Adolescent Intimate Partner Violence: Exploring the Experiences of Female Survivors

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<tr>
<td>AIPV</td>
<td>Adolescent Intimate Partner Violence</td>
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<tr>
<td>AP</td>
<td>Alternative Provision</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>BCS</td>
<td>British Crime Survey</td>
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<td>BNIM</td>
<td>Biographical Narrative Interview Method</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CDA</td>
<td>Critical Discourse Analysis</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>CSEW</td>
<td>Crime Survey for England and Wales</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
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<tr>
<td>CTS</td>
<td>Conflict Tactics Scale</td>
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<tr>
<td>CTS-2</td>
<td>Conflict Tactics Scale version 2</td>
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<tr>
<td>DASH-RIC-YP</td>
<td>Domestic Abuse, Stalking and Harassment Risk</td>
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<td></td>
<td>Identification Checklist for Young People</td>
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<td>DVA</td>
<td>Domestic Violence and Abuse</td>
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<td>DVPO</td>
<td>Domestic Violence Protection Order</td>
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<td>FANIM</td>
<td>Free Association Narrative Interview Method</td>
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<td>FOE</td>
<td>First Order Effects</td>
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<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
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<tr>
<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>IDVA</td>
<td>Independent Domestic Violence Advisor</td>
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<td>IEPs</td>
<td>Intimate Experiences and Partnerships</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MARAC</td>
<td>Multi-Agency Risk Assessment Conference</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<tr>
<td>OFSTED</td>
<td>Office for Standards in Education, Children’s Services and Skills</td>
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<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
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<tr>
<td>PFS</td>
<td>Postmodern Feminist Standpoint</td>
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<tr>
<td>PI</td>
<td>Prevention Interventions</td>
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<td>PSHE</td>
<td>Personal, Social, Health and Economic Education</td>
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<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>SCA</td>
<td>Serious Crime Act 2015</td>
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<td>SCS</td>
<td>Scottish Crime Survey</td>
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<td>SOE</td>
<td>Second Order Effects</td>
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<td>SQuIN</td>
<td>Single Question aimed at Inducing Narrative</td>
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<td>SRE</td>
<td>Sex and Relationships Education</td>
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<td>STIR</td>
<td>Safeguarding Teenage Intimate Relationships Project</td>
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<td>TOE</td>
<td>Third Order Effects</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>UNCRC</td>
<td>United Nations Convention for the Rights of the Child</td>
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<td>VAWG</td>
<td>Violence against Women and Girls</td>
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<tr>
<td>VR</td>
<td>Violent Resistance</td>
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<tr>
<td>WHO</td>
<td>The World Health Organisation</td>
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<td>WSA</td>
<td>Whole School Approach</td>
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Abstract

This research contributes to existing knowledge of intimate partner violence (IPV) by highlighting the lived experiences of female adolescent survivors through the examination of the lived experiences of seventeen participants. Framed within an intersectional feminist epistemology and informed by psychoanalytical theories, a hybrid of the Free Association Narrative Interview method (Hollway and Jefferson, 2001) and the Biographical Interview Method (Wengraf, 2002) was applied, allowing an in-depth analysis of the young women's adolescent experiences of IPV.

The female participants’ narratives highlighted significant levels of psychological, sexual and physical violence by various male partners, suggesting that gender is indeed a mediating factor. These experiences reflect Johnson’s Typologies of Domestic Violence (2008). In addition, consideration of other intersecting factors, such as age, socioeconomic demographic information, familial exposure to IPV and previous IPV victimisation, highlighted the necessity to consider all factors when determining risk and experience (Potter, 2015).

This research adds to the debate regarding gender symmetry of IPV perpetration and victimisation, with analysis of participants’ experiences suggesting gender symmetry is not experienced by all adolescents, thus further exploration of this phenomenon is required. Similarly, participants experienced severe forms of physical, sexual and psychological violence at each stage of adolescence (early 10 – 13 years; middle 14 – 16 years; late adolescence and young adulthood 17 – 25 years) contradicting the oft held assumption that more severe violence occurs solely in adulthood.

Analysis of participants’ experiences of informal and formal support, and an exploration of participants’ ideal prevention intervention model argues for a public health approach to preventing AIPV, with resources focused on primary, secondary and tertiary prevention. Ultimately the young women felt that with appropriate education, support and intervention they could have avoided, or at least reduced, their exposure to abuse. Hence in order to reduce and/or prevent adolescents from experiencing IPV resources should be aimed at giving young people the information, skills and abilities to resist gendered inequalities and unhealthy relationship behaviours, and promote healthy and happy romantic and sexual relationships.
Declaration

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Dedication

This thesis is dedicated to my wonderful mum.

Marion Caroline Bustin

(1960 – 2002)

To the incredibly courageous young women who shared their stories with me, your bravery in the face of adversity is truly inspirational. I wish you every happiness in the future.
Acknowledgements

This thesis would not have been possible without the love and support of my family and friends. Special thanks go to my Dad for being there no matter what. I couldn't have done it without your support and encouragement. I'm also incredibly thankful to Caitlin for her support and keen attention to detail. Who would have thought anyone could enjoy referencing?!

Mel, Philippa, Kim and Deb you have saved me from many moments of panic and inertia. Your love and patience will always be remembered. I'm looking forward to celebrating with you all. I'll make sure to have a drink for you too Jack. Thanks also to all those who have endured this project alongside me: Taz, Connor, Phil, Kerry and of course Lola.

Many thanks must also go to my supervisors Jo Deakin, Caroline Miles and Jon Spencer. Your patience, encouragement and constructive criticism have kept me going on what has been a turbulent PhD journey. Thank you for keeping me moving forward. Thanks also to the wonderful women at the gate keeping organisations. This thesis would not have been possible without your help and support.
Chapter One - Introducing Adolescent Intimate Partner Violence

Domestic violence and abuse is estimated to cost the UK £23 billion per year, including £3.8 billion per year for services such as health and criminal justice, and £1.9 billion in lost economic output (Walby, 2004). Furthermore, victimisation has been associated with significant physical and mental ill health (WHO, 2012), decreased educational and employment attainment, and almost 7% of the overall burden of disease (Vos et al., 2006).

Evidence suggests adolescents are the most likely to experience domestic violence and abuse (ONS, 2016). However, traditionally adolescents’ experiences of such violence have been dismissed as ‘trivial and fleeting’ (Collins, 2003). As a result we have a limited understanding of the aetiology of AIPV, and the nature of AIPV perpetration and victimisation (Barter et al., 2009). This has significant implications for estimating the number of victims of AIPV, and subsequently policy and commissioning decision-making, including for estimating the amount of resource required to respond to the phenomenon.

Since the landmark NSPCC report ‘Partner Exploitation and Violence in Teenage Intimate Relationships’ (Barter et al., 2009), there has been a considerable shift of attention towards adolescence as a site for domestic violence and abuse. Three large UK studies have begun to explore the phenomenon (Barter et al., 2009; Fox et al., 2013; Barter et al., 2015), identifying high prevalence of psychological, sexual and physical violence throughout adolescence (explored further in Chapter 2). Furthermore, the impact of such violence is thought to be significantly detrimental and continue into adulthood (WHO, 2016).

UK policy and legislation has responded to this evidence by including sixteen and seventeen year olds in the cross-governmental definition of domestic violence and abuse (Home Office, 2013), and the introduction of a young persons’ Domestic Abuse, Stalking and Harassment and Honour-based violence risk assessment (DASH-RIC-YP). However, there is a difference in how those under and over sixteen years of age are responded to. Those aged fifteen years and under are not represented in relevant definition of domestic abuse and therefore should be dealt with through child protection measures, despite evidence suggesting they are as likely as those over sixteen to experience such violence (Barter et al., 2015). In contrast, those aged sixteen and over are responded to in the same way as adult victims. The Serious Crime Act (2015) recognises coercive control in the relationships of those aged ten years and over for the first time, offering the first opportunity to protect all victims, including those under sixteen years of age. The age appropriateness of these measures are discussed in Chapter 2.
There are two dominant schools of thought regarding domestic violence and abuse: violence against women perspectives and family violence perspectives. Both suggest specific causes and typologies of violence, including adolescent intimate partner violence (AIPV). Violence against women perspectives view patriarchal society and the associated male domination of females as the cause of violence. This perspective views such violence as a symptom of attempts by males to enforce their dominance over females and younger males (Dobash and Dobash, 1979). Family violence perspectives on the other hand, suggest various structural inequalities, such as age, socioeconomic background and ethnicity, cause conflict between those in the family or relationship unit (Straus, 1979). The family violence perspective suggests that such conflict leads to violence when some individuals favour violent conflict resolution tools.

Furthermore, both ideological approaches champion different methodological approaches: qualitative and acts-based approaches respectively. Johnson suggests that the differing methodologies favoured by violence against women and family violence researchers, have in fact uncovered different types of domestic violence and abuse due to their differing methodologies, sampling and units of measurement (Johnson, 1995, 2006, 2010, 2011; Kelly and Johnson, 2008).

The first typology identified, Intimate Terrorism, is most frequently uncovered by ‘violence against women’ researchers (such as Dobash and Dobash 1979, 2002; Pence and Paymar, 1993; Stark and Flitcraft, 1996; Johnson 2010) and is reflected in the severity of the cases finding their way to the criminal justice and health sectors (Johnson, 2010). Intimate Terrorism is characterised by a pattern of coercive and controlling behaviours, which cannot be identified without considering the context of the individual incident within the broader pattern of violence and abuse over time (Johnson, 2008; Stark, 2007). Violent Resistance is the term Johnson attributes to the, sometimes extreme, violence women experiencing Intimate Terrorism perpetrate in response to their victimisation. The violent resistor is faced with a partner who is both controlling and violent but is not themselves controlling (Johnson, 2008).

In contrast, the core assumption of Situational Couple Violence is that all couples experience conflict. Consequently, some are more likely than others to experience chronic conflict. Among those couples, some individuals are more likely to turn to violence (Straus and Gozjolko, 2014). Arguably the most common form of IPV (Johnson, 2005, 2008, 2011), Situational Couple Violence, is not characterised by any attempt by either party to control the other. Instead, the violence is situationally provoked causing one or both partners to react to conflict with violence.
Subsequently, Johnson (2008) offers a more nuanced approach to understanding IPV by capturing these multiple contexts, motivating factors and types of IPV within three typologies: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. This thesis will apply Johnson’s typologies to AIPV through an intersectional lens to the experiences of female victims of AIPV, noting areas of fit and limitations. By doing so, this thesis aims to answer three research questions:

1) How do female victims of AIPV define their intimate experiences and partnerships;
2) How do victims of AIPV explain, and understand their experiences of victimisation; and
3) How do AIPV victims’ requirements of prevention interventions compare to existing prevention efforts in England and Wales?

These questions are addressed through the examination of the lived experiences of seventeen female victims of AIPV using the Free Association Narrative Interview Method (Hollway and Jefferson, 2000). This thesis adopts an intersectional feminist approach to studying AIPV, of which the core aims include empowering the voices of adolescent victims, drawing attention to the lived experience of a plurality of females, and recognising their diversity and varying social worlds. In addition, this thesis embodies the ethical and ideological underpinnings of feminist research.

Subsequently this thesis raises several significant findings. Firstly, this thesis identifies severe psychological, sexual and physical violence within the participants’ experiences of AIPV. Much of the violence narrated was compounded or enabled by recent developments in technology, highlighting a significant requirement for such technology to be considered in future policy, legislation and research developments. Secondly, the intersectional application of Johnson’s typologies locates three differing typologies of AIPV. Further testing of this theoretical framework is required to establish whether it holds across the trajectory of adolescence. Furthermore, the participants and staff of the gate-keeping organisations raised several key issues with existing prevention work which urgently require modernisation and investment to maximise their potential. Ultimately this thesis makes several recommendations (Chapter 9) for further work which will enable more accurate data collection, a better understanding of AIPV, and exponentially improved practice responses to AIPV.
Structure of the Thesis
The chapter which follows considers definitions relevant to the study of AIPV. These include a consideration of what is understood by the term gender, how we define adolescence, and an examination of the various intimate experiences and partnerships typical of adolescence. A definition of AIPV is then examined. Chapter 2 goes on to compile and analyse the emerging UK evidence-base regarding AIPV, highlighting the inconsistencies in attempts to theorise and understand the phenomenon. An examination of the prevalence of AIPV follows, citing the variety of definitional and measurement tools used to study it, subsequently providing data which is largely incomparable. Several gaps in the UK literature are identified, including areas which require further research attention. Such areas include potential risk and protective factors, the effect of gender on perpetration and victimisation and the self-report of these behaviours. Furthermore, multiple opportunities for prevention and intervention efforts are outlined.

The Intersectional approach to exploring AIPV is examined in Chapter 3. Johnson’s typologies produced are then presented, noting the limitations and benefits of each. The potential implications for employing this approach are considered, concluding that an intersectional lens is necessary, as emerging evidence suggests that the impact on gender and other structural inequalities on experiences are complex.

The methodological approach and analysis methods employed are presented in Chapter 4. The thesis adopts an intersectional feminist approach to studying AIPV. Hollway and Jefferson’s Free Association Narrative Interview Method is explored, demonstrating the importance of a psychoanalytical approach to eliciting participants’ narratives about sensitive subjects such as experiences of AIPV. The recruitment methods are set out, introducing the gate keeping organisations, and participants recruited. The ethical considerations of the project are then explored, including confidentiality, anonymity, and participant and researcher safety. Chapter 4 concludes with reflections of the research journey from the researcher.

Chapters 5, 6, 7, and 8 present the findings of the thesis. Chapter 5 explores the participants’ experiences of intimate experiences and partnerships and the age of onset of AIPV behaviours. The participants’ narratives are then analysed intersectionality to apply Johnson’s typologies to AIPV. The analysis highlights the significant prevalence and severity of the violence experienced. Implications of these findings for policy, practice and further research are identified, prompting an analysis of the impact of these experiences of AIPV.

The impact of participants’ experiences of AIPV are then explored in Chapter 6, utilising Riger, Raja and Camacho’s (2002) Radiating Impact of Intimate Partner Violence model. The effects
on the victim, her family and friends and her relationships with them are explored, noting the potential opportunities for prevention interventions.

Chapter 7 goes on to explore the participants’ experiences of formal and informal support. Sources of informal support included friends and family, whilst formal sources consisted of support from healthcare, the criminal justice system, victims’ services and social care. The participant’s help-seeking behaviours are considered, including the many obstacles to seeking and receiving effective support. The chapter concludes by presenting the participants’ suggestions for improvements to existing prevention interventions, which fall into four themes: universal preventative education through a cross-curriculum approach; wider awareness of AIPV and suitable responses to disclosures; high quality, consistent and empowering outreach work; and a significant review of formal responses to AIPV.

The final findings chapter (Chapter 8) explores the public health prevention model, citing the three key opportunities for prevention work to occur: primary, secondary and tertiary. The model is then utilised to highlight how existing policy and legislation tasks particular organisations with prevention work. Chapter 8 concludes by exploring the gate keeping organisation staff’s opinions about the limitations of their existing efforts, and how they would improve services given enough resources. Staff participants identified four key areas for improvement: staff development, equal access for all victims; modernised content of services; and increased resources allowing longer-term funding cycles. Existing prevention and intervention efforts are then explored, citing the ideologically favoured Whole School Approach as something to strive towards.

Chapter 9 concludes the thesis with a discussion of the key findings by addressing the gap in AIPV theory, exploring the prevalence of AIPV as demonstrated by the participants’ narratives and existing literature, and exploring the improvements required of prevention and intervention work in order for it to become truly effective.
Chapter Two - Exploring Adolescent Intimate Partner Violence in the UK

This chapter brings together literature from multiple disciplines to provide context for the empirical work within this thesis. The first section begins by exploring the definitions central to the project. The term Adolescent Intimate Partner Violence (AIPV) will firstly be examined; highlighting the limitations of the most widely used cross-governmental definition of domestic abuse and violence (DVA). The process of deciding on the term AIPV will then be presented, highlighting that adolescents rarely associate their own relationships with the term DVA, nor do they recognise themselves as potential victims of DVA. The utilised conceptualisation of adolescence will then be presented, acknowledging the various social, psychological, and physiological developments attributed to the phase of adolescence, which is defined for the purpose of this thesis as between the ages of ten and twenty-five years. To understand the exposure to the context for AIPV adolescents face, an exploration of adolescent intimate experiences and partnerships (IEPs) will follow, drawing attention to the significant number of same-sex and mixed-sex IEPs occurring. This section will conclude by exploring the conceptualisation of gender utilised for this thesis.

Section 2.2 goes on to explore the prevalence of AIPV, firstly considering the many challenges in determining an accurate measurement, namely the various definitions and measurement tools used, the various methodological approaches to research adopted, and the secretive nature of AIPV. With these challenges in mind, the prevalence of psychological, sexual, and physical AIPV are presented.

Section 2.3 explores the three most significant studies on AIPV within the UK and Europe from the last decade. The studies by the NSPCC, various university teams, and Daphne are examined in terms of their methodological approaches, definitions, and measurement tools. The findings of each study are presented, noting the implications for research, policy, and practice. The chapter concludes by discussing the existing knowledge about AIPV in the UK, highlighting the contribution to knowledge this thesis provides.

The government response to AIPV is explored in Section 2.4 through an examination of the policy and legislative changes that have occurred since the landmark NSPCC report on AIPV in 2009. The role of the criminal justice system, the health and education sectors, Local Authorities and multi-agency working in preventing and intervening in AIPV are also considered. Following on from this, the domestic violence sector response to AIPV is explored, highlighting their expertise and the challenges they have faced.
2.1 Key Definitions

This section will explore the key definitions relevant to this project. Firstly, the way in which adolescence is conceptualised will be set out, followed by the utilised definition of adolescent intimate partner violence (AIPV). This is followed by an exploration of the context in which AIPV occurs: adolescent intimate experiences and partnerships (IEPs). The section concludes by considering the concept of gender, and the victim/offender overlap.

Adolescence

The most widely accepted conceptualisation of adolescence is the period in which individuals move from childhood to adulthood (Cicchetti and Rogosch, 2002; Bowen and Walker, 2015). In Western societies adolescence typically begins with the physiological and psychological developments associated with the onset of puberty (Sawyer, Azzopardi, Wickremarathne, and Patton, 2018). The age of pubertal onset is individualistic, as is the age at which the process ends (Marcia, 1980).

It can be argued that whilst “the transition into adolescence is marked by clear and dramatic biological changes; the transition into adulthood is more socially defined” (Bowen and Walker, 2015: 2). Adulthood differs from adolescence in that it is truncated by milestones suggesting maturity: completion of education, entrance into the workplace, and the formation of a family (Smetana et al., 2006; Bowen and Walker, 2015). This suggests that the progression from adolescence to adulthood is gradual and individualistic, and largely determined by social milestones rather than physical or psychological development.

Sawyer et al. (2018) argue that the onset of adolescence has accelerated in nearly all populations, whilst the delayed timing of completion of education, marriage, and parenthood continue to push popular perceptions of when adulthood begins into the mid to late twenties (ibid). It follows that the “transition period from childhood to adulthood now occupies a greater portion of the life course than ever before at a time when unprecedented social forces, including marketing and digital media, are affecting health and wellbeing across these years” (ibid).

Throughout adolescence every individual moves through several physiological and psychological developmental stages (WHO, 2014; Smetana et al., 2006; Bowen and Walker, 2015), each involving varying levels of interaction with potential intimate partners. The developmental tasks of adolescence are vast, relating to puberty, sexual maturation, the evolution of personal and social interests, and the attainment of hypothetical and deductive reasoning skills and those that relate to the construction of identity and self-conception (Bowen
and Walker, 2015; Christie and Viner, 2005; Sawyer et al., 2018). This suggests that adolescence is a vital developmental stage.

Most research in this sphere to date has categorised adolescence into four developmental phases: early adolescence (ten to thirteen years); middle adolescence (fourteen to sixteen years); and late adolescence (seventeen to nineteen years) and young adulthood (twenty to twenty-five years) (Connolly and McIsaac, 2011; Smetana, Campione-Barr, and Metzger, 2006; Bowen and Walker, 2015). Connolly and McIsaac acknowledge that each developmental stage of adolescence as described above is soft and accommodating of the varying pace each individual may follow (Brown, 1999; Connolly and Goldberg, 1999; Collins, 2003). As such, their model presents a typical trajectory rather than a hard and fast rule for all adolescents, counteracting a criticism of the similar work done by Collins et al. (2009). This research aims to capture any experiences that may span more than one phase, including into young adulthood. Going forward, the term adolescence will be used to refer to all four developmental phases of adolescence, unless otherwise specified.

Considering the variation for individuals, research suggests that the period between onset of puberty and adulthood relates to the period between ten and twenty-five years old (Connolly & McIsaac, 2011 Sawyer et al., 2018). The World Health Organisation [WHO] (2014) offers a chronological definition of adolescence as the period between ten and nineteen years. However, Sawyer et al (2018) suggest that rather than ten to nineteen years, a definition of ten to twenty-five years is essential for developmentally appropriate framing of laws polices and services for adolescents. In addition, they suggest that this expanded definition is more closely aligned to adolescent growth, and understandings of this life phase. This is supported by recent developments in neurological research, which suggest the human brain is not fully matured until the mid-twenties (for example, Fuhrmann, Knoll and Blakemore, 2015). Therefore, this study conceptualises adolescence as between the ages of ten and twenty-five.

**Adolescent Intimate Partner Violence**

The violence that occurs during adolescent relationships has only just begun to be explored in the UK (Barter et al., 2009; Gadd et al., 2014; Barter et al., 2015). As such, the aetiology of violence is unclear, as is its origin in adolescent intimate relationships. It can be argued that the developmental seeds of violent and abusive behaviour, and the tolerance of them as conflict-resolution tools, are rooted in childhood behavioural problems (Moffitt, 1993; Bowen and Walker, 2015), as opposed to occurring for the first time in adolescence. Nevertheless, some evidence suggests that biological changes during adolescence, particularly the timing
of puberty, may increase the likelihood of adolescents engaging in sensation-seeking and risk-taking behaviours (Robbins and Bryan, 2004).

Traditionally, research and policy on violence between intimate partners has been referred to as domestic violence and abuse (DVA). The term intimate partner violence (IPV) is often used when describing the violence that occurs in adult relationships where the couple are not married or cohabiting (Kelly and Johnson, 2008). Arguably the term IPV is more encompassing of the violence that occurs in the various relationships that occur during adulthood. In addition, since adolescents’ romantic relationships are often less formal than those in adulthood, it also adequately encompasses the complex multifaceted adolescent experiences of relationships without assuming sexual relations, formality, length, or emotional depth and commitment (Collins, 2003). Therefore, this term is adopted here and will be referred to as Adolescent Intimate Partner Violence (AIPV) in order to recognise the age of victimisation.

To explore AIPV in more detail, an examination of the cross-governmental definition of DVA is necessary. There is no statutory offence of ‘DVA’ or ‘IPV’; instead existing law is used to prosecute violence against the person (Bowen, 2011). The cross-governmental definition of DVA, although not a legal definition, is widely adopted:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological; physical; sexual; financial; and emotional (Home Office, 2013).

The definition included 16 and 17-year olds for the first time (discussed in more detail on page 43), and included further descriptive notes defining controlling and coercive behaviours:

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim (ibid).

In addition, the Istanbul Convention\(^1\) defines DVA as:

All acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim (Council of Europe, 2011: 8).

\(^1\) The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, otherwise known as the Istanbul Convention, is an international effort to tackle the human rights abuses of male violence towards women.
This definition builds on the cross-governmental definition by acknowledging the victimisation potential for those who are non-cohabiting or in a more casual relationship context. The Convention also recognises that violence between intimates can occur between those aged “below eighteen years” without stipulating a lower age limit for inclusion, counteracting the issues with the cross-governmental definition discussed below (page 43).

**Victimisation**

The focus of this thesis is the victimisation of AIPV. A victim can be defined as “a person harmed, injured or killed as a result of a crime” (Stevenson, 2010). As such, victimisation is the process in which someone becomes a victim.

The process of becoming a victim of AIPV involves experiencing, whilst between the ages of ten and twenty-five years, “any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial or emotional violence” (Home Office, 2013), perpetrated by someone whom the victim is currently, or has in the past been intimate with, regardless of gender or sexuality. It is not necessary for a victim to recognise or identify their victimhood, as much of AIPV is hidden from view (Barter *et al*., 2009).

The term ‘victim’ will be used to describe persons who have been victimised once or more between the ages of ten and twenty-five. It could be argued that by focusing on victimisation, rather than or as well as perpetration, a significant element of the aetiology of AIPV is being ignored. However, the scope of this project encourages a specific focus on one key element of the phenomenon. This thesis contributes to existing knowledge by exploring the process of victimisation, the participants’ experiences of victimisation, support and recovery, and suggests further areas for research, including perpetration, building upon this new knowledge.

There is an ongoing discussion regarding the politics of using the terms ‘victim’ and/or ‘survivor’ when referring to those who have experienced AIPV. For clarity, the term ‘victim’ will be used throughout this thesis as it is the process of victimisation this thesis is predominantly concerned with, in addition to the ways in which participants survived their experiences. The term ‘survivor’ suggests there is a positive outcome from a potentially life-threatening event and represents the extent to which victims reconstruct their lives afterwards (Kelly, 1988). Whilst this recognises the agency of victims, it moves away from the core issue – experiences of AIPV itself (Gupta, 2014).
There is considerable research which suggests that the distinction between victim and offender is blurred, with research supporting a substantial and consistent overlap between the two (Tillyer, and Wright, 2014; Jennings Piquero and Reingle, 2012; Lauritsen and Laub, 2007), particularly during adolescence and young adulthood (Gadd et al., 2013; Barter et al., 2015). Studies exploring the victim-offender overlap suggest that victimisation increases the likelihood of offending and vice versa (Lauritsen and Laub 2007; Lauritsen, Sampson, and Laub 1991), highlighting the importance of its consideration here.

It has been argued that victims and offenders often share routine activities and traits which create opportunity(s) for both victimisation and offending (Lauritsen and Davis Quinet 1995; Jennings et al. 2010; Jennings, Piquero, and Reingle 2012; Tillyer and Wright, 2014). Intimate relationships by their very nature, routinely bring individuals together (Carbone-Lopez and Kruttschnitt, 2010), suggesting that this overlap is highly likely for AIPV, particularly in education and online settings. Tillyer and Wright (2014: 31) suggest that this may also account for the repeated nature of IPV, as the conditions which prompted the initial act of violence may remain unresolved, and/or may produce motivation or opportunity for additional conflicts.

The application of the victim/offender overlap to IPV has arguably been stilted by the long-held belief that IPV is solely a symptom of male oppression of women (see the feminist perspective on domestic violence, e.g., Dobash and Dobash 1979; Dobash et al. 1992; Lawson 2012). This has led to a commonly held understanding of male as perpetrator and female as victim. Indeed, many organisations which support victims of IPV work on the basis that there is a clear victim and offender, often stating that they will not support those with an offending history (Normand and Barron, 2011: 38). Conflict or family violence perspectives view violence between family members and spouses as an attempt to resolve inevitable conflict, rather than a symptom of domination and/or control (Lawson, 2012). Johnson (2008, 2011, 2013) suggests that it is this type of conflict motivated violence that represents his Situational Couple Violence typology (discussed in more detail in Chapter 3 beginning on page 72). Such a consideration of IPV allows for an investigation of the victim-offender overlap in cases of AIPV as it recognises the complexity of intimate relationships and settings, without assuming a victim-offender binary.

Adolescent Intimate Experiences and Partnerships

Despite widely held beliefs that adolescents, especially those in early adolescence, experience only ‘trivial and fleeting’ intimate experiences and partnerships (IEPs), research is beginning to explore the developmental and social importance of adolescent IEPs (Meier and Allen, 2009). Fox, Corr, Gadd and Butler (2013) found that 82.6% of 1143 British thirteen and
fourteen-year-olds had already experienced an IEP. Similarly, Barter et al., (2009) found that 88% of British adolescents (thirteen – seventeen-year-olds) reported at least one IEP, with 96% of those reporting only opposite sex partners. This suggests that the context in which AIPV can occur is a factor in many adolescents' lives.

Barter and colleagues’ findings also suggest that a significant number of adolescents (4%) are exploring non-heterosexual experiences (2009). This is supported by Collins, Welsh and Furman’s assertion that adolescent IEPs are marked by “expressions of affection and perhaps current or anticipated sexual behaviour” regardless of gender or sexuality (2009:3). As such, this research seeks to explore AIPV within both mixed-sex and same-sex adolescent IEPs (Bowen and Walker, 2015: 3).

Carver et al., (2003) found that fourteen-year-olds’ IEPs typically lasting four weeks to four months. Whereas, sixteen-year-olds reported partnerships lasting approximately six months, and eighteen-year-olds reported IEPs lasting twelve or more months. This suggests that adolescents spend more time with partners and invest more in IEPs as they progress through adolescence. Interestingly, Carver et al. (2003), and more recently Meier and Allen (2009), found that there was little difference between the sexes in terms of frequency and length of adolescent IEPs, later substantiated by Connolly and Mclsaac (2011). The increasing prevalence of IEPs in adolescence, is especially relevant to this study, as it demonstrates the exposure to IEPs and AIPV adolescents face.

Furthermore, the increasing commitment to IEPs across adolescence seemingly reflect adult IEPs, consisting of factors such as exclusivity, family formation, and cohabitation. These factors may alter individual and societal perceptions of and IEP, arguably increase its credibility as a potential site for AIPV to occur. This has been reflected in the inclusion of sixteen and seventeen-year-olds in the cross-governmental definition of DVA (discussed in more detail on page 43) (Home Office, 2013) and increasing research highlighting the prevalence of AIPV (Bowen and Walker, 2015).

Various disciplines, including psychology, sociology, and criminology have attempted to define and label adolescent relationships. Collins conceptualises them as ‘romantic relationships’, which he describes as “on-going voluntary interactions that are mutually recognised” (2003: 2). He does not specify gender, recognising adolescents’ experiences of both other-sex and same-sex ‘relationships’, as substantiated by Barter and colleagues’ findings (2009). Collins goes on to describe ‘romantic relationships’ as “complex, multifaceted experiences ...” identified by “involvement [and] identity of partners, the content and the quality of the relationships and the thoughts and feelings associated with them” (p. 12). Madsen and Collins (2011) also suggest that ‘romantic relationships’ are ongoing partnerships “characterised by
passionate feelings” where the focus is on the experiences of the couple as opposed to the individual (p. 798). These authors appear to recognise the complexity of adolescent IEPs, yet the term ‘romantic relationship’ simplifies them, suggesting that adolescents engage solely in something similar to the benchmark of adult committed relationships.

Considering the varying degree of importance placed on IEPs throughout the different adolescent developmental stages, the term ‘romantic relationship’ arguably only reflects the relationships described mostly in late adolescence and young adulthood (seventeen to twenty-five years old) and does not adequately reflect the variety of relationships adolescents’ experience. In an attempt to address this, American scholars have also used the term ‘dating’ to replace ‘romantic’ when conceptualising adolescent relationships (for example, see Connolly, Friedlander, Pepler, Craig and Laporte, 2010). AIPV is thus often referred to as ‘adolescent dating violence’.

The term ‘dating’ is synonymous with the tradition of ‘courting’ someone and is traditionally the phase of a romantic partnership that occurs prior to a formal commitment to one another (Buckley, Sheehan and Shochet, 2010). In the British context, the term ‘dating’ suggests formal outings of a romantic nature, which arguably does not fully encompass the range of activities of adolescent partnerships. For example, a couple’s partnership may solely be sexual, or casual, whereas others may not see one another outside of the school grounds yet classify themselves as being in a relationship. Collins et al., (2009) suggest that adolescent IEPs can also include a greater range of activities and cognitions, including those which do not involve direct experiences with another individual, such as online relationships, the use of dating apps, and those fostered via social media (Bowen and Walker, 2015). The format of such experiences is also likely to vary depending on the stage of adolescent development (Connolly and McIsaac, 2011). Furthermore, young people often amend the English language depending on their age and geographical location; it is also likely that the relationship terminology they employ will vary greatly (Barter et al., 2009; Fox et al., 2013). To address the varying nature of British adolescent intimate experiences they will be referred to here as intimate experiences and partnerships [IEPs].

To capture the entirety of adolescence and the experiences of IEPs and AIPV, this study builds on the models presented by conceptualising adolescence as between the ages of ten and twenty-five years old, and any IEP as any emotional, romantic, or sexual experience shared between two individuals when at least one individual is between the ages of ten and twenty-five years. Furthermore, AIPV is defined as “any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial or emotional violence” (Home Office, 2013), perpetrated by someone whom the victim is currently
or has in the past been intimate with, regardless of gender or sexuality, whilst one or both partners are between the ages of ten and twenty-five years.

**Gender**

Before delving into the hotly contested IPV gender a/symmetry debate (Straus, 1979; Dobash and Dobash, 2004), it is important to note how gender is defined and constructed, as ‘what is missing, oddly, from these claims of gender symmetry is an analysis of gender’ (Kimmel, 2002: 1334).

Over the years, the terms sex and gender have become confused despite being definitively distinct from one another. A person’s sex is the biological category assigned to them at birth, i.e. male or female. This biological view may well identify the anatomical body but does not identify the person’s gender (Barriteau, 2001). Use of the term gender in place of sex however, reduces what is a complex and contested concept into one which ‘attributes women’s’ psychological and social experiences to fixed and unchanging traits resident in women’s physiology’ (Ferguson, 1993: 81).

Gayle Rubin (1975) suggests that society constructs two different sexes, based around the family, which work to concentrate power with patriarchs, i.e. older men who control women and younger men. De Beauvoir (2009: 5) goes on to suggest that society itself is male and ‘man defines woman not in herself but as relative to him’. This ‘otherness’, de Beauvoir suggests, is a fundamental category of human thought, i.e. woman is not defined by her biological sex but by her otherness to men. This gender binary not only reinforces biological determinism but suggests gender is fixed and is restricted by sex (Butler, 2007; Squires, 1999). Despite this critique, society continues to uphold these oppositional associations of male/female and of masculine/feminine where the first is seen as strong, positive, rational, dominant and independent, and the latter is depicted as weak, soft, emotional, submissive and dependent (Davis, 2011).

In order to highlight the constraints of the biological determinist view of gender/sex, feminist scholars theorise gender as a social construct (Alloway, 1995), as institutional practice (Squires, 1999), gender as discourse (Weedon, 2000), and as a performance (Butler, 1993; 1999; 2000; 2004). ‘Feminist scholarship has appropriated the term [gender] to signify the complex social relations between women and men that is historically characterised by a disproportionate distribution of power’ (Barriteau, 2001). As such, the performance, practice and discourse of gender are constructed according to each situation and the individuals
involved. Such situations appear to be particularly gendered for adolescents (Wekerle and Wolfe, 1999) as will be discussed in the following section.

2.2 The Prevalence of Adolescent Intimate Partner Violence

Each individual may encounter AIPV differently, and will certainly bring individual contextual factors to each potentially violent partnership; for example, their socioeconomic status, whether they have experienced familial, peer, or IPV previously etc. This section will begin by exploring the difficulties in determining the prevalence of AIPV, followed by a detailed analysis of the existing data suggesting the prevalence of psychological, sexual, and physical AIPV.

Determining the Prevalence of Adolescent Intimate Partner Violence

Exact prevalence rates of AIPV are difficult to determine because of a range of factors: there are varied definitions of violence used, and differences in collection techniques, sampling frames, and methodological approaches employed (Foshee, Bauman, Linder, Rice and Wilcher, 2007; Vezina and Hebert, 2007; Bowen and Walker, 2015). Similarly, due to its largely secretive nature, AIPV is a difficult phenomenon to study (WHO/London School of Hygiene and Tropical Medicine, 2010).

There are many reasons why AIPV remains hidden, many of which reflect the underreporting of domestic violence incidents in adults. Victims may be unaware that the incident(s) are defined as abusive, and, therefore, a crime; they may fear retribution by the offender, their friends, or family (Fox, Corr, Gadd & Butler, 2013); they may feel that they are ‘better off’ in an abusive relationship rather than being single, for example due to peer pressure (ROTA, 2011); they may be unaware that adolescents can be victimised in such a way (Gadd et al., 2013); and/or they may fear that they will not be believed by the person(s) they report the incident(s) to (Fox et al., 2013; Foshee et al., 1996; Wood, Barter & Berridge, 2011). Any of these factors alone or in combination may discourage a victim from reporting their experiences to anyone, let alone the police. This may be complicated further for adolescents in that many sources of support, have a power advantage over them due to their status as adults. Consequently, the official crime statistics provided by the Crime Survey for England and Wales (CSEW), although incredibly useful, are fundamentally flawed.
The British Crime Survey (BCS) has attempted to counteract this by asking the British public to report their victimisation (The British Crime Survey ceased to cover Scotland with the first independent Scottish Crime Survey (SCS) launched in 1993 and has been known as the Crime Survey for England and Wales (CSEW) since then). Since its inception in 1982 the BCS/CSEW has capped the number of violent incidents a person can report per annum at five (Barrett, 2007). Any crimes experienced by the same person twice or more are therefore known as series crimes. It can be argued that the cap has led to a systematic underestimation of the true level of victimisation, especially in cases of repeat victimisation, which is the norm in cases of AIPV and DVA.

Professors Farrell and Pease (2007) re-analysed the 2005-6 BCS/CSEW statistics to include all series crimes, including common assault, wounding, robbery, and snatch theft. This analysis suggests that such violence is in fact 83% (or two-million violent crimes) higher than the BCS/CSEW suggests. They go on to propose that the prevalence of DVA and AIPV increase by 140% when all series crimes are included. This is reflected in statistics put forward by Burris and Jaffe (1984) suggesting that a victim of domestic violence is victimised on thirty-five separate occasions of increasing severity before they report an incident to the police. This figure is likely to increase further given that adolescents rarely relate to the term DVA due to the common misconception that it solely occurs during adulthood, and so are even more unlikely to report to the police (Gadd et al., 2014).

As previously discussed, this study conceptualises AIPV as the experience of any incident or pattern of incidents of controlling, coercive, or threatening behaviour, and/or psychological, physical, sexual, financial, or emotional violence, perpetrated by someone whom the victim is currently or has in the past been intimately partnered with, regardless of gender or sexuality, whilst one or both partners are between the ages of ten and twenty-five years. It is important to note that it is not necessary for more than one incident or type of violence to be present for victimisation to be validated, although it is anticipated that participants will have experienced many incidents before becoming known to gate-keepers (further discussion begins in Chapter 4). It is also expected that some participants may have perpetrated IPV, as per the discussion of the victim/offender overlap on page 24.

There are also issues surrounding how the various published studies measure violent behaviours. Many studies have solely considered the frequency of violent incidents, e.g. he slapped her across the face twice, whereas in recent years there has been an increasing amount of literature which has also considered the severity of the violence (See for example, Riggs and O’Leary, 1989; Barter et al., 2009; McHugh and Frieze, 2006).
Those using Straus’ (1979) Conflict Tactics Scale (CTS) or the amended CTS-2 categorise violence in the context of a disagreement by scoring incidents in terms of their severity as either ‘rational discussion’, ‘expressions of anger’, or ‘physical violence’ (McHugh and Frieze, 2006). The CTS has been used extensively over many years to allow some comparison between studies, however, it has some major limitations. It assumes that all violence and aggression occurs within the context of a disagreement between two adults, one male and one female, who are in a committed relationship (Archer, 1999; Straus and Mickey, 2012; DeKeseredy and Schwartz, 1998). These restrictions clearly ostracise those individuals who become victims of violence in same-sex relationships, are adolescent, in more casual or open relationships, and in any context which cannot be described as a disagreement.

With the CTS or CTS2, if a violent incident is reported to the researcher the couple itself and the individuals involved are labelled ‘violent’. This poses a further issue, as there is no way of differentiating between relationships with varying levels and/or frequency of violence, as they are all labelled identically. This study aims to overcome this by providing in-depth context via the victims’ lived experience through the victims’ narratives, as well as asking specific acts-based questions.

Although it is obviously important to know how frequently young people experience relationship violence, unless we also understand the impact violence has on their wellbeing we will only ever be able to present a limited understanding of the issue. Additionally, we will be unable to develop appropriate responses which reflect young people’s own understandings and experiences (Barter and McCarry, 2012: 106).

Despite these many inconsistencies, some have attempted to quantify the prevalence of victimisation of IPV (For example, CIETafrica, 2002; Garcia-Moreno, Jansen, Ellsberg, Heise, and Watts, 2005; Glass, Fredland, Campbell, Yonas, Sharps, and Kub, 2003; Hickman, Jaycox, and Aronoff, 2004). However, fewer have attempted to quantify the victimisation of adolescents, and even fewer have specifically considered British adolescents (See Barter et al., 2009; Fox et al., 2013; Barter et al., 2015), highlighting the urgent need for further research.

Another criticism of studies seeking purely quantitative data, or limited qualitative data as prescribed by tools such as the Conflict Tactics Scale (CTS), is the inability to measure the impact of the violence on its victims and perpetrators. Many disciplines (for example, social work, criminology, psychology, and sociology) have attempted to measure the impact of IPV on victims over the last three decades (Riger, Raja, and Camacho, 2002; Shonkoff and Garner, 2012; Wathen, MacGregor and MacQuarrie, 2016). They have unanimously agreed that IPV victimisation has a severe and profound negative impact on its victims, which can last a lifetime and cross generations, and has been found to “profoundly damage the physical,
sexual, reproductive, emotional, mental and social well-being of individuals’ families, and partnerships” (WHO, 2010: 3). The impact of the participants’ experiences can be found in Chapter 6.

