revictimization as the harms of repeated abuse by different perpetrators becomes the norm (Walklate and Clay-Warner, 2016). At the same time, the forms of coping described in this study are also normalized for those women experiencing revictimization.

Despite adopting coping strategies, many participants described unresolved trauma highlighting the need for trauma-informed, long-term care for adults who have experienced revictimization (Levenson, 2020). Longer-term care holds the potential to enhance recovery, increase agency and enable self-determination and, ultimately address the

long-term disempowerment, inequalities and harms experienced by women resulting from childhood trauma and subsequent revictimization. Repressed memories were common in the narratives which offers one explanation as to why survivors of childhood abuse with complex trauma often seek help much later (in addition to early disclosure resulting in silencing or not being believed). The consequence of survivors not being believed resulted in a barrier to disclosing abuse again, and to help-seeking (Cunnington and Clark, 2022). Survivors often disclosed childhood abuse to partners when memories surfaced in adulthood. Disclosures were often used as another mechanism of control and for exerting further abuse. In this way, survivors described a 'scaffolding of abuse' as a further mechanism that links victimization events in which current abuse builds upon previous abuse. In these instances, it is of little surprise that survivors felt completely lacking in agency, confidence and self-esteem highlighting the long-term impacts of CSA theorised by Finkelhor and Browne (1985).

Across the narratives, normalization was undergirded by one or more contextual factors - including gender, culture and temporality – which demonstrated the limitations in applying current theoretical explanations that account for the impact of CSA in adult revictimization through an understanding of ACEs (Feletti et al., 1998). Analysis of the narratives did illuminate multiple and overlapping forms of abuse in childhood (Sharratt et al., 2023) and serve as a means of understanding victim vulnerability to future violence and victimization, along with long-term consequences for recovery. However, the rich complexity of narratives also brings sharply into focus the limitations of ACEs as a population-level tool and their limits in theorizing and responding to individual-level vulnerabilities (Kelly-Irving and Delpierre, 2019) which in our sample were multidimensional and diverse. Additionally, the small sample of narratives in our study underscore a limitation of applying ACEs models, with defined concepts, to rich qualitative data extracted from people with diverse, multiple and complex life experiences.

The combination of normalization and the contextual factors of gender, culture and temporality was found to be especially potent and what unifies these four aspects of revictimization in the narratives is the presence of male hegemony and entitlement. This draws sharply into focus feminist perspectives on violence against women as rooted to patriarchy (Rogers and Ali, 2023). The narratives referenced different time periods (from the 1970s to present day) also indicating the endurance of patriarchal gender norms and male entitlement and the perpetuation of the myth that it is acceptable for boys/men to abuse and for girls/women to be abused. A feminist analysis of revictimization using a life-course perspective would benefit from further research however to examine the effects of patriarchy and influence of binary bender norms in contemporary contexts.

Finally, survivors were at different stages of processing trauma, and when successful, therapeutic intervention wase central to recovering, but it was often unsuccessful due to it being irregular, or untimely. For those accessing mental health services, many relapsed and experienced the "revolving door" effect characterized by repeat engagement; a phenomenon not uncommon across mental health services (Napoli et al., 2023). In combination, challenges associated with services including deficient resources, short-term intervention, revolving door experiences and a lack of specialist knowledge around revictimization. It was through engagement with specialist DVA/SV services that survivors found the most support. However, accessing specialist DVA/SV services was often difficult due to insufficient resources and the "disturbing gaps" in service provision for all, but especially those from marginalized communities (Domestic Abuse Commissioner, 2022, p.2). Overall, services were rarely offered on a continual, open-ended basis, which was unreflective of survivors' medium and long-term needs. This has implications for risk of further trauma and revictimization. Furthermore, as violence against women is a global pandemic (WHO, 2021), whilst the data for this study originated in the United Kingdom, our findings are relevant to an international audience. Additionally, there are potent barriers to obtaining data from women on the issues contained within this paper - not least due to widespread stigma around sexual victimization, mental health and substance misuse – and which could account for the lack of qualitative work on revictimization, our analysis offers useful insights for policy, practice and future research.

11. Implications for policy and practice

Our analysis suggests that a gender-sensitive, needs-led model of healthcare support is needed to address the impacts of revictimization and complex trauma over time. It should not be time-bound, but last for as long as the individual needs. The key to supporting women to move from a victim to a survivor positionality, was for them to receive timely support to enable them to process trauma, and to actively construct narratives about early abuse experiences and, in doing so, they were enabled to make sense of why it happened, or why they made the future choices that they made. This sense-making can be both cathartic and empowering, and is critical to processing trauma and abuse, and to longer-term recovery. Working collaboratively women enables them to reach better resolution or management of their circumstances; e.g., by including them in decision-making and safety planning.

It is also evident that professionals need a better understanding of repeat victimization and about how childhood and adult trauma processing works. In itself, this enhanced understanding can improve practice responses to survivors. It can be achieved by agencies that offer mental health and substance use support, employing a trauma specialist and through specialist training. Such training should enable professionals to embed evidence-informed practice in assessment, professional judgement, decision-making and interventions. This would also promote a trauma-informed approach which creates a safe environment for women enabling trust, choice, collaboration and empowerment (Levenson, 2020).

12. Limitations

There were several limitations to the original study. Regarding sample generalizability, women were self-selecting. Those who agreed to be interviewed were further along in the process of recovering from repeat victimization and all had accessed services. All women were no longer in the abusive relationship, but some had benefited from a longer period of separation to reflect and engage with services than others. Time and professional involvement may have influenced survivors' narratives. Although the research did not aim for representativeness (Williamson et al., 2021), interviews were conducted across urban/rural contexts in the UK, ensuring representation from ethnically/culturally diverse backgrounds and across a range of demographic indicators (e.g., gender, age, socio-economic status). For this project, as we used the interview transcripts as a sub-sample, varied representation was unachievable as we had to draw on participants whose narrative of their abuse history was sufficient for analysis.

Response bias represents another limitation. Survivors were asked to recall their abuse experiences retrospectively, which can be affected by memory relapse, unconscious response errors or inability to recall certain events (Veague and Hooley, 2014). As our findings highlight, this is a particular risk with revictimization because many of the survivors in our sample reported symptoms of complex trauma which may make the linear recollection of abuse memories harder to identify, recall or describe. This provided the justification for undertaking a narrative analysis because it recognizes and values the importance of survivors telling their story in their way – which is in and of itself a critical part of re-defining identities and learning to live with abuse experiences.

This important and original study has used a life-course approach to shed light on the revictimization experiences of women. This is the first study in which such an approach is used to explore how one abusive experience led to normalizing and tolerating further abusive experiences by women and how these affected their lives from childhood into

adulthood.

Declaration of competing interest

None.

Data availability

Data is available via the UK Data Service.

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