In the first UK study of AIPV victimisation, Barter et al. (2009) aimed to determine both the frequency and severity of participants’ experiences. They asked respondents “if any of their partners had used physical force such as ‘pushing, slapping, hitting or holding you down’ … or more severe physical force such as ‘punching, strangling, beating you up, hitting you with an object’” (Barter and McCarr, 2012: 106). This enabled a cursive examination of British adolescents’ experiences of IPV whilst providing a basis for further quantitative and qualitative study of the lived experience, including the present study. A more detailed analysis of this study can be found in Section 2.3, beginning on page 35.

The Prevalence of Psychological Adolescent Intimate Partner Violence

Psychological violence is perhaps the most pervasive facet of AIPV, often occurring on its own but also as a precursor to, and amongst a campaign of, both sexual and physical violence (Stark, 2007; Johnson, 2008). Little attention has been paid to it in adolescent populations in comparison with adult populations (Bowen and Walker, 2015; Giordano, Soto, Manning, and Longmore, 2010; Leen et al., 2013). This said, the conceptual overlap of controlling behaviours and psychological violence has been theorised and tested among adolescent populations (for example, see Bowen and Walker, 2015).

Psychological abuse consists of a vast array of behaviours, such as insults, humiliation, name-calling and isolation (CDC, 2006; Bonomi, 2012; Bowen and Walker, 2015); damaging property, provoking jealousy, and threatening to end the relationship or commit suicide (Orpinas, Nahaptyan, Song et al., 2012). Bonomi et al. (2012) found that stalking and threats were also common. Stalking involves “harassment and excessive monitoring activities … and insisting that the partner always can account for where they are, what they are doing, and with whom” (Bowen and Walker, 2015). Threats can be direct, including verbal threats to hurt or kill, threats to damage a partner’s property, or threats with a weapon (Draucker and Martsolf, 2010; Bowen and Walker, 2015). A newly identified concept borrowed from peer-violence literature is the issue of ‘relational aggression’, involving attempts to harm relationships with friends by spreading rumours, and revealing personal information and images (Leadbeater, Banister, Ellis, and Yeung, 2008), cumulating in the new ‘Revenge Porn’ offence under the Criminal Justice and Courts Act (2015).
Pressure and/or coercion play a significant role in the victimisation of young women (Stark, 2007; Johnson, 2008). Stark argues that coercive control is not only the most common form of AIPV, but also the most hidden, due to its individualised nature whereby perpetrators specifically target behaviours towards their victims, usually on a gradually increasing scale. These behaviours are difficult to identify unless looked at and understood from within the wider context of violence and patterns of incidents (ibid). Such controlling behaviour is encompassed within Johnson's Intimate Terrorism typology, discussed in more detail on page 68.

Many victims struggle to identify non-physical forms of violence, instead perceiving them as normative aspects of relationships. This is especially likely for adolescents whose relative inexperience in IEPs may lead them to believe that this level of control indicates a “committed relationship, a partner’s love, or being extremely important to their partner” (Catollozzi, Simon, Davidson et al., 2011: 317). O’Leary and Smith-Slep (2003) suggest that some psychological tactics are normative in adolescence.

Nevertheless, existing research has attempted to quantify psychological violence victimisation, with some studies identifying victimisation rates as high as 90% (Jezl, Molidor and Wright, 1996). Bonomi and colleagues, when surveying 297 adolescents (64% female, 36% male) aged thirteen to nineteen years old, found that of those who had ‘dated’, 64.7% of females and 61.7% of males reported experiencing psychological AIPV, with 36.5% of the abused females and 42.1% of the abused males experiencing controlling behaviours (2012), suggesting psychological abuse is prevalent in adolescent IEPs.

The Prevalence of Sexual Adolescent Intimate Partner Violence

Definitions of sexual violence include rape, attempted rape, sexual assault, and other forms of sexual coercion (Rickert, Weimann, Vaughan, and White, 2004; Bowen and Walker, 2005), including sexual acts without consent (Smith and Donnelly, 2000), unwanted touching and kissing, and not letting a partner use contraception. Bonomi and colleagues succinctly describe sexual abuse as “forcing a partner to engage in a sex act(s) when he or she does not or cannot consent” (2012: 637).

Cawson, Wattam, Brooker, and Kelly (2000) recognised the role that both sexual coercion and physical force play in the sexual victimisation of young women. Reflecting this, Barter et al.’s (2009) study asked participants if they had ever been pressured or physically forced (original emphasis) to “do something sexual, such as kissing, touching, or something else”, and if they had ever been pressured or physically forced into “sexual intercourse” (Barter and McCarry, 2012: 109).
The evolution of portable sharing technology, such as smart phones, has somewhat complicated the study of sexual abuse. Younger generations are more technologically literate, making it more difficult for those less savvy to clearly identify abusive behaviours. The transmission of sexually explicit images, videos, and messages, known collectively as ‘sexting’, has caused much concern despite the growing normality of such behaviours among adolescents (Meyer, 2016). Similarly, the act of sharing sexually explicit pictures and videos without consent, known as ‘revenge porn’, has had an increasing coverage, cumulating in the introduction of a ‘revenge porn’ offence (Section 33 of the Criminal Justice and Courts Act 2015). The first Europe-wide investigation into the interconnectedness of adolescents’ on and offline lives, Safeguarding Teenage Intimate relationships (STIR), was published in 2015 (further discussion in Section 2.3).

Sexual victimisation rates have typically ranged from 1.2% (Ackard and Neumark-Sztainer, 2002) to 32% (Collin-Vezina et al., 2006) in girls and from 1.0% (Ackard and Neumark-Sztainer, 2002) to 16% (de Bruijn, Burrie and van Wel, 2006) in boys. Due to the pervasive nature of rape culture and myths surrounding sexual violence (Burt, 1980; Abrams, Viki, Masser, & Bohner, 2003), researchers suggest that victims, and especially teenage victims, struggle to define their own experiences as sexual violence (Barter, 2011).

The Prevalence of Physical Adolescent Intimate Partner Violence

Physical aggression and violence is the most widely recognized form of AIPV, with prevalence rates ranging from 3.3% to 87% (Leen et al., 2013; Krahe and Berger, 2005; Coker, Smith, McKeown and King, 2000; Barter et al., 2009). As such, there is considerable widespread agreement regarding the behaviours that constitute physical violence in the context of AIPV (WHO, 2005; Collins, 2003; O’Keefe, 2005; Shorey et al., 2008; Windel & Mrug, 2009; Halpern et al., 2009; Murphy & Smith, 2010; Sunday et al., 2011; Shorey et al., 2011; Foshee, et al., 2001; Foshee et al., 2014; Bonomi et al., 2012). For example, Riggs and O’Leary (1989, 1996) suggest that physical violence includes behaviours such as slapping and grabbing, in addition to assaults with weapons and beatings. Foshee and colleagues expand upon this, and include “scratching, slapping, pushing, slamming or holding someone against a wall, biting, choking, burning, beating someone up, and assault with a weapon” (Bowen and Walker, 2015: 8).
2.3 Adolescent Intimate Partner Violence in the UK

This chapter has thus far introduced the associated definitions and prevalence of AIPV. Building upon the ground-breaking NSPCC study in 2009 two further UK studies have been published (From Boys to Men and STIR). Each of the studies add original contributions to the knowledge of AIPV. This section will examine the three landmark studies, NSPCC (2009), From Boys to Men project (2014), and STIR (2015), highlighting how this thesis will build on the knowledge they have created.

Partner Exploitation and Violence in Teenage Intimate Relationships (2009)

The NSPCC study was the first of its kind in the UK, highlighting a significant prior knowledge gap (Barter et al., 2009). The study aimed to establish the nature and prevalence of AIPV, to identify if there were any specific risk or protective factors associated with experiencing AIPV, and to identify any wider societal systems which might underpin AIPV.

The study adopted a mixed-methods approach, including a survey completed by 1,353 adolescents between the ages of thirteen and seventeen, from several schools across England, Wales and Scotland. In addition, interviews were held with sixty-two girls and twenty-nine boys.

The levels of violence found clearly identify AIPV as a significant child-welfare, human rights, and public health issue requiring urgent attention. There were several key themes in the findings. Firstly, there was a clear gender divide in the experiences of AIPV. Girls experienced more AIPV, a greater negative impact, and more self-blame for their victimisation than boys. Girls also experienced coercive control more acutely than boys, often reporting control over where they could go, who they could see, and what they could do. The female participants often reported being isolated from their support networks, and being under constant surveillance using new technologies, including mobile phones.

This gendered divide continues in the individual internal responses to their experiences, with many reporting being unsure whether their victimisation was control or concern for their wellbeing. In addition, many girls reported being too scared of their partner’s reaction to challenge their behaviour. Conversely, boys reported being amused by their partner’s attempts to control them, often ignoring their attempts or ending the relationship. Due to the reported fear, girls frequently remained in an abusive relationship longer than they would have liked, often for a considerable time. Although, when they did exit the abusive relationship, some experienced an escalation in post-separation violence, reflected in the adult literature.
Interestingly, the NSPCC study found that participants in early and middle adolescence (aged thirteen to fifteen) were just as likely as their older peers (sixteen years and over) to experience AIPV, distinctly contrasting the pervasive dismissive discourse of AIPV widely held prior to the publication of this study. Help-seeking was not often reported, with those asking for help turning first to their friends, a small minority turning to an adult, and the majority telling no one. The quality and appropriateness of the support received varied, especially when the source of support held inappropriate views about the acceptability of violence.

There were several risk factors identified with victimisation and perpetration: previous maltreatment and abuse, familial domestic violence, pro-violence peer groups, and for girls, having an older, and especially a much older partner (two years or more). Interestingly, all the girls reporting a much older partner experienced AIPV, highlighting a significant opportunity for intervention. Furthermore, all acts of severe AIPV were instigated by older partners.

The NSPCC study was the first of its kind in the UK highlighting the prevalence and nature of AIPV and some of the factors associated with experiencing it. Whilst the report highlights the significant gendered differences in experiences, it does little to theorise why this may be the case. This thesis aims to explore the prevalence and nature of AIPV, how victims of AIPV experienced it, and the ways in which their identity affected their experiences, namely their age, gender, disability, and other factors from an intersectional approach (discussed further in Chapter 3). This exploration will be utilised to highlight the significant increased risk to adolescents when compared to adults, and will make clear recommendations for research, policy, and practice.

**Precluding the Proclivity to Perpetrate: The From Boys to Men Project (2014)**

The aims of the From Boys to Men project (Gadd et al., 2014) were to explore the impact of gender on the prevalence of AIPV victimisation and perpetration and to explore why some boys perpetrate AIPV and others do not. By identifying these factors, the research team aimed to establish what could be done to reduce the number of AIPV perpetrators.

This project also used mixed-methods, this time with a survey of 1,203 thirteen and fourteen-year olds, focus groups with sixty-nine young people aged thirteen to nineteen years of age, and life-history interviews with thirty young men aged sixteen to twenty-one who had experienced domestic abuse as a victim, perpetrator, and/or witness.

Analysis of the survey data found several interesting points. Firstly, over half (52.5%) of the survey population had experienced IPV as a victim, perpetrator, and/or witness. This highlighted that prevention interventions should be designed with the assumption that a
significant number of the audience will have prior experience of domestic abuse, even at ages thirteen and fourteen. Furthermore, 44% of boys and 46% of girls had experienced at least one facet of AIPV, mostly within the last twelve months. This contrasts heavily with the statistics for adults, which suggest one in six men and one in four women will experience domestic abuse (Office for National Statistics, 2017). Furthermore, it suggests that preventative education needs to start at least before age thirteen (Fox et al., 2013; Gadd et al., 2014).

In addition, emotional abuse and controlling behaviours were experienced by 38% of respondents, physical AIPV was experienced by 17% of respondents, 21% experienced threatening behaviour and/or property damage and 14% experienced sexual AIPV. Interestingly, there was only a statistically significant gendered difference in experiences for sexual violence, in that girls were more likely than boys to experience it.

There was no statistical gendered difference in the self-reported perpetration of emotional abuse and controlling behaviours (20%), physical violence (7%), and sexual abuse (4%), with 25% of respondents reporting having perpetrated at least one abusive behaviour. However, girls reported noticing and/or witnessing more abuse, especially psychological abuse, which perhaps makes them more perceptive to it and more likely to self-report perpetration and victimisation of it. In addition, over half (51.2%) of the AIPV victims also self-reported perpetrating at least one form of AIPV. Furthermore, 92.3% of self-reported perpetrators also indicated that they had been victims of at least one form of AIPV. This highlights the requirement for further exploration into the role of gender in the perpetration and victimisation and bidirectional violence of AIPV across the trajectory of adolescence, considering that it may well change over the developmental period. As such, it is recommended that an intersectional approach to studying AIPV is adopted, which allows the study of gender to be studied alongside other factors, such as age, without becoming gender-neutral and losing the understanding of the overall impact of gender on AIPV experiences. This is discussed in more detail in Chapter 3.

The survey also considered the respondents’ attitudes towards AIPV. Interestingly, there was a statistically gendered difference in those who thought it was acceptable to hit their partner in at least one of twelve scenarios: 49% of boys compared to 33% of girls. Furthermore, female-to-male violence was more socially accepted than male-to-female violence. However, it is important to note that many of the boys (17.5%) thought it was acceptable to hit their girlfriend if she had hit him first, suggesting that female victimisation might be more prevalent in this scenario, perhaps explaining the victim-offender overlap found in adolescence.
Respondents who had experienced domestic abuse as a victim, perpetrator, and/or witness were more likely to think hitting a partner is acceptable: 44% compared to 37% of those without previous experience. Therefore, the acceptability of AIPV appears to be shaped by both gender and previous experiences of domestic abuse. This is particularly significant, as it highlights potential risk factors associated with victimisation and perpetration and suggests potential opportunities for prevention and intervention efforts. It also highlights that victims of AIPV, especially females, are more vulnerable to re-victimisation, and subsequently considerable investment in intervention should be earmarked to avoid such re-victimisation.

The survey went on to explore the help-seeking behaviours of this group of thirteen and fourteen-year-olds. A further gendered difference was identified here, with half as many boys (33.3%) than girls (67.5%) stating that they would seek help from an adult if experiencing AIPV. However, this difference levelled out when respondents had experienced familial domestic abuse. Those with previous experience were also statistically less likely to seek help from an adult compared to those who answered hypothetically. This suggests that perhaps those already experiencing DVA and/or AIPV had experienced poor responses to previous requests for help and highlights the requirement for those giving support to be aware that their response and attitudes will likely influence those of the help seeker.

Whilst the results of this survey bring to light several interesting findings, the survey uses an acts-based approach, and consequently the findings do not take the context of each experience into consideration. This is particularly important when considering gendered differences in experiences, as other studies (including the NSPCC and STIR projects) have identified significant gendered differences in both the context and impact of AIPV for boys and girls. Repetition of the survey taking this into account and supplementing it with contextual and impact data could perhaps overcome this.

The second phase of the project involved focus groups with sixty-nine young people. They uncovered complex attitudes towards AIPV among young men. Participants described potential perpetrators as ‘scumbags’, ‘druggies’ and as being from ethnic minorities. This suggests that perpetrators are viewed as being ‘others’. However, on elaboration many participants justified perpetration when the male was insecure, aggrieved, or paranoid, suggesting that a lack of trust both explained and justified abuse, despite at other times claiming AIPV was never acceptable. Gadd and colleagues suggest this perhaps explains why some perpetrate despite their condemnation of ‘proper’ perpetrators. Interestingly, when discussing domestic abuse as opposed to AIPV, participants viewed this it as an adult phenomenon, supporting a move towards identifying it as AIPV rather than DVA.
Phase three of the project involved life-history interviews with thirty young men aged sixteen to twenty-one who had experienced domestic abuse as victims, perpetrators, or witnesses. The interviews uncovered much vulnerability in the narratives of these young men, including feelings of powerlessness, a perceived duty to protect women whilst covering their own vulnerabilities, little or no support, and significant self-loathing, although participants did not describe living in fear of violence, unlike females in other studies (Barter et al., 2009; Barter et al., 2015).

Motivations for perpetration included a desire to ‘win’ fights with their girlfriends, in response to an infidelity, on separation, and/or due to misogyny and racism. It appears that the capacity to use threats and/or violence to intimidate and control their girlfriends was developed gradually over time, suggesting that older adolescent males are more likely to use coercive control. This perhaps explains why female victims with older and much older perpetrators experience more frequent and more severe AIPV (Barter et al., 2015). Interestingly, this group of young men had experienced many escalating punitive responses to their behaviour, including school exclusion and prison, yet they continued to hold pro-AIPV beliefs. This suggests that an alternative tactic is required which is more constructive and diverts them away from the criminal justice system via a more holistic intervention (Miles and Condry, 2014; Condry and Miles, 2015). It would also be useful to include female respondents in both the focus groups and interviews to distinguish whether the gendered differences explored above are replicated for girls.


The aims of the STIR project (Barter et al., 2015) were four-fold: it aimed to raise awareness through the provision of robust evidence, to enable young people’s experiences and views to inform policy and practice; to enhance the development of appropriate prevention and intervention programmes; and provide a resource which young people can access directly. The project was delivered through three phases across five European countries: Bulgaria, Cyprus, England, Italy, and Norway. Stages two and three are most relevant to this thesis and will now be explored.

Phase two of the STIR project involved a school-based survey of 4,564 young people aged fourteen to seventeen years old, across forty-five schools in five countries. Almost three quarters of respondents (72%) reported having had a boyfriend or girlfriend, and so the survey
results are based on those 3,277 respondents. The project focused on online and offline abuse, physical, sexual, and psychological violence.

With regards to online abuse, approximately 40% of both males and females in each country reported victimisation, apart from young men in Norway and England, who reported 23% victimisation. Control and surveillance were the most frequently cited forms of online abuse for both genders.

Interestingly, young women in England and Norway reported the highest levels of physical violence, representing almost one in five, compared with one in ten in the other countries. Sexual violence was reported by 17% to 41% of young women, and 9% to 25% of young men. Pressure into sexual activity was more frequently reported than physical force. The majority of sexual violence occurred offline or both on and offline, with very few reporting only online sexual violence. Young women in England and Norway also reported the highest rates of sexual violence, with one in three reporting some form of unwanted sexual activity.

The STIR project also considered the self-reported impact of victimisation, and found it varied depending on the type of violence. However, it was clearly gendered, supporting the NSPCC study (2009). Female respondents were much more likely than male respondents to report a negative impact; this was most noticeable for sexual violence victimisation. Female respondents reported a negative impact 81% to 96% of the time, whereas male respondents reported a positive or no effect response 60% to 75% of the time.

Impacts varied across the different types of violence. Nevertheless, a clear pattern emerged. Young women were much more likely to report a negative only impact, whilst young men were more likely to report a positive or no effect response to their experiences. This was most noticeable for sexual violence, where between 81% and 96% of young women reported a negative only impact, whilst between 60% and 75% of boys reported a positive or no effect response. It therefore appears that young women may be more negatively affected by their experiences than young men, especially in the case of sexual violence.

The STIR survey also asked respondents to report their perpetration of AIPV behaviours. An interesting pattern emerged, whereby female respondents identified themselves as perpetrators more often than male respondents. Female respondents were most likely to report using offline emotional violence and physical violence, whereas male respondents were substantially more likely to report sexual violence perpetration. Yet, when incident rates

2 Negative responses were as follows: feeling upset, scared, embarrassed, unhappy, humiliated, bad about oneself, angry, annoyed, and shocked.

3 Affirmative/no effect responses were as follows: feeling loved, good about oneself, wanted, protected, thinking it was funny, and no effect.
perpetration and victimisation are compared anomalies appear. The data suggests that females generally reported higher levels of perpetration compared to males (except for sexual violence), yet they also report similar or greater levels of victimisation. This suggests that females are more likely to report their own perpetration and victimisation, whilst males are likely to under-report both their victimisation and perpetration. This also supports the From Boys to Men study in that females are more likely to notice and subsequently report violence (Gadd et al., 2014).

Furthermore, the practice of sending and receiving a sexual image or text message to a partner appeared to be largely reciprocal and normalised for both genders. In England, some adolescent girls reported their motivation to send sexual images and/or text messages was either to prove their commitment their boyfriend (43%) and/or because they were pressured by their boyfriend (27%). Additionally, between 13% and 59% of females and 9% to 25% of males recorded a negative impact after sending images or messages, with girls in England, Norway, and Italy most likely to report a negative impact. Furthermore, when image(s) or message(s) were shared with other people, young women were more likely to report a negative impact (97% in England). In all countries adolescents were more likely to have sent a sexual image or message if they were experiencing AIPV. In addition, those reporting any form of victimisation were at least twice as likely to have sent an image or text as those not experiencing AIPV, regardless of gender.

The third phase of the project involved conducting semi-structured interviews with one-hundred young people, of which ninety-one (sixty-seven females and twenty-four male) were analysed as the interviewees had experience of AIPV. The interviewees were between the ages of thirteen and nineteen years old. There were two key themes in the findings of these interviews.

Firstly, a considerable amount of AIPV is normalised among adolescents, including sending sexual images and text messages, control and surveillance both on and offline, verbal abuse and physical violence when one or both individuals had consumed alcohol, and offline sexual pressure being extensive and normalised to the extent that rape was sometimes not recognised. This suggests that urgent awareness raising and preventative education regarding consent, healthy boundaries, and appropriate behaviours are required urgently across Europe.

Secondly, the impact of AIPV varies according to gender and type of violence; however, females report a substantially more harmful impact than males, which is worsened when social networking is involved. This highlights the significant changes in adolescent behaviour since the initial NSPCC project brought about by developing technology, suggesting that all
preventative and intervening efforts should include online behaviour as a matter of course. Furthermore, they should be regularly updated to acknowledge the constantly changing nature and availability of smart phone applications, such as Snapchat, which are difficult for parents and care-givers to monitor.

2.4 Responses to AIPV in England and Wales

This section will explore the development of national and EU laws and policies affecting AIPV in England and Wales. The Government’s response will be explored through a consideration of the Violence against Women and Girls agenda, the criminal justice response, and the role of the health and education sectors in preventing and responding to AIPV, and VAWG more broadly. The section goes on to discuss the contribution to the prevention and response of AIPV by the domestic violence sector.

Government Responses to AIPV

In 1989 the United Kingdom signed the United Nations Convention on the Rights of the Child (UNCRC). The UNCRC aimed to shift the understanding of children (defined as those under the age of eighteen) from “passive objects of care and charity” towards children as “human beings with a distinct set of rights” (UNICEF, 2014). Article 19 of the UNCRC places a legal imperative on signatory states to “take all appropriate legislative, administration, social & educational measures to protect children from all forms of physical and mental violence” (1989: Article 19, paragraph 1; Ellis and Thiara, 2014), both key aspects of AIPV.

Furthermore, Article 17 states that children should have “access to information and material … aimed at the promotion of [their] social, spiritual and moral wellbeing and physical and mental health” (1989: Article 17, paragraph 1). This includes information regarding healthy relationships, sexual health, and mental wellbeing. Whilst these statements are broad, and the process of translation to practice may be complex (Ellis, 2014), they highlight the responsibility of the government to protect children from violence.

Policy level discussions regarding AIPV become explicit through the Call to End Violence against Women and Girls strategy (VAWG strategy) published in November 2010, in response to the findings of the first UK study on teenage experiences of IPV discussed above (NSPCC, 2009). The strategy noted that the definition of domestic violence (Home Office, 2004) might exclude victims under 18-years, and recognises that there may be further vulnerabilities for those who are disabled. In addition, the strategy recognises that children and young people require an understanding of consent, healthy relationships and skills for dealing with conflict,
noting that Sex and Relationship Education (SRE) in schools could deliver this (further discussion of SRE and PSHE education begins on page 46), although the government missed this opportunity to make this a statutory requirement. Furthermore, the strategy drew attention to the high rates of AIPV among teenage mothers (Harrykissoon et al., 2008) suggesting that midwives and health visitors should play a significant part in addressing this (discussed further on page 47).

In 2011 the Home Office went on to publish an Action Plan in support of the VAWG strategy. Amongst various points of action for DVA more generally, the Action Plan introduced a campaign to tackle ‘teenage relationship violence’ (TRA) (Home Office, 2011: 4), by encouraging ‘teenagers to rethink their views of acceptable violence, abuse or controlling behaviour in relationships and direct them to places for help and advice’ (ibid: 4). Launched in September 2011, the TRA campaign, later called This Is Abuse, used a combination of advertising (online, TV, outdoor) and supporting documents (e.g. posters) to deliver their message (Home Office, 2015).

The campaigns were supported by a website which provided further information and live webchat support delivered by third-parties such as Women’s Aid. Since the launch of the This Is Abuse website, there have been 2,000,000 unique visitors, suggesting a wide campaign reach (Home Office, 2015). An evaluation of the adverts with eight-hundred 13 to 18-year-olds found that eight in ten respondents agreed they were more likely to do something about an abusive relationship (their own or a friend’s) because of their engagement with the campaign (Home Office, 2012). In addition, two thirds agreed that AIPV is a serious issue (ibid).

Whilst the campaign was received positively, there was some concern that raised awareness does not necessarily contribute to attitudinal or behavioural change (Home Office, 2015). It was recognised that such change takes time to embed and is most likely to be successful through a multipronged approach. To achieve this, the This Is Abuse campaign was supported by a discussion guide for teachers and professionals, which was received by over 7,000 people (Home Office, 2015). However, with 700,000 young people entering the target audience (13 to 18-year-olds) every year, it was acknowledged that the campaign should work continually to raise awareness and understanding among the audience (ibid).

The Ending Violence against Women and Girls Strategy 2016-2020 provided an opportunity for the campaign to be updated. The government invested £3.85 million in the new Disrespect NoBody campaign, with a new website, adverts and supporting materials and the inclusion of additional issues like ‘sexting’, revenge pornography and child sexual exploitation (HM Government, 2016). In consultation with the PSHE Association, two new discussion guides (for 8 to 12-year-olds, and 16 to 18-year olds) for teachers were developed, with a focus on
developing fundamental key skills and attributes to healthy relationships (PSHE Association, 2016). The HM Government Tackling Child Sexual Exploitation Progress Report (2017) suggests that one-third of teenagers surveyed suggested they would change their behaviour in relationships after engaging with the Disrespect NoBody campaign, and three-quarters would be more confident in challenging abusive behaviour.

The second phase of the Disrespect NoBody campaign was launched in March 2017, focussing on consent using digital and mobile resources, including Spotify, X-Box, YouTube, Snapchat, and adverts on TV (Rape Crisis, 2017). This demonstrates a necessary acknowledgement that young people interact with technology and media in new ways. The campaign has been supported by two further programmes of activity Internet Matters and the Thinkuknow programme, both of which focus on raising awareness among young people, parents and professionals about the increased risks online (Home Office, 2015). In recognition that this is “the first generation of children who are learning about relationships and sex in an online world” (Home Office, 2018), the government published the Internet Safety Strategy Green Paper in October 2017. In addition, the Department for Digital, Culture, Media, Sport with the Department for Education are developing the ‘online safety’ aspects of the RE and SRE made compulsory through the Children and Social Work Act 2017, for delivery from September 2019 (discussed in more detail on page 47). It is hoped that this multipronged approach will build the literacy skills of young people, so that they can make informed choices online.

The inclusion of 16 and 17-year-olds in the cross-governmental definition of DVA (Home Office, 2013) also aimed to increase awareness of the issue and prompt early intervention in this high-risk age group (Home Office, 2018), whilst also challenging the pro-violence attitudes often held by this age range. As a result of the consultation, the government also formulated definitions of controlling and coercive behaviours for the first time in 2013.

Concern was raised by campaigners, such as Women’s Aid, that an increase in awareness of AIPV is likely to increase the demand for services by teenagers, yet many existing services were not adequately resourced for this. The Government sought to address the exclusion of those under 18-years in the existing definition of Domestic Abuse, particularly following the murder of 17-year-old Hannah Windsor by her 18-year-old boyfriend, despite her attempts to seek professional support. The consultation found that a majority (85%) felt that 16 and 17-year-olds should be included in the definition, whilst 54% felt the definition should include all under 18-year-olds (Home Office, 2012). The government agreed that as those aged 16 and over can legally enter into intimate partnerships, cohabit and marry, they should be afforded the same protections as those over 18. However, it was argued that those under 16 are
appropriately covered by existing child protection measures which might cause confusion for professionals when responding to cases. That said, the Home Office advocated for professional discretion in referrals to specialist domestic violence organisations and MARACs when dealing with those under 16 who are at high risk (ibid). It was also recognised that further developments were required to adequately assess the risk and needs of those aged sixteen and seventeen years. This is discussed further through the analysis of the staff participants’ data in Chapter 8.

The extensions to include coercive and controlling behaviours and to include sixteen and seventeen-year-olds were positively received and were built upon with the criminalisation of Coercive Control for all victims over the age of ten through Section 76 of the Serious Crime Act 2015 (SCA). Section 76 of the SCA ensures that patterns of coercion and control are criminalised alongside physical and sexual abuse. It is hoped that by amending, clarifying, and strengthening the existing domestic abuse legislation understanding and awareness of AIPV, and VAWG, will improve.

It is anticipated that these amendments will empower more women and girls to recognise abusive behaviours in their lives, and feel confident that the police, and other statutory agencies, such as social services, health, education, and housing, will also recognise such behaviour as a core element of IPV and be better equipped to support these individuals. It is anticipated that this will also lead to more accurate data regarding the prevalence and impact of AIPV and VAWG.

Since signing the Istanbul Convention in 2012, the government have considerably improved their response to domestic violence and abuse, and AIPV specifically, under four key themes: promote awareness, protect and support, pursue and deter, and improve performance (Home Office, 2017). Each theme has the central aim of preventing DVA. To put in place the remaining requirements and formally ratify the Convention, the government has proposed a Domestic Abuse Bill. The Bill is currently out to consultation with responses due by 31st May 2018.

Whilst these are viewed as improvements for victims, there is some concern over the impact this will have on adolescent perpetrators. There is considerable debate (see Goldson, 2013) regarding the appropriateness of the current age of criminal responsibility (10 years of age) and the subsequent likelihood that responses to AIPV will be dealt with the in the same way as for adult perpetrators. There continues to be concern over the potential for such policy and legislative changes to result in the unnecessary criminalisation of young people (Condry and Miles, 2016; Miles and Condry, 2015; Kelly and Armitage, 2015), particularly as labelling
young people as offenders can limit future opportunities, inhibit their capacity for change and increase their risk of delinquency in adulthood (Hackett, Holmes and Branigan, 2016).

Gadd and colleagues (2013) found that criminal justice responses often led to participants leaving mainstream education and being subject to community-based supervision and monitoring and custodial sentences, each of which is likely to interfere with a young person’s life prospects. Furthermore, this kind of response can perpetuate the ‘hurts and vulnerabilities encountered in adolescence … turning [them] into engendered resentments articulated as sexism and violence in later life’ (Gadd et al., 2015: 8). Subsequently, criminal justice responses to adolescent perpetration will not have the desired desistance effect.

AIPV perpetration interventions, therefore, should be guided by diversionary principles, and designed with the perpetrator’s age, history and complexity in mind if they are to be ‘constructive and containing’ (Gadd et al., 2013, 2015). Ultimately, such interventions should recognise adolescent perpetrators as children first, offenders second (Hackett, 2004). However, the context for perpetration, for example when older perpetrators who target younger victims, should be considered and accounted for in any response, using the criminal justice system where necessary.

Hackett, Holmes and Branigan (2016) suggest that successful interventions aim to promote stable and supportive relationships, help young people develop self-awareness, self-management and a healthy lifestyle. Most importantly, interventions should provide protection for victim(s) and recognise that young people may be naive about some or all aspects of relationships (NSPCC, 2017). Subsequently young people are likely to need assistance to amend their attitudes and behaviours to prevent recidivism (SafeLives, 2017). Therefore, any continuing developments in this area must consider the age of the perpetrator and victim when deciding upon the intervention plan and recognise that adolescents require a response which is cognisant of their needs. Furthermore, the child protection pathway for victims of AIPV who are not included in the cross-governmental definition requires review to ensure that it accounts for the hidden nature of AIPV. This should allow for the required improvements in the process without the requirement for legislative change.

The Role of the Criminal Justice System in Tackling AIPV

The criminal justice system’s response to domestic violence has developed over many decades to become more aware of victim needs, however it has been criticised for doing so at the expense of a perpetrator’s capacity for change (Hoyle, 2008; Condry and Miles, 2015). Each police force has specialist domestic violence officers hosted within a specialist domestic
violence unit, who focus on responding to and managing domestic violence cases. Officers are trained to respond positively to all cases, which often translates into a ‘pro-arrest’ policy, whereby the perpetrator is identified and arrested regardless of the victim’s wishes (Hoyle and Sanders 2000; Gadd 2012). Critics of pro-arrest policies argue they increase risk to victims, particularly where an arrest does not lead to a conviction (Hoyle and Sanders 2000; Miles and Condry, 2015; Gadd 2012).

Following recognition of the complexities of domestic violence cases, specialist domestic violence courts have recently been introduced, alongside several legal measures to assist in the response to incidents of domestic abuse, including Non-Molestation Orders, and Occupation Orders (Miles and Condry, 2015; Hoyle 2008; Groves and Thomas 2014). Such tools are aimed at restricting contact between the victim and offender to give the victim respite during a period of decreased risk.

Whilst these are positive amendments to the existing policy provisions for victims of IPV, they are less likely to be applied to teenagers. Furthermore, they do not take into consideration the likelihood of an adolescent victim and perpetrator attending the same school, college, or university; or the ability for a perpetrator to use technology to continue their perpetration. Nor does it acknowledge that many victims are younger than sixteen years old and are unlikely to be cohabitating with their perpetrator. This undermines the value of DVPOs for victims of AIPV and highlights the need for more inclusive policy development.

The Role of Education in Tackling AIPV

The school environment has consistently been identified as an ideal location for the prevention and intervention of AIPV (HM Government, 2016; Home Office, 2012; 2016; 2017). Evidence suggests that preventative education reduces the social acceptability of violence (Fox, Corr, Gadd and Butler, 2013), however there is currently no statutory requirement for schools to educate pupils of any age about unhealthy relationships and IPV (House of Commons, 2008; Gadd et al., 2014; Formby et al., 2011). Consequently, schools are left to decide what, how, and by whom personal, social, and health issues are covered.

The NSPCC’s Childline spoke out in 2007 about the ‘inadequate’ and ‘patchy’ state of PSHE across the country (House of Commons, 2008: 37), stating that “50 calls a day to the helpline [are] from children seeking advice on sex and relationships” as they have no access to such information in school (ibid: 37). Those schools opting to offer their students SRE/PSHE education do so with varying quality and commitment, leading to a ‘postcode lottery’ of
preventative education almost a decade after the NSPCC’s report. This suggests that adolescents still are not being given the necessary skills for engaging in healthy relationships.

In addition, many teachers report a lack of confidence in broaching sensitive issues including AIPV with pupils (Thiara and Loy, 2014; Barter et al., 2015; Ellis and Thiara, 2014; Ellis, 2014; Siddiqui and Bhardwaj, 2014; Mahony and Shaughnessy, 2007). Some have reported anxiety about eliciting disclosures as they are unsure of the protocols for managing them, despite all schools in England and Wales having a dedicated safeguarding lead in which teachers can seek support and guidance (Ellis and Thiara, 2014).

An amendment to the Children and Social Work Act (2017) created power enabling the government to make regulations requiring Relationships Education (RE) to be taught in all primary schools, and Relationships and Sex Education (RSE) to be taught in all secondary academies and state-maintained schools from September 2019. The regulations and statutory guidance were put to consultation in December 2017, with results pending. It is expected that the Secretary of State guidance will include: “safety on forming and maintaining relationships; the characteristics of healthy relationships; how relationships may effect mental and physical health; and that schools must publish and make available a policy on the subject” (Hayes, 2017: 6). It is unclear at this stage what support will be available to teachers and schools for the preparation and delivery of the new curriculum. The PSHE Association CEO Jonathon Baggaley is clear “this is a historic step and a clear statement of intent from the government” (Hayes, 2017: 6). The full range of PSHE education (including alcohol and drugs, media literacy, mental and physical health, online safety, tackling extremism and developing employability skills) however remains non-statutory (HM Government, 2017).

The Role of the Health Sector in Tackling AIPV

Various health professions are in a unique position for identifying and intervening in AIPV, as victims are likely to turn to them when injured or unwell, or through routine healthcare when pregnant or in other circumstances (Home Office, 2012, 2016). GPs, midwives, health visitors, mental health, drug, and alcohol services, sexual health, and A&E staff are particularly well placed to become agents for AIPV prevention (HM Government, 2016). This highlights the necessity for routine enquiry, and for health staff to be rigorous when screening for AIPV. The NSPCC, From Boys to Men, and STIR projects advocate that a move away from just ‘asking the question’ is required, instead focusing on developing a rapport with patients to enable a comprehensive and accurate clinical history of the patient to be gathered. This is highlighted in the Home Office review of domestic abuse services, which found that 85% of victims seek
help from professionals at least five times before receiving the help they need (ibid). This could be overcome with specialist training of staff which addresses their concerns about routine inquiry.

The inclusion of the early identification of DVA in the NHS mandate (2017/18) recognises the vital role that the NHS has in prevention and early intervention in AIPV. Despite positive developments, there is much more to do to ensure every victim gets adequate support from health professionals the first and every time they ask for it (Home Office, 2017).

The Role of Local Authorities in Tackling AIPV

Local Authorities also have a significant role to play in preventing and intervening in cases of AIPV. The statutory responsibility for safeguarding and promoting the welfare of children falls to local authority children’s social care, where domestic abuse remains the most prevalent factor identified by social workers when assessing children’s needs (Department for Education, 2017). There is some concern that sixteen and seventeen-year-olds are often treated as adults, particularly when they are parents, rather than their own status as children being acknowledged. Therefore, clarification of safeguarding responsibilities for adolescents is required. Victims of AIPV should be identified at the earliest opportunity so that they can be signposted towards specialist organisations promptly, whilst effective multi-agency partnership work should ensure that this process is seamless.

The Role of Multi-Agency Partnership Work in Tackling AIPV

Over the last decade, governmental policy has changed the response to high-risk domestic violence cases exponentially (HMIC, 2014). Specialist Police Domestic Violence units and risk assessments have been created to capture high-risk victims and ensure they receive effective support via Independent Sexual Violence Advisors (ISVAs), Independent Domestic Violence Advisors (IDVAs), and Multi-Agency Risk Assessment Conferences (MARACs) (HMIC, 2014).

IDVAs are specialist domestic abuse case workers who focus on mainly adult victims determined to be most at risk of serious harm or homicide according to the Domestic Abuse, Stalking, and Honour-Based Violence Risk Identification Checklist (DASH-RIC). The victims’ risk is determined according to the number of ‘yes’ answers they provide to DASH RIC, and the evidence of escalation in severity and frequency of IPV incidents. If a victim answers yes to fourteen or more questions they are deemed high risk and are referred to their local MARAC. Those answering yes to between six and thirteen questions are deemed medium risk. In these
cases, the professional is encouraged to use their professional judgement to determine whether the individual should be referred to MARAC or could be managed with existing support services. Standard risk denotes those who answer yes to zero to five questions. Those aged 16 and over should be managed through this referral pathway.

MARACs provide representatives such as the police, social care, probation, substance abuse services, an Independent Domestic Violence Advisor (IDVA), housing, mental health, and health care with a forum to share the information they hold about high-risk victims and their children and aim to use this information to put safety action plans in place. MARACs typically meet monthly to discuss high-risk cases. By the end of the first quarter of 2014 there were two-hundred and seventy accredited MARACs in the UK, dealing with over sixty-four-thousand cases and over seven-hundred and fifty children and young people, including sixteen and seventeen-year olds.

MARACs attempt to overcome obstacles to information sharing and allow the organisations present to manage the victim’s risk in a coordinated manner. IDVAs directly represent the victim at the MARAC and relay the concerns and safety plans discussed during the conference back to them. This aims to ensure that victims can maintain their agency and be as involved as possible in the discussions about their risk and the subsequent development of safety action plans.

Adolescents might be facing sexual exploitation, gangs, honour-based violence, forced marriage, and online stalking and abuse, in addition to the potential risk an adult victim of IPV might face. To capture this in their risk and needs assessments, CAADA (now Safe Lives) developed a DASH-RIC-YP for young people (YP). Those under eighteen are protected by existing child safeguarding policies. However, the use of the DASH-RIC-YP aims to develop local care pathways which integrate the existing safeguarding practices and expertise from domestic violence professionals, including MARACs, essentially bridging the gap between children’s social care, young people, and adult social care.

Reflecting the amendments to the definition of domestic violence, sixteen and seventeen-year-olds who answer yes to fourteen or more of the DASH-RIC-YP should automatically be referred to a MARAC. Guidance suggests thirteen, fourteen and fifteen-year-olds will instead be referred to the individual agencies as per the risks they face, and the policies put in place by child safeguarding. The 2012 national dataset collated by all MARACs, showed that seventy-five-thousand young people were being represented at MARACs, and 67% of teenagers in the adult IDVA service were experiencing strangulation, rape, broken bones, and stalking (CAADA, 2012), highlighting the necessity for such procedures for adolescents. Interestingly, the rate of referrals to MARAC for sixteen and seventeen-year olds is 1.7%, yet
they are 3.1% of the general population and represent the highest risk group for DVA (SafeLives, 2017). This suggests that many sixteen and seventeen-year olds are not being referred to MARAC, perhaps because they are not known to referring agencies. This also suggests the visibility of victims under age sixteen is likely to be even lower (ibid).

Whilst these examples of multi-agency work are positive, there is a continuing need for the voluntary and public sectors to work better together with integrated approaches, to identify risk of AIPV as early as possible, prevent escalation, and facilitate earlier intervention. This is especially the case for those with complex needs, and those who fall within the standard and medium risk categories. In recognition of this, through the Children and Social Work Act 2017 the government is in introducing new multi-agency safeguarding arrangements and local safeguarding arrangements which will be led by local authorities, chief police officers and clinical commissioning groups. These new working arrangements are aimed at improving the quality of multiagency working to safeguard children and young people.

The Domestic Violence Sector Response to Adolescent Intimate Partner Violence

The domestic violence sector has been acknowledged by the government as the expert in this sphere (HM Government, 2016). Yet, they operate in increasingly difficult financial environments (Women’s Resource Centre, 2013), often relying on volunteers, to provide specialist counselling, outreach work, victim support services, refuge provision, and perpetrator programmes (Towers and Walby, 2012). However, there are few AIPV specific services available across England and Wales, beyond outreach preventative education. This leaves the majority of victims of AIPV able only to access support designed for adults, despite the differences in their risk and needs (ONS, 2016; SafeLives, 2017). Furthermore, many providers do not feel equipped to support young people beyond providing preventative education (ibid).

Since 2013 local Police and Crime Commissioners (PCCs) have been tasked with commissioning local domestic violence services. In 2016/17 PCCs reported spending £20.8 million on services for victims of DVA across England and Wales. The government has also protected £123 million between 2010 and 2020 (£28 million announced in 2010 (Home Office, 2010); £80 million announced in 2016 (Home Office, 2016); and £15 million through the Tampon Tax (House of Commons, 2015), for specific risk-based services, such as the IDVA (Neate, 2015). In the meantime, local specialist domestic violence charities, including those focusing on the needs of young people and BAME women, have been forced to engage in a process of annual funding cycles, resulting in many closing (ibid).
Where curriculum-based education is not available, one approach is for schools to purchase ad-hoc services from specialist NGOs (House of Commons, 2008). Ellis (2004) found half of all local education authorities (LEAs) had commissioned preventative education from such an organisation. Specialist staff at NGOs can provide depth and variety to the content and style of training programmes due to their wealth of expertise and experience (Friend, 2014). Such good practice is encouraging, but further work is required to evaluate the efficacy and potential for this to be scaled up and implemented across the country (Barter et al., 2015). Lundgren and Amin (2014) found that school-based interventions have experienced considerable success, with long-term programmes offering repeated coverage of AIPV-related topics, which report better results than one-off awareness-raising discussions (Maxwell et al., 2010; Meyer and Stein, 2001).

Despite their success, the DV sector often faces many obstacles in reaching young people. Many schools are reluctant to cover AIPV and challenge pro-violence attitudes, or even display materials that raise awareness of the phenomena, despite their cohort being recognised as most at risk of AIPV (House of Commons, 2008; ONS, 2016). Some schools appeared to rationalise this by claiming AIPV was not a problem among their students (Barter et al., 2015; Moore, Sargent, Ferranti et al., 2015), or by claiming AIPV was an issue for safeguarding via social care rather than education providers (Ellis and Thiara, 2014). In addition, some schools failed to recognise AIPV as a major public health issue (Moore et al., 2015; Barter et al., 2015). Thiara and Coy (2014: 188) found it incredibly tough to engage schools for fear of ‘opening a can of worms’ of sensitive disclosures (Mahoney and Shaughnessy, 2007).

Whilst providing preventative education in schools ensures access to a majority of young people, those in Alternative Provision (AP) are likely to miss out (Radford et al., 2011; Ellis and Thiara, 2014). This group of young people are likely to include those living in the care system, those with a history of school exclusion, or those whose school attendance is minimal (Corr et al., 2013). Each of these factors has been linked to an increased risk of experiencing AIPV, therefore, alternative methods of reaching such individuals should be explored as a matter of urgency.

There is currently little evidence pointing to the most effective form of preventative education in the UK, both in terms of providing lasting change and reducing AIPV. Existing UK programmes such as Zero Tolerance, Trust, and Tender have mainly been evaluated using qualitative methods (Stanley, Ellis & Bell, 2011). Such evaluations have highlighted good practice suggestions and the challenges of service delivery, but rarely use methods deemed appropriate to assess attitudinal and behavioural changes. This highlights the need for further research into the efficacy and sustained preventative nature of such programmes. Any future
developments in AIPV policy and legislation should continue to consult with the expertise of the DVA sector to ensure maximum success, and good practice.

Conclusions
This chapter has brought together the literature from multiple disciplines to define the nature and prevalence of AIPV. Calling on the cross-governmental definition of DVA, AIPV has been defined as “any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial or emotional violence” (Home Office, 2013), perpetrated by someone whom the victim is currently, or has in the past been intimate with, regardless of gender or sexuality, whilst one or both partners are between the ages of ten and twenty-five years. This thesis explores the lived experiences of female victims of AIPV in terms of their victimisation, perpetration, and survival, bringing an original contribution to the existing knowledge of AIPV in the UK.

Adolescence itself is defined as between the ages of ten and twenty-five, with four individual phases identified within this period: early adolescence (ten to thirteen), middle adolescence (fourteen to sixteen), late adolescence (seventeen to nineteen), and young adulthood (twenty to twenty-five) (Connolly and McIsaac, 2011). Each individual phase contributes to vital social skills developments, including in the romantic domain. Due to the various formats in which adolescents experience relationships, it was determined that a label which could encompass all experiences across the trajectory of adolescence was needed. IEP was decided upon due to the flexibility it allowed.

The existing literature regarding adolescents' IEPs suggest that a significant number of adolescents are engaging in same-sex as well as, or instead of, mixed-sex IEPs. Therefore, this study will seek to explore them both. Furthermore, it has been suggested that the increasing importance of IEPs across adolescence represents a higher risk factor. This thesis will explore this assumption with the participants' narratives.

Whilst there are several longstanding challenges in determining the prevalence of AIPV, this chapter has examined those which are methodologically robust. The pervasive dismissive discourse surrounding AIPV has been diminished through the prevalence statistics presented. Psychological AIPV was experienced by 51% (male) to 72% (female) of adolescents (Barter et al., 2009; Gadd et al., 2014; Barter et al., 2015). Furthermore, physical AIPV was experienced by 3.3% to 87% of adolescents over all (Barter et al., 2009; Gadd et al., 2014; Barter et al., 2015). In addition, sexual AIPV, including rape, was experienced by 1.2% to 32% of females, and 1% to 16% of males (Barter et al., 2009; Gadd et al., 2014; Barter et al., 2015).
This data suggests that victimisation is mediated by gender and is frequent during adolescence.

By drawing on the three key studies of the nature of AIPV in the UK, this chapter has also determined that there are a considerable number of gaps in existing knowledge. All three studies used robust methodological approaches with slightly different aims. Ultimately, they found that AIPV is a significant human rights, public health, and child-welfare issue requiring urgent prevention and early intervention in the UK.

There were mixed findings regarding the gendered nature of AIPV victimisation. The NSPCC study identified a clear gendered divide, as females were more likely to experience AIPV, were more likely to experience a greater negative impact, and more self-blame for their victimisation. Male victims, however, suggested they experienced a positive effect or no effect at all. The From Boys to Men study, in contrast, found that there was no gendered difference in the prevalence of victimisation for psychological or physical AIPV, or for threats and/or property damage. Sexual violence victimisation was the only facet to be mediated by gender for all three studies, with significantly more females becoming victims. The STIR project found a significant gendered difference in physical, psychological, and sexual violence with females experiencing each facet significantly more frequently than males.

In addition, there were conflicting findings regarding the gender of AIPV perpetrators. The From Boys to Men study found that there was no gendered difference in perpetration, with as many males and females self-reporting perpetration of at least one facet of AIPV, except for sexual violence, which was found to be predominantly perpetrated by males. Interestingly, the STIR project found that females were more likely to report perpetration than males for both psychological and physical violence. However, it appears that there may be some biases at work, as females self-reported both victimisation and perpetration at a higher level compared to males. Furthermore, the From Boys to Men study uncovered a complex link between victimisation and perpetration, with over half of all victims reporting perpetration and almost all perpetrators reporting victimisation. In addition, girls appeared to notice DVA at home more frequently than males, suggesting they may be more able to identify it, perhaps explaining this anomaly. However, further research is required to explore the nature of the link between victimisation and perpetration.

The STIR project was the only study to comprehensively consider the impact of technology and the internet on the experiences of AIPV. It reported that sending sexual images and text messages was normalised during adolescence, with a negative impact only reported when the initial image or message was sent under duress, or when the image or message was shared without consent. Furthermore, psychological violence was experienced online, with
social networking being identified as a significant complicating factor. Sexual coercion was also experienced online but was usually enforced by offline sexual AIPV. This suggests that there is a greater interconnectedness in adolescents’ lives on and offline of which we know little about, especially in the context of AIPV. Therefore, this thesis aims to explore the impact of technology and the internet on the participants’ experiences of AIPV.

Beyond suggesting that age, gender, misogyny, and patriarchal society in some way mediate the propensity for adolescents to become victims of perpetrators of AIPV, neither study attempts to theorise AIPV. Therefore, this thesis aims to explore the conceptual nature of AIPV through an intersectional lens, considering the impact of gender, age, and other sociodemographic factors.

In response to the NSPCC report in 2009, the Government has overhauled their approach towards AIPV, recognising violence between teenagers in both VAWG strategies (Home Office, 2010; 2016) and amending the cross-governmental definition of DVA to include sixteen and seventeen-year olds (Home Office, 2013). However, there is much debate regarding the limitations of not including all those under eighteen-years (Home Office, 2012).

The This Is Abuse and Disrespect NoBody campaigns have raised awareness of AIPV among young people using on- and offline advertising and interactive support (Home Office, 2015). The VAWG strategies (Home Office 2010; 2016) have also highlighted the important role of the criminal justice, education and health sectors in tackling AIPV, as well as the role of PCCs in the commissioning of locally sensitive services.

Short-term specialist domestic violence NGO-delivered work often consists of innovative techniques with considerable success, however, they have yet to be robustly evaluated. Early evaluations suggest that they fail to have a long-term effect on behavioural and attitudinal changes in adolescents, arguably because the culture of the school has not been addressed. A Whole School Approach which aims to tackle the gendered culture of schools, noting the role of schools in producing and reproducing norms favouring AIPV could overcome this. We await the government response to the consultation on RE and SRE provision enacted by the Children and Social Work Act 2017, which will be compulsory in all schools from September 2019.

Ultimately, there is much work left to do in this regard. To explore some of these areas for improvement, focus groups with staff from the two gate-keeping agencies were undertaken. The findings of these focus groups are presented in Chapter 8. The intersectional approach to understanding AIPV is presented in Chapter 3 followed by an application of Johnson’s Typologies of DVA to AIPV. The methodological approach and tools are then explored in Chapter 4, followed by an examination of the participants’ experiences of AIPV (Chapter 5).
the impact of their experiences (Chapter 6), and their experiences of both formal and informal support (Chapter 7).
Chapter Three – Conceptualising Adolescent Intimate Partner Violence

The purpose of this chapter is to outline the theoretical framework which informs this project’s research design, analysis of the data and discussion of the findings. Theoretical frameworks are crucial for understanding the origins and nature of behaviour, and for informing the actions required to prevent an undesirable phenomenon (Dixon and Graham-Kevan, 2011). Researchers, clinicians, and policy makers alike have adopted various theoretical perspectives over the past five decades in an attempt to understand and address IPV (Beech and Ward, 2004). Adolescent IPV [AIPV] should be no exception to this yet has only featured in such attempts in the past decade in response to the NSPCC report in 2009 (Barter et al., 2010; Barter et al., 2015; Taefi, 2009; Johnson, 2008).

Different ideological and methodological perspectives have resulted in alternative views regarding appropriate policy, research, and the design of AIPV prevention and intervention efforts. There have been two dominant schools of thought regarding the study of adult domestic violence and abuse: the violence against women approach informed by various feminisms (for example Dobash and Dobash, 1979), and family violence traditions (for example Straus, Gelles and Steinmetz, 1980). Arguably both also lend themselves to a framework for understanding and exploring AIPV, although care must be taken to account for the difference in the needs and associated risk of adolescence (ONS, 2016; HM Government, 2016; Home Office, 2018). An intersectional analysis explores how multiple identifying factors, including age, shape experiences of AIPV through an examination of how power contributes to the complexity of people’s lives (Potter, 2015; Collins and Bilge, 2016). This thesis employs an intersectional approach to explore how adolescence shapes the participants’ experiences of AIPV.

The violence against women approach to understanding IPV argues that society is fundamentally structured by patriarchal gendered inequalities. Consequently, IPV is viewed as a symptom of patriarchal power dynamics which favour males and subjugate females (Dobash and Dobash, 1979, 2004). Furthermore, it suggests that males actively construct masculinity through social practices which further their domination, including violence towards females (Anderson, 1997; Kelly, 1988; Brown and Walklate, 2012; Messerschmidt, 1993). Intersectional scholars have questioned the primacy of gender in the analysis of society (Cho, Crenshaw and McColl, 2013; Gadd and Corr, 2017), instead favouring an approach which can account for the multiple ways in which society is structured and the multiple systems of oppression which work interactively to shape experiences of IPV, including age (Potter, 2015; Crenshaw, 1989, 1991). Intersectional feminists (such as Potter, 2015; Daly and Chesney-
Lind, 1988; Daly and Maher, 1998; Britton, 2000; DeKeseredy, 2011) subsequently critique the violence against women’s unidimensional understanding of gender as the core cause of IPV since there is growing evidence that not all perpetrators are heterosexual males (Straus and Gozjolko, 2014; Williamson, Morgan, and Hester, 2018; Johnson, 2005; Donovan and Hester, 2015; Sokoloff and DuPont, 2005; Cho et al., 2013; Potter, 2015).

In contrast, family violence perspectives view IPV as a symptom of inherent conflict (Hunnicutt, 2009; Straus and Gozjolko, 2014). Family violence perspectives suggest that specific sociodemographic factors of structural inequality, including age and ethnicity, influence the propensity to perpetrate IPV, reflecting intersectional approaches (Anderson, 1978, 1997, 2011; Messerschmidt, 1993, 1997, 2013; Potter, 2015). Conflict theories, on which the family violence perspective is based, draw attention to interpersonal power dynamics and the constant strive for individual advantage (Catollozzi et al., 2011). By applying conflict theory to IPV, the family violence perspective suggests that this constant struggle founds the basis of all relationships and leads to a conflict for resources between individuals (ibid). Violence occurs, therefore, when one or both partners view it as a legitimate conflict resolution tool and a device for enforcing roles for individuals in the family or relationship unit (Miller and Meloy, 2006). An intersectional lens allows for an analysis of this conflict and associated power relations through an exploration of the axes of oppression experienced by the individuals both within and beyond the abusive relationship. Critics suggest that this approach assumes IPV is entrenched and inherent, and therefore not preventable (Anderson, 2002), which has considerable consequences for work with both victims and offenders of AIPV.

Johnson (2008) offers a more nuanced approach to understanding IPV by capturing these multiple contexts, motivating factors and types of IPV within three typologies: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. This thesis will apply Johnson’s typologies to AIPV through an intersectional lens. After all, IPV is not a monolithic phenomenon (Johnson, Leone, Xu, 2014; Sokoloff and DuPont, 2005), “intersectionalities colour the meaning and nature of [IPV], how it is experienced by the self, and responded to by others, how personal and social consequences are represented, and how and whether escape and safety can be obtained” (Bograd, 1999: 276).

This chapter proposes that Intimate Terrorism is relevant to AIPV since adolescence is a highly gendered period in which hyper-masculinity and lad culture dominate (Farvid et al., 2017; England and Bearak, 2014; Hunnicutt, 2009; Brownmiller, 1975; Caputi, 1989). Such cultural dynamics, have been linked to Intimate Terrorism in adulthood (Holtzworth-Munro et al., 1994; Johnson, 2008). As these cultural dynamics are also visible in adolescence (Tolman et al., 2003; Teitleman et al., 2008) it is likely that Intimate Terrorism will also be present however,
the frequency, mode and severity may differ in comparison to adult experiences. It is anticipated that Intimate Terrorism is particularly likely to be identified in cases where the perpetrator is significantly older (2+ years) than the adolescent victim. It is proposed that this is due to the added complexity of the power dynamics in these relationships because of the disparity in age of the partners involved (Barter et al., 2009; Barter et al., 2015). It follows that Violent Resistance, a response to Intimate Terrorism, will also be relevant to AIPV. Johnson suggests that Violent Resistance is perpetrated by females in self-defence, in retaliation or as a pre-emptive measure to male violence, however, high rates of bidirectional violence have been found in adolescent samples (Gadd et al., 2013, 2015) suggesting that this might be better identified as Situational Couple Violence.

In contrast, Situational Couple Violence is likely to be highly prevalent in adolescence, since those with poor conflict resolution skills are most likely to resort to such violence (Johnson, 2006; 2008; 2011; Collins, 2003). Adolescence is a time of increased impulsivity and social identity development (Collins, 2003; Blakemore, 2013; Sawyer et al., 2018). In addition, the high rates of bidirectional violence found by Gadd and colleagues (2013, 2015) suggest that the gender symmetry debate translates into adolescence. This may account for the additional cases reported for those aged sixteen to twenty-five years of age (ONS, 2016). These hypotheses will be explored through the consideration of the experiences of seventeen female victims of AIPV in Chapters 5 and 6.

Section 3.1 will set out how an intersectional approach to AIPV recognises the ways in which age interacts with other key factors of discrimination, such as gender, class and ethnicity, to shape experiences of AIPV (Potter, 2015; Collins and Bilge, 2016). Section 3.2 explores Johnson’s typologies of domestic violence (2008) and abuse which offer a framework in which to conceptualise the patterns and manifestations of IPV during adolescence. Intimate Terrorism, Violent Resistance, and Situational Couple Violence are flexible enough to recognise that IPV can present itself differently depending on the individuals involved, and that they may be motivated by different means, whilst recognising that experiences are mediated by age, gender and other factors.

### 3.1 Intersectionality and Adolescent Intimate Partner Violence

Despite growing recognition that those aged 16 to 25 years most frequently experience IPV, relationships experienced by adolescents are often cited as being at low risk of IPV (Collins, 2003). This has contributed to the lack of theories encompassing adolescent experiences of
IPV (Anderson, 1997; Wekerle and Wolfe, 1999; Wolfe, Wekerle, Reitzel-Jaffe and Lefebvre, 1998). A further difficulty with attempts to theorise AIPV has been the significant lack of comprehensive research which considers the technologies of violence and the contexts in which they occur for adolescents (ten to twenty-five-year-olds). Although, research is beginning to counter this flaw, as explored in Chapter Two (Barter et al., 2009; Barter et al., 2015; Gadd et al., 2015). Theories of AIPV at present rely on the troublesome practice of translating theories of adult IPV to adolescent experiences. As established in Chapter 2, adolescence is the most significant developmental period for IEPs and the time in which victimisation is most likely to occur (Blakemore, 2012; ONS, 2016). Hence, there is urgent need to systematically conceptualise AIPV in order to better understand it and to develop effective prevention and intervention efforts.

There have been two dominant schools of thought regarding the aetiology of IPV within adult relationships: the violence against women and family violence perspectives, as outlined above. Both approaches focus on single-factor analyses, gender and conflict respectively and have been criticised for being too narrow (Cho et al., 2013; Potter, 2015). In recognition of the white-washing of feminism (Hooks, 2000), feminist scholars began to employ Crenshaw’s (1989, 1991) concept of Intersectionality to account for the multiple ways in which various factors work together to shape experiences of IPV, how others react to it, how experiences are represented, and whether safety and escape can be obtained (Bograd, 1999; Sokoloff and DuPont, 2005; Collins, 2006; Crenshaw, 1991). Potter (2015:3) defines intersectionality as “the concept or conceptualisation that each person has an assortment of coalesced socially constructed identities that are ordered into an inequitable social stratum”.

This section will explore the how the concept of intersectionality can be applied to AIPV, noting the contributions to knowledge produced by the gender-central violence against women perspective, and the conflict approach favoured by family violence theorists. Whilst these approaches were not designed with adolescents at the forefront, they have been applied to the experiences of those aged 16 years and over for some time (Fox et al., 2013). Ultimately this section will conclude that an intersectional approach to understanding AIPV is vital in order to acknowledge the affect being adolescent has on one’s experiences of IPV.

The initial exploration of IPV was instigated by the feminist movement in the 1970s. It sought to highlight the everyday nature of domestic and sexual violence in the lives of women and girls. Whilst there is no singular ‘feminism’ (Daly & Chesney-Lind, 1988; Weedon, 1997), various feminisms, including radical, liberal, Marxist and intersectional, are united in their core commitment: to highlight and ultimately change gendered inequalities. There is not the scope to explore the intricacies of each school of feminist thought here, however they are discussed
Feminist approaches to explaining and understanding IPV cite the traditional patriarchal structure of society, as the fundamental cause of IPV (for example Dobash and Dobash, 1979; Busch, Bell, Hotaling and Monto, 2002). Early criticisms of this approach included its lack of flexibility and inability to account for female perpetrators (Straus and Gozjolko, 2014), male victims (Williamson, Morgan, and Hester, 2018; Johnson, 2005), and IPV within same-sex couples (Donovan and Hester, 2015), and in cases where the victim and/or perpetrator is trans* (Sokoloff and DuPont, 2005; Cho et al., 2013; Potter, 2015). In response to these criticisms the violence against women approach recognises a “constellation of causes”, although it considers gender to be the core structure in society, and subsequently the predominant cause of IPV (Dixon and Graham-Kevan, 2011: 1149; Potter, 2015).

Intersectional feminists challenged the “primacy of gender as an explanatory model” of IPV (Collins and Bilge, 2016: 39), emphasising the need to broaden the analytical horizons of the study of IPV to consider how other forms of oppression and inequality, such as ageism, heterosexism, racism and class privilege intersect with sexism to shape individuals’ experiences of IPV (Potter, 2015; Bilge, 2013). Such systems of power and their interconnected identities traverse all lived experience and consequently will shape individual experiences of AIPV.

Intersectional analyses of IPV allow for recognition and exploration of the multiple ways in which individuals and groups of people are oppressed and how these intersecting oppressions shape their experiences of IPV. Collins and Bilge (2016) argue that intersectionality’s core insight is that “major axes of social divisions in a given society at a given time, for example class, race, gender, sexuality, dis/ability and age, operate not as discrete and mutually exclusive entities, but build on each other and work together”. By analysing how these axes of power relate to one another, an intersectional approach allows scholars to better understand how the organisation of power contributes to the complexity of people’s lives and experiences (Crenshaw, 1989, 1991: Potter, 2015).

Mann and Grimes (2001) argue that analyses of this ‘matrix of domination’ (Collins, 2006) are integral to understanding IPV, as they allow scholars to uncover the structural underpinnings of such abuse whilst highlighting the differences in individuals’ lived experiences. Research on the links between ethnicity and IPV, for example, have found that when socioeconomic factors (youth, employment status, poverty etc.) are controlled, ethnic and racial differences

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4 Trans* is an umbrella term which refers to any individual who does not identify with the gender they were assigned at birth.
in the prevalence of IPV largely disappear (Rennison and Planty, 2005; West, 2005). This demonstrates that it is the multiple, interconnected nature of these factors which create these links.

Furthermore, Bograd suggests that an intersectional consideration of IPV asks us to recognise that IPV may not be “the only or primary violence shaping their lives … [rather] the trauma of DV is amplified further by further victimisation outside of the intimate relationship, as the psychological consequences of battering may be compounded by the ‘microaggressions’ of racism, heterosexist, and classism [and ageism] in and out of the reference group” (1999:281). This study seeks to undertake an intersectional exploration of AIPV by considering how such axes of power shape adolescent females’ experiences of IPV.

Critics argue that this categorisation of social identity, is deterministic and exclusionary, and creates a hierarchy of oppression. Furthermore, it has been argued that intersectionality overuses identifying characteristics for analysis, at the expense of structural analyses (Collins and Bilge, 2016). Arguably, this criticism ignores the centrality of structural analyses of power which characterise intersectional analyses. By considering the effects of racism, sexism, ageism and so on, an intersectional framework of analysis allows for careful consideration of how structural elements of society are affected by individual characteristics (ibid).

However, the material and symbolic sources of subordination and disadvantage may not be directly observable and subsequently must be theorised. This is a considerable task, and arguably a flaw of intersectionality as it is not always possible to empirically test theories of sources of subordination, such as age, class, gender, race etc (Nash, 2008; Bilge, 2013). Despite this, each of us lives our lives in certain ways because we are gendered, raced, aged, dis/abled, classed, ascribed a nationality and so on. Furthermore, we may display and/or experience our various identities differently depending on the setting, something Potter refers to as ‘social shapeshifting’ (2015). As a result, intersectionality is a study of diversity and the affect it has on the lived experience.

Collins and Bilge suggest that there are six core ideas that emerge when Intersectionality is used as an analytical framework: “inequality, relationality, power, social context, complexity and social justice” (2016: 25). Whilst not essential, Collins and Bilge argue that these reoccurring themes provide ‘guideposts’ for an intersectional analytical framework.

Due to its consideration of power and other social dynamics, Collins and Bilge argue that intersectionality encourages consideration of how a phenomenon may cause, or be the result, of social inequality for various social groups (2016). This particular project is focused on the experiences of seventeen adolescent females who have experienced IPV. Furthermore, as the exploration of their profiles shows (beginning on page 88) many of the participants were
from differing class backgrounds, held various religious beliefs, had multiple disabilities, and/or sexualities, placing them at specific social positions. These social positions are ‘multiple, multiplicative and inseparable [sic]’ (Potter, 2015: 70). Therefore, these positions have shaped the participants’ experiences of IPV and how their experiences were and continue to be responded to.

Intersectionality is born out of the recognition that complex identities and phenomenon cannot be understood through single factor analyses, such as gender (favoured by violence against women scholars) or conflict (as suggested by the family violence tradition) (Crenshaw, 1989). Cho, Crenshaw and McCall (2013:787) suggest that such “single-axis thinking undermines legal thinking, disciplinary knowledge production, and struggles for social justice”. By considering power through a relational lens, we can move beyond binary thinking, towards an intersectional both/and framework (Collins and Bilge, 2016; Cho et al., 2013).

Crenshaw noted that women of colour are not only women but also are also black (1989, 1991). Furthermore, their gender and ethnicity cannot be separated from one another - they are woven and intersecting. As such women of colour are, through socially constructed categories, situated within multiple interacting forms of privilege and subordination (Alanen, 2016). Crenshaw argues that these woven characteristics of women of colour’s identities produce their lived experience (1989, 1991). However, through an intersectional lens, women of colour do not experience subordination solely for being women, and/or for being black (female + black) – an additive approach. Instead the subordination they experience is intersecting and multiplying (female x black) (Potter, 2015). This acknowledgment grew out of frustration that the feminist and black rights movements were focusing on single factors, rather than multiple factors of oppression (Cole and Guy-Sheftall, 2003; Potter, 2015). Black women were not recognised within the white middle-class approach of the feminist movement, whilst simultaneously could not be identified within the male approach of the black rights movement (hooks, 2000). As such, these intersecting sources of subordination can be concurrently analysed to observe individual-level differences in lived experiences (Alanen, 2016; Potter, 2015).

This interwoven approach can also be applied to adolescent females as they are female but also adolescent. Adolescent females are given subordinate status within the domestic violence and abuse movement as they are assumed to be adequately represented within the term ‘women and girls’ without analysis of how age affects the experience of womanhood (Taefi, 2009). Arguably girls are also marginalised within children’s rights movements due to their gender (ibid). It is the interconnected nature of these identities which create their complex nature (Crenshaw, 1989, 1991; Potter, 2015; Collins and Bilge, 2016).
Critics of intersectionality suggest that its affiliation to identity politics encourages the repetition of, and identification with, traumatic events, emphasising the original oppression of individuals (Brown, 1995). However, this assumes those being analysed have no agency, and fails to recognise that many disenfranchised people use identity politics for empowerment. The suggestion that such an analysis encourages individuals and groups to ‘cling to the status of victim’ (Brown, 1995: 55) can be firmly rebutted through an analysis of the interconnections of difference, rather than focusing on specific factors which make individuals different. Subsequently, by considering these power relations, an intersectional analysis gives us insight into the relationships which form everyday life. This thesis presents in depth interviews with seventeen females, which explore how their intersecting identities affect their experiences of AIPV. Furthermore, by highlighting the voices of victims of AIPV, this thesis allows for the strongest form of visibility of the participants’ intersectional identities (Strid, Walby and Armstrong, 2013).

We cannot truly understand power relations without analysing them in context. Historical, social and political contexts shape our lives, how we think and what we do. Crenshaw argues that the significance of specific historical contexts, such as colonialism, should be recognised within these analyses (1989, 1991). This is particularly true for adolescents who are at a phase of their development where they are still learning about these contexts. As a result, they might ‘feel’ the contexts before they understand them (Taefi, 2009). That is not to suggest that they are passive within their environment, however they are placed at a distinct disadvantage because of their age. As such being a child or adolescent becomes one of the major social axes of power and oppression with which intersectionality is concerned.

These concepts of inequality, relationality, power, and social context are complex to consider individually. Yet an intersectional framework encourages analysis of how these concepts interact, intensifying this complexity somewhat. Furthermore, “attending to how intersecting power relations shape identities, social practices, institutional arrangements, and cultural representations and ideologies in ways that are contextualised and historicised introduces a level of complexity into everything” (Collins and Bilge, 2016: 202). This project addresses this complexity by acknowledging the political, social and cultural contexts of the participants’ experiences of AIPV, and by analysing the similarities and differences in their positions and experiences (discussed further in Chapter 4).

Collins and Bilge (2016) suggest that there are four distinct yet interconnected domains of power at work: interpersonal, disciplinary, cultural and structural. Such power relations are produced and reproduced through key social institutions, such as schools (structural); ideas, customs, behaviour, the media and culture more widely (cultural); and the ways in which
language and behaviour are used as reward and punishment (disciplinary) in everyday interactions between people (interpersonal) (Collins and Bilge, 2016; Potter, 2015).

The interpersonal power domain refers to the power produced and reproduced within any given social interaction. This is particularly important for the study of AIPV as it requires an analysis of the manifestations of interpersonal power relations. Disciplinary power is evident in the different ways people experience the implementation of societal rules. Analysis of the disciplinary domain of power highlights the significance of social institutions, including schools, in shaping and resolving social problems, such as AIPV (ibid).

The cultural domain of power highlights the differences in power relations between cultural groups. This is important when considering experiences of IPV as different groups will likely have differing views on violence and help-seeking, for example black female victims not wanting to draw attention to black male perpetrators of IPV for fear of further enforcing the typecast of blacks as violent (Sokoloff and Dupont, 2005). Indeed, evidence suggests that adolescents are more likely to hold pro-violence attitudes (Teitleman et al., 2008) and therefore may be less likely to identify their experiences as AIPV. In addition, they have repeatedly been found to seek support from their peers rather than adults in positions of authority (Barter et al., 2009; Gadd et al., 2014; Barter et al., 2015).

Arguably, the gendered divide is particularly acute during adolescence as gendered norms are less likely to be challenged by younger people (Tolman et al., 2003; Teitleman et al., 2008). Consequently they are normalised through the cultural practices of the group (Ridgeway and Cornell, 2004). Whilst gendered norms, expectations, and divisions of labour are less likely to be based around the home for adolescents than they are for adults, they are clearly evident in lad culture and the sexual double standard that favours teenage boys over girls (Farvid, Braun and Rowney, 2017; England and Bearak, 2014). In addition, sexual harassment and pornography are extreme forms of this gender bias as they help reproduce females as objects for men’s use and pleasure (Wright and Bae, 2015; Ward, Vandenbosch and Eggermont, 2015; Frable, Johnson and Kellman, 2006). Furthermore, there is growing evidence that teenage girls are struggling to negotiate their sexual safety and are engaging in risky sexual behaviours because they believe this is what boys expect of them (Teitleman et al., 2008; Wright and Bae, 2015). Teitleman et al. (2008: 1697) go on to argue that such “asymmetries can become internalised and may lead [adolescent girls] to feel inferior and to lose confidence in negotiating for their sexual safety”. This suggests that adolescents’ age, gender and lack of experience in relationships mediates their vulnerability to and experience of AIPV.

The structural domain of power highlights the complex relations of class, gender, and race etc. and how they organise the given society (Collins and Bilge, 2016). Analysis of the
domain of power is useful for considering the ways in which neo-liberalism is shaping society’s response to violence from, within and towards particular social groups (Potter, 2015). The structural domain of power’s effect on AIPV is most noticeable through the policy and practice narratives of the time (Chapter 2 and 7).

Adolescents will experience structural discrimination via the education system, through the curriculum, the presence of negative or positive staff role models, school policies and how culture from outside the school is present on site (Collins and Bilge, 2016). Such cultural practices include the sexualisation of female adolescents (Taefi, 2009), transmitted through the media, social media, music, fashion and so on. Furthermore, discrimination is re/produced through the interpersonal domain for adolescents through peer, parental and familial relationships, interactions at school with teachers, staff and other pupils, and romantic relationships (Collins and Bilge, 2016). Each of these domains are influenced by the disciplinary domain which encourages the socialisation of adolescents (and children) depending on their gender, dis/ability, ethnicity, religion and so on. This is evident in the double standards attributed to male and female sexual activity, and the pervasive rape-culture which encourages victim-blaming (Sills, Pickens, Beach et al., 2016; Ami, Kågestenm Adebayo and Chandra-Mouli, 2018).

Arguably children, adolescents and young adults have a ‘special vantage point’ (Taefi, 2009) on the power relations they experience since age straddles class, gender, disability, sexual identity and so on. Thus, Collins and Bilge argue that adolescents are likely to experience these power relations more acutely than adults, as they experience these inequalities whilst also being disadvantaged due to their age (2016). In addition, female adolescents are marginalised through both their age and gender, reinforcing their disadvantaged position. Taefi (2009) suggests that the paternalistic attitudes towards female children instils a sense of vulnerability, whereas the socialisation of boys leads to a feeling of superiority (Ras-Work, 2006). This is produced and reproduced through the patriarchal structuring of society, and is complicated further by religious and cultural differences, dis/ability, ethnicity and other factors. Taefi suggests that whilst there are degrees of discrimination experienced by girls depending on their additional factors of discrimination, the intersection of gender and age has a ‘universal relevance in the lives of female children’ and adolescents (2009: 350; Potter, 2015; Collins and Bilge, 2016).

By applying the ‘special vantage point’ to adolescent IEPs, an intersectional analysis highlights that adolescents will be unlikely to have experience in the romantic domain, and therefore may be at an increased risk of negative experiences, including AIPV. This may account for why there is, for example, an increased risk of AIPV for adolescent girls, and a higher risk for those
with older (2+ years) boyfriends (Barter et al., 2009). Adolescent experiences will be shaped through the structural, cultural, disciplinary and interpersonal power domains discussed above, culminating in a belief that males, particularly older males, have the right to be dominant over females (Amin et al., 2018). As a result, the belief that females are inferior and should feel grateful to be in a relationship regardless of its quality, is perpetuated. This results in adolescent cultural practices which endorse the idea that females are validated by male attention and may in turn go some way to explain the increased risk of AIPV in those aged sixteen to twenty-five (ONS, 2016).

3.2 Johnson’s Typologies of Domestic Violence

Adolescence and young adulthood (16-25 years) have consistently been identified as high-risk periods in terms of victimisation of IPV (as discussed in Chapter 2). However, as the discussion of the intersectional framework above has shown, age is not the only axis of oppression that shapes experiences of AIPV. It is hypothesised that the participants’ gender, class, sexuality, ethnicity, dis/ability and so on will also shape their experiences (Collins and Bilge, 2016; Potter, 2015). This section will outline Johnson’s Typologies of Domestic Violence (Johnson, 1995, 2006, 2010, 2011; Kelly and Johnson, 2008), which enables an exploration of how these factors mediate the participants’ experiences of AIPV. Existing knowledge surrounding adult experiences of Intimate Terrorism, Violent Resistance and Situational Couple Violence will be applied to adolescence.

Johnson suggests that the differing methodologies favoured by violence against women and family violence researchers, discussed above, have in fact uncovered different types of domestic violence and abuse due to their differing methodologies, sampling and units of measurement (Johnson, 1995, 2006, 2010, 2011; Kelly and Johnson, 2008). Subsequently Johnson suggests that research needs to move away from methods which use one approach or perspective, be that violence against women, family violence or otherwise. The alternative, Johnson suggests, is to move beyond single-casual factor arguments entirely, towards a more nuanced understanding of IPV (1995, 2006, 2010, 2011; Kelly and Johnson, 2008) such as an intersectional approach.

This begins, Johnson argues, with recognising that serious and chronic violence(s) – predominantly uncovered by feminist methodologies - are more likely to come to the attention of law enforcement and hospitals than other types (1995, 2006, 2010, 2011; Kelly and Johnson, 2008). Consequently, research in these settings is more likely to find specific types
of intimate partner violence: Intimate Terrorism and Violent Resistance (Johnson, 2008), explored in more detail below. Similarly, methods which avoid sampling these groups – family violence methodologies - are more likely to find conflict specific violence, or Situational Couple Violence [SCV] (Johnson, 1995, 2006, 2010, 2011; Kelly and Johnson, 2008). As such each bias has led to the identification of three distinct typologies of IPV – Intimate Partner Violence, Violent Resistance and Situational Couple Violence (Johnson, 2008, 2010, 2011). Johnson also proposed a fourth typology – Mutual Violent Control, though it is rarely utilised due to the rarity of cases (Johnson et al., 2014).

Arguably, studies which seek to minimise each of these biases will find all three types and find that Intimate Terrorism and Violent Resistance are heavily (although not exclusively) gendered, whilst SCV is largely gender symmetric (Johnson, 1995, 2006, 2008, 2011; Kelly and Johnson et al., 2014). Johnson argues that this pattern explains the dramatic differences the two disciplines have found in the representation of gender in victimisation and perpetration (See for example Stark and Flitcraft, 1996; Straus, 1999). Kelly and Johnson (2008: 477-8) suggest that recognising the nuances of these typologies will allow researchers, policy-makers and practitioners to develop “appropriate screening instruments and processes … that more accurately describe the central dynamics of IPV, its context and consequences. This can lead to better decision making, appropriate sanctions, and more effective treatment programmes tailored” to the individuals involved (Gadd et al., 2015). However, Kelly and Johnson offer a note of caution: ‘misapplication [of these typologies could have] potentially lethal results” (2008: 477-8). Hence this thesis aims to apply these typologies to the experiences of seventeen female adolescents with varying backgrounds, using both in-depth interviews and acts-based structured questions (discussed in more detail in Chapter 4).

By recognising that there are different typologies of IPV, Johnson provides a framework that allows a move away from a gender or conflict perspective, towards an understanding of IPV which accounts for the individuals' identities and the relationship characteristics. This section will demonstrate how an intersectional approach to Johnson’s Typologies provides an understanding of AIPV which achieves this aim.

**Intimate Terrorism**

The first typology identified, Intimate Terrorism, is most frequently uncovered by feminist researchers (such as Dobash and Dobash 1979, 2002; Pence and Paymar, 1993; Stark and Flitcraft, 1996; Johnson 2010) and is reflected in the severity of the cases finding their way to the criminal justice and health sectors (Johnson, 2010). Intimate Terrorism is characterised by
a pattern of coercive and controlling behaviours, which cannot be identified without considering the context of the individual incident within the broader pattern of violence and abuse over time (Johnson, 2008; Stark, 2007). Intimate Terrorism reflects Stark’s theory of Coercive Control (2007) with victims finding themselves within a web of abuse (Kirkwood, 1993) which is increasingly difficult to escape.

Perpetrators of Intimate Terrorism use non-violent tactics such as financial abuse, intimidation, threats and coercion, isolation, monitoring and emotional abuse in order to control their victim (Johnson, 2006, 2008). In some cases, this may then escalate to physical and/or sexual violence, often in reaction to any perceived or real threat to their control. Such physical violence is, according to Johnson, frequent, severe and unilateral, and typically male-to-female (2008; Johnson et al., 2014). However, the associated pattern of controlling behaviours may mean that the perpetrator never, or very rarely, resorts to physical or sexual violence.

Johnson argues that Intimate Terrorism is a largely gendered phenomenon, perpetrated predominantly by males towards females ‘simply because of sex differences in size and strength’ (Johnson, 2008: 105). Whilst this may be the case for many, this simplification of the gendered divide fails to account for heterosexual couples in which this size difference is not present, nor for same-sex couples (Hester and Donovan, 2015). Arguably, the gendered socialisation of childhood and adolescence, in which boys are encouraged to be aggressive in sports, fantasy and real-life conflict and girls are encouraged to be passive and accommodating (Sills et al., 2016; Amin et al., 2018; Johnson et al., 2014), will increase the chance of this gendered typology occurring. Furthermore, individual gendered roles, and the cultures of hyper-masculinity and hyper-femininity favoured by adolescent peer groups are likely to mediate the meaning and interpretation of violence in a gendered manner (ibid). As a result, the internal functions of adolescent relationships are likely to be shaped by individual and peer perspectives more acutely than for adults (Klein and Milardo, 2000; Johnson et al., 2014), potentially resulting in a higher occurrence of Intimate Terrorism. This may therefore account for the higher rates of IPV reported for sixteen to twenty-five-year olds (ONS, 2016).

Critics have argued that Johnson has denied the capability of females as intimate terrorists (Straus and Gozjolko, 2014). However, Johnson recognises that Intimate Terrorism can be found within LGBT relationships, and can be perpetrated by females within heterosexual relationships, highlighting that gender is not the only contributing factor to the likelihood of Intimate Terrorism occurring (2008). This strengthens the argument for an intersectional approach to understanding AIPV which recognises gender, age and the other intersecting structures of oppression, although Johnson doesn’t explicitly do this.
Such gendered norms arguably affect the internal workings of all relationships through the interpersonal domain of power (Klein and Milardo, 2000; Collins and Bilge, 2016). Furthermore, there is a growing body of evidence which suggests that individual males with hostile attitudes towards women are more likely to be perpetrators of Intimate Terrorism than those who perpetrate Situational Couple Violence or who do not commit IPV (Holtzworth-Munro et al., 1994; Johnson, 2008). The socialisation differences of males and females can go some way to account for the higher rates of pro-violence attitudes and behaviours in males compared to females (Sills et al., 2016; Ami et al., 2018; Johnson et al., 2014).

Perpetrators of Intimate Terrorism use both subtle and explicit techniques to isolate and control their victims (Johnson, 2008; Stark, 2007). Many of these techniques are also used to reduce the victim’s ability to resist the perpetrator’s control and reduce their attempts to exit the relationship. Johnson suggests that by convincing their victim that they have the right to control and punish them, perpetrators of Intimate Terrorism can legitimise their abuse, and ultimately blame it on the victim (ibid). This may be particularly significant with adolescent victims, as their age makes them unlikely to have relationship and related skills experience in order to rebuff this technique (Ang, 2015). Furthermore, patterns of interpersonal control and authority which favour males are thought to be more normative during adolescence (Tomlin et al., 2003). Catallozzi et al (2011) suggest that as controlling behaviours during adolescence occur so frequently, it may be normative for this period. However, care must be taken to combat the perceived normalisation of gendered control to ensure adolescents understand that control does not reflect a more committed relationship, their partner’s love, or that they are important to their partner (Collins, 2003).

Johnson also hypothesises that by isolating the victim from their social support networks, either physically by moving away or by eliminating methods of social contact, for example by deleting the victim’s Facebook profile and/or not allowing them to have a mobile phone, the perpetrator can further their control over the victim (2006, 2008, 2010). This may be a particularly powerful technique of abuse during adolescence, as at this stage of development, adolescents are shifting their focus away from the family, towards their peers and romantic relationships (Collins, 2003). Furthermore, young people as a group tend to have fewer resources than adults, therefore relationships, language, access to technology and/or social media, and social capital may have a greater emphasis during this period (Crosby, Holtgrave, DiClemente, Wingood and Gayle, 2003; Barter et al., 2009). Perpetrators therefore, demonstrate their power over the victim through privileged or coerced access to the resources required for adolescent personhood (Villalonga-Olives and Karachi, 2017). Furthermore, if these first experiences are negative, it is arguably more likely that adolescents will develop
unhealthy expectations of future relationships (Collins, Welsh and Furman, 2009), including those in later adolescence and young adulthood.

Perpetrators may also attempt to isolate their victim by controlling or removing access to a victim’s income by monitoring or confiscating any income they do receive, refusing to help with household chores and/or childcare (Johnson, 2008; Stark, 2007). This works to isolate the victim and can limit the victims’ potential resistance to ongoing abuse. Whilst this traditionally may be seen as a technique used successfully against adult victims, monitoring and controlling one’s access to education, undermining their educational performance through sleep deprivation, confiscation of any income and/or controlling access to transport can have significant negative effect on adolescents’ lives (Barter et al., 2009).

Johnson (2008; 2011) and Stark (2007) argue that as Intimate Terrorism (and coercive control) develop over time in an existing relationship, responses to it must consider the victim’s coping strategies as learnt survival strategies, rather than seemingly irrational responses to individual incidents. Research has found that many victims of Intimate Terrorism struggle to identify the overarching pattern of control and coercion until it has escalated significantly (Johnson, 2011). Some tactics employed by intimate terrorists are designed to minimise and deny the violence, and blame the victim thereby making it more difficult to identify (Pence and Paymar, 1993; Johnson, 2006). Perpetrators are thought to achieve this by engaging in a cycle of violence (Walker, 1979), whereby the relationship goes through tension-building, explosion and honeymoon phases. During the honeymoon phase perpetrators may well apologise profusely, claiming it will never happen again, buy gifts and pledge to change their behaviour (ibid). Johnson argues that this phase works to encourage victims to identify their own behaviours, for example not speaking to a specific friend identified as a threat by the perpetrator, as trigger(s) for the violence (2008). However, Johnson suggests this leads to the victim ultimately having to change whole classes of behaviour, for example how they communicate with the opposite sex. This cycle may continue until significant aspects of the victim’s behaviour have been changed to placate the perpetrator. This also works to isolate the victim as it often has huge impacts on their relationships with those around them (Riger et al., 2002). This may be a particularly detrimental technique for adolescents whose focus on social capital is notably acute as argued above (Crosby, Holtgrave, DiClemente, Wingood and Gayle, 2003; Barter et al., 2009).

Whilst we must be careful not to undo the vital work of the violence against women movement, we must continue to develop our understanding of IPV by recognising that power is exists between and across multiple structures of oppression, of which gender is one (Johnson,
Therefore, an intersectional consideration of Intimate Terrorism will enable a more in-depth exploration of the experiences of AIPV presented in this thesis.

**Violent Resistance**

The violence against women literature base has long argued that female violence is a reaction to male violence, for example in self-defence (Dasguta, 1999; Dobash *et al.*, 1992; Henning and Feder, 2004). From this perspective male violence towards females is intrinsically different to female violence towards males. Dobash and Dobash argue that as “…IPV is primarily an asymmetrical problem of men's violence toward women, and women's violence does not equate to men's in terms of frequency, severity, consequences and the victim's sense of safety and wellbeing” (2004: 324).

Research informed by the violence against women perspective has consistently concluded that males use the power attributed to them through patriarchal structural inequalities to further subjugate women, using sexual and domestic violence to maximise their societal advantage (Dobash and Dobash, 2002; Wekerle and Wolfe, 1999; Hunnicutt, 2009). This has been reflected in literature exploring adolescent ‘lad culture’ also (Hunnicutt, 2009; Brownmiller, 1975; Caputi, 1989). As such females are viewed as archetypal victims who use violence in a qualitatively different way to males, exclusively in self-defence, in retaliation, or as a pre-emptive measure to male violence (Wekerle and Wolfe, 1999; Dobash and Dobash, 2004). This view has largely been upheld despite growing evidence of female perpetration which cannot be attributed to self-defence (Dobash and Dobash, 2004; Dasgupta, 1999; Dobash *et al.*, 1992; Henning and Feder, 2004), including high prevalence of mutual adolescence IPV (Gadd *et al.*, 2013), suggesting that not all female violence is motivated by or in response to male violence.

Violent Resistance is the term Johnson attributes to the, sometimes extreme, violence women experiencing Intimate Terrorism perpetrate in response to their victimisation. The violent resistor is faced with a partner who is both controlling and violent but is not themselves controlling (Johnson, 2008). Johnson suggests the violent resistor is usually female and the victim usually male since most Intimate Terrorists are male (2008, 2011). Her motivation differs greatly from the Intimate Terrorist as she perpetrates in self-defence, an attempt to cease the escalation of violence, an attempt at retaliation and/or escape (ibid). Johnson suggests that this typology represents a significant portion of female IPV perpetrators found within criminal justice and healthcare settings. Since there is little evidence of Violence Resistance in the
literature on AIPV, this study will seek to explore its presence and significance in the experiences of the participants.

There is growing evidence to suggest that whilst Violent Resistance has alternative motivations, the act of the female victim responding to violence with violence increases their risk of serious injury (Pagelow 1981; Miller, 2005; Dixon and Graham-Kevan, 2011). Johnson suggests that the physical size difference between the male and female will ensure that he is able to more seriously hurt her than she can him (2008, 2011). During early and middle adolescence, this size difference is likely to be minimal where both partners are the same age due to the variation in gendered development (Collins, 2003). However, this might account for the increased risk to the adolescent female victim found where the perpetrator two or more years older than her (Barter et al., 2009; Barter et al., 2015). In addition, Dixon and Graham-Kevan (2011) suggest that the strongest risk factor for female injury is female initiated violence towards a male partner. This suggests that any female-initiated violence, regardless of motivation, may result in increased risk to the female. In addition, Gadd and colleagues (2014) found that one in five male adolescents thought it was acceptable to hit their girlfriend if she had hit him first, suggesting this risk is also likely in adolescence.

It is suggested that in cases of unilateral assaults, females are more likely to be the initial perpetrator (Anderson, 2002; DeMaris, 1987; Gray and Foshee, 1997; Morse, 1995; O'Leary et al., 1989; Riggs, 1993; and Roscoe and Callahan, 1985), even when data from arrest records is considered (Simmons, Lehmann, Cobb, & Fowler, 2005). It also appears that female use of IPV increases the frequency and severity of male IPV (for example, Graham-Kevan & Archer, 2005), and bidirectional violence increases the likelihood of injury for both males and females (for example, Capaldi et al., 2007; Fergusson et al., 2005; LeJeune and Follette, 1994; Milardo, 1998; and O'Leary and Slep, 2006). This suggests that the gendered nature of victimisation and perpetration is far more complex than prescribed by the violence against women perspective and is likely to be complicated further by the neurological and physiological developments associated with adolescence (Blakemore, 2012; Potter, 2015; Crenshaw, 1991).

Dixon and Graham-Kevan (2011) suggest that this increase in risk of female injury highlights the requirement for an understanding of AIPV which accounts for the context of the relationship and specific incidents (Graham-Kevan and Archer, 2005; Stith et al., 2004), rather than a purely gendered analysis. Furthermore Stith et al. (2004) suggest that we must move away from an accountability or blame model towards a needs-based model, such as an intersectional perspective of Johnson’s typologies of domestic violence. This provides further
support for an intersectional approach to understanding AIPV which takes these various factors into consideration.

Violent Resistance allows for recognition that some extreme violence, including homicide, can be perpetrated by females. However, care should be taken not to conflate Violent Resistance with all female perpetrated violence, particularly in adolescence during which mutual violence has been found (Barter et al., 2009; Gadd et al., 2015; Barter et al., 2015). As previously discussed, Johnson’s framework also recognises that some intimate terrorists are female, and that Situational Couple Violence (explored further below) is largely gender symmetric. There has been significant discussion between violence against women and family violence authors, notably Johnson and Straus, regarding the ability for a contemporary feminist framework to recognise female violence in its multiple forms, whilst also recognising that male violence towards females is in the majority, and is more frequently more damaging (Johnson, 2011; Straus, 2011). Significant gendered differences in both the prevalence and impact of AIPV on females has also been found (Barter et al., 2009; Gadd et al., 2015; Barter et al., 2015). An intersectional framework enables recognition of the gendered self, whilst also considering the other individual and structural factors which shape the experience of AIPV.

Situational Couple Violence

The core assumption of Situational Couple Violence is that all couples experience conflict. Consequently, some are more likely than others to experience chronic conflict. Among those couples, some individuals are more likely to turn to violence (Straus and Gozjolko, 2014). Arguably the most common form of IPV (Johnson, 2005, 2008, 2011), Situational Couple Violence, is not characterised by any attempt by either party to control the other. Instead, the violence is situationally provoked causing one or both partners to react to conflict with violence. The motives for such violence can be varied, for example in an attempt to get attention, ‘win’ the conflict or express emotion. Situational Couple Violence may be “minor and singular, or it could be chronic, minor and/or severe”, and even life threatening (Johnson 2008:11). However, Johnson suggests this violence is not indicative of the relationship as a whole. Empirical research that uses the acts-based approach associated with family violence research typically finds mutual, conflict motivated IPV the norm in dating relationships (Capaldi and Owen, 2001; Davies et al., 1998; Graham et al., 2002; Graham-Kevan and Archer, 2009; Johnson, 1995; Straus et al., 1980; Straus and Gelles, 1986; and Whitaker et al., 2007). It also identifies females as frequent initiators of this aggression (e.g., Capaldi et al., 2004; Capaldi et al., 2007; and DeMaris et al., 1992). Since adolescents are thought to
engage in more casual dating type relationships (Meier and Allen, 2009; Barter et al., 2009; Fox et al., 2013) it follows that experiences of SCV will be found in adolescent samples.

Care must be taken when analysing patterns of incidents as many separate incidents of situation couple violence may look like those found in cases of Intimate Terrorism, although the dynamic of power and control will be absent (Johnson, 2008, 2011). Rather, one or more conflicts have resulted in violence. The violence is thus a result of a particular situation rather than a wider attempt by one partner to control the other (Johnson, 2008).

There are 3 identified risk factors associated with Situational Couple Violence. Firstly, the source of couple conflict is relevant. Johnson (2005, 2008, 2011) suggests that the less formal the relationship status of the couple the greater the risk of SCV, perhaps due to ‘separation-precipitated violence’, financial concerns, the division of labour, and substance misuse. Due to adolescents’ relative lack of experience of romantic relationships, and the informal nature of many of them, this risk factor is particularly relevant for adolescents (Catallozzi et al., 2011).

Secondly, the communication patterns of the couple are significant (Johnson, 2008, 2011). Johnson suggests that the use of verbal aggression, such as character or competence attacks, hostility and the use of triggers, whether public or private, adds a significant risk to the likelihood of SCV occurring. Furthermore, he suggests that if one or both partners have verbal and/or argumentative skills deficits the risk will escalate further (Johnson, 2008, 2011). Due to their relative immaturity and neurological development, adolescents may experience such behaviours and may be more likely to have the skills deficit Johnson refers to (Collin, 2003; Blakemore, 2012; Sawyer et al., 2018). This risk is likely to increase further if peer groups or their wider community endorse such behaviours. In addition, Straus (2008) suggests that bidirectional violence, motivated by anger, hostility, or the desire to punish ‘misbehaviour, is most common among younger couples (Kimmel, 2002).

Thirdly, Johnson suggests there are individual personal and background factors which can affect the propensity for escalation to violence (2008, 2011). These factors include a family history of violence, communication and/or conflict resolution skills deficits, education attainment and ethnicity. Many of these factors are linked to specific axes of power and discrimination, such as race and class (Potter, 2015). In addition, it has been argued that the intergenerational transmission of violence thesis is not a sufficient explanation for future DVA perpetration, until it is analysed alongside other sociodemographic factors such as educational attainment and ethnicity (Black, Sussman and Unger, 2013).

Longitudinal data suggests that IPV can be predicted from risk factors present during childhood (Moffitt, Caspi, Rutter and Silva, 2001), or even before birth (Côté et al., 2002). Risk factors for perpetration and victimisation, such as holding pro-violence attitudes (Gadd et al.,
2014), having previous victimisation experiences (Barter et al., 2015), and belonging to a low socioeconomic group (Anderson, 1997), seemingly co-occur for males and females (Broidy et al., 2003; Barter et al., 2015). This suggests that such risk factors are developmentally similar for all genders and are subsequently mediated by context (Dixon and Graham-Kevan, 2011). This goes some way to explain why there is an additional risk associated with adolescence (Gadd et al., 2015; Tolman et al., 2003; Teitlemen et al., 2008). Indeed, research (Graham-Kevan and Archer, 2005; Stith et al., 2004) suggests that one of the strongest predictors of female victimisation is female violence towards her male partner. Therefore, there is strong empirical support for studying male and female IPV in an intersectional manner, which also considers the context of individual incidents, and the lives of those involved in the relationship.

The SCV typology reflects the family violence perspective of DVA (Johnson, 2008). Johnson suggests that it is the inevitability of conflict within relationships that mediates the subsequent likelihood of one or both partners escalating to violence (ibid). This goes some way to explain why a majority of IPV can be classified as Situational Couple Violence in adult populations (Johnson, 2011). Since adolescents are suggested to have reduced conflict resolution skills and a lack of experience in romantic relationships (Collins, 2003), it follows that their experiences of IPV will also be classified as SCV in many cases.

In contrast with Intimate Terrorism and Violent Resistance, Johnson suggests that Situational Couple Violence is mostly gender symmetric, as the family violence literature suggests. Interestingly, Gadd et al. (2015) found no gender difference for experiencing emotional or physical victimisation, and no gender difference in the self-reported perpetration of emotional, physical or sexual violence, suggesting that there may be gender symmetry in some AIPV. Conversely, the two other significant studies of AIPV (Barter et al., 2009; Barter et al., 2015) both found significant gendered difference in both the prevalence and impact of all forms of AIPV. Johnson notes that whilst Situational Couple Violence may appear to be gender symmetric, the identification of it relies on specific acts-based methods, such as the Conflict Tactic Scale [CTS] (Straus, 2008), which seek to identify the presence of a list violent behaviours within, usually, the last 12 months.

Critics of the acts-based methodological approach favoured by the family violence perspective argue that participants are asked to report the use and experience of a variety of non-aggressive and aggressive acts in the context of relationship conflict, as opposed to criminal assault or domestic violence, skewing the data (Dixon and Graham-Kevan, 2011). Furthermore, they argue that the gender-neutral approach fails on several levels. Arguably, it fails to contextualise the incident(s), does not allow differentiation between incidents of varying severity and fails to distinguish between individual incidents and patterns of abuse (Miller and
The lack of nuance in this method is thought to create the appearance of gender symmetry (Leen et al., 2013). However, Johnson argues that this method is in fact capturing a different type of IPV in comparison to feminist qualitative methods. This may explain the higher rates of self-reporting in surveys using this approach (Straus, 1999). In addition, if the results of such research are to be taken at face value, they suggest that prevention and intervention efforts should focus on ensuring females do not provoke or respond to male violence, rather than preventing male violence.

Johnson argues that the presence of these behaviours may well appear gender symmetric, however on further analysis it becomes clear that specific acts, frequency and severity, and/or the resulting levels of fear are still gendered (Johnson, 2008; Straus, 2008). In addition, Straus suggests that ‘minor and harmless’ assaults by women may in turn provoke more severe retaliation from men, as with Violent Resistance. This is of particular concern for adolescents and young adults as females “initiate violence and particularly in teenage and young adult samples, women perpetrate violence against their partners more frequently than do men” (Johnson, 2011: 292).

Such findings of gender symmetry in perpetration of IPV behaviours present a significant challenge to the gendered framework of IPV. Rather than female violence being ‘self-defensive’, evidence suggests that findings have instead been interpreted in this way (Dixon and Graham-Kevan, 2011). What is more, empirically rigorous research provides little support for such explanations of female violence (for example, Stets and Straus, 1990), especially regarding female violence towards non-violent males (Simmons et al., 2005; Straus and Ramirez, 2004). In contrast to the violence against women perspective, studies have reported alternative motivations for female IPV, such as control, anger, jealousy, desire for attention, and in a bid to ‘get through’ to their partner (Graham-Kevan and Archer, 2005; Harned, 2001; Carrado et al., 1996).

Sokoloff and Dupont (2005: 43) suggest that a further major challenge to the gender symmetry debate comes from the same-sex DVA literature since its presence suggests gender is not the central risk factor (e.g. Renzetti, 1998; Ristock, 2002; Donovan and Hester, 2015; Barnes, 2013). When considering the presence of SCV in same-sex relationships, Johnson suggests that some aspects of the partners’ gendered identities will manifest themselves in the resulting acts, severity and fear (2005, 2008, 2011). In other words, it is not the individual’s biological sex but their gendered identity (Barritteau, 2001) which mediates an individual’s risk of perpetration and/or victimisation of IPV. For example, a more submissive (i.e. feminine) male may experience more resulting fear than a more dominant (i.e. masculine) male (Donovan and Hester, 2015; Hester and Donovan, 2016). This is particularly important given that
adolescents are still formulating their sexual and gendered identities despite operating in hyper-gendered contexts (Wekerle and Wolfe, 1999; Rideway and Cornell, 2004; Fox et al., 2013; Potter, 2015; Tolman et al., 2003; Teitleman et al., 2008). Hester, Kelly and Radford argue that “including women’s use of violence is only a threat to a version of feminism which views men and women, masculine and feminine as fixed, unchanging and biologically based, and which defines violence as an inherent potentiality in men. A feminism which begins from understanding gender as a social construct, which recognises the variability with which gendered selves and individual biography combine, can locate women’s use of violence within its existing framework” (1996: 36).

Whilst the motivation for same-sex perpetration may reflect the motivations in heterosexual perpetrators, the context of homosexuality must be considered in order to avoid the ‘heterosexual assumption’ (Weeks et al., 2001; Donovan and Hester, 2015; Potter, 2015; Collins and Bilge, 2016). The ‘heterosexual assumption’ pervades interactions in everyday lives since heterosexuality is “not just a sexual identity but a set of expectations about a certain kind of life and a particular form of intimacy” (Donovan and Hester, 2015: 59). This may determine how intimate lives are lived and includes the ways that gendered identities might be enacted within opposite-sex and same-sex relationships, at different ages, in different social classes and so on (Donovan and Hester, 2015). Due to the ‘heterosexual assumption’ LGBTQIA individuals may experience additional technologies of violence (Stark, 2007), and may anticipate additional risks with seeking help (Donovan and Hester, 2015), including the risk of being ‘outed’ before they are ready; fear that the police, family members, religious institutions etc. may respond with homophobia (Irwin, 2006); and internalised homophobia. As such the same-sex literature demonstrates that power and conflict may be the central issues. An intersectional approach to understanding the participants’ experiences of AIPV will enable consideration of these additional factors (Potter, 2015).

**Conclusion**

Intersectionality challenges the primacy of gender in the violence against women approach to understanding IPV and advocates for a broader consideration of how systems of power structured by classism, sexism, racism, and ageism, and so on, intersect and interact to shape individual experiences of IPV (Potter, 2015; Collins and Bilge, 2016; Crenshaw, 1981). These complex power relations are experienced by individuals depending on characteristics including class, gender, ethnicity and age, and their positioning within these social divisions (Potter, 2015). It has been argued throughout this chapter that analysis of these factors allows for a greater understanding of the lived experience of AIPV.
In order to analyse the intersecting nature of power and discrimination in the lives of adolescent victims of IPV, this project will consider how ‘inequality, relationality, power, social context, complexity, and social justice’ manifest (Collins and Bilge, 2016: 25; Crenshaw, 1981). Due to the ‘multiple, multiplicative, and inseparable’ (Potter, 2015: 70) nature of these factors, this chapter has argued that an intersectional analysis of the participants’ experiences capture the relationality of these factors, and the influence they have on their experiences. Such an analysis is complex (Crenshaw, 1981) and must recognise that age straddles all other factors of discrimination, providing adolescents with a ‘special vantage point’ (Taefi, 2009; Collins and Bilge, 2016).

Furthermore, recognition of the context across the four key domains of power: interpersonal, disciplinary, cultural, and structural in which AIPV occurs is vital to an intersectional analysis of AIPV (Collins and Bilge, 2016). This chapter has outlined the social and cultural contexts of AIPV, building on the political context explored in Chapter Two. It has demonstrated that socialisation via the social institutions adolescents experience in their day to day lives, e.g. school, church, youth clubs, libraries and so on, shape their experiences of AIPV and how others respond to it.

Adolescence has been identified as a key developmental phase for identity development (Collins, 2003; Blakemore, 2013; Sawyer et al., 2018). Cultural domains of power, produced and reproduced through language and behaviour, influence adolescents’ identity development to varying degrees (Potter, 2015), which may in turn affect their experiences of AIPV. Pro-violence attitudes expressed by those endorsing ‘lad culture’ for example, often encourage misogyny and the negative treatment of women (Hunnicutt, 2009; Brownmiller, 1975; Caputi, 1989). Evidence suggests that the norms and values of adolescence are more likely to be pro-violence than for other age groups, going some way to explain the peak in IPV cases for sixteen to twenty-five-year olds (Teitleman et al., 2008; ONS, 2016).

Every individual will experience adolescence in a unique way as shaped by the structural power dynamics featured in their lives, associated with their class, gender, ethnicity etc. It is the way in which their age intersects with these factors through what Collins and Bilge called the ‘special vantage point’, which appears to be unique (2016; Taefi, 2009). This project seeks to explore how the participants’ age interacted with their experiences of these axes of power, to determine the ways in which they have shaped their experiences of AIPV using Johnson’s Typologies of Domestic Abuse to frame the analysis.

Johnson’s analysis of the gender symmetry debate in the study of IPV has led to the identification of three typologies of IPV: Intimate Terrorism, Violent Resistance and Situational Couple Violence (2005, 2008, 2011). Johnson’s typologies reflect the differing methodologies,
sampling and units of measurement employed by the two dominant perspectives which have debated the issue: the violence against women approach and the family violence perspective. Johnson’s analysis concludes that multi-factor analyses overcome many of the inadequacies associated with the single-factor analyses presented by the violence against women and family violence perspectives (2008, 2011). This integration of perspectives has led to a detailed framework which is considerate of gendered, conflict and intersectional approaches to understanding AIPV. This thesis will explore the framework’s applicability to AIPV, considering how and if each typology fits with the participants’ experiences (Chapter 5).

To conclude, an intersectional approach to Johnson’s typologies of domestic abuse suggests that adolescents will likely experience Intimate Terrorism in medium- and long-term relationships. Violent Resistance may also be reported in these relationships. Situational Couple Violence is most likely to be identified due to the poor communication patterns and relative immaturity of adolescents, and the high prevalence of less formal relationships during adolescence. In addition, Situational Couple Violence will be particularly likely when the participants have experiences of discrimination beyond their age and gender, for example if they are disabled. However, this may be affected by the sampling procedure (see page 84) utilised for this study. The chapter that follows will set out how the research conducted for this PhD employed an intersectional approach to studying AIPV.
Chapter Four - Researching Female Adolescents’ Experiences of Intimate Partner Violence

In order to gain a better understanding of the lived experience of adolescent intimate partner violence (AIPV), this study sought to speak directly with female victims/survivors of AIPV. The intersectional feminist research approach adopted for this thesis will be examined throughout this chapter. This project is framed within an intersectional feminist approach, as it is grounded in the lived experiences of the female participants, recognising their diversity and varying social worlds, whilst also embodying the ethical and ideological underpinnings of feminist research.

Section 4.1 will examine the chosen research methodology and design, highlighting a feminist approach to researching AIPV. Section 4.2 will explore the purposive sampling approach, which identified participants through two gate-keeping organisations in the Midlands and North West of England. The resulting data set compromises thirty-five interviews with seventeen females aged between seventeen and fifty-two years, during which participants were encouraged to reflect upon their experiences of intimate partner violence during adolescence (age ten to twenty-five years). Section 4.3 will introduce the participants in terms of their socio-demographic and contextual data.

Section 4.4 explores the psychoanalytically informed qualitative methodology employed to address the following research questions:

1. How do female victims of AIPV define their intimate experiences and partnerships?
2. How do victims of AIPV identify, explain, and understand their experiences of victimisation?
3. How do victims’ requirements of prevention interventions compare to existing prevention efforts in England and Wales?

The methodology utilises aspects of the Free Association Narrative Interview method, in which participants are encouraged to share their chosen narratives as a whole (Hollway and Jefferson, 2000). This is complemented by aspects of Wengraf’s Biographical Narrative Interview Method [BNIM] (2001). The particular applications of the Free Association Narrative Interview Method and Biographical Interview Method are explored in Section 4.5. This is followed by consideration of accompanying focus groups with staff from the gate-keeping organisations in Section 4.6.
Section 4.7 considers the various ethical issues associated with the project, namely informed consent, confidentiality and anonymity, personal safety, and research impact and reflections. The analytical processes will then be examined, highlighting the use of Thematic and Critical Discourse Analysis to uncover the power dynamics in the participants' narratives. The chapter concludes by summarising the research journey.

4.1 The Research Methodology

Intimate partner violence [IPV] is particularly prevalent in adolescent relationships, as established in Chapter Two (ONS, 2016). Adolescence (ten to twenty-five years) is a time of increasing opportunity and desire to engage in intimate experiences and partnerships (IEPs), thus providing contexts for AIPV to occur (Connolly and McIsaac, 2011; Brown, 1999; Collins, 2003).

It has been argued that being adolescent and female is strongly associated with increased vulnerability for AIPV victimisation (ONS, 2016). In addition, further vulnerabilities, such as ethnicity, disability, being working class and so on, intersect with gender and age to multiply an individual’s risk and experience of AIPV victimisation (Potter, 2015; Collins and Bilge, 2016; Taefi, 2009). An intersectional approach to researching AIPV acknowledges the multidimensional discriminating factors associated with victimisation, which sit alongside gender, as explored in Chapter Three. Whilst these factors do not necessarily carry the same weight, each requires consideration (Veenstra, 2013).

Patriarchal gender inequalities are frequently cited as the dominant cause of such violence in Western society, despite the lack of a robust definition of patriarchy and consideration of its limitation as the sole cause of AIPV. Research suggests normative patterns of interpersonal control and authority tend to favour males, especially during adolescence (Teitelman et al., 2008; Tolman et al., 2003). The resulting perceived inferiority increases female adolescents’ vulnerability to AIPV.

The positivistic orthodoxy of research as a search for an objective truth, to the exclusion of women, went unchallenged until the late twenty-first century (Heidensohn and Gelsthorpe, 2007; Durkheim and Alcock, 1983). This orthodoxy assumes the existence of a value-neutral and objective scientist, void of any emotions, and a universal social reality (ibid). Feminists challenged this, highlighting the inability of any researcher to be truly objective, and the non-existence of a universal social reality (for example, see Oakley, 1981, and Reinharz and
Davidman, 1992). Consequently, it was suggested that the positivistic paradigm had also wrongly assumed that men’s social reality was also women’s social reality (Heidensohn and Gelsthorpe, 2007). Instead, the differing perspectives, feelings, and lived experiences of women should be valued as appropriate knowledge (Hesse-Biber, 2007; Durkheim, 1983).

Lived experience structures one’s understanding of the social world, and therefore to understand a social phenomenon we must speak with those who have experienced it (Marx, 1859; and Hegel, 1816). Arguably, victims of AIPV have a more nuanced understanding of it, as survival requires an understanding of their own and their perpetrator’s social worlds (Hesse-Biber, 2012). It should be noted that the researcher has lived experience of AIPV, and is subsequently interconnected to the research, participants, and research findings (Stanko, 1996). Further exploration of the effect this has had on the research can be found in Section 4.9.

This research is framed within an intersectional feminist epistemology. Intersectional feminism argues that there is no single universal knowledge or social world (Hesse-Biber, 2012). Such an approach rejects the dominant androcentric discourse by recognising the diversity of women’s lives. This approach is also intersectional in that its ontological perspective strives to highlight and is grounded in the diverse lives of the female participants (Williams, 2003). Intersectional feminism emphasises the importance of researching difference and empowering oppressed groups, sitting in contrast to some radical feminism(s) which critics argue ignore difference between individuals and groups of women (Hesse-Biber, 2012).

A methodology is a theory of how we approach and proceed with research (Hesse-Biber, 2007), in this case from an intersectional feminist research approach. The researcher’s role, therefore, is to link the project’s epistemology with its techniques of investigation, its methods, and analysis. Consistent with its intersectional feminist epistemology, this research requires a feminist methodology (Hesse-Biber, 2012). Arguably, there is no singular feminist methodology, as feminisms exist within a range of epistemological and ontological locations (ibid). Nevertheless, there is consensus between feminist researchers regarding key characteristics or principles that make research feminist (Hesse-Biber, 2012; Heidensohn and Gelsthorpe, 2007; Skinner, Hester and Malos, 2005).

Skinner and colleagues (2005: 10-17) suggest there are seven key principles of feminist methodologies. The first, “gender and existing gender inequality are central to the research topic and research questions” is evident throughout this research. Whilst using a gender-inclusive approach rather than a gender-focused approach, the aim of the project is to highlight the experiences of female victims of AIPV.
An intersectional feminist epistemology favours a naturalistic approach to research over a positivistic one. Therefore, the second principle, "the positivistic dualism of the researcher and the researched is rejected with the view to acknowledge and minimise the power dynamic between researcher and researched", is met. To balance the researcher-researched power dynamics, the researcher and researched should be "on the same critical causal plane" (Harding, 2004: 136). Arguably, this can be achieved through researcher reflexivity, which will be discussed in line with principle five.

The third principle, an “emphasis on empowering women and other marginalised groups, allowing their voices to be heard and valued”, is also a central tenet of this research. Adolescents have been largely absent from the IPV literature until very recently. In order to counteract this, it was important to highlight the voices of adolescent victims who are marginalised due to both their gender and age, along with other individual difference(s). Likewise, it is the nuanced similarities and differences to adult victimisation which are of interest. The methodology and methods therefore needed to hear and share participants’ voices. The central aim of the FANIM is to elicit participants’ gestalt, or whole story (discussed further in Section 4.4), and by doing so empower them by providing space to reflect upon their experiences and be heard, without interruption or fear of the listeners’ reaction. By sharing these narratives, the research meets the third principle.

The fourth principle of feminist research asserts “the importance of politically active and emancipatory research”. This is achieved by enabling the participants’ voices to be heard by practitioners, academics, and policy makers. By applying the participants’ voices to current policy and legislation, and by disseminating the findings to an international audience through conference papers and academic journal articles, this principle is met.

Skinner and colleagues (2005) suggest that for research to be feminist there is a “need for continuous researcher reflexivity” (principle 5). Reflexivity allows for ongoing perspectives to be challenged and enforced. Arguably, it has allowed the power dynamics between researcher and researched to be reviewed and minimised and has encouraged the researcher to develop both professionally and personally. The processes of research supervision, gaining ethical approval, and disseminating early findings have been particularly conducive with this principle. Gaining ethical approval allowed the epistemological, ontological, and axiological stance of the researcher to be identified at the earliest opportunity. Supervision allowed discussion of both the positive and negative experiences of insider research, whilst critically analysing the effect of the research on the researcher and participants. Disseminating findings to peers also enabled space to plan the presentation of the research, and the purity of the voices shared.
Crucially, this continual reflection allowed for a thesis firmly grounded in the lived experience of the participants. Further reflections can be found in Section 4.9.

Ethical research such as this mediates any harm to the participants and researcher. This is conducive with Skinner and colleagues’ sixth principle, “the emotional and physical wellbeing of the researcher and the ‘researched’ should be considered at all times”. The process of gaining ethical approval ensured that this principle was met, along with the continued reflexivity of the researcher. There is a full discussion of the ethical considerations of the project in Section 4.7.

The Free Association Narrative Interview technique employed here allows for the elicitation of participants’ narratives of their experiences of AIPV, the way they interpret their experiences, the way they construct their reality, and the meanings attributed to their experiences (Hollway and Jefferson, 2000; Gadd, 2012). The analysis and presentation of these narratives is based upon the gestalt principle, which advocates for participants’ whole story to be shared as they present it. As such, this project meets Skinner and colleagues’ seventh principle, “the selected methods of evidence gathering, interpretation and presentation should reflect rather than distort the experiences of women and children”. The chosen research methods are explored in full in Sections 4.4 and 4.5.

4.2 Sampling

This section will set out the participant criteria for inclusion and exclusion, and the process of identifying and managing gate-keepers. The chosen method of sampling - strategic purposive and chain sampling - will be examined. A discussion of an ‘ideal’ and achieved sample size will follow.

Gate-keepers

On scoping the fieldwork area, thirteen potential gate-keeping organisations were identified. Table A shows the identified potential gate-keeping organisations, their identifier, their ability and/or willingness to act as gate-keepers, and the number of participants recruited through them.
Table A: Potential gate-keeping organisations, their ability to act as gate-keepers, and the number of participants recruited through each organisation.

<table>
<thead>
<tr>
<th>Organisation Identifier</th>
<th>Type of organisation</th>
<th>Able to act as gate-keepers?</th>
<th>Participants recruited</th>
</tr>
</thead>
<tbody>
<tr>
<td>LWAC-1</td>
<td>Local Women’s Aid Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LWAC-2</td>
<td>Local Women’s Aid Centre</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>LWAC-3</td>
<td>Local Women’s Aid Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LWAC-4</td>
<td>Local Women’s Aid Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LWAC-5</td>
<td>Local Women’s Aid Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>WHAG-1</td>
<td>Women’s Housing Action Group</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LRCC-1</td>
<td>Local Rape Crisis Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LRCC-2</td>
<td>Local Rape Crisis Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LFCC-1</td>
<td>Local Family Crisis Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LFCC-2</td>
<td>Local Family Crisis Centre</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LWP-1</td>
<td>Local Women’s Project</td>
<td>No</td>
<td>-</td>
</tr>
<tr>
<td>LDAS-1</td>
<td>Local Domestic Abuse Service</td>
<td>Yes</td>
<td>6</td>
</tr>
<tr>
<td>LDIS-1</td>
<td>Local Drop in Service</td>
<td>No</td>
<td>-</td>
</tr>
</tbody>
</table>

Many potential gate-keepers could not assist due to a lack of resources and the ever-tightening restrictions on funding and resources. For those who could assist, it was agreed as part of the gate-keeping arrangement that a report would be produced in order to demonstrate that their resources had been put towards a study on prevention of AIPV.

Participants were identified through these gate-keepers because they had been referred for support for IPV, suggesting that a professional had identified IPV within their relationship. The so-called ‘clinical fallacy’ is of note here due to the ongoing discussion considering potential gate-keeper bias. Past feminist research into IPV, albeit predominantly on adult victims, has focused on samples living in refuge or seeking medical care in hospital. Critics argue that this had led to an over-representation of victims of Intimate Terrorism compared with Situational Couple Violence AIPV cases (Johnson, 2008; Dixon and Bowen, 2012; Dixon and Graham-Kevan, 2011). In order to minimise this ‘clinical fallacy’ gate-keepers were asked to identify potential participants across the spectrum of AIPV. A further four participants were identified.
through chain sampling, they therefore had reduced input from specialist organisations, further minimising the potential for clinical fallacy.

Each gate-keeper was asked to give the researcher’s contact details and information sheet (Appendix 1) to potential participants. Contacts within the organisations confirmed that as many of the potential participants were on tight budgets themselves, they would prefer that the researcher contacted them. Subsequently gate-keepers gave the researcher potential participants’ contact details so that the researcher could instigate the process.

In order to minimise researcher bias, potential participants were advised of the research agenda in a manner that explained the purpose of the research without disrupting their system of relevancy to the topic, i.e. with minimal use of language that may lead them to produce narratives that are biased towards what they believe the researcher might want to hear. It was explained that the research aims to explore how we can help to prevent unhealthy adolescent relationships, and that they had been chosen to participate because during their adolescence they experienced unhealthy IEPs. The open questioning style of the FANIM is also likely to have minimised researcher bias.

**Strategic Purposive and Chain Sampling**

A strategic purposive and chain sampling framework was utilised for this project. Both methods of sampling are non-probability based in that they recruit participants who meet certain criteria beneficial to the research, so-called ‘good informants’ (Adler and Clark, 2014; Morse, 1998). As such, the sample recruited does not intend or attempt to be a representation of adolescence as a population or its heterogeneities, but instead explore the practical and theoretical concerns that emerge from the participants’ data and analysis (Paler-Calmorin and Calmorin, 2007). The sampling framework for this project was required to recruit twenty participants who had experience of IPV during adolescence and the ability to articulate their experience.

Thirteen participants were identified using this framework. Once the strategic purposive technique had been saturated chain sampling was employed. Chain sampling is a particularly useful tool when researching hard to reach groups such as victims of AIPV (Sadler, Lee, Lim and Fullerton, 2010). By utilising participants’ links to other potential participants, chain sampling is pragmatic and time effective. However, critics argue that chain sampling is biased as it “might include an over-representation of individuals with … similar characteristics” (ibid: 370).
Criteria for Inclusion

In order for the research questions to be adequately addressed, the criteria for inclusion were: a) participants are female; b) participants have experience of any facet of IPV between ten and twenty-five years of age (as defined in Section 1.6); c) they are able to reflect on their experiences of AIPV and articulate them to the researcher during an interview; d) they are within reasonable distance of the researcher’s base. There were no exclusionary criteria.

Sample Size

The target sample size for this project was twenty, to enable enough variation of response whilst acknowledging the limited resources available to the project. There are varying opinions regarding appropriate sample sizes. Warren suggests that in order for a qualitative interview study to be publishable, it should be based on a minimum of twenty to thirty interviews (2002: 99), whereas Gerson and Horowitz argue that “fewer than 60 interviews cannot support convincing conclusions, and more than 150 produces too much material to analyse effectively and expeditiously” (2002: 223). These varying opinions suggest that although there is emphasis on the importance of purposive sampling, there are minimum levels of acceptability in operation. In contrast, Mason (2010) argues that data saturation, rather than quantity, is the determining factor.

It is widely accepted that in-depth interviews, including the Free Association Narrative Interview Method adopted for this project, provide such rich data that lower minimum interview quotas are acceptable. Whilst the project initially aimed to recruit twenty participants, limited access and data saturation (Strauss and Corbin, 1998) meant that thirty-five interviews with seventeen participants gave sufficient in-depth qualitative data sets, whilst being a suitable size to analyse given the project’s time frame.

In total, twenty potential participants were identified [LDAS-1 N=8; LWAC-2 N=8; Chain M=4]. Successful contact was made with eighteen women, representing an attrition rate of 10%. First, interviews were successfully completed with seventeen participants. Participant A008 had arranged their first interview but subsequently was no longer contactable, representing a further attrition rate of 5%. All participants who completed their first interview [N=17] went on to successfully complete their second interview. Stephanie [A016] requested a third interview which was also successfully completed. The total completion rate was 85%.
4.3 The Participants

Participants were asked multiple questions about their identity, sexuality, and socio-demographic profile in order to consider the well-documented risk and protective factors explored in Chapters 2 and 3 (see Interview Schedule, Appendix 4). These will now be explored.

Age and Identity

The youngest participant was seventeen years old and the oldest was fifty-two years. The average age of participants was twenty-six years and nine months. All participants described themselves as British. Sixteen identified as White British, and one identified as Arab British. Ten participants declared a religion (Muslim – 2; Catholic – 2; Roman Catholic – 2; Christian – 2; Church of England – 1), and seven had no religion. Fifteen participants described themselves as working class, and two as middle class.

Fourteen participants identified as heterosexuals, two identified as bisexual, and one participant identified as lesbian. The three non-heterosexual participants [18%] described sexual experiences with both same-sex and other-sex individuals, whereas the heterosexual participants described only other-sex experiences.

Four participants [23.5%] identified as disabled. The disabilities described were both physical and psychological. All four disabled participants noted the effect victimisation had had on existing disabilities and on creating new disabilities.
Table B: Participant Age, Nationality, Religion, Sexuality and Disability Status

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age at first interview</th>
<th>Number of Interviews conducted</th>
<th>Nationality</th>
<th>Religion</th>
<th>Sexuality</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilly</td>
<td>28</td>
<td>2</td>
<td>White British (WB)</td>
<td>None</td>
<td>Gay</td>
<td>None</td>
</tr>
<tr>
<td>Skye</td>
<td>22</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Rachel</td>
<td>23</td>
<td>2</td>
<td>WB</td>
<td>Catholic</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Molly</td>
<td>34</td>
<td>2</td>
<td>WB</td>
<td>Catholic (non-practicing)</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Jane</td>
<td>40</td>
<td>2</td>
<td>WB</td>
<td>Church of England</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Emily</td>
<td>18</td>
<td>2</td>
<td>WB</td>
<td>Christian (non-practicing)</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Jemma</td>
<td>18</td>
<td>2</td>
<td>WB</td>
<td>Christian</td>
<td>Heterosexual</td>
<td>“Learning difficulties”; Schizophrenia; PTSD</td>
</tr>
<tr>
<td>Jessica</td>
<td>17</td>
<td>2</td>
<td>British Arabic</td>
<td>Muslim (non-practicing)</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Sam</td>
<td>22</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Milly-May</td>
<td>23</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Heterosexual</td>
<td>Limited mobility; depression; anxiety</td>
</tr>
<tr>
<td>Ishara</td>
<td>37</td>
<td>2</td>
<td>WB</td>
<td>Buddhist</td>
<td>Bisexual</td>
<td>Severe depression; anxiety</td>
</tr>
<tr>
<td>Amy</td>
<td>17</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Natalie</td>
<td>36</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Bisexual</td>
<td>None</td>
</tr>
<tr>
<td>Stephanie</td>
<td>33</td>
<td>3</td>
<td>WB</td>
<td>Roman Catholic</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Catherine</td>
<td>52</td>
<td>2</td>
<td>WB</td>
<td>Roman Catholic</td>
<td>Heterosexual</td>
<td>Fibromyalgia; mental health</td>
</tr>
<tr>
<td>Sarah</td>
<td>17</td>
<td>2</td>
<td>WB</td>
<td>None</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
<tr>
<td>Caitlin</td>
<td>18</td>
<td>2</td>
<td>WB</td>
<td>Muslim</td>
<td>Heterosexual</td>
<td>None</td>
</tr>
</tbody>
</table>
Family Background and Current Situation

Participants were asked several questions about their family, childhood, and parental status in order to understand their potential risk factors for victimisation, such as pregnancy, family makeup, familial domestic violence, and lower socio-economic status.

Ten participants lived with both of their parents throughout their childhood. Three participants lived with both parents for a period until they separated. A further four participants lived solely with their mothers.

Ten participants disclosed domestic violence in their parents' relationships. This resulted in relationship breakdowns, relocations, stays in refuge and maternal deaths. Nine participants were parents themselves, and a further two were pregnant when interviewed. Three participants no longer had custody of one or all their children.

Five participants were living with their parents at the time of interview, seven were privately renting, four were currently in refuge, and one owned their own home. Eleven participants had at some point, been in refuge due to their victimisation.
Table C: Participant living arrangements, academic achievement, relationship status, parental status and familial structure

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Current living arrangements</th>
<th>Highest education level</th>
<th>Relationship status</th>
<th>Parental status</th>
<th>Family structure (growing up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilly</td>
<td>With parents</td>
<td>Further Education</td>
<td>Single</td>
<td>No</td>
<td>Both parents</td>
</tr>
<tr>
<td>Skye</td>
<td>Social housing</td>
<td>Further Education</td>
<td>Single</td>
<td>Yes</td>
<td>Single Mother</td>
</tr>
<tr>
<td>Rachel</td>
<td>Private renting</td>
<td>Further Education</td>
<td>Single</td>
<td>No</td>
<td>Both parents</td>
</tr>
<tr>
<td>Molly</td>
<td>Private renting</td>
<td>Further Education</td>
<td>In a relationship</td>
<td>Yes</td>
<td>Both parents</td>
</tr>
<tr>
<td>Jane</td>
<td>Social housing</td>
<td>Secondary</td>
<td>In a relationship</td>
<td>Yes</td>
<td>Both parents</td>
</tr>
<tr>
<td>Emily</td>
<td>Private renting</td>
<td>Further Education</td>
<td>Engaged</td>
<td>No</td>
<td>Grandparents/Care</td>
</tr>
<tr>
<td>Jemma</td>
<td>With parents</td>
<td>Secondary</td>
<td>Single</td>
<td>No</td>
<td>Both parents</td>
</tr>
<tr>
<td>Jessica</td>
<td>Refuge</td>
<td>Further Education</td>
<td>In a relationship</td>
<td>No</td>
<td>Both parents</td>
</tr>
<tr>
<td>Sam</td>
<td>Refuge</td>
<td>Further Education</td>
<td>In a relationship</td>
<td>Yes</td>
<td>Single Mother</td>
</tr>
<tr>
<td>Milly-May</td>
<td>Refugee</td>
<td>Secondary</td>
<td>Single</td>
<td>Yes</td>
<td>Both parents/Care</td>
</tr>
<tr>
<td>Ishara</td>
<td>Social housing</td>
<td>University</td>
<td>In a relationship</td>
<td>Yes</td>
<td>Both parents</td>
</tr>
<tr>
<td>Amy</td>
<td>With parents</td>
<td>Further Education</td>
<td>Single</td>
<td>No</td>
<td>Both parents</td>
</tr>
<tr>
<td>Natalie</td>
<td>Social housing</td>
<td>University</td>
<td>Cohabiting</td>
<td>Yes</td>
<td>Single Mother</td>
</tr>
<tr>
<td>Stephanie</td>
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<td>Further Education</td>
<td>Cohabiting</td>
<td>Yes</td>
<td>Both parents</td>
</tr>
<tr>
<td>Catherine</td>
<td>Home Owner</td>
<td>University</td>
<td>Separated</td>
<td>Yes</td>
<td>Both parents</td>
</tr>
<tr>
<td>Sarah</td>
<td>Refugee</td>
<td>Further Education</td>
<td>Single</td>
<td>Yes (pregnant)</td>
<td>Both parents</td>
</tr>
<tr>
<td>Caitlin</td>
<td>With parents</td>
<td>Further Education</td>
<td>Single</td>
<td>Yes (pregnant)</td>
<td>Both parents/Care</td>
</tr>
</tbody>
</table>
4.4 The Free Association Narrative Interview Method

The Free Association Narrative Interview Method (FANIM) was initially devised by Hollway and Jefferson (2000). They noted that analysis of the British Crime Survey in the 1980s assumed that those who ticked the same box meant the same thing, with no test for validity (ibid). They concluded that the research instruments failed to anticipate the variety of public experiences of crime and fear of crime.

Hollway and Jefferson (2000) aimed to develop a method which encouraged individuals to share their unique and complex experiences, and allowed researchers to investigate “not only what people say about themselves, but also how they say it, what they struggle to say, and what they cannot or do not (quite) say” [original emphasis] (Gadd, 2012: 37). This is of particular importance when interviewing victims of AIPV, as the narratives themselves may evoke anxiety, causing the participants to talk around, or defend against, issues of particular significance to the study.

Psychoanalytical theory asserts that anxiety is an inherent part of the human condition (Klein, 1988a, 1988b). Attempts to defend against anxiety are unconscious and have influence over individuals’ actions, lives, and interactions with others, thus making individuals “defended subjects” (Hollway and Jefferson, 2008). Such defences may cause a memory to be forgotten, or to be narrated in an alternative less anxiety-inducing way. Subsequently, anxiety defences affect the context and meaning of narratives, and affect the listener, who is also a defended subject (Hollway and Jefferson, 2000).

Informed by psychoanalytical theory, the FANIM encourages the elicitation of narratives related to a research topic. Whilst the researcher determines the theme or topic of the interview, the interviewee is in control of the agenda, which will develop according to their lived experiences (Hollway and Jefferson, 2008). Such an approach acknowledges that the meaning created within the research context is dependent on the research ‘pair’, i.e. the researcher and researched (ibid). By acknowledging this joint creation of the narratives, Hollway and Jefferson assert that whilst not transparent, narratives are a means to understand the respondents better, as “storytelling stays closer to the actual life events than methods which elicit explanations” (ibid: 26).

The research interview is as unique as any social interaction in terms of time and space, and therefore will produce unique jointly created knowledge. The time, day, and life stage of the participant and researcher will alter the product. For example, Stephanie’s first interview followed on from a celebration event after spending time with those who had known her story and those whom she had practiced it with; therefore, her story came easily and seemed...
somewhat rehearsed. The presence of an audio recorder was also likely to have some impact on the narratives produced.

Given the highly sensitive nature of the subject matter, it is hypothesised that participants’ narratives will be highly defensive. Hollway and Jefferson propose that to consider the narratives effectively, the analyst must consider the data as a whole, to include any incoherent aspects – known as the gestalt principle. Arguably the gestalt is always greater than the sum of its parts. To understand someone’s lived experience, researchers should maintain the data in its truest form. This can be achieved by capturing how it is organised, presented, and structured, any incomplete, contradictory, or confused sentences, and any word-perfect responses. Presence or absence of these characteristics of language is suggested to provide evidence of the defended subject.

The art and the skill of the exercise is to assist narrators to say more about their lives without at the same time offering interpretations, judgements, or otherwise imposing one’s own relevancies as interviewers, which would thus destroy the interviewee’s gestalt (Hollway and Jefferson, 2008).

In order for the narratives elicited to contribute to the participants’ gestalt, the researcher must follow some key principles. Firstly, open-ended, rather than closed questions must be used to encourage the elicitation of narratives. Whilst this isn’t always a simple task, the narrative shared, manner and detail of the delivery, the parts emphasised, and conclusions drawn represent choices made by the narrator. However, these choices are said to be distorted by the use of ‘why’ questions, and hence they should be avoided (Hollway and Jefferson, 2008).

The final principle asserts that the researcher should use the respondents’ phrasing and ordering when following up threads of narrative, in order to respect and retain the interviewees’ gestalt. Hollway and Jefferson suggest this can be achieved by attentive listening and note-taking. Gadd suggests that chronological note-taking works to prevent participants feeling “misconstrued, or, worse still, prejudged … [which may] make them much more guarded … in terms of what they are prepared to say and how they are prepared to say it” (2012: 40). As such, participants’ gestalts are not all that can be known about the person; instead they consist of “all we have managed to accumulate relating to a particular person” (Hollway and Jefferson, 2008: 32). In a research encounter this includes the transcripts, researcher memories and notes, and what was said by others, e.g. the gate-keeper.

Hollway and Jefferson go on to argue that in order for respondents to explore their feelings of vulnerability, they should be provided with a safe environment without fear of judgment or unnecessary distress (2000; Gadd, 2012). They suggest this can be achieved through an appropriate interview location and rapport-building. Similarly, the authors suggest that by
calling upon the Biographical-Narrative Interview Method’s invitation to share narratives, in the form of a single open initial question, all participants are offered the same starting point, allowing the differentiation between their chosen narratives to be explored.

Arguably, as with every other hermeneutic approach to research, the FANIM is value-laden, and is critiqued for its reliability and validity credentials. Critics suggest that its interpretative nature is at risk of imposing the researcher’s influence over the data, subsequently diluting the participant’s gestalt (Wetherall, 2008; Plummer, 1995). Whilst the researcher’s subjectivity and axiology affects all qualitative research, it is understood that absolute objectivity is an unrealistic aim, which sits in contrast to feminist principles of research (Oleson, Bryant and Charmaz, 2010; Skinner et al., 2005). By acknowledging the researcher’s involvement in creating the knowledge, acknowledging their status as a defended subject through reflexivity, and sharing the interpretive process with other researchers – in this case supervisors, any negative effect is minimised.

4.5 Applying the Free Association Narrative Interview Method

In order to better understand participant lived experiences and develop an understanding of AIPV victimisation, this study sought to speak with women who had experience of it. In order to achieve this, a data collection method capable of eliciting participant narratives about their lived experiences, considering the feminist principles of research, was required. As such, the Free Association Narrative Interview Method (FANIM) was decided upon.

The location of the interview varied depending on the participant’s wishes and method of recruitment, i.e. via a gate-keeping agency, or chain sampling. Eleven participants chose to be interviewed in their own homes, and six participants were interviewed at their gate-keeping organisation.

Several logistical issues became apparent when interviewing participants. Some participants had their children with them, which distracted both the participant and researcher at times. Secondly, some had experienced violence at the homes in which they were interviewed. It could be argued that talking about abuse in a location in which it has occurred may further increase the likelihood of distress. Whilst this could not be anticipated, participants preferred to remain there rather than relocate. This may have been because they expected a negative reaction from the researcher, however, every effort was made to minimise that potential.
The interview schedule (Appendix 4) was designed according to the principles of the FANIM, to include sufficient room for rapport-building, note-taking and researcher reflections. To begin the first interview participants were introduced to the project and asked non-invasive questions, such as what their nationality and religion was. In order to capture detail about their potential risk and protective factors, questions were then asked about their family, their upbringing, and their current support network.

The Biographical-Narrative Interview Method highlighted by Hollway and Jefferson (2008) was then called upon to open the free association aspect of the first interview. Wengraf’s (2001) Single Question aimed at Inducing Narrative (SQuIN) technique aims to prompt narratives about, in this case, their experiences of AIPV. A SQuIN is a carefully constructed interview opener which is conceptually focused on a specific biographical strand of the participant’s life, in this case their adolescent intimate relationships (Wengraf, 2001). Wengraf argues that it provides the participant with the autonomy to decide how and when to commence and conclude their stories, and what to include and omit from them.

**Figure 4A: The SQuIN used in this project.**

| Please tell me about your experiences of intimate experiences and partnerships. |
| Include all the events and experiences which were or are important for you, and how it all developed up to now. |
| You can start around the time you began thinking about relationships, or the period in your life when they became personally important. |
| We’ve got about an hour, so please take all the time you need. |

Both Hollway and Jefferson (2000) and Wengraf (2001) endorse the use of minimalist cues, such as “hmm”, or encouraging the respondent to “go on” etc. when they are telling their story, in order to further reassure them that their narratives are interesting. This worked for the most part, but as the FANIM does not fit with a typical schema for an interview, in that it departs from the structured question-answer approach, some participants sought further reassurance. As suggested by Wengraf (2001), participants were prompted by reiterating the SQuIN, or parts of it where necessary, to avoid closed questions, so as not to disrupt the participants’ gestalt (Hollway and Jefferson, 2000). Alternatively, more narrative-focussed questions were asked, for example “can you tell me more about that?”
Great care was taken to avoid interrupting the respondents' gestalt or fill pauses or silences. However, during the first few interviews there were occasions where on reflection the respondent should have been allowed to continue with their narrative. This extract from Jemma’s (18) first interview offers an example:

**Jemma:** He was bringing young girls to his flat while I were there. Erm, basically seeing other young girls while he were with me. Bringing them round the flat and making out I were mad, saying I was not seeing these girls when I was. (**KM:** Right) So...

**KM:** Mm, Ok. And could you tell me more about how he was physical with you?

Jemma was narrating how her perpetrator would bring younger girls to their flat and have sex with them, arguably an element of coercive power and control. Rather than allowing her to explore this further, the researcher interjected with a prompt for more information about how her perpetrator had been physical with her. On reflection, Jemma should have been allowed the space to continue with this narrative, allowing her to provide detail that perhaps would not have been elicited otherwise. Ideally, the researcher should have made a note of the question for later in the interview (Gadd, 2012).

Hollway and Jefferson go on to suggest that the researcher should prompt narratives of whatever comes to the interviewee’s mind, regardless of seeming irrelevancy, as it often brings up aspects of their experience(s) which would not have been elicited with closed questions (2000; 2008). Sky offers an example of this regarding her relationship with her brothers:

**Skye:** I used to fight with my brothers a lot (**KM:** Yeah) like really, cos I was a horrible child and I used to do a lot to my mum so they, they used to batter me a lot ... they're like 15 years older than me

**KM:** Ok, and what would typically happen?

**Skye:** Erm, I'd just tell them to fuck off and they'd come flying at me, just brother and sister but literally. One time, my brother had, I don't know how it started but I'd literally got, I was running down the street to get away from him and he caught [sic] me and strangled me and everything and punched me and kicked me and everything but that’s just brother and sister relationships so …

Skye describes this relationship and level of violence as typical for siblings, which perhaps gives an insight into why she later normalises the severe violence she experienced at the hands of her boyfriend (explored further in Chapter 5).

In order to reflect the participants’ frame of meaning, the Interview Schedule had space to allow for chronological notes of the interviewees’ narratives to be made as they were being told, whilst allowing the researcher to remain attentive to the information being provided.
(Wengraf, 2001; Hollway and Jefferson, 2000; Gadd, 2012). This was at times complex and
difficult; however, these notes were vital for formulating questions and themes which reflected
the participants’ frame of meaning. Care was also taken to reflect the narratives in the order
they were initially delivered, to further prompt disclosures (Wengraf, 2001).

Once the participants’ first interview was complete, the second interview was scheduled for
approximately four weeks later, allowing time for reflection whilst being a short enough time to
reduce the probability of attrition. This time frame also meant the researcher could transcribe
the first interview, conduct primary analysis, and develop provisional questions for the follow-
up interview. Some second interviews were delayed beyond this timescale due to the
Christmas period. More detailed information regarding the analysis techniques follow in
Section 4.6.

The aim of the second interview was twofold: to validate the data already gathered by seeking
further information to test the provisional hypotheses; and to give the participants a chance to
reflect on their research experience. The second interview also provided an opportunity to ask
questions which were not raised or answered in the participants’ free association narrative,
whilst also questioning any discrepancies, contradictions, or issues within the data already
gathered (Hollway and Jefferson, 2000).

The interview schedule included a final section of structured questions about participants’
relationships, experiences of violence, and their thoughts and opinions regarding topics
related to AIPV, such as their ideal prevention intervention. The answers to these questions
were particularly interesting as they often contrasted with the participants’ narratives.

Once the second interview was complete the research encounter came to a close. The
participants were debriefed and reminded of the support services available. Stephanie was
the only participant to request a third interview as she ran out of time to answer the structured
questions planned for the second interview. Once complete, the second (and third) interviews
were transcribed, analysis of the gestalt for each participant began, and participant case
studies were written up (examples of which can be found in Appendices 4 and 5). The
analytical process will now be explored.

4.6 Thematic and Critical Discourse Analysis of Interview Data

Discourse analysis is driven by the epistemological and ontological approach of the research.
Therefore, the planning, research, and analysis must be framed within an intersectional
feminist framework. Critical Discourse Analysis (CDA) has been applied within a growing
number of disciplines and it incorporates a number of different approaches. Traditionally feminist research has used CDA to demonstrate the inequalities of power within society and the subordination of women, as discourse creates power relations within society (Foucault, 1972) (see Schwartzman, 2002; and Mendes, 2012 for examples). As such, CDA has been utilised to identify the hidden power inequalities in the participant narratives.

The varying approaches subsumed under the umbrella of discourse analysis are linked by its defining principle, i.e. that language is not an impartial communication mechanism reflecting reality, but a powerful and varied tool which is used to construct and define social life (Gill, 1996; Pugh and Coyle, 2000). Discourse can be defined in numerous ways. Burr proffers that:

A discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event (a person or class of persons), and a particular way of representing them in a certain light (Burr, 1995: 48).

Narrative construction is associated with a particular aspect of subjective positioning, and has been recognised within psychoanalytical theory (Klein, 1988a, 1988b) and psychosocial criminology as the “defended psychosocial subject” (Hollway and Jefferson, 2000; Gadd and Jefferson, 2007). Psychoanalytical theory offers a way of understanding how people negotiate meaning within particular circumstances and hence construct their narratives in a specific way. Hollway and Jefferson suggest that in order to understand someone’s lived experience, researchers should maintain the data in its truest form by including how it is organised, presented, and structured. Presence or absence of these characteristics of language is suggested to provide evidence of the defended subject.

CDA emphasises that the researcher’s role in the construction of discourse must be critiqued as part of the analysis, i.e. the questions asked, biases, preconceptions of social identity, and personality. Such preconceptions held by the researcher and the researched determine the context of the joint interaction that is the research encounter. Reflective research therefore helps to uncover any power relations that may exist, for example the perceived power held by the researcher as affiliated with the University of Manchester, and/or the power held by the participant as owner of the data (Gadd and Jefferson, 2009).

CDA is best utilised in the analysis of naturally occurring speech. The FANIM enables speech as natural as possible in a research environment, as it is guided by the gestalt principle (Hollway and Jefferson, 2000). Critics have argued that this interpretive approach lacks reliability and validity. However, this is minimised by building rapport with the participants, successfully employing the method, and continuing researcher reflexivity (Gadd, 2012).
In order to identify discourses and critique the hidden power relations within the participant data, the researcher self-transcribed the interviews and repeatedly listened to and read the transcripts and notes to ensure the whole data set was digested. The researcher then began searching for common themes throughout the participants’ accounts using the NVivo qualitative analysis software. This coding process allowed multiple themes to be identified at once and theme reports to be generated for analysis. The coding framework consisted of eighty-nine nodes organised into sixteen codes or themes (Coding Framework can be found at Appendix 8). Care was taken to acknowledge any preconceived hypotheses or prejudices throughout this process so as not to influence the analysis.

4.7 Focus Groups with Gate-keepers

In order to triangulate the participant data, the gate-keeping organisations’ staff also took part in focus groups to determine their experience and opinions on supporting adolescent victims of IPV. Krueger and Casey (2015) suggest that a focus group is a non-directive interview, guided by open questions about a particular topic with participants useful to the discussion focus. They suggest there are five characteristics of focus groups. Firstly, the people recruited are identified – in this case the staff at the gate-keeping organisations. Whilst focus groups are generally made up of at least five individuals, the number of organisational staff dictated the numbers available (ibid). At the time of writing the only service wholly dedicated to supporting under-twenty-fives was acting as a gate-keeper [LWAC-2], and therefore it was particularly important to include them in this study, despite there being just three staff members available. The focus group with gate-keeper LDAS-1 included all members of staff [N=5] in the organisation, including their dedicated young person’s support worker. Whilst the total participant sample [N=8] is relatively small, the data produced in a focus group is incredibly rich (Stewart and Shamdasani, 2015), thus reducing the negative impact on reliability and validity.

As the aim of the focus groups conducted was to consider the participants’ views on AIPV and AIPV prevention interventions, the participants were asked five questions:

1. What services does your organisation offer victims of adolescent intimate partner violence?
2. How do young people engage with your service?
3. What other services for adolescent victims are you aware of a) locally, b) nationally?
4. How can existing services be improved upon?
5. In an ideal world with unlimited resources, what would a service that aims to prevent AIPV and support its victims look like and consist of?

It was important to understand the gate-keeping organisations’ opinions about the existing prevention interventions, so that the third research question - How do victims’ requirements of prevention interventions compare to existing prevention efforts in England and Wales? - could be comprehensively answered. Staff members are much more likely to have a broader awareness and understanding of the existing intervention efforts than the participants and will be more likely to identify logistical improvements.

The focus group data was analysed thematically, considering the five key questions above and the threads of discussion offered by the gate-keeper participants. This was also supplemented with the researcher’s notes of informal discussions held on the various visits to the gate-keepers’ organisations.

4.8 Ethical Considerations

Ethical research such as this is concerned with avoiding harm to participants, ensuring the research has an identifiable and positive benefit, ensuring the values and decisions of the participant are respected, and ensuring that all people are treated equally. Careful consideration of these areas ensures a research project has integrity and is ethically sound. Victims of AIPV have an added layer of vulnerability, and as such the project required clear ethical integrity.

Informed by the British Society of Criminology and the University of Manchester’s code of ethics, the key ethical concerns of this qualitative research project relate to appropriately gaining access to participants (as discussed in Section 4.2), obtaining informed consent, protecting participants and the researcher from harm, and maintaining confidentiality and anonymity of participants. Each of these factors will be explored in this section. The University of Manchester’s ethical committee gave approval to commence the empirical research element of the study via an application for ethical approval in March 2013 [Appendix 9].

Willing Participation and Informed Consent

In order to ensure all participation was voluntary the researcher operated on an ongoing informed consent basis (Hollway and Jefferson, 2000), i.e. each participant could withdraw
certain information or from the study entirely at any time without sanction. Although participants were aware of the research purpose and what their research experience would entail, they did not have details of the likely subjects they may themselves bring to the table for discussion (Oliver, 2010). Whilst undesirable, this was unavoidable. In order to elicit narratives that do not interrupt their gestalt and take into consideration their own systems of relevancy as opposed to those of the research and researcher, they could not be forewarned (Hollway and Jefferson, 2000). Arguably, the information participants were given was sufficient for them to make a decision about whether or not to take part (Oliver, 2010).

Participants were given as much information as was necessary in order to make an informed decision of whether or not to take part in the study whilst confirming their right to withdraw at any time (Bryman, 2015). Each potential participant was issued with a research information sheet [Appendix 1] explaining the research purpose and what participation would entail. This ensured that each participant had the necessary information in the appropriate format before a decision to participate was made. Any questions raised were answered in person.

The information sheet contained a statement confirming the participants’ right to withdraw from the study at any time regardless of their initial agreement to participate, and their right to reclaim any information regarding them. A more detailed discussion of anonymity and confidentiality can be found below.

After a discussion about the content of the information sheet, written informed consent was obtained from those willing to participate [Appendix 2]. Although participants were offered a fourteen-day cooling off period between reading the research information and signing the consent form, the participants wanted to get started straight away. Participants were reminded of their continued right to withdraw at any time.

Many participants confirmed at this point that they were keen to take part and share their experiences, so they could prevent others from having similar experiences, linking with Skinner and colleagues’ (2005) third and seventh principles of feminist research. Whilst participants were happy to share their experiences, some participants expressed concern that their perpetrators and/or their perpetrator’s family may become aware of their participation through reading a project output. Participants were reassured that all identifying information would be removed and that anonymity and confidentiality would be respected. Participants were offered the opportunity to check and confirm their transcripts in order to instil confidence in their control over their data. All participants were keen to see the final thesis but did not request to read anything further.

A £10 High Street Voucher was issued to all participants on completion of the second interview (after the third interview for Stephanie). This amount was decided upon as it would reasonably
cover any expenses the participant may have encountered due to participation in the research, yet it is small enough to minimise the likelihood that potential participants would feel coerced to take part (Clark and Walker, 2011).

**Confidentiality and Anonymity**

It is impossible to offer unequivocal guarantees of confidentiality, due to the nature of the research encounter and dissemination of the research. Participants were advised in the information sheet and at the beginning of any communication that all information they provided would be kept confidential and would only be discussed by the researcher and the supervisors in a research environment. Participants were made aware that the sole exception to this would be in the case of an immediate safeguarding risk.

Furthermore, participants were asked to choose a pseudonym at the beginning of the first interview to ensure any documents containing their sensitive data would be anonymised at the first opportunity. The pseudonym/real name coding frame was saved on to a USB drive, encrypted, and stored in a locked draw, and was destroyed once all the data had been gathered and the withdrawal deadline had been reached. On two occasions the pseudonyms were duplicated, so participants opted for a name suggested by the researcher – the second Jane became Jessica, and the second Skye became Sam.

As some participants know one another through their experiences of support services, all identifying features (including children’s names, ages, and genders, along with partner’s names and locations) were removed, and replaced with pseudonyms. Participants reported confidence in the processes for anonymity as the likelihood of recognition was minimised and they felt they had control over their data.

All interviews were recorded using a digital Dictaphone. At the first opportunity each recording was transferred on to an encrypted USB drive and deleted from the Dictaphone. Each interview was transcribed verbatim by the researcher and saved on to an encrypted USB drive, and only accessed through a password-secure University of Manchester computer or the researcher’s personal password-secure laptop. The documents themselves were also encrypted.

All digitally-stored data relating to this research was treated in accordance with the Data Protection Act 1998 and was backed up on a weekly basis on to an encrypted external hard drive ensuring that if the researcher’s personal laptop or University of Manchester computer became damaged or stolen the data would be secure from loss (Aldridge et al., 2010).
Similarly, research notes and completed interview schedules were securely stored in a locked filing cabinet and will be destroyed in accordance with the Data Protection Act 1998. These steps ensure that the participants are not identifiable, except perhaps by themselves, and that the data itself is protected from loss, damage, and unauthorised access offering the participants the highest level of justifiable anonymity and confidentiality.

**Participant Safety**

In line with the feminist and ethical principles of research, the safety of both the participants and the researcher are of vital importance. AIPV is a highly sensitive topic, and hence talking about personal experiences of it may cause distress. Despite being identified through IPV specialist services, it appeared that some participants were not fully aware of the extent of their abuse. Similarly, participants who had received therapeutic support, and thus were sharing practiced versions of their lived experience, may not have anticipated the emotionality and potential distress of taking part, despite warnings via the information sheet and discussions with the researcher.

It was vital to this project that those with direct experience of AIPV were recruited in order to address the unknowns in policy, theory and research which AIPV victims' voices could respond to. However, their involvement brings an added ethical dilemma due to their vulnerability as victims. The British Society of Criminology’s stance that victims of violence need extra protection whilst participating in research (for example see Buchanan, Fisher, & Gable, 2009, or Clark and Walker, 2011) was therefore adopted for this project. As such, the project’s methodology and methods were chosen to ensure that victims could be involved in this potentially empowering process whilst safeguarding them from harm.

To ensure participants were not exposed to harm as a result of the researcher’s initial contact, gate-keepers confirmed when sharing participant contact details whether it was safe to leave voicemails on the number provided, whether they would prefer contact by text message or phone call, their current living arrangements, and whether they were currently known to be in an abusive relationship. Similarly, the location of the interviews was decided upon on discussion with the gate-keepers and participants. Interviews took place in participants’ homes or refuge provision for those known to be living alone or in refuge, or at their support service where necessary.

Informed by psychoanalytic theory, this application of the FANIM provided participants with a safe environment in which they could share their lived experiences of victimisation without fear of judgement or harm. Such an approach challenges the assumption that distress is equal to
harm, and that it is therefore optimal to avoid distress (Holloway and Jefferson, 2000). Furthermore, research which raises painful experiences and is managed in a way that leaves the participant feeling positive about their research experience, arguably is not harmful (ibid).

A majority of participants showed symptoms of distress, such as crying, at some point during their interviews. The option to halt or continue the research was placed firmly in the participants’ control. The Kleinian theory of defended subjects suggests that if an event is too painful to recall, the participant will omit it (ibid). Therefore, participants essentially monitored their own potential to become distressed. This ensured that they did not feel forced to stop or continue an interview at the point of distress, which would arguably prolong the distress and perhaps cause harm. Furthermore, this avoids the intrusion of the researcher’s frame of reference, by interrupting their narrative and disrupting their gestalt.

As prescribed by the FANIM and BNIM, the researcher continued to attentively listen to participants presenting symptoms of distress without judgement or interruption. Wengraf’s active listening principles (explored in detail in Section 4.2) were employed so that the emotion presented was acknowledged rather than discounted and allowed participants to engage their defences to anxiety where necessary (2001).

To ensure that each participant was sufficiently protected from ongoing distress, they were reminded of the information sheet which detailed the services offering emotional and practical support to victims of crime in their local area and debriefed after each interview regardless of whether they showed visible signs of distress. Participants were also reminded of the researcher’s contact details in case they had any queries or wished to add to their data set. Participants expressed that they found their research encounter cathartic, as they had not previously had the chance to consider and share their complete story. Several participants compared their research experience with good counselling. Considerations of the impact of this on the researcher will follow in the next section.

**Researcher Safety**

In order to minimise the risk to the researcher, due to the sensitive nature of the research, and the fact that the researcher was acting as a lone worker conducting research in participants’ homes, several procedures were put in place. During field work the researcher had a mobile phone with them at all times should the need to initiate the Lone Worker policy arise. The Lone Worker policy stipulated that a dedicated ‘buddy’ was given the field work details in a sealed envelope, only to be opened if they needed to escalate their concern. The ‘buddy’ was informed at entrance to and exit of the field. If contact was not made when expected the ‘buddy’
was advised to firstly try contacting the researcher, and if unsuccessful should open the sealed envelope and notify the research supervisors of the situation. If necessary, the supervisors would decide on a course of action.

If the researcher at any point felt threatened or at risk by the participant or situation the designated ‘buddy’ would be sent a text message containing an emergency code word. This would prompt them to contact the researcher via telephone and if unsuccessful they would relay their concerns to the supervisory team who would then decide which action to take. There was no incident in which such measures were required.

Researching AIPV, particularly as a survivor, is psychologically difficult and associated with increased risk of vicarious trauma (Coles, Astbury, Dartnall and Limjerwala, 2014). Defined as “the transformation of the therapist’s or helper’s inner experience as a result of empathetic engagement with survivor clients and their trauma material” (Pearlman & Saakvitne, 1995), vicarious trauma can disrupt the researcher’s view of themselves, others, and the world (Coles et al., 2015). In order to minimise this risk, debriefs were planned with the supervisory team and contact details of the University’s Counselling service were identified. The researcher did indeed experience vicarious trauma during this project, a reflection upon which can be found in the next section.

4.9 Researcher Reflections

This section will present the various reflections of the researcher over the period of research. It will depart from the format of the rest of the thesis by reflecting in the first person.

One of the main motivators for conducting this research was the frustration I have experienced when discussing AIPV with those working with adult survivors. There appears to be an assumption that adolescents are at less risk of victimisation, and if they are victimised it is less severe and the impact is less profound than adult experiences. However, it is widely cited that sixteen to twenty-five-year-olds are most frequently victimised (ONS, 2016). As a result of this assumption there is a significant lack of resources available to adolescent victims. That said, I was pleasantly surprised to discover an IPV service and refuge dedicated solely to supporting under-twenty-fives, despite the extreme pressure they were facing by being on an annual funding cycle.

Another motivator was my own experiences of AIPV. In researching the potential risk factors of IPV in adolescence I was surprised to discover I was somewhat ‘protected’ by my middle-class egalitarian upbringing (Vagi et al., 2013). This led me to question the prevalence of the
phenomenon for those deemed to be at a higher risk of victimisation. As the research progressed I became particularly aware that as a white female victim of male AIPV I had similar lived experience to the participants; however, as a middle-class queer adult these similarities ended for the most part. Participants described unenviable upbringings and an almost inevitability to their victimisation, which led me to feel some guilt for being somewhat ‘protected’.

Furthermore, my own lived experience exacerbated my desire to provide participants not only with a platform to be heard, but an experience which would positively affect their emotional and psychological wellbeing. Caution was taken here to avoid falling into the ‘rescuer’ role (Karpman, 1968).

Recognising the positive affect of reflecting upon a traumatic experience with someone you trust, I set out to find a method which allowed the elicitation of the required narratives whilst also being directed by the participant in order to minimise harm. Informed by psychoanalytical theory the FANIM ensured that the participants were in control of the interviews, allowing them to reflect on whichever experiences they wished in the ways they wanted (Hollway and Jefferson, 2000). This allowed participants to express emotion and share experiences, the severity of which was unexpected.

A somewhat anticipated impact of this research was the vicarious trauma I experienced. In order to deal with this, I kept a research journal and debriefed myself after each interview (Coles et al., 2015). On the occasions in which I needed further support I contacted my supervisors, and later the University’s counselling service. This was vital for remaining objective whilst acknowledging the impact these interviews had on me.

Having never shared my own experiences of AIPV, I found that I relived many previously forgotten memories throughout the research journey. Interestingly, I put significantly more effort into protecting the participants from harm than myself. Whilst I had identified sources of potential support in my supervisors and the University counselling service, I had not fully anticipated the impact of doing this research on my wellbeing. Although distressing at times, the research journey has become synonymous with my recovery journey, as it has had an almost therapeutic effect.

It is likely that the gate-keepers introduced me to potential participants as a researcher and as a survivor of AIPV, as some were explicit in their assumption of our shared knowledge of victimisation. Jane, for example, confirmed that she felt comfortable talking with me because she knew I had had similar experiences, although I had not actually shared this with her. It is possible that this also led to a greater perception of the interview as a safe space for the
participants to air their narratives and, in some cases, events they had not previously shared with anyone.

On several occasions participants’ children were present, which caused some level of distraction to the participant and to me. Nevertheless, some participants stated they would rather have their young children present, presumably for comfort. It is likely that the young age of the children present meant that the participants were still happy to share their narratives, and did not they appear to edit the content. On reflection, one particular participant, Natalie, was perhaps less explicit with her narrative when her grown up son came downstairs mid-way through the interview. Whilst this may have broken her gestalt, I found her to be one of the most articulate participants interviewed. This may be because in her adult life she has become a counsellor and has had significant amounts of therapy herself, and so has practiced her story.

Conclusions
In order to explore the lived experience of British female adolescents, this study was framed within an intersectional feminist epistemology. Designed to meet Skinner and colleagues’ (2005) seven principles of feminist research, the project explored AIPV. The positivistic approach to research was rejected, instead acknowledging the co-creation of knowledge. By highlighting and applying the voices of those marginalised due to their age, gender, and victimisation experience to policy and legislation in the United Kingdom, this project sought to be politically active and emancipatory. Informed by psychoanalytical theory, the gestalt principle was applied to ensure participant voices were accurately reflected rather than distorted.

Continuous researcher reflexivity via supervision, gaining ethical approval, and disseminating findings allowed the emotional and psychological wellbeing of the researcher and participants to be carefully considered. Ethical issues such as appropriately gaining access, obtaining informed consent, protecting participants and the researcher from harm, and maintaining confidentiality and data security were considered in line with the British Society of Criminology and University of Manchester codes of ethical conduct.

A strategic purposive sampling [N=13] framework, supplemented by chain sampling [N=4] was employed to recruit seventeen female victims of adolescent intimate partner violence via two gatekeepers – a local domestic abuse service and a local Women’s Aid centre. Participants
varied significantly in terms of their socio-demographic data but were linked by their experiences of AIPV.

The Free Association Narrative Interview Method was drawn upon to elicit narratives of the participants’ experiences of AIPV. An interview schedule was designed which prompted rapport-building, an invitation to share narratives (SQuIIN), researcher note-taking, and reflection, and follow-up semi-structured and structured questions. Informed by psychoanalytical theory, the FANIM aimed to capture not only the language used to narrate participants’ experiences, but also the topics which they struggled to discuss, as evidence of their defended subject.

After the first interview the researcher transcribed the interview and conducted primary analysis and question generation for the follow-up interview. Approximately two to six weeks after, the second interview allowed any hypotheses to be tested, narratives to be clarified, and specific structured questions about victimisation experience to be asked. Once complete, the second interview was also transcribed, and a critical discourse analysis of both transcripts could begin. Such analysis highlighted five key discourses: the everyday nature of coercive control; the increasing severity and frequency of AIPV with time; saving damaged boys; techniques of neutralisation; and various positionings within the good vs. bad victim discourse.

To triangulate the participant data, focus groups were held with staff at the two gate-keeping organisations [N=8]. This allowed a more comprehensive understanding of AIPV and broader analysis of the participant data. This chapter concluded with some reflections from the researcher.

The chapters that follow present the analysis and findings of the interviews and focus groups. Chapter 5 explores the participants’ experiences of AIPV. Chapter 6 examines the impact of victimisation and the participants’ understandings of their experiences. Chapter 7 considers the participants’ experiences of prevention intervention efforts, and the opinions and experiences shared during the focus groups by the staff from the gate-keeping organisations. Chapter 8 goes on to apply these findings to the existing prevention intervention efforts in the United Kingdom. The concluding chapter summarises the thesis and makes recommendations for policy, practice, and future research.
Chapter Five - Participants’ Experiences of Adolescent Intimate Partner Violence

Adolescent intimate partner violence [AIPV] is conceptualised here as any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial, or emotional violence, perpetrated by someone whom the victim is currently or has in the past been intimate with, regardless of gender or sexuality, where one or both partners are between the ages of ten and twenty years (Home Office 2013). This chapter will apply Johnson’s Typologies of domestic abuse (Situational Couple Violence, Intimate Terrorism, and Violent Resistance) to AIPV through an intersectional lens (Johnson, Leone and Xu, 2014; Potter, 2015). This will allow for recognition of the nuanced patterns and manifestations of IPV during adolescence.

This chapter will begin by exploring the participants’ narratives of intimate experiences and partnerships (IEPs) (Section 5.1), as they provide context for AIPV victimisation (Barter et al., 2009; Carver et al., 2003). This consists of determining the age at which participants first started ‘going out’ with boys or girls, had their first ‘girlfriend or boyfriend’, and first experienced sexual intercourse. The onset of experiences of psychological, sexual, and physical violence is then explored at each developmental phase (Connolly and McIsaac, 2011).

Section 5.2 considers the onset of the various facets of AIPV experienced by participants. This is followed by an exploration of the AIPV experienced by participants during early adolescence (ten to thirteen years); middle adolescence (fourteen to sixteen years), and late adolescence and young adulthood (seventeen to twenty-five).

Participants’ experiences of Situational Couple Violence during adolescence are then explored in Section 5.3, highlighting the bidirectional nature of the narrated experiences, and the low prevalence of the phenomenon. Section 5.4 explores participants’ experiences of Intimate Terrorism during adolescence using the four technologies of Johnson’s Intimate Terrorism: threats and intimidation, monitoring, undermining the will to resist, and undermining the ability to resist. Participant experiences of Violent Resistance are discussed in Section 5.5. The high frequency and varying severity of participants’ experiences are presented, calling upon the categorisations of violence used by the landmark NSPCC report on AIPV (Barter et al., 2009). This chapter concludes by highlighting the ways in which adolescence interacts with gender and other key factors of discrimination to shape the context and experience of AIPV narrated by the participants (Potter, 2015; Collins and Bilge, 2016).
5.1 Participant Experiences of Adolescent Intimate Experiences and Partnerships

In order to explore the level of exposure to contexts for AIPV, this section will explore the age at which participants first started ‘going out’ with boys and/or girls, the age at which they had their first boyfriend or girlfriend, and the age at which they began engaging in sexual intercourse. The term ‘going out’ was used within the interview schedule to refer to those intimate and/or romantic experiences participants may have experienced which were not identified as being part of a relationship with a girlfriend or boyfriend, this includes a range of activities and cognitions, such as those which do not involve direct experiences with another individual, such as online relationships, the use of dating apps, and those fostered via social media (Bowen and Walker, 2015). Furthermore, ‘going out’ was used here as it is seen to be more in keeping with the British context rather than the Americanised term ‘dating’ (discussed in more detail on page 26) (Connolly et al., 2010; Buckley et al., 2010). Whilst this was open to interpretation by the participants many of their narratives suggested this was a term they utilised themselves to describe their own IEPs reinforcing its validity. Participants were asked about these three behaviours as part of the semi-structured section at the end of the second interviews (third for Stephanie). These questions were used to establish the prevalence and age at onset of the likely intimate experiences and partnerships [IEPs] experienced during adolescence.
Table D: Participant Relationship History

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age (years) first started going out with girls/boys</th>
<th>Age (years) had first girlfriend or boyfriend</th>
<th>Age (years) became sexually active</th>
<th>Number of abusive relationships (identified by participant)</th>
<th>Number of abusive relationships (identified by researcher)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilly</td>
<td>11</td>
<td>13</td>
<td>13</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Skye</td>
<td>8</td>
<td>12</td>
<td>13</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rachel</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Molly</td>
<td>14</td>
<td>16</td>
<td>15</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Jane</td>
<td>17</td>
<td>19</td>
<td>19</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Emily</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Jemma</td>
<td>14</td>
<td>14</td>
<td>13</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sam</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jessica</td>
<td>15</td>
<td>16</td>
<td>16</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Milly-May</td>
<td>14</td>
<td>14</td>
<td>16</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Ishara</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Amy</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Natalie</td>
<td>14</td>
<td>14</td>
<td>15</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stephanie</td>
<td>15</td>
<td>15</td>
<td>16</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Catherine</td>
<td>15</td>
<td>15</td>
<td>17</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sarah</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Caitlin</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The mean age at which participants began ‘going out’ with boys and/or girls was thirteen years and ten months, whilst the median was fourteen years. The mean age at which participants had their first girlfriend or boyfriend was thirteen years and five months, and the median was fourteen years. Both the mean and median age at which participants first had sexual intercourse was fifteen years. This demonstrates that for this group of females, IEPs were most likely to have begun by age fourteen, and sexual intercourse by fifteen years, both below the current age of consent in the United Kingdom.

One participant began ‘going out’ with boys at age eight, prior to Connolly and McIsaac’s (2011) conceptualisation of adolescence. This is of importance when considering the age at which to begin healthy sex and relationship education, as it highlights the variance in experiences, and the requirement for prevention to occur prior to IEPs to ensure adolescents can make informed decisions. Further discussions of the intervention and prevention efforts required to adequately reduce and/or eliminate AIPV can be found in Chapters 7 and 8.
These findings are significant for two reasons. Firstly, participants began ‘going out’ with boys or girls, had their first boyfriend or girlfriend, and first had sex prior to the current age of consent in the UK. Secondly, the current Home Office definition of domestic violence, which applies to AIPV, considers only those over sixteen years to be at potential risk of victimisation, ignoring those aged fifteen and under. Consequently, the current definition and targeted efforts are ignoring a significant majority of adolescent victims of IPV.

5.2 The Onset of Participant Experiences of Adolescent Intimate Partner Violence

The age in which participants first experienced AIPV varied for both the type of violence (physical, sexual, psychological) and between participants. AIPV is defined here as: any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial, or emotional violence, perpetrated by someone whom the victim is currently or has in the past been intimate with, regardless of gender or sexuality, where one or both partners are between the ages of ten and twenty years. This section will examine the age at onset of psychological, physical, and sexual violence for the participant group.

Psychological violence was experienced by all participants. One participant first experienced psychological violence in early adolescence (ten to thirteen years); eleven participants experienced psychological violence for the first time during middle adolescence (fourteen to sixteen years); and four participants first experienced psychological violence in late adolescence (seventeen to nineteen years) [N=2] and young adulthood (twenty to twenty-five years) [N=2].

Sexual violence was experienced by 94% [N=16] of participants. Two participants experienced sexual violence for the first time during early adolescence (ten to thirteen years); nine participants experienced sexual violence for the first time during middle adolescence (fourteen to sixteen years); and five participants experienced sexual violence during late adolescence (seventeen to nineteen years) [N=3] and young adulthood (twenty to twenty-five years) [N=2].

Physical violence was also experienced by all participants. One participant first experienced physical violence in early adolescence (ten to thirteen years); twelve participants experienced physical violence for the first time during middle adolescence (fourteen to sixteen years); and four participants first experienced physical violence in late adolescence (seventeen to nineteen years) [N=2] and young adulthood (twenty to twenty-five years) [N=2].

The peak onset of all AIPV behaviours was during middle adolescence (fourteen to sixteen years).
years. This clearly highlights the importance of middle adolescence and the years prior as a vital opportunity for preventative work and asserts the need for prevention interventions at and/or before this key developmental stage. Further discussion such opportunities can be found in Chapter 7, beginning on page 139.

Table E demonstrates the abusive relationship history of each participant, including the age of the participant and perpetrator when the relationship began, and the duration of the relationship. Analysis of Table E shows that those experiencing AIPV during early adolescence (10 – 13 years) \( N=1 \) the age difference between participant and perpetrator was four years. For those first experiencing AIPV in middle adolescence (14 to 16 years) \( N=12 \) the age difference between the participant and perpetrator varied, from the perpetrator being one year younger to twenty-one years older than the participant. The average number of years between the participant and perpetrator during the participants’ first relationship was 6.92 years. In subsequent relationships beginning during middle adolescence the age difference dipped slightly to 6.71 years. For participants \( N=3 \) experiencing AIPV for the first time during late adolescence (17 – 19 years) the average age difference was 6 years, and 7.25 years in subsequent relationships starting in late adolescence. One participant experienced AIPV for the first time during young adulthood, in which there was a 9-year age difference between her and her perpetrator. Four participants had subsequent abusive relationships during young adulthood, with an average age difference of 2.75 years. This clearly corroborates Barter et al’s (2009; 2015) findings regarding the increased risk associated with partners who are two or more years older than their adolescent female partners. Interestingly, the lesbian participant (Lilly) also experienced a five-year age gap between her and her first girlfriend, suggesting that this risk requires further exploration with LGBTQIA adolescents.

On further analysis, alongside the additional intersecting factors presented in Tables B and C, on pages 89 and 91 respectively, it becomes apparent that participants with lower economic backgrounds (Skye, Jane, Jemma, Jessica, Milly-May, Ishara, Natalie, Stephanie, Sarah and Caitlin), experiences of being in care (Emily, Ishara, Milly-May, Caitlin), lower educational attainment (Jane, Jemma, Milly-May), LGBT identities (Lilly, Ishara, Natalie), and/or disabilities (Jemma, Milly-May, Ishara and Catherine) experienced abusive relationships earlier, than those with fewer intersecting factors. These intersecting factors provide the context in which perpetrators can exert power and control (Donovan and Hester, 2015).
Table E: Participant abusive relationship history

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age (years) at first abusive relationship</th>
<th>Age (years) at subsequent abusive relationship(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lilly</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>Skye</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Rachel</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Molly</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Jane</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>Emily</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Jemma</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>Sam</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Jessica</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Milly-May</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Ishara</td>
<td>14</td>
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</tr>
<tr>
<td>Amy</td>
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</tr>
<tr>
<td>Natalie</td>
<td>15</td>
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<tr>
<td>Stephanie</td>
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</tr>
<tr>
<td>Catherine</td>
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<td>20</td>
</tr>
<tr>
<td>Sarah</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Caitlin</td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>
Experiences of Intimate Partner Violence during Early Adolescence

In order to consider the experiences of the participants over the trajectory of adolescence it is important to look at both the behaviours they experienced and the age at which they occurred, so that differences and similarities can be examined. Early adolescence is conceptualised as between ten and thirteen years old (Connolly and McIsaac, 2011).

A significant number of participants had experienced AIPV during early adolescence: psychological [N=2], sexual [N=2], and physical [N=1] violence. Whilst participants of this study shared narratives of psychological violence during this phase, few recognised it, or considered it problematic. This suggests that societal environments in which early adolescents exist fail to effectively recognise and respond to AIPV behaviours without victim blaming, minimising, or denying the violence (WHO, 2010; Fox et al., 2013; Wood et al., 2011).

Policy and practice to date has been reluctant to identify early adolescents as victims (and perpetrators) of AIPV, except in situations where the perpetrator is in a position of authority, such as a teacher, or is a family or extended family member. Yet, even in the latter case this is often contested (Barter et al., 2015). This is problematic considering the prevalence and narratives shared in this study (explored further throughout Section 5.4), and the recent finding that under-sixteen-year-olds were most at risk of psychological and sexual violence (Gadd et al., 2013; Gadd et al., 2014).

Experiences of Intimate Partner Violence during Middle Adolescence

Middle adolescence is conceptualised as between the ages of fourteen and sixteen years (Connolly and McIsaac, 2011). Collins (2003) suggests that this period is particularly important in the study of adolescent relationships since it coincides with an increased importance placed on peer and romantic relationships. Indeed, a significant number of participants reported having experienced psychological [N=11], sexual [N=9], and/or physical [N=12] violence during middle adolescence.

Significantly more [Psychological: + 52.9%; Sexual: +41.1%; Physical: +64.7%] participants reported experiencing at least one form of IPV during middle adolescence than during early adolescence. Gadd et al. (2013, 2014) also found that under-sixteen-year-olds were most at risk of psychological and sexual violence. Whilst participants of this study narrated experiences of psychological and physical violence during this phase, few recognised it, and appeared to normalise it in their narratives (Leen et al., 2013; Barter et al., 2009). This is perhaps evidence of the normalisation of violence.
Ridgeway and Cornell (2004) found during adolescence (Teitleman et al., 2008; Farvid et al., 2017; England and Bearak, 2014).

By combining the data from early adolescence (ten to thirteen years) and that from ages fourteen and fifteen (middle adolescence), it emerges that 74% of participants had started ‘going out’ with boys or girls; 71% of participants had had their first boyfriend or girlfriend; and 59% of participants had engaged in sexual intercourse between the ages of ten and fifteen years old. Furthermore, one half to two thirds of participants had experienced sexual (53%), psychological (65%), and/or physical violence (59%) during this period (ten to fifteen years).

Participants’ reporting of IEPs and victimisation between ages ten and fifteen years old is significant, as it highlights the high levels of engagement in the context of AIPV before the age of consent and age of potential victimisation (that is not coercive control) according to the Home Office definition of domestic violence (2013). This calls into question the current cross-governmental definition of domestic abuse which includes those aged sixteen-years and over. The justification for doing so is that those under sixteen are dealt with via existing child protection measures, however this appears not to be the case for this sample of adolescents (discussed further in Chapters 7 and 9).

**Experiences of Intimate Partner Violence during Late Adolescence**

When considering the three main facets of AIPV separately, a further 24% of participants first experienced psychological [N=4] and/or physical violence [N=4] during late adolescence and into young adulthood, and a further 29% first experienced sexual violence [N=5] at this stage. The entire sample [N=17] of this study had experienced physical and psychological AIPV before and/or during late adolescence and into young adulthood. Sexual violence was experienced during late adolescence and young adulthood by all but one participant (Amy, 17) (Wright and Bae, 2017). This supports the Crime Survey for England and Wales (CSEW) statistics, which suggest that sixteen to twenty-five years of age is the peak period for recorded cases of IPV (ONS, 2016).

**5.3 Participant Experiences of Situational Couple Violence**

Situational Couple Violence (Johnson, 2008, 2011) is IPV which is motivated by conflict, rather than control. It was hypothesised that Situational Couple Violence would be prevalent within the participants; narratives due to the participants’ ages and associated lack of skills in the romantic domain (Johnson, 2005; 2008; 2011; Collins,
Participants narrated experiences of Situational Couple Violence which was situationally provoked by conflict. For example: “any little argument had the tendency to explode” (Molly); “erm arguments that I said, basically I would turn round and say ‘I don’t want to be with you anymore’ and he used to kick off, start pushing me around” (Jemma); “we started arguing and then he started like, pushing and shoving me, he kicked me once with his soldiers’ boots” (Milly-May); “I can’t actually remember what it was about … he pushed me, threw his apple at a picture and it smashed and went everywhere then he stormed out through the kitchen and punched one of mum’s chairs” (Amy). These incidents appeared to be an extension of an argument, in which one party became ‘explosive’ reacting to the conflict with aggression (Johnson, 2008).

One explanation for Situational Couple Violence within adolescent populations is the increased likelihood that individuals have poor conflict resolution tools and are more likely than adults to be impulsive and take risks (Blakemore, 2012). Such a skills deficit is thought to limit the possible alternative conflict resolution tools available to adolescents (Johnson, 2005; 2008; 2011; Collins, 2003; Blakemore, 2012; Sawyer et al., 2018). In addition, those with previous experience of familial domestic violence (Skye, Emily, Jessica, Milly-May, Ishara, Natalie, Sarah, Caitlin) (Riger et al., 2002), those who experienced the care system (Emily, Sam, Milly-May, Ishara and Caitlin) (Ahner, Pinquart, and Lamb, 2006), and those with learning disabilities (Jemma) (Bryan, Burstein, and Ergul, 2004) may have an even greater skills deficit.

However, Situational Couple Violence occurred in just 10% of the participants’ narratives. This is significantly lower than the adult literature (Johnson, 2008; Dixon and Graham-Kevan, 2011), which has found Situational Couple Violence in up to 50% of cases (Straus, 2008; Whitaker, et al., 2007). This is perhaps due to the methods of recruitment – via support services which may have filtered the cases available for sampling (Johnson, 2006, 2008, 2011). However, it may also be because such aggression does not occur as frequently during adolescence as in adulthood. In addition, participants may have wanted to avoid disclosing their own perpetration for fear of judgement, and wanting to maintain their victim status, since it is that status which provided them with access to support. This may be particularly the case for the participants staying in refuge as their accommodation provision is allocated based on their experiences as victims. Being a homeless adolescent female victim of IPV positions the participants in a particularly vulnerable social location, relying on those
in authority, whilst estranged from friends and family. Furthermore, those with disabilities (Jemma, Ishara, Amy, Catherine), those with children (Skye, Molly, Jane, Sam, Milly-May, Natalie, Stephanie, Catherine, Sarah Caitlin), and to some extent those who identify as LGBTQIA (Lilly, Ishara and Natalie) are likely to experience this vulnerability even more acutely due to the intersecting nature of these various axes of social division (Potter, 2015; Collins and Bilge, 2016). Therefore, further research is required to explore this.

Interestingly, the experiences of Situational Couple Violence narrated appeared to be predominantly unilateral rather than bidirectional as expected (Johnson, 2006, 2008, 2011). This is not to suggest the participants had never used aggression as a conflict resolution tool or during an argument, but because of their current, or most recent experience(s). It is possible that they had internalised the notion of Intimate Terrorism and extreme physical violence as ‘true’ domestic violence and did not feel that any experience of Situational Couple Violence was relevant (Amin et al., 2018).

Participants often narrated their experiences of AIPV as an extension of an argument, which could be interpreted as Situational Couple Violence if analysing it using conflict theory. However, on closer inspection, the arguments narrated occurred within a broader pattern of coercive control (Stark, 2007), which included examples of isolation, intimidation, and partner assault. As such, these incidents of AIPV were interpreted as Intimate Terrorism and will be explored within Section 5.4.

5.4 Participant Experiences of Intimate Terrorism

Intimate Terrorism aims to reduce the victim’s will to resist the perpetrator’s demands and instil the perpetrator’s perceived right to control and punish the victim (Stark, 2007; Johnson, 2008). Perpetrators of Intimate Terrorism fundamentally use a pattern of coercive behaviours to control their victim. Contexts which favour male dominance of females are thought to be most conducive to the development of Intimate Terrorism (Johnson, 2008, 2011; Tomlin et al., 2003). Since adolescence is hyper-gendered (Sills et al., 2010; Amin et al., 2018; Klein and Milardo, 2000; Tomlin et al., 2003) both culturally and interpersonally (Potter, 2015; Collins and Bilge, 2016) Intimate Terrorism is likely to prevalent in adolescence. This chapter will explore the participants’ narratives through the four technologies of Johnson’s Intimate Terrorism: threats and intimidation, monitoring, undermining the will to resist, and undermining the ability to resist. Such technologies are used to diminish the victim’s self-esteem, promote dependence on the perpetrator, and convince them that there are no alternatives to the abusive relationship (Johnson, 2008, 2011). Considering the majority of
participants were recruited through IPV charities, including refuges (ibid), Intimate Terrorism was expected within their narratives (Johnson, 2008, 2011); however, the prevalence and severity found was not anticipated. Whilst there was no typical trajectory of violence, there were some commonalities in the stories told which will now be explored.

Undermining the Ability to Resist

Participants described how their relationships began as loving and affectionate and their partners as gentlemanly: “everything were perfect, you know, for the first month. It were just like a big whirlwind” (Milly-May); “at the start he was like dead nice … and he treated me and spoiled me” (Amy). This ‘honeymoon period’ was often conflated with the ‘princess effect’ (Keeling and Fisher, 2012; Burns, 2001; Davis, 2003; Hunnicutt, 2009). According to the participants, perpetrators were charming, often showering them with gifts and affection at the beginning of their relationship: “he seemed like a really decent lad, like he’d always bring me fruit or like come round to the house and bringing me gifts and all sorts” (Sky); “so, so he took me on holiday and you know I was sucked in by you know all these grand gestures and then he he had me then” (Molly):

I'd never met anybody like him before and [he] swept me off me feet, like oh this is the ideal man, never met, the ideal life ahead and then I got promises of ‘oh we'll change your car?’ and we did change me car and ‘we'll have all these holidays’ and all this and flashing the cash (Jane).

The level of attention and affection narrated was something many of the participants had not experienced before, particularly those who had not had a romantic relationship prior to this. This suggests that adolescents have a lack of experience which may translate into vulnerability, particularly when the perpetrator is significantly older than them (see discussion on page 36) (Barter et al., 2009). This ‘princess effect’ was particularly apparent when the perpetrator was significantly (two years or more) older than the participant (Hunnicutt, 2009). Stark (2007) and Johnson (2008) suggest that this manipulation and charm is a key tactic in isolating the victim from their friends and family, which works to gain the victim’s commitment to the perpetrator. Once gained, Johnson suggests that to effectively quash any attempts by victims to resist their control, Intimate Terrorists use isolation and limit victims’ access to resources for escape (2008).

Between two weeks and six months into the relationship, tactics of isolation and control began to creep into the relationship. The most common tactic of control was to isolate
the participant from their friends and family: “he just started stopped me going out, seeing my friends, my family” (Milly-May); “I wasn’t allowed out with my friends, erm. So, I didn’t have a teenage life” (Ishara); “I didn’t see anybody” (Jessica) (Barter et al., 2009; Fox et al., 2013). For Amy (15) the isolation and control became so extreme she was not allowed out without Adam (15) acting as a chaperone: “I couldn’t see who I wanted, had a problem with me going to college and work he didn’t let me out at all. I had to go everywhere with him he was still like paranoid and jealous and stuff”. This attempt to regulate Amy’s behaviour is a key element of Intimate Terrorism, as it acted to prevent disclosure, instil dependence on Adam, and keep her from getting support (Stark, 2007; Johnson, 2008). Arguably, the intersection of age and gender created the context for this isolation and control (Potter, 2015). However, on this occasion, the perpetrator was the same age as their victim, suggesting that gender is a significant factor which is likely to interact with adolescence without a significant age difference present.

Sarah narrates Kieran’s psychological control of her: “we’d be in his house and all my mates would knock on his door knowing full well I’d be there, asking if I was coming out and he’d go to the window and say ‘no she’s not go away’”. When non-violent tactics would not work, Kieran began physically restraining Sarah to ensure her isolation from friends and family, as Johnson suggests (2006, 2008, 2011).

I asked him if I could go out, even in the back garden and, or he’d lock me in the room, and just keep me there, and, he used to sit on me as well … he just wanted me to stay in with him or go out with just him and stuff … so, I didn’t really go home.

Gradually Kieran pressured Sarah to stay at his house every night. Sarah’s mother became so exasperated by the situation that she offered Sarah an ultimatum: break up with Kieran or move out. Kieran made Sarah feel like her only choice was to leave her family home and move in with him, despite admitting to feeling that even then, something was not right with their relationship. Sarah was 16 when this occurred, she had not yet left school and had no financial resources, putting her in a particularly vulnerable situation. Further exploration of partner assaults as a technique to undermine the victims' will to resist control can be found beginning on page 126.

Natalie also shared her experiences of extreme isolation and control. At age sixteen, and just four months into a relationship with Ken (26), they moved intogether. Almost immediately she narrated feeling that she had to minimise her contact with friends and family to avoid conflict with Ken at home (Stark, 2007). Natalie had a daughter from a previous relationship whom Ken offered to look after at home whilst Natalie continued at college. This suggests that teenage motherhood will also interact with age and
gender to shape the context and experience of AIPV (Collins and Bilge, 2016). Natalie’s friends and family thought this was an ideal scenario, but the truth was far different. Before long Natalie was pregnant again and felt she had no other option but to leave college. This meant that in the short time Natalie had been in a relationship with Ken, she was completely isolated from friends and family, was pregnant with her second child at age sixteen years and was no longer attending college. These factors - the differences in Ken and Natalie’s age, gender, income, background and so on - intersect to create a context in which Ken exerted his power and control over Natalie.

Tactics of isolation were often fuelled by high levels of morbid jealousy (Enoch and Ball, 2001): “if I talked to a lad, if, if a lad come on to me and it wasn’t my fault he’d blame me for it and he’d kick off … he would stop me going to college because of lads” (Jemma). Below, Amy (16) describes how Adam (16) would try to stop her from seeing friends:

> He just started getting like dead jealous and controlling and stuff and it got to the point where my friend Jess, I’ve known her since like nursery [K: Yeah] and she only lives like over the road so it’s not like I’m going dead far away to see her literally over the road and he didn’t even like me going over there to see her and then the arguments got like more constant and then pretty much 24/7 every day we was arguing.

Interestingly, Amy’s narrative suggests that she would understand Adam’s objections had she been travelling further, suggesting that she felt it necessary to minimise this isolation (Johnson, 2008, 2011). As Amy continued with this narrative she revealed that Adam was particularly against her spending time at Jess’ house because her mother was openly bisexual. This suggests that he viewed her as a threat to his control over Amy, much like he did with other males. Subsequently, Adam also used technology to monitor and isolate Amy:

> ... Deleted all my boy contacts, like all my friends from college and stuff. Then I needed to contact someone from college and none of the numbers were there ... so I couldn’t get hold of anyone erm, and then he deleted them all off Facebook ... knew my email and must of guessed my password ...he was going on all the time saying ‘delete your Facebook nah nah nah’ ... but he literally went on my phone all the time … he’d brush me away and stuff [K: mm] and he’d be like holding me down with one arm and deleting them so I was like [sigh] ‘great, thanks’. And then he’d always like say I’d go to college the next day or whatever he’d always check my phone every time I saw him to make sure I hadn’t got the numbers back and stuff, he always read my texts.

Amy describes how Adam linked isolating tactics with control and jealousy in order to make her behave in ways he deemed appropriate (Johnson, 2008, 2011). Amy felt that in hindsight this was obvious, however, she and other participants found it difficult to identify abusive behaviours whilst in the relationship (Leen et al., 2013; Barter et al.,
2009). The hidden nature of AIPV is a significant issue to address when designing prevention interventions.

Despite an anticipated lack of resources within an adolescent sample, due to their reduced ability to earn, drive, own or rent property etc., there were several cases of resource control narrated by the participants. Participants as young as fifteen were controlled financially by their partner (Stark, 2007), with many having their bank cards removed: “he’d have the bank card, so I didn't have any money” (Jessica); or having their money stolen: “he robbed my bank account” (Jemma):

> He knew my pin number cos one time I, I, I was, I had a part time job working at McDonalds. So, I, put, I just to go to cash point machine and what not. I’d put my card in and he saw me one time putting my pin in and remembered it and I didn’t think he saw, so, didn’t know and, then, once he had that control he took everything (Stephanie).

For some participants the threat of violent consequences was enough to curtail their spending. Karl would monitor Rachel’s bank account so intensely that she felt she could only make purchases he would approve of. This provides another example of how the fear of violence leads victims of AIPV to alter their behaviour to avoid escalating consequences (Ullman and Filipas, 2005; Johnson, 2008).

**Threats and Intimidation**

Threats and intimidation are the second technologies of Intimate Terrorism (Johnson, 2008, 2011). Participants’ narrated extensive examples of being threatened and intimidated by their perpetrator(s). There were threats to damage or steal their, or their parent’s, property: “when I said I didn’t have any money he was like ‘well I suggest you get some otherwise I’m going to steal it from your mum anyway’” (Caitlin); “I’m guna smash this fucking place up” (Jessica); and threats of physical violence: “he started shouting abuse at me and stuff like, saying ‘come any step closer and I’m guna kick your fucking head in’” (Milly-May).

There were also threats from perpetrators to abandon the participants: “he used to threaten me with you know, ‘I'll chuck you out, I keep this roof over your head, you don’t earn enough’” (Ishara), and death threats: “after I tried to leave I went back because of my daughter and umm, he opened the door and said ‘you ever do that again I will kill you’” (Ishara); “he come running in screaming ‘I'm guna finish you off’
... he even death threatened me in college and he got escorted off the premises” (Emily). There were also death threats online: “like threatening me on Facebook and you know erm, [K: was that often?] oh all the time” (Milly-May).

Molly experienced threats of self-harm and suicide if she left:

He was horrible and then it was like, oh, my god, now we’d split up it was like ‘oh I love you dah dah dah’. Sending me pictures of his arms all cut up threatening suicide … so in a way I was probably a bit, scared. And I felt a bit, I felt a bit responsible, so I was just trying to keep the peace.

Narrations of property damage and direct threats were common place: “[he would be] physically hitting walls he’d get like dead frustrated, like blood boiling and he’d just burst, and then punch himself, or, punch a pillow or punch a wall [laughs]” (Amy).

Taking an incident approach to analysing this narrative would suggest that this is situational aggression, caused by Adam (15) losing his temper during an argument. However, when these incidents are considered alongside the threats, intimidation, isolation, and humiliation Amy endured, it becomes clear that this is part of a pattern of Intimate Terrorism shaped by the intersecting differences and inequalities in power held between them.

Fourteen participants narrated that they had been psychologically terrorised by their perpetrator(s) to such an extreme that they felt completely controlled through fear of retribution and/or escalation (Johnson, 2008; Stark, 2007). Molly recalled her second boyfriend never using severe or direct physical force; instead, he would use threats, degradation and humiliation to induce fear of partner assaults and to take control of conflict, and of Molly, yet she struggled to identify this abuse as such: “He never hit me”.

Indirect physical violence is characterised by aggression, threats of physical violence, and destruction of property to induce fear of escalation within the victim, and to contribute to a pattern of coercive control (Johnson, 2008, 2011). It acts as a bridge between psychological and physical violence and was experienced by all the participants in this study. For many participants, indirect physical violence acted as a precursor to physical and severe physical force, either within a specific situation or within the wider context of their relationship. Each of these examples worked to make the victims feel that they had no choice but to be compliant and be fearful of their perpetrator, as he appeared both omnipotent and omnipresent (Stark, 2007; Johnson, 2008). This feeling was also instilled by the monitoring and micro-surveillance imposed on them.
Monitoring

Rachel (19) narrated Karl’s (29) increasing control and jealousy, which began very quickly. At nineteen, this was Rachel’s first relationship and so she was inexperienced in IEPs despite being in late adolescence at this stage. Furthermore, there was a significant age difference between Rachel and Karl. He was also in a hyper-masculine job which held considerable cultural power, making Rachel feel she was lucky to be in a relationship with him. Two weeks into the relationship Rachel cancelled a date with him due to a sore throat: “I found myself apologising erm, texting and ringing him all night to prove I hadn’t gone anywhere”. Within a few months Karl began attempting to modify Rachel’s behaviour at work [a beauty counter at a city-centre department store]:

He used to come into work and meet me on my lunch breaks and then it was nice at first but then it was every shift I worked … and then he, he, he’d try to cause an argument so I won’t go to work … and then erm, he’d, want me to take my own lunch to work because otherwise if I was buying food I could be buying it from a man … then I couldn’t eat on eat on the canteen table with my friends because, I always rang him on my dinner and after I’d eaten I told him what I ate and, and he thought that the girls at the table were laughing at him.

This high level of regulation via manipulation, jealousy, and control continued until Rachel felt compelled to quit her job (Stark, 2007; Johnson, 2008, 2011). As a fire fighter, Karl often worked antisocial shifts, making it difficult for him to have control over Rachel all the time. To combat his fears that Rachel might have contact with someone he disapproved of, Karl escalated his methods of monitoring:

He’d go to the gym and he’d lock me inside the bedroom … but I couldn’t use the toilet because, the guys who was in the house who lived there as well would think ‘why is Rachel just confined to the room all the time?’ And, I was, I just gave him my phone so that he could take it with him in case anybody was texting me that shouldn’t have been.

This quote demonstrates Rachel understood how others might view his psychological violence, which appears to diminish her attempts to minimise or deny Karl’s violence. By this point, Rachel had been so intensely monitored and controlled that she described complying with Karl’s demands to avoid conflict (Johnson, 2008). Such complicity could be interpreted as a learnt coping mechanism to minimise escalation of violence (Ullman and Filipas, 2005).

Stark (2007) and Johnson (2008, 2011) suggest that surveillance acts to detect disobedience and disapproved of conduct by enforcing routine and destroying the victim’s autonomy by gathering information about her everyday movements. Amy felt
that the requirement to report her daily activities was implicit:

_He didn’t tell me I had to contact him, but I felt like I had to, because otherwise he’d go mad at me, like after I’d finish work on Saturdays … I won’t speak to him for about an hour cos I’d be getting something to eat and sorting myself out. And he’d ring me like, five times saying ‘why aren’t you speaking to me, what you doing, who you with …’_”

Rachel, on the other hand, shared how her boyfriend Karl (29) used mobile phones to explicitly gain access to all aspects of her life. Karl began demanding photographs to prove whenever she went out without him that she was with the person she said was meeting, in the place she said she would be:

_If I was with a friend I’d met for lunch or dinner or something he’d want me to take a picture to prove I was with them so then I, I had to lie and say ‘oh let’s have our picture took’ so I could secretly send it to him … He’d want to have a bath with me because he’d think I was texting someone or ringing someone I shouldn’t be while I was in the bathroom. Even the toilet. He’d used to say you’re not comfortable around me enough and he’d get the duvet off my bed and make me go to toilet in front of him…_

Rachel suggested that Karl irrationally believed he could catch Rachel out by recording her sleeping: “he used to record me in my sleep on this Dreamcatcher app because he thought I was coming out with lies in my sleep”. This meant that Rachel was too scared to sleep in case she said something Karl disapproved of. Eventually she was hospitalised due to sleep deprivation. Whilst in hospital, Karl became so paranoid that Rachel might disclose his abuse that he secretly recorded her conversations with the doctor. Once home Karl became aware that Rachel had disclosed to a nurse, so he responded with severe physical force. Such intense micro-surveillance made Rachel feel that Karl was truly omnipresent and omnipotent (Johnson, 2008; Stark, 2007), and prevented her from disclosing again.

Furthermore, Karl began demanding video calls at various times of the day and night to satisfy his obsession with knowing where she was, what she was doing, and with whom. This also worked to enforce a routine on Rachel, as she had to have her make-up off and be in bed by a certain time every night, so they could video-chat. Not long after this Karl proposed that the couple should download the Find My Friends application for their smart phones. Find My Friends is described by Apple as “a great way to share your location with people who are important to you… [You and they] appear on a map so you can quickly see where they are and what they’re up to” (Apple, 2014). The application accesses the phone’s contacts and uses GPS via the Maps

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5 The Dreamcatcher app uses an advanced recording system to monitor and record any noise while you sleep
application to enable location-based alerts which automatically tell others if the phone leaves or arrives at a specific location. Such technology allows an abusive partner to monitor their victim twenty-four hours a day without having to be with them. Since adolescents are likely to be at school or with family for significant periods each day this offers perpetrators an alternative tool to monitor their victims without guardians being aware. Karl initially sold the app to Rachel as a way of being able to see where he was being sent to tackle a fire, but it soon became his preferred method of monitoring her. These techniques also added to her isolation from friends and family, and her attendance at work.

Ken was extremely possessive and controlling of Natalie and would use monitoring techniques to ensure she was obeying him (Stark, 2007; Johnson, 2008). It is worth noting the lack of technology in this relationship, as it occurred in the 1990s prior to the development of smart phones and similar devices. Ken demanded to see physical proof of Natalie’s whereabouts at all times:

I then got the possessiveness of where I was. I finished work at half past five and if I’m going to Sainsbury’s and then for a couple of bits, and then getting on the bus home well then ‘you’ll show me your receipt from Sainsbury’s and the time on your bus ticket so I can gather why, why did it take you 45 minutes to get home if the bus says this time’ and or, ‘you fucked the whole of the market’.

When Natalie’s receipts and tickets did not placate Ken, in terms of the time it had taken her to perform errands dictated by him, he would chastise her psychologically and physically. Eventually he would not let Natalie out of the house without at least one child “cos you can’t go fucking all of [town] when you’ve got a child with you”. This demonstrates how Natalie’s age (16), parental status, low economic background and forced reliance on Ken, who was ten years older than Natalie, intersected to create a context in which Ken had power and control over her (Potter, 2015; Collins and Bilge, 2016). Ken also ensured Natalie could not go out by enforcing fixed daily cleaning routines which would take her most of the day: “the doors, skirting boards and all that couldn’t have dust, no drips on the draining board [K: wow] and there couldn’t be any mess if I was going on my fortnightly shopping trip”. When asked how this micro-surveillance made her feel Natalie said, “I hated it, but it was like five minutes of ‘there you go’ and it saved two hours of accusations of who have I been fucking. So, it was modified behaviour, but it was the lesser of two evils” (Johnson, 2008).

The presence of such intensive surveillance in the lives of adolescents distinctly contrasts with the pervasive discourse surrounding adolescence which suggests relationships at this time are ‘trivial and fleeting’ (Collins, 2003). Both technological
and traditional methods of surveillance were narrated, demonstrating the flexibility and persistent nature of perpetrators’ techniques in these circumstances. This also highlights the necessity for preventative work to focus on such behaviours both on and offline, including the subtle ways in which they gradually escalate, and where victims seek help safely both on and offline.

**Undermining the Will to Resist**

Degradation and psychological attacks were used by perpetrators to wear down their victims will to resist their control (Johnson, 2008). Such behaviour works to attack the victim's self-esteem and self-identity, ensuring compliance and loyalty (Stark, 2007; Johnson, 2008; Barter et al., 2009; Fox et al., 2013; Gadd et al., 2013; Murphy and Smith, 2010). This was the most widely-cited form of intimidation by participants. Perpetrators employed a range of acts, including mind games, jealousy, cheating, monitoring, and putdowns, to make the participant subordinate and/or dependant on them, and to minimise resistance to their controlling demands (Stark, 2007; Johnson, 2008; Barter et al., 2009; Fox et al., 2013; Gadd et al., 2013; Murphy and Smith, 2010). Sam experienced attempts by her perpetrator to make the victim question their own sanity, known as ‘gas-lighting’:

… *He tried to mess with my head, like he'd try to do something to me and then the next day he'd be like 'no I didn't do that', and I'd be like 'yes you did'! And he'd try and make me feel like I'm going crazy or he'd start moving furniture around the house like, if I left the house to go, I don't know to put the bins out, he'd move something around I'd come back and be like 'where is it?' Then I'd go into another room and it would be back to its normal place.*

Potentially motivated by jealousy and a fear of rejection, many perpetrators continually put down and humiliated their victims (Stark, 2007; Johnson, 2008): “you stupid cow, you bitch … you dirty bitch” (Stephanie); “he’d call me a slut, call me a prostitute, and he went round telling people I’d slept with doctors at the hospital” (Sam). These were particularly damaging threats for Sam as her father was a respected member of the local Muslim community. As such Sam’s age, gender and religion mutually shaped her experience of AIPV. Insults and rumours about the participants’ sexuality and sexual performance were common, as were those specifically targeting participants’ self-esteem regarding their appearance and self-worth: “he’d always say ‘you’re just too fat you shouldn’t be eating you need to get out the house and do stuff’, but he wouldn’t let me out the house so it were all like dead confused” (Sarah); “he’d compare me to these posters on his wall, why can’t you look like her?” (Molly). Attacks on self-esteem and confidence have an acute effect on adolescents’ sense of self, which is particularly
concerning given the developmental phase they are in and potential long-term effects (Blakemore, 2012; Collins, 2003).

Participants spoke of the constant nature of such abuse: “it were just horrible. All the time, everything were my fault” (Jane);

*He would tell me I was mad all the time … he just kept on all the time, shouting, giving me the gob all the time, and, he wouldn’t stop, even if I wanted to go to sleep … he would criticise me and say I was ugly and everything* (Jemma);

Molly experienced a particularly humiliating incident in which she recalled feeling confused:

*He pushed me back on the bed [pause] and I don’t know if we were having a drink, or, and he just poured it all over me and was laughing like, ‘look at the state of ya’ … and then he was just laughing at me. But then he wouldn’t let me have a bath. He used to keep the plug in his pocket."

Emily described an incident in which Jimmy tried to demonstrate he could do what he liked: “we all got drunk and he decided he wanted my best friend, so he slept with her in the room next to me … he told me they didn’t do it, but I heard them”. Jemma describes a similar event: “he’d been cheating on me for a while and then just started bringing younger girls back to the flat for sex and making out like I was mad, saying I’d not seen these girls when I had”.

Molly’s ex-partner Michael used to find ways to subtly wind her up so that when she lost her temper or started crying in front of friends and family he could accuse her of being crazy. Jane eventually left the home she shared with her perpetrator, although he somehow managed to get a set of keys, and tried to make her question her sanity:

* … The kids said, ‘dad’s letting himself in reading your post and listening to your messages and searching the house’. I wasn’t sure if they were fibbing, so I used to put a ball in the hallway and a book behind one of the bedroom doors and set up lots of little traps and then one day I walked in and they’d been moved. I knew then."

Such abuse would often take place in public: “he started shouting and raging at me you know in the shopping centre and calling me scum and ‘I wish you’d die’ and stuff like this” (Milly-May); “He used to go mad at me all the time like in front of everyone so and then he’d just leave me so I’d be stood there like crying my eyes out” (Amy). The public nature of these incidents was particularly humiliating and worked to damage the participants’ social capital (Crosby, Holtgrave, DiClemente, Wingood and Gayle, 2003; Barter et al., 2009; Villalonga-Olives and Karachi, 2017) and discouraged them from suggesting they go out in the future.
Technology was also used to publicly embarrass the participants. Lilly described how her ex-girlfriend Leanne hacked into her Facebook account: “she put all these horrible things like under interests she put licking cunt … people could see, and it was all to do with lesbians and sex like stuff”. This was particularly traumatic for Lilly as this incident meant she was outed to family members on her account (Donovan and Hester, 2015). This demonstrates the privileged access perpetrators have to victim’s personal information (Villalonga-Olives and Karachi, 2017) and the added level of complexity experienced by LGBT adolescents (Donovan and Hester, 2015).

These attacks on the participants’ self-esteem had a profound negative effect, with participants referring to psychological violence as being far worse and longer lasting than any physical abuse (Stark, 2007; Riggs and O’Leary, 1996; Barter et al., 2009; Fox et al., 2013; Gadd et al., 2013). Participants shared that they could not necessarily see the psychological violence at the time, until it had escalated, or even as they were talking about it in the interviews. This is perhaps due to their young age and the likelihood that they will ‘feel’ systems of oppression before understanding them (Taefi, 2009; Potter, 2015). This further highlights the pervasive nature of AIPV.

**Partner Assaults**

When non-violent methods have not had the desired effect, Intimate Terrorists use physical violence or partner assaults, to exert power over the victim (Johnson, 2008, 2011; Stark, 2007). Other suggested motivations include expressing anger, further monopolising the victim’s resources, and subjugating the victim to quash any attempt for them to become independent by making conflict or escape too costly (Johnson, 1996, 2006, 2008, 2011). Such violence is thought to be unilateral and predominantly perpetrated by males against females (ibid). However, some researchers have located it within lesbian relationships (Donovan and Hester, 2015; Hines and Douglas, 2010) and have found incidents of female-to-male-perpetrated Intimate Terrorism (Graham-Kevan, 2011; Archer, 2009).

To distinguish between different violent acts and their severity this study has adopted the categorisation of physical violence used by the 2009 NSPCC report by Barter and colleagues: ‘physical force’, ‘more severe physical force’ and ‘sexual coercion and violence’. All participants described incidents of physical force (including pushing, slapping, hitting, and being held down), severe physical force (such as punching, kicking, strangling, being beaten up, or attacked with a weapon), and sixteen (of seventeen) participants narrated experiences of sexual violence, including rape.
Physical violence which was not part of a pattern of coercive control was deemed to be Situational Couple Violence and has been discussed in Section 5.3. The participants’ experiences of direct physical force will now be examined.

**Partner Assaults: Physical Force**

Physical violence was the most explicitly recognised and narrated facet of AIPV, with all participants describing at least three incidents of physical violence in at least one relationship (Leen *et al.*, 2013; Krahe and Brager, 2005; Coker *et al.*, 2000; Barter *et al.*, 2009). The context and situational factors leading to incidents of physical violence varied, although the majority of incidents described were an extension of an argument. An acts-based approach to interpreting these incidents might well identify them as Situational Couple Violence (Johnson, 2008), however consideration of the relationship as a whole, uncovered a pattern of Intimate Terrorism.

Pushing was the most frequently reported form of physical force \([N=15]\): “there would be a hell of a lot of pushing, that would have been, daily” (Natalie). Whenever Stephanie and Neil got into an argument he would become more and more outraged: “pointing his finger at [her] pushing [her], push pushing [her] on the bed”.

Amy described how Adam would use physical violence to enforce her isolation: “he’d be like holding me down with one arm while he deleted my boy contacts” (from her mobile phone). If she tried to fight back for custody of her phone (evidence of Violent Resistance – discussed in Section 5.5) he “…always pushed [her] down on the bed but not gently like he’d shove [her]”. This is an example of how the different forms of violence intersect with one another to ultimately control the victim (Stark, 2007; Johnson, 2008; Dixon and Graham-Kevan, 2011).

All participants experienced physical force in at least one of their adolescent relationships. The severity and frequency of such violence varied for each participant and within individuals’ IEPs. Many did not identify this use of force as physical violence, potentially due to a lack of, or minimal presence of injuries and a collective understanding of domestic abuse as a phenomenon that affects adults (Taefi, 2009). As the participants have described, the majority of physical force was experienced as part of a pattern of Intimate Terrorism, and often took the form of attempts to control the victim (Dixon-Kevan, 2001; Stark, 2007; Johnson, 2008). For some participants the physical force escalated, as will be explored in the next section.
Partner Assaults: Severe Physical Force

The second category of physical violence – severe physical force – includes behaviours such as punching, kicking, strangling, beating someone up, or using a weapon (Barter et al., 2009). There were high levels of severe physical violence throughout the participants’ narratives. Eleven (65%) participants shared experiences of severe physical violence. The experiences shared ranged from kicking and punching, to burning and stabbing. As anticipated, the context leading up to each incident of severe violence within their relationships varied for each participant.

Punching was the most frequently disclosed form of severe physical violence \([N=11]\) (Plichta, 2004). The severity of the incidents varied from a singular punch \((N=6)\) to punching as part of being ‘beaten up’ \((N=11)\). Emily (15) describes how Jimmy (17): “...picked [her] up by [her] [neck] with one hand and head butted [her]. [She] ended up with a broken nose and two black eyes”. Milly-May shared how Ricky would beat her up regularly and on one occasion pulled her hair out leaving significant bald patches:

_Erm, he attacked me again, kept me hostage for four hours in the house. Erm, I tried to run out the house, he would drag me straight back in. I tried to scream for help but he would just like cover my mouth so I couldn’t scream. He stamped on me. He dragged me down stairs. Erm. Pulled me hair out._

Lilly (19) and Leanne (24) were together for nine months. Leanne was psychologically violent, sexually coercive, and physically violent: “Her favourite thing to do was burn me with her fucking cigarettes … it would be like her marking me, would be like her ownership of me”. As a female perpetrator, Leanne’s violence reflects Donovan and Hester’s (2015) findings and supports the requirement of an intersectional approach which recognises female perpetration (Hines and Douglas, 2010; Dixon and Graham-Kevan, 2011).

Sam describes how her husband (from an Islamic forced marriage) burnt her: “he shoved, I think it was a sock in my mouth and he poured hot oil on me”. This was after just three weeks of cohabitation. She was refused medical treatment by her perpetrator. Both Sam and Lilly had permanent scarring from their burns (Plichta, 2004).

Five participants described perpetrators using weapons, such as hammers and knives, against them, causing severe bruising and lacerations. For two participants this had severe consequences (WHO, 2012; Reza et al., 2009): “he attacked me with a hammer. Umm. Which then resorted in me, erm miscarriaging [sic] the baby” (Milly-May):
He physically erm, killed me daughter [at 36 weeks gestation]. He used the combat knife and went between my legs and just stuck it in and pulled it out and done it again ... the top of the knife had gone straight through her skull into her brain (Stephanie).

A further two participants (Jessica and Sarah) reported having miscarried as a direct consequence of being beaten up (Wilbur et al., 2001; Smith, Mill and Taliaferro, 2001). Attempts at strangling and drowning were experienced by four participants (Skye, Emily, Jemma, and Milly-May). For Skye, being strangled was a regular and potentially life-threatening occurrence:

I knew, I knew deep down he wouldn’t do it but I was scared for my life … he used to grip me up and stuff like that a lot … he used to strangle me that much that I was going red, I couldn’t breathe, he’d run the bath and tell me that he’s guna kill me and everything.

Furthermore, both Jemma and Stephanie were forcibly injected with Class A drugs by their perpetrators, Amphetamines and Heroin respectively. This form of violence worked to subdue and control the victim whilst making them uniquely and wholly dependent on the perpetrator, not only for drugs, but for accommodation and sustenance. The impact of such severe violence and victimisation is discussed in more detail in Chapter 6.

Partner Assaults: Sexual Violence and Coercion

All but one participant described at least one incident of sexual violence and/or coercion. Four participants described non-consensual first sexual experiences. Molly, for example, was forthright describing her experiences: “When I was fifteen, erm, I was raped”. Molly’s rapist was an acquaintance whom she had only met briefly through her wider social circle. She was not sure, but thought he was around seventeen years old at the time, suggesting that he took advantage of the power dynamic created by the age and gender difference.

Many participants described healthy sex lives, both physically and emotionally, during the ‘honeymoon period’ of their adolescent partnerships. However, as the tactics of psychological abuse seeped in and their partner’s sex drive and demands began to surpass their own, issues began to arise. Participants described feeling that they had to give in to their partners’ sexual advances to keep the peace, maintain the relationship, and avoid escalation of violence (Stark, 2007; Johnson, 2008): “Ricky always used to say he had high testosterone levels, so he always demanded sex all the time. I used to do it to keep the peace” (Milly-May); “we’d do it like four times a day cos he wanted to” (Sarah); “he was guna leave me because I wouldn’t sleep with him”
(Emily). Some participants spoke of how their partners would force them to engage sexual acts that they did not want to: “Sometimes I’d wake up and he’d be on top of me, but he’d be like ‘I’m nearly done just a minute’” (Sarah):

He just used to force himself on me [starts to get teary] erm, it weren’t very often that I went out with friends, but when I did, that was always a time when I knew, I had to have sex when I came back … There was times when I just used ta, erm, put my head into the pillow and scream and cry and I knew I had to be quiet. It were horrible. He used to force me to have anal sex as well and I hated that, it was like being raped (Jane).

What is particularly striking about Jane’s retelling of her experiences of sexual violence is the phrase “it was like being raped”, despite both the vaginal and anal intercourse she describes clearly being non-consensual. Jane was still seemingly unable or unwilling to identify her experiences as sexual violence, a finding echoed in research by Barter and colleagues (2011). Arguably, Jane was protecting herself by minimising the experiences so that she did not have to face the associated trauma.

Similarly, Stephanie experienced forced sadomasochism in her ongoing relationship with Jimmy: “choking me, pinning me … like forcing me to do certain things”, yet she described her relationship as happy and healthy (Barter et al., 2011). Jane and Stephanie’s narratives highlight the need for better understanding of the ongoing nature of consent among adolescents. This may be particularly vital during adolescence due to the highly-gendered nature of interpersonal dynamics at this time, which favour males over females (Tolman et al., 2003; Teitleman et al., 2008; Ridgeway and Cornell, 2004; Farvid et al., 2017; England and Bearak, 2014). Both Stephanie and Jane had completed the Freedom Programme yet seemed unable or unwilling to recognise these experiences as sexual violence. This suggests a review of current prevention and intervention work is required, to include a consideration of whether the Freedom Programme is effective as a tool for the prevention of AIPV.

All but one participant narrated incidents of being coerced or physically forced into unwanted sexual activity; however, it was largely unrecognised as such by all participants. Perhaps, as suggested for Jane, this was to protect themselves from the potential psychological trauma acknowledgment might have provoked. This could also be because their experiences of sexual violence do not match the widely held myths about it, i.e. that it is perpetrated by a stranger, outside, in the dark, with a weapon present, and with evidence of attempts by the victim to physically defend themselves (Barter et al., 2011). For two participants, their experiences did match these myths to some extent, as criminal justice and healthcare interventions were initiated. Detailed examinations of these cases can be found in Appendices Ten and Eleven. This
suggests that further work on consent, healthy relationships and sexual education is required, including LGBTQIA specific work.

5.5 Participant Experiences of Violent Resistance

As hypothesised, there were some examples of Violent Resistance within relationships experiencing Intimate Terrorism (Johnson, 2006, 2008, 2011). Emily described an occasion in which her experiences of AIPV were bidirectional and appeared at first to be Situational Couple Violence. She experienced severe injuries, reflecting the adult IPV literature, which suggests that bidirectional Situational Couple Violence is the most likely to result in injury (Straus, 2008; Whitaker et al., 2007):

He raised his fist to me so I said ‘I dares ya’. He went to hit me so I ducked and he hit the wall [coughs] so at that point I thought ‘right’, I then went to hit [him] and he said ‘I dares you to go for my throat’ and I … so I ran at him to get him by his throat, he picked me up, just picked me up by mine with one hand and head butt me. I ended up with a broken nose and two black eyes … I think that’s when I started fighting back.

However, when considering her narrative about this relationship alongside this incident of bidirectional violence, it became clear that Jimmy was an Intimate Terrorist. Emily’s example demonstrates that when participants disclosed perpetration, it was in response to male violence, fitting Johnson’s Violent Resistance typology (2008). Molly was also injured as a result of her Violent Resistance:

He was on top of me and I was like kicking him and he got hold of my foot and he squeezed, squeezed my foot erm, again I don’t know what that was. And he was squeezing my foot like ‘is that hurting?’ And I was like ‘yeah it is’, but there was something, I lashed out, so there was obviously something; he’d been pushing me for ‘till I’d snapped. So, I was lashing out, erm, but he did something to my foot and I couldn’t walk on it for days and days (Molly).

Five participants (Emily, Skye, Molly, Jessica, and Sam) disclosed their own perpetration of violence towards their male partners. The self-reported context for each of their offences was in response to male violence, most frequently in retaliation or self-defence (Dobash and Dobash, 2004; Stark, 2007; Johnson, 2008; 2011), representing Johnson’s Violent Resistance Typology. The presence of Violent Resistance within these narratives may be due to the sampling strategy employed by the study. Therefore, further research with females who have perpetrated AIPV in other contexts would also contribute to our understanding of the typology during adolescence.
Conclusions

Using Connolly and McIsaac’s model of adolescence, this chapter has identified early and middle adolescence as the developmental phases in which most participants began engaging in IEPs. As demonstrated in Section 5.1, this includes the average age for going out with boys or girls (thirteen years ten months), having a first girlfriend or boyfriend (thirteen years five months), and the onset of sexual intercourse (fifteen years). Each of these ages are below the current age of consent in the UK. This has significant implications for policy and practice, including the age at which preventative education should begin (discussed further in Chapter 7). Furthermore, 53% of participants had experienced sexual violence, 65% experienced psychological violence, and 59% experienced physical violence between the age of ten and fifteen years. Each facet of AIPV was experienced by participants below the current age at which AIPV is recognised by the Home Office definition of domestic violence (2013). This suggests that being in adolescence does indeed interact with gender to create a context in which abusive relationships take place. Furthermore, those with additional intersectional factors, such as disability and sexuality, mutually shaped their experiences in a variety of ways.

The current legislative and policy framework and supportive services acknowledge victims of AIPV once they are aged sixteen years and over. It is therefore not surprising that all the participants of this study only became known to support services once they had reached age 16. However, as demonstrated in Section 5.2, all participants had already experienced at least one facet of AIPV before reaching this milestone highlighting a significant area of weakness in the support available to and accessed by victims of AIPV during early and middle adolescence.

Psychological violence was experienced by all participants [N=17] during adolescence (early: N=2; middle: N=11; late and young-adulthood: N=4). Participants of this study described how after a ‘honeymoon period’ in which they were treated like a princess, jealousy, isolation, and control began to seep into their relationships, supporting existing research (Stark, 2007; Johnson, 2008; Dixon and Graham-Kevan, 2011). The most common tactic experienced was isolation from friends and family, education, and work. Constant control of the participants’ clothing, activities, and access to loved ones was experienced acutely, with many participants describing the effects of such psychological violence as more damaging than any physical violence experienced.

For some participants, surveillance became so intense that digital confirmation, receipts and tickets confirming times of movement were demanded. Several perpetrators’ paranoia was described as so intense they would lock the participants in
a room or house to ensure they could monitor their whereabouts. For Milly-May, this intensive regulation meant social services became involved and her daughter was removed from her care for fears of abuse and neglect.

Technology played a significant role in the participants’ experiences of psychological violence. Smart phones and camera phones provided perpetrators with access to their victims twenty-four hours a day. Applications downloaded on to smart phones, such as Chatroulette, Dreamcatcher, and FindMyFriends, were used to locate participants, record them when with others, and share images and videos of an explicit nature. Participants’ access to social networks, such as Facebook, were heavily monitored, with some perpetrators deleting all male contacts, and demanding Facebook be deleted from a victim’s phone. Surprisingly, financial violence was experienced by participants as young as fifteen years old. Some perpetrators stole cash or bank cards, while others heavily monitored the participants’ spending and instilled chronic fear of consequences of ‘inappropriate’ spending.

Physical violence was experienced by all participants [N=17] during adolescence (early: N=1; middle: N=12; late and young-adulthood: N=4) and was the most explicitly narrated facet of AIPV. There were three levels of severity noted among the participants’ experiences: indirect physical force, physical force, and severe physical force. Indirect physical force, such as threats, property damage, and aggression, was significantly associated with fear of physical violence. For many participants, indirect physical force acted as a precursor to physical and severe physical force. Direct physical force was often noted as an extension of an argument, suggesting that it could be explained as Situation Couple Violence (Johnson, 2008). However, on analysis of the relationship as a whole, a pattern of coercive control was identified, suggesting it was Intimate Terrorism rather than Situational Couple Violence.

Pushing was the most frequently reported form of direct physical violence. Participants also narrated examples of being held down or being slapped. Severe physical force was also frequently reported, with punching being the most common form of severe physical force narrated. Participants also disclosed hair being pulled out, burning, stabbing, and use of weapons, strangling, drowning, and being forcibly injected with Class A drugs.

Sexual violence was experienced by all but one participant (Amy) during adolescence (early: N=2; middle: N=9; late and young-adulthood: N=5). Sexual coercion was experienced by all sixteen participants shortly after the ‘honeymoon phase’ of the
relationship dissipated. Many described giving in to a perpetrator’s demands for sex because it was their duty, or to keep the peace and avoid escalation of violence. Fourteen of the participants who experienced sexual violence \(N=16\) struggled to identify their experiences as sexual violence, instead normalising and minimising it. Arguably this is because their experiences contrast with ‘real rape’ stereotypes but perhaps also because of the gendered double standard that has been found to be particularly acute during adolescence (Teitleman et al., 2008; Sills et al., 2016; Amin et al., 2018). Two participants recognised their experiences as sexual violence (see Appendices 10 and 11), perhaps because their experiences involved severe physical violence, health care, and criminal justice involvement, thus fitting with ‘real rape’ stereotypes.

It could be argued that the high prevalence of Intimate Terrorism within the sample population is a result of recruitment bias (Dixon and Graham-Kevan, 2011; Foshee et al., 2001), as the majority of participants had accessed support services (Johnson, 1995, 2006, 2008, 2010, 2011; Kelly and Johnson, 2008). Literature suggests, certainly for adult women, seeking such support is unlikely to occur unless severe violence is experienced, or when the safety of a child is at risk (Liang, Goodman, Tummala-Narra, and Weintraub, 2005). Some participants were referred to services by their healthcare worker during pregnancy \(N=8\). Many were referred due to their second or third more severe violent relationship in late adolescence and young adulthood. This suggests that these participants may have previously experienced undetected forms of AIPV and suggests that AIPV had escalated through their adolescence. This also suggests that other recruitment methods targeting younger adolescents may have missed these young women as they and their support team may not have recognised physical force, such as pushing, as a signifier of potential future severe physical violence.

This chapter has demonstrated that adolescent experiences of AIPV are certainly more frequent and severe than suggested in previous literature (Leen et al., 2013; Barter et al., 2009; Fox et al., 2013; Gadd et al., 2013). The onset of AIPV for these participants, was before the age of sixteen, although perpetrators were usually much older (2+ years). The findings presented here have demonstrated that age, gender, sexuality, disability, socioeconomic status, educational attainment and so on, interact to produce a context for abusive relationships to occur, and create the opportunity for older more powerful individuals to take advantage of these systems of oppression (Potter, 2015; Taefi, 2009; Collins and Bilge, 2016). This chapter has highlighted multiple opportunities for policy development, preventative work, and suitable interventions for adolescents. These opportunities will be explored further in Chapters
7 and 8. The implications of these findings and subsequent recommendations will be explored in Chapter 9.
Chapter Six - The Radiating Impact of Adolescent Intimate Partner Violence

Participants of this study narrated their experiences of Adolescent Intimate Partner Violence (AIPV) over two interviews. As reported in Chapter 5, they experienced Situational Couple Violence, Violent Resistance and Intimate Terrorism (Johnson, 1996, 2006, 1008, 2011), made up of psychological violence, financial violence, direct and indirect physical violence, and sexual coercion and rape. The World Health Organisation has reported that such victimisation has a severe and profound negative impact on its victims, which can last a lifetime and cross generations (2012). AIPV has been found to ‘profoundly damage the physical, sexual, reproductive, emotional, mental and social wellbeing of individuals’, families, and partnerships’ (WHO, 2010:3). AIPV victimisation has also tentatively been associated with an increased risk of poverty, unemployment, and low educational attainment (WHO, 2010; 2012).

This chapter will explore the impact of victimisation on the seventeen female participants using Riger, Raja and Camacho’s (2002) Radiating Impact Model (RIM). The RIM suggests that there are three categories of impact on victims and their surrounding communities. First-Order effects (FOEs) are those which directly affect the victim’s health and wellbeing. FOEs include physical, sexual and reproductive, and psychological effects. An exploration of the impact of FOEs on the participants in this study begins on page 140. This is followed by an exploration of the Second-Order effects (SOEs) experienced by participants beginning on page 150. SOEs affect the victim’s relationships with others, and their ability to function in society, such as their educational attainment. Third-Order effects (TOEs), which directly impact the victim’s family, friends, and children will then be examined, beginning on page 156.

Riger and colleagues suggest that these wide-ranging effects interrelate to create a cumulative impact on the victim (2002). Furthermore, they assert that external factors will shape the impact of response to victimisation. For instance, at this time of economic austerity, funding for victim support services is considerably reduced in comparison to pre-austerity times. Furthermore, the social axes relevant to each individual will likely shape their experiences of help seeking and the response of support organisations (Potter, 2015; Collins and Bilge, 2016). The interrelatedness of FOEs, SOEs, and TOEs will therefore be explored along with the effect of external factors.
This chapter will conclude by highlighting the vast negative impact of AIPV on participants, their relationships, and on their children, friends, and family. Subsequently, opportunities for prevention and intervention will be highlighted, including suggestions for further research.

6.1 First-Order Effects of Adolescent Intimate Partner Violence Victimisation

The FOEs of AIPV, as described by Riger and colleagues (2002), are those affecting the victims’ physical and mental health and wellbeing. Considering the context of the participants’ lives, it became apparent that many of their lives had been plagued by adversity, which has consistently been linked to poor outcomes (Shonkoff and Garner, 2012). Experiences of familial domestic violence, physical and mental illness, and bereavement mediated the way the effects of their victimisation were narrated (potter, 2105). The emotional and psychological impact of AIPV will be explored firstly, followed by an exploration of the physical impact, and finally the sexual and reproductive impact of AIPV.

The Emotional and Psychological Impact of Adolescent Intimate Partner Violence

The emotional and psychological impact of AIPV victimisation can be huge, with participants’ narratives suggesting all forms of AIPV impact on their psychological wellbeing. Emotional and psychological impact can be categorised into two subcategories: internalising and externalising behaviours (Plichta, 2004). Internalising behaviours, such as depression and anxiety, are symptoms or behaviours which are directed towards the self (Fergusson, Horwood, & Boden, 2006). Externalising behaviours, such as aggression or criminal activity, are directed outwards, or towards society, other people, or objects (Barnow, Schuckit, Smith, Preuss & Danko, 2002).

Fifteen [of seventeen] participants narrated symptoms of internalising behaviours. The most common of which [N=13] were depressive symptoms. Symptoms included, but were not limited to, continuous low mood or sadness, feeling hopeless and helpless, having low self-esteem, feeling tearful, feeling guilt-ridden, feeling irritable and intolerant of others, having no motivation or interest in things, finding it difficult to make decisions, not getting any enjoyment out of life, feeling anxious or worried, and having suicidal thoughts or thoughts of self-harm (American Psychiatric Association, 2013). Such depressive symptoms are likely to impact upon an individual’s ability to have
healthy relationships with friends, family, and children, thus impacting upon those in their life beyond their abusive relationship (Riger et al., 2002).

Depressive symptoms are complex and vary from person to person. Diagnosis often rests on the length of time (usually for more than two weeks) symptoms persist and whether they interfere with one’s work, social, or home life (NHS, 2014). Many of these symptoms are reported in the literature on adult IPV victimisation (For example: Coker et al., 2002; Wright, Pinchevsky, Benson and Radatz, 2015). However, the long-term nature, age at onset, and severity of symptoms experienced by adolescent participants is significant and concerning, as Amy’s example demonstrates:

"I were literally crying every day and every night like in public and everything cos he made me feel like proper little and he made me feel dead worthless and stuff [laughs] … it made me feel crap and dead, dead self-conscious, like I wasn’t good enough for people."

Lilly felt so depressed as a result of her experiences of AIPV that she began drinking and using cocaine to self-medicate. However, her depression continued to worsen, including experiencing suicide ideation:

"I think that’s what I was doing with the [cocaine] is just anything to [change the way I really felt]."

Similarly, Jamie’s perpetration led to severe depression for Skye. She contemplated suicide and giving up her children:

"I just wanted to give my kids to social services and jump off a bridge, it was horrible … I'd be crying and dead upset and it made me erm, not, not, not, but well yeah, I didn't want me son to be honest … sometimes I’d just think, I can’t even be bothered anymore I might as well just let him [perpetrator] do it [kill her] and get it done with."

Milly-May's victimisation has led to severe depression and later postnatal depression, which has severely affected her ability to sleep well:

"I had a breakdown like, not last night but the night before erm. Just emotions flying everywhere … I was diagnosed after my daughter, like post, postnatal and that's when I came here [refuge] … I'm not, I'm not sleeping, I've been getting like three hours a night if I'm lucky."
Jane narrated how her victimisation led her to hate herself, and in punishment she began self-harming. This became one of her favoured coping mechanisms. More recently she attempted suicide:

*Cos [sic] I hated myself when I was with me ex, was I cut me arms [K: Mm] with scissors, like on the inside, I didn't want to die, I just hated myself … I've been back to the doctors this morning cos I'm suffering with anxiety so they've all this heart burn and stuff they've doubled my anti-depressants now and I'm also on beta-blockers … I got dead emotional and then I just started thinking about all me past [begins crying] and I took a load of tablets and ended up in hospital so, at the time I felt as though I just didn't want to be here … I'm waiting to go for counselling at the moment … I just don't want to feel like this anymore [crying gently] I just want to stop it.

Jane's experiences demonstrate the long-term psychological impact of all facets of AIPV. Natalie also describes experiencing suicide ideation and self-harm leading her to give her neighbour temporary custody of her children:

*I had a nervous breakdown with all my demons from my childhood and everything else … I tried to slit my wrists … I ended up signing my kids over to a neighbour for short term support because I couldn't stop crying. I was an absolute mess … I was suicidal … I had a big thing about bridges with cars underneath [K: Mm] the temptation, I'd freeze on them and I would literally have the temptation to go over the side.

Such intense depression, with suicidal ideations, self-harm, and suicide attempts in adolescents is particularly troubling due to the long-term effect on wellbeing associated with adolescent depression (Oldehinkel, Ormel, Verhulst, and Nederhof, 2014). The examples presented also highlight the requirement for intensive psychological support for victims of AIPV. However, within a context of severe governmental funding cuts to mental health services this requirement is not being met. It is estimated that thirty women attempt suicide every day and three women die by suicide every week due to domestic violence (Refuge, 2016). As demonstrated throughout this thesis, sixteen to twenty-five-year-olds represent at least one quarter of the statistics, highlighting AIPV as a public health issue requiring urgent attention. As such, effective prevention intervention efforts could not only reduce or eliminate AIPV, they could also save lives. Further exploration of existing prevention and intervention efforts and participants’ thoughts about improvements can be found in Chapters 7 and 8.

For four participants, the internalizing effects of AIPV victimisation developed into severe psychiatric conditions. At age nineteen, Molly developed Bulimia Nervosa:

6 People who have Bulimia Nervosa try to control their weight by severely restricting the amount of food they eat, then binge eating and purging the food from their body by making themselves vomit or using laxatives.
He made me dead self-conscious and compared me to, he compared me to other people you know. … I got really depressed with him, I remember him saying to me look you’ve not even brushed your hair today. Anyway because following that I became bulimic … on my break rather than sit upstairs I used to run round the block and then if I was to go into the kitchen and the chef was cooking I might eat a chip with mayonnaise on and then straight away I’d make sure I was sick … I was bulimic for four years … I’ve been on antidepressants for fifteen years … I wanted to end my life … I was going to crash my car.

The psychological violence Molly experienced appears to be directly linked throughout her narrative to her experience of depressive symptoms, such as low mood, low self-esteem, feeling anxious or worried, and having suicidal thoughts or thoughts of harming herself. These depressive symptoms and the development of Bulimia Nervosa demonstrate the hugely detrimental effect of AIPV for Molly. Similarly, Ishara developed Body Dysmorphic Disorder7 (BDD) following the continual use of psychological violence by her ex-partner and his wider social circle:

I got called tiny tits by [daughter’s] dad and his friends. I was supposed to think it was funny he he. Well it wasn’t. I had major, major hang ups about the way I looked. I didn’t feel feminine. So erm, I went out with a multimillionaire and erm, he paid for me to get them done. I’m actually a size A/B but now I’m a DD/E.

This surgical response to BDD appears to have reduced Ishara’s symptoms; however, she still struggles with depression and Post-Traumatic Stress Disorder8 (PTSD) following her mother’s murder at the hands of her father and her own experiences of AIPV. Ishara narrated the cyclical nature of the impact of her experiences of AIPV and familial domestic abuse:

When my daughter was born, I erm, started having flashbacks of my childhood like really vivid dreams of being killed and her [mother] being killed over and over again and they were horrific … post-traumatic stress from me mum dying … sometimes I still self-harm. If, if I get upset I still do it cos it’s the only way of coping with the way I feel … I’d get panic attacks.

Ishara’s narrative highlights the impact of witnessing domestic abuse in childhood on the long-term ability to cope with adversity in a healthy manner, which was worsened for her by her own experiences of AIPV.

Jemma has complex mental health illness following her experiences of AIPV. As a child she was diagnosed with epilepsy and has a mild learning difficulty. Her epilepsy was exasperated by her perpetrator’s forced use of intravenous amphetamine, which

7 Body Dysmorphic Disorder (BDD) is an anxiety disorder that causes a person to have a distorted view of how they look and to spend a lot of time worrying about their appearance.

8 Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder caused by very stressful, frightening or distressing events.
also caused further issues with her heart. Jemma directly associates the forced intravenous amphetamine use with her development of Paranoid Schizophrenia¹ (Nelson, Heath, Lynskey et al., 2014), along with a severe sexual assault causing her to develop PTSD:

*I’ve got post-traumatic stress and schizophrenia basically, so I, I was developing a mental illness because of the drugs ... I was addicted [to amphetamines] ... in some situations that I find dis- distressing I find, completely schiz [sic] out. I think there’s someone out to get me, I think there’s cameras, people watching me, cars following me … and I tried to jump out of a, err car. Alright, err yeah I jumped off a bridge as well umm. I jumped into train tracks to try and kill myself [laughs] yeah … I err I used to err, razors, umm, slit my wrists … when I got sexually assaulted, and it just brings flashbacks and nightmares, and um, I have to lock every single door, check every single window.*

Jemma’s narrative highlights the ways in which existing medical conditions can be worsened and complicated by AIPV victimisation. Jemma also developed two serious psychiatric conditions as a result of her experiences, causing self-harm and several suicide attempts. This reinforces the argument for intensive mental health support for victims of AIPV.

Externalising behaviours were narrated by five participants. Their narratives centred predominantly on alcohol and risky sexual behaviours. Molly shared strong internalised blame for the rape she experienced at age fifteen years, and in response “went off the rails” by drinking alcohol to excess and engaging in casual sex whilst working for a season on a Greek island.

Following the breakdown of her abusive relationship with Simon, Molly “turned to drinking, you know partying and stuff”, and had several one-night stands and “fuck buddies”. She viewed these sexual experiences as affection seeking, but struggled with an internalisation of the patriarchal assumptions of femininity instilled in her throughout her relationship and wider life: “I lost all self-respect … I’m not proud of it”. Whilst the feminist movement has made it more socially acceptable for young women to drink alcohol and have casual sex, it is clear that Molly continues to internalise the conservative patriarchal assumptions of femininity, which adds to Simon’s perceived omnipresence.

Similarly, Stephanie describes how she had little self-esteem following two abusive relationships, and sought sex with strangers in order to experience intimacy:

¹Paranoid Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms, including: hallucinations – hearing or seeing things that do not exist, delusions – unusual beliefs not based on reality that often contradict the evidence, muddled thoughts based on hallucinations or delusions, and changes in behaviour.
After I had been with Sean and Neil I became a female slag. Because all blokes, I thought sleeping with people was how you got them to love ya. And it's like I actually felt loved for that brief twenty minutes or however long it was [K: Mm] and I come to realise no, no it don't, what you're getting isn't love.

This discourse echoes the internalised patriarchal chastisement experienced by Molly. Whilst not explicitly narrated by participants, it is well documented that such risky sexual experiences have potential for further negative impact: sexually transmitted diseases, unwanted pregnancy, sexual violence, and negative psychological impact (Hair, Park, Ling and Moore, 2009). AIPV victimisation, risky alcohol and drug use, and sexual behaviours should be acknowledged in any preventative intervention in order to minimise further risk of repeat victimisation and further negative impact.

For one participant, survival sex (Conner, 2015), arguably another risky sexual behaviour, enabled her to earn enough money to free herself and her daughter from the cycle of violent victimisation she had experienced for over a decade:

You see, I went on to do other stuff. You know, I had to, when I was with my daughter in my twenties I had to sell myself to survive [K: Mm] you know, I got £150 an hour. It could buy her shoes, it could pay the bills. (Ishara)

Whilst there isn’t the scope here to discuss the ‘empowering versus abusive’ debate regarding sex work (see for example: Kempadoo, Sanghera, and Pattanaik, 2015), analysis of Ishara’s narrative identifies her lack of choice and highlights her experiences of survival sex as an extension to her AIPV victimisation. As with Molly and Stephanie, these sexual encounters could have had negative consequences, both physical and psychological. Whilst Ishara appeared indifferent about selling sex to survive, her experience highlights the financial requirements of young mothers fleeing AIPV, and the psychological impact sexual violence can have (Jina and Thomas, 2013). As such, these factors should also feature in the response to AIPV.

For Jane, losing custody of her children led her to an unhealthy relationship with alcohol: “I turned to the drink, err about six months ago. I wasn’t physically dependant on it … the doctor said I was mentally dependant”. Similarly, Emily describes how she uses alcohol to cope with her depression, often with further negative impact on her mental wellbeing: “I’ve been depressed for years and I’ve always had a problem with alcohol … I ended up taking an overdose … I was drunk. I had no intention of going out to do it … I use it [alcohol] as a coping mechanism for everything”.

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Emily and Jane’s self-medication with alcohol demonstrates the negative impact of victimisation and the extensive impact it and subsequent coping strategies can have. These examples demonstrate how without appropriate support young women are using alcohol and other potentially risky coping mechanisms to self-medicate. Successful prevention interventions must therefore inform young people of the associated risks of negative coping strategies and support them in pursuing positive alternatives.

As the participants’ stories demonstrate, the psychological, psychiatric, and emotional impact of AIPV is huge, and was experienced in various forms by all participants, and often those beyond the primary victim (SOEs and TOEs discussed below). In order to combat this impact, a national strategy of wellbeing and recognition of suffering is required, as will be discussed in more detail in Chapter 7.

The Physical Impact of Adolescent Intimate Partner Violence

The physical impact of AIPV can be catastrophic, with two women a week on average killed by a current or former partner in England and Wales (Women’s Aid, 2014; Riger et al., 2002; WHO, 2012). Three participants experienced the death of their mother due to domestic violence perpetrated by their fathers or step-fathers. Adolescent fatalities are less common, making up approximately 10% of femicides in England and Wales annually (Women’s Aid, 2014). At the time of publishing the author has no knowledge of participant fatalities. Other physical impacts of AIPV are more common and can be categorised into three groups: immediate and direct - such as injury or death, longer-term and direct - such as a disability, and indirect - such as long-term disorders (Plichta, 2004).

Each participant described at least one occasion on which they were injured during their adolescent relationship(s). The severity of the injuries varied from person to person and within their various relationships. Immediate and direct physical impact included bruising, lacerations, burns, and injuries related to strangulation. Longer-term and direct physical impact included broken bones, scarring, partial blindness, and ongoing pain and discomfort. Indirect impact experienced included Epilepsy and Arrhythmia.

Bruising was the most common immediate injury: “I’d be bruised everywhere and lumps and everything” (Sky); “bruises all over my body where he stamped on me … I had a big bruise all the way down me thigh” (Milly-May); “I had twenty bruises all over and my face as well “ (Rachel); “I woke up with bruises all over my legs” (Jemma);
“I’ve been to hospital, all bruised” (Sam). Bruising occurred in isolation, but also alongside multiple more severe injuries: “[I had] two black eyes, my nose was like out here, my lips were all swollen like, I was covered in blood” (Lilly); “my neck and all my face was all cut ... And then [clears throat] I couldn’t see out of one of my eyes” (Rachel); “I ended up with a broken nose and two black eyes” (Emily); “I used to sit there with black eyes, he’s err broke my nose a few times … broken toes” (Stephanie). Emily describes additional injuries through strangulation:

I did end up in hospital last time he strangled me though cos he tore something in me throat and I thought nothing of it and I had all my mates round at the flat and ... I thought I was guna throw up ... ran to the bathroom and I was projectile vomiting blood and then as soon as that stopped I was coughing up blood clots and ... couldn’t eat couldn’t drink. That lasted about three days.

Many of these direct injuries had longer-term impact causing scarring, disability, and ongoing pain and discomfort: “I’ve got scars on my legs through him hitting me with a Pyrex bowl” (Jane); “I’ve got cracked ribs, a broken rib, all sorts” (Natalie); “I ended up with a massive scar on my leg ... it swelled basically and erm, it got infected ...” (Jemma):

I’ve got scars under my hair from glasses and stuff. I’ve got funny ribs. Erm, the erm, I don’t know what he did, he never broke them, but now, every now and again they all like, instead of like that [up and down], they all move and crack, and it’s from that. Its cause of how he’s hit your ribs. (Jessica).

In addition to injuries caused by direct violence as described above, some participants experienced different types of physical harm. Both Jemma and Stephanie had been forced by their perpetrators to inject amphetamines and heroin respectively. The long-term impact of drug use on their physical and mental wellbeing was significant. Jemma described how the forced amphetamine use had impacted her heart function and existing epilepsy:

Since sixteen I kept doing drugs because he kept pumping it into my system ... and then I got really bad on it then and I kept on going to hospital and all sorts ... I had a massive fit and banged my head on the table [unconscious] ... my heart was being un-regular [sic] again and [the cardiologist] said you had to monitor it because the drugs that I’d taken, my heart could stop at any time.

Whilst the majority of the participants were within a few years of their most recent abusive relationship, recall bias makes it difficult to gain an accurate picture of the long-term physical disorders experienced by this group of young women (Whitaker, Haileyesus, Swahn, and Saltzman, 2007). Nonetheless, many described ongoing psychological disorders as described above.

As highlighted by the participants’ stories, the physical impact of AIPV was vastly detrimental to their health and wellbeing (WHO, 2012), suggesting the impact of AIPV
is similar to that found in the adult literature (Wathen, MacGregor and MacQuarrie, 2016). Arguably, due to the developmental significance of the age at which the IPV is occurring, AIPV victimisation is a particularly acute public health issue (Howell, Barnes, Miller and Graham-Bermann, 2016; Cisler, Begle, Amstadter et al., 2012; Park, Smith and Ireland, 2012). The impact of AIPV victimisation is, however, not limited to physical symptoms. The sexual and reproductive impacts on participants will now be explored.

The Sexual and Reproductive Impact of Adolescent Intimate Partner Violence

Sixteen (of seventeen) participants told of their force and/or coercion into sexual acts, including rape. The narrated impact of their experiences of sexual violence and coercion fell into two categories: internalising and externalising behaviours (Plichta, 2004). Internalised psychological effects, such as depression and anxiety, were consistently experienced by this group. For some participants, the impact developed into externalised behaviour, including risky sexual behaviours and substance misuse (Walsh, Latzman and Latzman, 2014).

One particularly prevalent and gendered impact of victimisation experienced by participants was the impact on pregnancy and pregnancy-related complications (WHO, 2012; Stephenson et al., 2006; Asling-Monemi et al., 2008; Boy & Salihu, 2004). Almost a quarter of participants had experienced at least one miscarriage as a result of AIPV (Reza et al., 2009). At age sixteen Milly-May was four months into her relationship with Ricky when she found out she was pregnant. Less than two months later “[he] attacked me with a hammer. Umm. Which resulted in me, erm, miscarrying [sic] the baby”.

This traumatic experience led Milly-May to fear negotiating the use of contraception (Pearson, 2006): “a month later I got pregnant again, erm. But with the stuff that were going on, the violence was getting worse, I had erm, I, an abortion, at twelve weeks”. This demonstrates the considerable impact of coercion into sexual intercourse without contraception (WHO, 2012), and supports Jacoby et al.’s (1999) findings of rapid-repeat pregnancies in adolescence. Milly-May feared Ricky’s reaction to the abortion so intensely that she “told Ricky [she] had a miscarriage so it didn’t cause more commotion” (Coyle, Shuping, Speckhard and Brightup, 2015). A further two participants narrated their experience of having an abortion at ages fifteen and nineteen.

Milly-May was not the only participant to experience rapid-repeat pregnancies. Jane “had [son] in July, the following year I had the twins in July, and then I had, got caught
pregnant after the twins and then had [daughter] on August. So, there were four of them under two years old” (Jacoby et al., 1999; Plichta, 2004). Jane felt this was a deliberate plan concocted by her perpetrator to imprison her, as having four children under two made leaving the house very difficult (Stark, 2007).

Aged sixteen years Stephanie was married, forcibly addicted to heroin, and pregnant when her husband at the time attacked her:

"I was about eight months pregnant at this time … he come and found me err I was in a local park … he actually carried around a combat knife with one side smooth one serrated [K: right] and he physically erm, killed me daughter. He used the combat knife and went in between my legs and just stuck it in and pulled it out and done it again. But he got disturbed … Next minute I woke up and I’d just got out of surgery. They had to remove the baby… because the top of the knife had gone straight through her skull into her brain."

This attack meant that Stephanie’s pregnancy ended, she required extensive vaginal reconstructive surgery, and was told she would not be able to have more children. This was psychologically devastating for Stephanie, however, she was extremely pleased to share that she had since had four children. Unfortunately, the psychosocial impact of this incident was huge, and during the second and third interviews she shared that her four children had been placed in the care of her sister-in-law due to her current abusive relationship. Both Stephanie and Milly-May’s narratives highlight the impact of AIPV on its victims’ sexual and reproductive health, and their subsequent experiences of motherhood. These extreme early experiences also appear to have increased Stephanie’s tolerance of AIPV behaviours; hence, she described her current relationship as happy and healthy in all other narratives, until disclosing the loss of custody of her children.

As demonstrated by the participant narratives above, the impact of AIPV on pregnancy, including rapid-repeat and unwanted pregnancies, miscarriage, and termination were significant and long-lasting (WHO, 2012; Coyle et al., 2015; Jacoby et al., 1999; Plichta, 2004). Not only are these adolescents being forced to engage in unwanted sexual activity and rape, they are refused contraception by their perpetrator/s and must then face pregnancy/pregnancies, difficult decisions regarding those pregnancies, risk of miscarriage, as well as being ostracised due to their victimisation and the stigma associated with teenage pregnancy. These findings suggest that teenage girls, including those under sixteen years old, are at risk of significant sexual and reproductive health issues in association with AIPV victimisation. This must be recognised within a public health approach to tackling AIPV.
It is widely accepted that pregnancy is a catalyst for adult IPV, yet there is little evidence of this with adolescents (Burnett, Schminkey, Milburn, Kastello, Bullock, Campbell and Sharps, 2016). The participants’ narratives provide such evidence, however, further research which explores the nature of pregnancy within the context of AIPV is required.

These findings suggest that adolescents require intervention as early as possible to minimise the impact of their victimisation. Safe sex and relationships education and support must address these issues from a multiagency public health perspective. Further discussion of the intervention efforts experienced by participants can be found in Chapter 8, followed by their suggestions for improvements to existing prevention interventions. The next section considers the Second-Order effects of AIPV.

6.3 Second-Order Effects of Adolescent Intimate Partner Violence

Second-Order effects [SOEs] of AIPV are those which affect an adolescent’s ability to function in society, and harms their relationships with others (Riger et al., 2002). As discussed above, AIPV victimisation can have an impact on an individual’s ability to have positive relationships with their children, family, and friends, the ability to gain educational achievement, and to gain and maintain employment. The impact directly on family members, friends, and children is considered to be a TOE, and is explored in the next section. At the time of interview, many of the participants were in the initial recovery stages after fleeing their most recent abusive relationship, and hence struggled to discuss in much detail the wider impact of their experiences.

Eight participants described the impact their victimisation had had on their relationship with their family, children, and friends, supporting Riger and colleagues’ finding that IPV has a significant effect on the victim’s relationships with friends, family, children, and future partners (2002). These experiences will now be explored.

Family

Participants’ narratives explored varying impacts on their relationships with family members. Ishara describes her shame at remaining with her abusive partner who had also sexually abused her younger sister, and the impact this has had on her familial relationships going forward:
I’m deeply ashamed I got back with him … me and my little sister still don’t speak and that relationship is ir-irreparable. She got married. She had a baby two years ago. I wasn’t there. She got married, last year, everyone went, I wasn’t there. Deeply hurtful. But it’s my fault, I stayed with him. I’ve got to live with the consequences.

This long-lasting negative impact has caused Ishara much pain, and continues to distress her decades later, highlighting the importance of recognising the gravity of AIPV victimisation and its potential lifelong impact. Stephanie shared that, she felt so incredibly distrustful of men following her experience of being stabbed by her ex-husband that she struggled with intimacy with her male family members: "at first I wouldn’t even let my dad give me a cuddle because of what I’ve been through". This distrust led her to turn down the opportunity to move to Canada with her family, choosing to remain in England. This is something she regrets as an adult, as she believes the move could have had protective qualities. The lack of a consistent support network was at least one factor which led to Stephanie’s continued and repeated victimisation by at least two subsequent male partners. Stephanie felt that her victimisation had negatively impacted upon her relationship with her family in Canada, as she was not allowed regular contact with them whilst in her abusive relationships. However, she went on to describe the evolving strong bond she now feels with her father.

Molly described how her family were manipulated into not believing anything she said by her perpetrator, as they “were totally taken in by him”. Molly felt that her family had sided with her perpetrator, and this has had huge ramifications, especially on her relationship with her mother, who directly blamed Molly for involving them “at this time in their lives”. Molly also described her mother’s disbelief in mental health problems, and the lack of familial support she has received due to the “mental” picture her ex-partner painted of her. It was not until Molly’s perpetrator vandalised her parents’ cars in a fit of rage that they began to recognise his abuse, but Molly felt the impact on their relationship was irreversibly damaged. Molly’s story demonstrates the multiple effects of AIPV on victims’ relationships with their family. Not only were Molly’s family manipulated by her abuser, and used by him to further isolate her, they were also caught up in the violent aftermath of the relationship. These examples highlight the need for holistic prevention interventions which enable the victim and those around them to recover together in order to overcome the detrimental impact of AIPV.
Children

For three participants, victimisation led them to lose custody of their children, as is common when IPV is identified and a mother is deemed to be failing to protect her child or children from risk (Riger et al., 2002). This relationship separation caused distress and shame to participants experiencing it, despite the blame for the violence falling firmly and solely at the perpetrators’ feet. Milly-May lost custody of her daughter at eighteen months, due to her victimisation:

My mum’s got social guardianship now. She’s got her ‘til she’s eighteen, or until my mum decides to give her back, but … I’m seeing her like once a month, for like, two hours which is shit basically … so [sigh] I’ve lost everything basically. Through Ricky.

This feeling of loss appears to have compounded Milly-May’s internalised feelings of low self-worth, and at the last time of contact she was considering rekindling her relationship with Ricky on his release from prison, as she felt her relationship with her family and daughter were irreconcilable. This is of particular concern, as this relationship is extremely abusive and is likely to place her at great risk of further injuries, and perhaps death. On consultation with Milly-May’s support workers it became clear they were aware of this potential risk to her safety, and had already initiated safeguarding procedures.

Care must be taken when working to prevent and intervene in cases such as Milly-May’s to ensure that the loss of custody is seen as a symptom of the abuse and their own victimisation, as a coping strategy employed to protect their children from ongoing abuse, rather than judging and blaming the victim for ‘failing to protect’ their children (Johnson, Saccuzzo, and Koen, 2005). Ideally, holistic approaches to repair and recover the mother–child relationship(s) would be employed, however, it is recognised that child safeguarding must be paramount. That said, victims of AIPV are often children themselves, and should be protected under the same legislation and policy, rather than largely ignoring the issue until another child is born.

Jane lost custody of her eldest daughter when she was approximately six years old due to victimisation during her relationship with her daughter’s father. Some years later this was repeated with her younger four children, when her most recent ex-partner took her to court for custody based on her homelessness (Second-Order) and alcohol misuse (First-Order), both symptoms of his abuse (Zeoli et al., 2013):

I couldn’t afford to keep the house on so, I had to sort of make myself homeless … my oldest daughter went to live with my mum because of him [first abusive relationship] … he [most recent ex-partner] has custody of the kids, erm, I don’t have them over night, one week I have them Saturday the next I have them Sunday [K: right] it’s rough not having your children I can’t tell ya … I turned to alcohol.
Losing custody of her children has had a massive negative effect on Jane’s mental (First-Order) and social (Second-Order) wellbeing, and likely the wellbeing of her children (Third-Order). Evidence is beginning to mount regarding abusers’ tactics to get custody of children as an extension of their control and abuse following separation (Zeoli et al., 2013), culminating in the Women’s Aid Child First campaign (2016). Jane shared several examples which appear to support this, including an occasion when her children were due to visit on her birthday. Jane’s ex-partner refused to let her children visit, giving ten minutes notice and notifying her via a text message from her eldest daughter’s phone. This was devastating for Jane on many levels, and almost caused her to self-harm and begin drinking alcohol again.

Stephanie was the third participant to narrate custody loss:

_The social worker didn’t like the way he was talking to me … and err in the end she took us to court and, and had the four, four, four, my four, erm, three at the time were out in my sister-in-law’s care … at the moment she’s been doing that for the last ten months, what I’m, erm, when Jimmy was born, erm my youngest, we had him for six days in our care like then I had to give him to my sister-in-law._

Stephanie described her initial despair at losing her children, but repeatedly claimed that this had had a positive impact on the violence in her relationship, leading to her acceptance of her referral to her local domestic abuse charity. Arguably, this repeated claim was an attempt to neutralise the shame she felt due to losing custody of her children, and perhaps by repeating this in the interview she was also seeking the researcher’s approval (Agnew, 1985). Stephanie seemed motivated and determined to improve her living and relationship situation so that her children would be returned to her as quickly as possible; however, she acknowledged that her plans might be undone should her partner continue to be abusive. Stephanie’s example highlights a key intervention opportunity in terms of attempting to keep the mother and children together in the event of a custody hearing due to a violent parent’s behaviour.

Stephanie’s experience highlights the power imbalance between the social worker and client (Maiter, Palmer, Manji, 2006). The social worker has, in this case, imposed her understandings of IPV on the family whilst using tactics of victim-blaming, causing Stephanie to be separated from her children (Keeling and van Wormer, 2012). Alternatively, a holistic approach would have enabled the social worker to remove the perpetrator from the premises and implement an approach to enable Stephanie and
her children to recover together and support one another, minimising the Second- and Third-Order effects experienced by Stephanie and her children (Riger et al., 2002).

Friends

Intimate Terrorism during adolescence has been narrated by a significant number of participants, as discussed in Chapter 5. In order for a perpetrator to gain control over their victim they must isolate them from their support network (Stark, 2007; Johnson, 2008). This isolation had a severe negative impact on many participants’ relationships with friends. Some perpetrators directed their aggression towards victims’ friends in order to discourage them from making further contact and continuing their friendship:

… Erm, didn’t have friends, they just disappeared. Well at first it was because we were always together … so it was that thing where they didn’t disappear I’d changed my lifestyle … no one came in, his family would come round but none of my friends would come round, and it was because he’s make them feel fucking awkward so they’d just stop. (Natalie)

Three participants described scenarios in which friends became impatient with them for staying with their perpetrator. For example, Lilly said: “they couldn’t understand why I couldn’t just walk away”. Eventually the friendships dissipated, adding to the victims’ isolation.

For Rachel, the effect on her friendships differed depending on the friend. Her closest friends would often hear about the violence and support her, whereas others fell away over time. Rachel felt especially grateful to her closest friends for keeping in touch, because at one point her perpetrator had forced her to contact them all to tell them they could not be friends anymore.

These examples demonstrate how AIPV victimisation spills into other relationships and often becomes the reason for them to end (Riger et al., 2002). However, participants often displayed regret when speaking about their past friendships. This is significant considering the increasing importance of peer relationships during adolescence (Cotterell, 2013; Greenberg, Siegel, and Leitch, 1983). This would suggest that it is important that friends of victims are fully informed about the nature of AIPV and how to support their friends during and after a violent relationship, whilst considering their own wellbeing as well (further discussion in Chapters 7 and 8).
Educational and Employment Attainment

Adult IPV victimisation has been repeatedly linked to poor education and employment attainment (for example, see Wather, Tanaka, MacGregor et al., 2016). Stephanie and Natalie described the impact AIPV had had on their ability to gain educational achievement (MacMillan and Hagan, 2004; Riger et al., 2002). Stephanie described her early education exit (age fifteen), and how since leaving her family and marital home she feels too financially unstable to consider returning to and completing her education: “I need to find work to get enough money to live, and like, the stress puts me off”. Natalie speaks retrospectively about when she was fifteen: “I was hardly going to school, well on and off, spent a year in a refuge”. This means that Natalie has just five GCSEs, and did not complete her full-time further education, quashing her potential.

Natalie did, after a significant period post abuse, return to college in her late-twenties, and is now a qualified counsellor. Natalie attributed this success to the consistent and long-lasting support she received from her social worker and counsellor over many years. Arguably, the process of becoming a counsellor has also assisted in building Natalie’s resilience and conflict-resolution skills, reducing the likelihood of re-victimisation and continued negative impact on her education and employment attainment. Further exploration of participants’ experiences of formal and informal support can be found in Chapters 7 and 8.

Both Stephanie and Natalie’s stories demonstrate that at least in the immediate aftermath, full-time education can be significantly affected by an adolescent’s IPV victimisation. Both Natalie and Stephanie’s narratives highlight a key opportunity for intervention, as their early exit and poor attendance were symptoms of a broader issue which required investigation by the school and safeguarding authorities. Add to this the experiences of AIPV occurring on school premises and within school hours, and it becomes clear that schools have a significant role to play in the recognition of and response to AIPV. Further discussion of this role can be found in Chapters 7 and 8.

A further Second-Order effect of AIPV victimisation is that upon the ability to gain and maintain employment. Whilst the majority of participants had yet to leave full-time education, some had part-time or full-time jobs. As part of the campaign of psychological abuse they experienced, some described having to give up their work in order to satisfy their partner’s needs to control their whereabouts and interaction(s) with others. For example, Ishara’s ex-partner verbally abused her in front of a female colleague: “I didn’t go back to that job, I was too humiliated”. Rachel was experiencing
extreme and severe physical, sexual, and psychological abuse whilst working full time as a beautician:

> It got the way with what I looked like [bruising] sometimes that I couldn’t go to work so I had to leave my job … I didn’t have any other friends, so I’d just be on my own if, so I just like I was used to the four or five phone calls a day, he would ring me and it was just like normal.

Such Second-Order effects dramatically affect the victim’s ability to function in society and maintain existing or foster new friendships and relationships. Prevention interventions must enable victims of AIPV to overcome these effects whilst encouraging safe and holistic recovery. Further examination and discussion of such interventions can be found in Chapter 7, beginning on page 139.

### 6.4 Third-Order Effects of Adolescent Intimate Partner Violence

As well as effects to the relationships between the participants and their family members and children, AIPV victimisation had a direct impact upon the participants’ family and children (Peled, Gueta and Sander-Almoznino, 2016; Riger et al., 2002). Parental and familial experiences of violence and/or fear of violence were sparingly narrated by participants; however, this does not imply that it was not experienced. Molly suggested her parents felt frustrated that they were involved and were experiencing abuse by her perpetrator. They also experienced criminal damage to their cars in the period immediately after Molly separated from her perpetrator. Rachel also thought her “dad hated [her relationship]” but wasn’t sure what impact it had had on him. Eight participants had spent at least some of their childhoods in care, suggesting complex relationships and some impact on their families, if indeed there was an ongoing relationship. Whilst it can be assumed that there will be some negative impact on parents of victims of AIPV, there is little literature considering this, highlighting a key gap in existing research (Peled et al., 2016; Riger et al., 2002).

Before the first interview with Amy, Amy’s mum was keen to express the fear and stress she had felt when her daughter was experiencing AIPV. It had caused sleepless nights, hyper-vigilance, and arguments between her and her husband, echoing research conducted by Peled and colleagues, which defines the experiences of mothers of victims as secondary traumatisation (2016). She also shared her frustration at the lack of information and support for parents of victims. Amy’s mum attributed some of her reaction to having one child, however these reactions have begun to be documented in other research concerning the parents of victims of child sexual
exploitation, suggesting they are experienced by others regardless of the number of children they have (ibid).

Another direct impact to parents and family members was the increased requirement for child care, and in some cases custody of their grandchildren (Riger et al., 2002). Nine participants were parents, and a further two participants were pregnant at the time of data collection. Family members were called upon to look after children whilst participants spent time in hospital [N=5], due to participant depressive episodes [N=4], because the perpetrator demanded the children were out of the house [N=3], and/or because social services interventions demanded they have custody [N=3]. The impact of this increased requirement alongside the stress and fear of violence is likely to have had a significant impact on the families of victims of AIPV (Gregory, Williamson and Feder, 2016). In order to establish the form and effect of this impact on parents, further research should be undertaken with families of victims.

Participants with children [N=9] also shared instances in which their children were exposed to their victimisation [N=9] or were also victimised by their perpetrator [N=5]. Five participants narrated the impact their victimisation had had on their children. Skye was, and continues to be, in a relationship with Jamie, who she has been with since the age of sixteen. They have two children together. There have been various incidents in which the children have witnessed Jamie’s violence towards Skye, and further incidents in which Skye had been holding one or both of their children when Jamie attacked her. Skye was evidently concerned that her young son and daughter were going to be negatively affected by these experiences (McDonald et al., 2016; Blair et al., 2015; Riger et al., 2002). She describes their reactions:

_He started crying … my son gets really protective over me … and then afterwards I was saying to my daughter, I said, she was asking why daddy wasn’t here and I said d’ya know when you was in the back garden and mummy and daddy was arguing? I said, we can’t have that round you anymore and she said yeh I’ll just stay in the back garden._

Skye was devastated at her young daughter’s response, and this acted as a catalyst for her temporary separation from Jamie. They are now back together but living apart and are co-parenting with support from social services.

Jessica describes an incident in which her second child’s father began being very aggressive towards her despite her having their son in her arms: “[my son] is terrified of his dad because he grabbed hold of me shouting and swearing and spitting and everything”. As Jessica was living with her abuser, there were many incidents in which her children were either exposed to or present when IPV was occurring. These
examples demonstrate support for the literature base concerning the impact of children’s exposure to IPV (Blair et al., 2015; McDonald et al., 2016).

Participants shared experiences of the immediate impact of their children witnessing or being exposed to AIPV (Holt, Buckley and Whelan, 2008): Jessica’s son is “terrified of [dad]”; and Milly-May’s daughter “started like, you know, clinging on to me more … then she started cowering and covering her head you know when he would go near her”. Participants also shared instances in which their children were directly victimised by their perpetrator. Instances in which children were held under the bath water, thrown on the bed, burnt, bruised, isolated, and left to cry for prolonged periods of time were narrated by participants.

Existing literature suggests that such experiences and exposure results in children presenting with poor social and emotional functioning, psychological and behavioural problems (including internalising and externalising behaviours), poor physiological functioning and physical health problems, and reduced cognitive and intellectual functioning (Howell, Barnes, Miller and Graham-Bermann, 2016). Such consequences are seen prenatally and continue through adolescence, potentially making these children more vulnerable to victimisation themselves (ibid). It is clear from this participant group that adolescents’ children are at significant risk of direct and indirect harm when their mother is being victimised, and as such any prevention intervention must holistically involve mother and child.

The Interrelated Nature of the Effects of AIPV

From the discussions above, it is evident that there are wide-ranging negative effects of AIPV victimisation, extending beyond the immediate impact on the victim. It is important to note the interrelated nature of these effects and their significant and cumulative contribution to the lived experience of AIPV victimisation (Riger et al., 2002). For instance, Molly’s experience of AIPV included negative impact on her wellbeing (First-Order), manipulation of her family members into believing she was clinically insane (Second-Order), and direct threats of violence and vandalism towards her family (Third-Order) to ensure Molly’s compliance with her perpetrator’s demands. The participants of this study have narrated their experiences of depression, anxiety, substance misuse, and other internalising and externalising behaviours. Such behaviours do not occur in a vacuum; instead, much like the victimisation itself, they are likely to affect every aspect of the victim’s life.
Factors external to the participants will also have likely shaped their experiences of AIPV. For example, the significant shortage of refuge provision and other housing in the current economic climate means that on an average day in the UK one-hundred and fifty-five women and one-hundred and three children are turned away from refuge (Women’s Aid, 2014). Similarly, the availability of free child care, IPV charities offering specialist support, and rapid response mental health care have all been diminished due to the austerity measures currently implemented. Further discussion of the existing efforts to prevent or intervene in cases of AIPV can be found in Chapter 7, and the formal and informal support received by participants and external factors affecting it will be examined in Chapter 8.

Conclusions
This chapter has highlighted the wide-reaching and profoundly negative impact AIPV had on the participants, their immediate families, and wider society (Riger et al., 2002). The First-Order effects experienced by participants were grouped into three categories: physical, sexual and reproductive, and emotional and psychological.

Participants experienced physical effects in the form of injuries, such as bruising, lacerations, and broken bones, and worsening of existing medical conditions, including epilepsy. These effects are often cited in literature exploring the impact of IPV in adult populations, with adolescent experiences minimised. The effect on participants’ sexual and reproductive health was both highly gendered and prolific. Contraception negotiation was implicitly narrated as participants shared many examples of unwanted pregnancies, pregnancy complications, miscarriages, terminations and rapid-repeat pregnancies (WHO, 2012).

The emotional and psychological impact of AIPV on participants was experienced in two ways: internalising and externalising behaviours (Plichta, 2004). Internalising behaviours included depressive symptoms, self-harm, suicide ideation, suicide attempts, Bulimia Nervosa, Body Dysmorphic Disorder, Paranoid Schizophrenia, and PTSD. Externalising behaviours included the misuse of alcohol and drugs, risky sexual activity, and transactional sex. Each of these impacts are significant in their own right, yet many occurred concurrently with one another and with Second- and Third-Order effects. This demonstrates the requirement for additional prevention intervention efforts to be targeted at adolescents displaying any of these effects. Participant experiences of interventions will be discussed in more detail in Chapter 8.
The participant narratives explored in this chapter have demonstrated not only the physiological, sexual and reproductive, and psychological impact on the adolescent victim herself, but also on those around her and her ability to function in her world. Such narratives evidence the significant ramifications victimisation has on the victim’s children and her immediate and extended support network. Child care, financial support, and housing were all provided by members of the participants’ support network, suggesting that housing statistics are likely significant underestimates of the true impact of IPV on homelessness, and may go some way to explain the disproportionate number of homeless adolescents. Without such support the victim’s victimisation would have likely continued and escalated. Violence and property damage were also experienced by participants’ supporters.

Participants described how their victimisation had severe and long-lasting Second-Order effects on their relationships with their family, and particularly with their parents. All of the nine participants who had children described a perceived failure to protect their children as they wished, and severe associated guilt. For three of these participants, their relationship with their children was disrupted due to custody orders placing their children with other relatives. Friends were often pushed away by perpetrators, and participants’ relationships with them terminated due to their victimisation. Participants also described a longing to reignite these friendships, but did not act upon this due to fear of chastisement and embarrassment.

Due to the age of participants it was difficult to gain a full understanding of the impact victimisation had on their education and employment attainment. However, some themes emerged from the available data. Participants described exiting education earlier than anticipated, and a reluctance to return to education at a later date due to their experiences of AIPV. Similarly, employment was negatively affected by victimisation, with participants reducing or giving up work entirely due to the perpetrators’ demands and control.

The direct impact on participants’ family members and children was also significant (Third-Order effects). Whilst this research did not directly contact family members or children, participants, and one participant’s mother, described threats of and actual violence and criminal damage, subsequent significant increases to stress levels, and the physical symptoms of stress. Participants with children [N=9] also narrated family members’ experiences of increasing demand for assistance with child-rearing, and in three cases parents and a sister-in-law took custody of one and four children respectively. This demonstrates the significant impact of AIPV on the parents and family members of victims, highlighting a vital area of future exploration.
Participants who were parents narrated their children’s experiences of victimisation, sharing incidences of injuries, fear, protection of the victimised parent, and signs of internalising and externalising behaviours, supporting research found largely in the adult IPV literature (Plichta, 2004). Whilst the use of Riger et al.’s Radiating Impact Model has allowed a thorough exploration of the impact of AIPV on participants, it is also important to acknowledge the interrelated nature of First-, Second-, and Third-Order effects, and the external factors at play. Victimisation, and thus its impact, does not occur in a vacuum; instead it is likely to affect every aspect of life, as demonstrated by the participants’ narratives. Each narrative shared highlighted the severe and detrimental effect AIPV has on its victims and those surrounding them, promoting a shift of thought from adolescents, their relationships and their IPV as ‘trivial and fleeting’ to a severe and developmentally-significant public health issue. Prevention Interventions must also be developed with this in mind (further discussions in Chapters 7 and 8).

The participants of this study narrated experiences of depression, suicide ideation, self-harm, suicide attempts, and the development of psychiatric disorders including Body Dysmorphic Disorder, Bulimia Nervosa, Post-Traumatic Stress Disorder, and Paranoid Schizophrenia. These findings support the literature regarding adult victims of IPV, subsequently suggesting that the impact of IPV is similar for adults and adolescents. However, there is a significant body of literature which asserts adolescence as a particularly vulnerable time in terms of neurological and social development. Furthermore, experiences of psychological and psychiatric conditions as a result of AIPV may be more problematic for adolescents due to the developmental phase they are in; therefore, AIPV should be regarded as an urgent public health epidemic requiring immediate preventative action.

Locating psychological and psychiatric impact in adolescent victims of IPV also highlights an opportunity for prevention interventions. Ideally, appropriately targeted preventative work with all young people, the design and delivery of interventions which take into account the complexity of existing and developing psychological and psychiatric conditions, and the opportunity to practice and develop self-care and healthy coping strategies would all be included. Furthermore, the experiences narrated by participants highlight the requirement for all young people to have knowledge and understanding of their own wellbeing and how to maintain it, so that they can seek help if and when required. Further discussion of how and what these interventions might look like can be found in Chapters 7 and 8.

The physical impact of AIPV also appears to echo that found in the adult literature, despite the dismissive discourse associated with it (Wathen et al., 2016). Not only
were participants bruised, cut, burned, and stabbed, they were repeatedly and seriously assaulted, resulting in, for example, broken bones, partial blindness, ongoing addictions, and several disclosures of loss of consciousness. Such severe physical injuries require recognition so that we can move beyond the dominant dismissive discourse regarding AIPV and recognise the potential for it to be severe and long-lasting. Furthermore, by recognising AIPV as a public health epidemic, adolescents seeking medical support can also be triaged for AIPV and be identified for prevention interventions. The ways in which participants sought support for their experiences will be explored in Chapter 8.

Pregnancy is widely cited as a catalyst for adult IPV (Burnett et al., 2016). This was also narrated by the adolescent participants of this study. This suggests that vulnerable adolescents who are pregnant are likely to seek medical advice for the pregnancy, creating an ideal opportunity for preventative work, and where necessary, intervention. Furthermore, it highlights a lack of understanding about the nature of adolescent pregnancies and the decision-making process regarding continuation, termination, or adoption for pregnant adolescents.

Not only was pregnancy a catalyst, it was also a technique for isolation of the victim via rapid-repeat pregnancies and enforced pregnancy, which were symptoms of contraception refusal and a technique for demonstrating ownership over the victim. Similarly, the process of deciding to continue or terminate a pregnancy, terminations, and miscarriages within the context of AIPV had significant impact on the participants, with almost one quarter experiencing miscarriage as a result of physical violence. Therefore, by recognising AIPV as a public health issue requiring consistent multi-agency responses, adolescents may be able to be assisted in making informed decisions which are right for them, and enable them to recover from AIPV whilst minimising the long-term effects of it.

The participants' narratives have also highlighted the requirement for holistic interventions which include their friends, family, children, and wider community to encourage recovery. For example, by taking a holistic approach to child custody in cases of AIPV, rather than the current ‘failure to protect’ perspective, participants’ narratives suggest that adolescent parents will be more likely to experience long-term recovery. Similarly, by recognising that adolescents are themselves children requiring safeguarding, support, and guidance, supporting organisations may be better able to keep families together.

The importance of peer relationships during adolescence is widely understood. Therefore, it was not surprising that participants narrated significant distress due to
their isolation from their peer groups as a result of AIPV. Further consideration of the ways in which peer groups can reduce AIPV and limit the impact of it is required. The role of peers in support will be explored further in Chapter 8.

Participants narrated wide-ranging experiences of education. Some found school to be their safe place, whilst others reported truanting, early exit, and poor outcomes as a result of AIPV. The role of the school, college, university, and to some extent the workplace in preventing AIPV should be investigated further to ensure this opportunity for targeting preventative work at an already-engaged audience (See Chapter 7 and 8).

Whilst this study did not set out to explore the impact of AIPV on the families of the participants, there were several examples shared. Such examples highlighted the overwhelming negative impact of victimisation on the participants’ parents and wider families. Further research which explores the impact on families and their role in providing support and requirement for support themselves should be undertaken so that preventative work can fully encompass all those affected by AIPV.

Further discussion of existing efforts to prevent and intervene in AIPV will be discussed in Chapter 7, followed by a discussion of how they can improve, drawing upon the participants’ thoughts on the issue. Implications and recommendations for future research, policy, and practice can be found in Chapter 9.
Chapter Seven - Participants' Experiences of Prevention and Intervention Efforts

The support experienced by the participants of this study varied vastly in terms of quality and source. Issues with access to support, the individual’s awareness of their victimhood, and the way in which support was offered moderated the efficacy and value of the intervention. This chapter firstly considers the obstacles faced by participants in accessing support, namely their struggle to recognize AIPV behaviours and subsequently their victimhood, the invisibility of AIPV and related interventions, the participants’ refusal to initially access support, and their fear of retribution for accessing such interventions. Secondly, the points of access will be explored, considering how participants experienced formal and informal prevention interventions. The participants’ narratives will be presented to demonstrate the key points for improvement, where intervention opportunities were missed or insufficiently utilised for participants.

7.1 Barriers to Accessing Support

One of the key dilemmas when designing AIPV-prevention work is establishing how best to identify and locate individuals requiring support. The phenomenon has, until very recently, remained largely unrecognized by wider society and those able to provide preventative interventions (Bowen and Walker, 2015). Subsequently, those experiencing AIPV have struggled to recognise abusive behaviours within their relationships or have deemed themselves unbefitting victims due to their age, marital status, and/or living arrangements. This demonstrates why careful choice of language, for example using intimate partner violence rather than domestic violence, is required beyond the research sphere.

Participants narrated their stories retrospectively and therefore were able to frame their experiences within a learnt assumed meaning of what constitutes abusive relationships. Yet, many stated they were unable to recognise abusive experiences at the time: “I didn’t realise, I wasn’t educated” (Stephanie); “I hadn’t been in a relationship before; I didn’t know what to expect” (Lily). This inexperience discourse suggests that by being unaware of what constitutes AIPV, the participants were unable to protect themselves from it or identify when they needed to ask for support. Ishara builds on this by suggesting she knew something was wrong, but without knowledge of what support was available she could not confirm this or prompt an attempt to leave:
I wanted to move out within a year, but I didn't have anywhere to go, and I didn't have any money [K: Mm], I didn't have any family, I didn't have any friends, I didn't have anybody to advise me.

It is particularly interesting that this discourse was also present in Ishara’s narrative, as she had witnessed and experienced IPV between her parents and caregivers. Ishara lived in the volatile family home until the age of nine, when her father killed her mother in front of her and her younger sister with an axe. Following her mother’s death and her father’s imprisonment, Ishara moved in with her maternal grandparents for two years, where she also witnessed IPV. Whilst Ishara recognises these experiences as extreme, she felt at the time they were “normal”. Consequently, she had no experience of healthy relationships to refer to. When speaking about her father, she expressed his assumed patriarchal right over his wife and children: “he owned us, so he could do what he wanted with us”. This is perhaps why she then described feeling a duty to fulfil a patriarchal role within her first serious relationship at the age of sixteen:

I had no experience of relationships I thought that was normal [K: Yeah], thought that’s the way it was. I thought that’s my duty, as a female to clean up tidy up, to make sure everything was right at home and get a little part time job. I thought it was my duty to have sex with him. It was my duty to do so.

Ishara and her sister had been wards of the court and therefore were known to social services. Ishara’s experiences highlight an inadequacy in current support strategies put in place to protect vulnerable children and demonstrate the need for continuing support to ensure victims of AIPV do not end up in abusive relationships themselves. Ishara felt that she was failed by the systems which were intended to protect her, and later, her daughter. In order to prevent others from having similar experiences, Ishara has begun working with an IPV charity to support victims of AIPV.

During Lily’s first relationship at nineteen, she found herself reluctant to ask for help in order to prevent herself being viewed as a victim, or in some way weak. Subsequently, Lily placed herself within a saviour discourse:

I wanted to be the one to like fix Leanne, I wanted to be the one that was so special she would change … well, I was in denial. Like obviously I knew what was going on was wrong but there was no way I’d tell any of my friends.

This suggests that Lily placed more value on her perceived ability to ‘fix’ Leanne than she did her own wellbeing – evidence of low self-esteem and confidence. She goes on to suggest that this compulsion to ‘fix’ Leanne became her priority, regardless of any offers of support:

When I was I was with Leanne I don't think I would have accepted any help because I didn't really realise like looking back now it's easy to say yeah help would have been really beneficial but when you’re in that moment at that time I would have turned it down anyway.
This suggests that some adolescents may find it difficult to separate their emotional selves from their rational selves in order to recognise AIPV and seek assistance and/or exit the relationship, and therefore strengthens the argument for universal healthy relationship education (discussed further in Chapter 8). This is perhaps particularly the case for Lilly who, as a lesbian, would have been required to seek help in an environment which assumes heterosexuality (Donovan and Hester, 2015; Potter, 2015). Similarly, some participants felt they were inappropriate targets for IPV support.

Jemma struggled to accept her boyfriend’s ex-partner’s warnings:

I heard he, well, he used to hit all of his girlfriends and I used to think oh alright yeah. And basically it were wrong what they had been saying. I had his ex-girlfriend text me and warning him, well warning me that she, well he had locked her in a cupboard and smashed her phone, so yeah. I didn’t believe it ‘cause I was immature.

Molly’s perpetrator’s ex-wife tried to warn her about him at the beginning of their relationship: “look, he’s tried to run me [ex-wife] over’ and I was like, you know you don’t believe the ex do ya”. This refusal to acknowledge risk, or perhaps the source of information about risk, led Molly to invest more heavily in the relationship. It then came as a surprise to Molly when her antenatal health worker began suggesting her experiences were abusive. This prompted her to question her referral to the Freedom Programme at her local IPV charity: “I was like ‘domestic abuse?’ That wasn’t me and Michael”. However, after a few sessions she found herself realising that she had been victimised: “and I went ‘oh my god oh my god’”.

Skye found it difficult to accept her mother’s attempts to separate her from her abusive boyfriend, and found that these attempts enhanced her desire to work at the relationship:

You can’t say ‘ooh get out of it, get out’ cos my mum used to do that, and I just think, thought to myself ‘well I’m guna make it work now cos everyone doubting me.’ So really everyone doubting me and saying stuff to me just pushed me closer to him.

Similarly, Stephanie disagreed with her social worker’s identification of IPV within her third relationship, even after her children had been removed from her care through the courts due to her abusive partner:

The social worker didn’t like it the way he told me to shut up, erm, I never heard him say it but she says she heard him call me a dirty bitch, erm, and just things in general that, that she sees as offensive and I don’t [K: Right] right, and it’s like ‘hold on you find that offensive?’ That’s nothing compared to cos of what I’ve been through right, she hasn’t been through anything I’ve been through so my understanding and her understanding of what domestic violence is totally different! … She said that I also don’t have the concept of what domestic violence is. Hold on that’s the one that got me! I’ve been through not been through domestic violence I’ve been tortured [K: Mm] physically and mentally.
This quote suggests that Stephanie’s tolerance levels for AIPV have increased due to her extreme previous experiences, including forced intravenous drug use, sexual assaults, being beaten up, and the loss of an unborn child due to an attack with a combat knife. Subsequently, she appears to be more accepting of psychological and emotional abuse. Interestingly, her ongoing custody battle does not appear to have highlighted the psychological violence within her continuing relationship. Yet, when probed for further information, Stephanie recognised the value of the space and support she has received since losing custody of her children: “I know this sounds horrible but being away from the kids has actually made me see what, where I’ve actually gone wrong”. Despite the participants’ initial struggle to identify risk in their relationships, many received formal support as detailed below.

7.2 Participant Experiences of Support

Each participant had received some level of support for their experiences of AIPV. Whilst the point of access to support varied, as demonstrated by Figure 7A, some sources were accessed more frequently than others.

Figure 7A shows that the most frequent prevention interventions accessed were IPV charities [N=14], followed closely by refuges (often linked to the IPV charities) [N=11], friends and/or neighbours [N=11] and parents, grandparents and care givers [N=11]. Medical support, via GPs, hospitals, and antenatal and postnatal health workers was accessed by nine participants. Parents and care givers provided support for eight participants. Social workers, the police and/or criminal justice system, and the Freedom Programme were each accessed by seven participants. Three participants received support from therapists, whilst two participants received support from schools or colleges, workplace or colleagues, and IDVAs. Community Mental Health Teams, MARACs, and the National Domestic Abuse Helpline were each accessed by one participant.
The prompt for initial help-seeking depended on the individual’s circumstances and availability of effective support from informal sources in the first instance. Section 7.3 will firstly explore the participants’ experiences of informal support, for example via friends and family, followed by a consideration of how formal support was accessed and experienced.

### 7.3 Participant Experiences of Informal Support

Friends were the most frequently cited source of informal support [N=14], however, the support received was not always positive. For example, Lily felt unable to talk with friends about her experiences of AIPV, as they were judgmental and impatient:

> *Erm … they couldn’t understand why I couldn’t just walk away because they said you know, ‘what’s the matter with ya? Why are you standing for this?’ … Erm, my best friend was like trying to force me, like she said ‘you’ve got to walk away from this it isn’t right, it’s not healthy, she’s a terrible girlfriend. Are you really happy?’ You know, she says ‘you can’t be bringing any positives from this’ … But, they just, they thought I was an idiot, they thought I was an absolute idiot. I lost respect off people for staying with her [K: Mm] cos they were like ‘just get a backbone Lily, do something about it.’*
Sarah experienced a friend sharing images of her injuries online without her consent in order to shame her perpetrator. Unfortunately, this led to her experiencing severe humiliation, leading to her withdrawing from her friendship group and becoming more isolated: “she snapped and just told everyone about it because she had taken pictures of all my bruises, so she just put them on Facebook to show everyone”. These examples demonstrate how damaging and detrimental judgmental support can be, and how appropriate consensual support is vital in limiting the damage AIPV causes.

One of the key aims of support for victims of AIPV should be to empower them to have autonomy over decisions affecting their lives, something often lost through AIPV victimisation. There were many positive experiences of support from friends narrated by participants. Natalie describes how on identifying AIPV within her relationship a friend suggested she seek medical treatment. This was proposed in front of her perpetrator but in a way which protected Natalie from further victimisation, and empowered her to not only tell the hospital about her abuse, but also to document her injuries with the police:

_He did the sweetest thing because he knew something was going on … he convinced Ken, he sort of, ‘oh it won’t be no trouble, I’ll get the car and take her to the emergency room, she’ll get an x-ray just to make sure nothings broke then I’ll drive her straight back … you don’t have to give me any money for it and she’s not going on her own’ … [the] minute I got in the car he’s like ‘why don’t you leave? We’ll look after the kids’. [5 second pause] I think I knew if I’d stayed long enough I would be dead … so I went to the hospital and I told them exactly what happened so I had it documented … and I also reported it to the police [K: Mm], but he took me to the police and waited outside._

Further discussion of the formal support Natalie received can be found in Section 7.4. Amy was fortunate to have a best friend whose mother (Theresa) worked in a young people’s IPV charity. When Amy began experiencing AIPV she felt she received well-informed, patient, and non-judgmental support from her network of friends:

_Theresa and Sophie and my mum and my family like all my friends, everyone just was saying to me ‘why are you even with him? Like he’s treating you like crap and you’re down all the time, crying, he’s not good for you’ … Theresa actually got me, it was like a little bookmark, thing, and one side it said ‘loves me’ and on the other it says ‘loves me not’ [K: right] and then like he literally did nothing on the loves me and I was like, ‘oh, right’ … she got me a little booklet as well saying what emotional abuse is and stuff and it like has examples. And like things that he would, that people do when they’re emotionally abusing people and things what they don’t do [clears throat] and like he pretty much did, like it sounds horrible but he pretty much did all of what they did … [I felt] crap, cos I just like woke up to the fact that he was actually not a nice person … when we broke up they were saying we could hang out and go for a couple of drinks, and that we can all go out and do something for the day._
Theresa provided the tools, a bookmark and leaflet, for Amy to consider her options in her own time, whilst friends and family helped her realise the negative impact her experiences were having on her and her other relationships. These two key approaches, together with distractions when the relationship ended, meant that Amy not only recovered quickly from her experiences of AIPV, but also empowered her to have full autonomy over her decisions and future relationships.

Similarly, when Rachel had experienced severe physical injuries, a friend stepped in to offer her a retreat in which to recover:

*My friend Charlie, he came to pick me up because Karl was really angry that mum and dad had phoned the police, so I went to stay at his apartment for a bit in [town] so no one knew where I was.*

A family friend also offered support when Rachel was not speaking with her mother: “my mum’s friend Kathy … I used to ring her up all the time and tell her about Karl and she didn’t like it, but she used to listen to me cos I weren’t speaking to my mum”. This sort of patient, non-judgmental, and consistent support meant that Rachel had at least one confidant, even after being isolated from the majority of her friends and family. Sarah also had one friend who listened and was there to support her throughout her abusive relationship: “every time we had an argument, or I’d go down hers and she’d be straight there with me and she’d drop anything to just be there to help me [3 seconds] just to talk really”.

Stephanie required more specialist support from her friends due to the complex nature of her recovery following forced intravenous opiate abuse, a sexual assault causing her to lose a baby at eight months gestation, and on discovery that her new husband was in fact a convicted paedophile. Stephanie found such support in a friend who had herself struggled with substance misuse:

*She err got me clean. Got me back into college, got me to get my life back in order and got me back talking to my parents … she said ‘are you guna let this bastard bloody ruin your life, be like this for the rest of your life?’*

Sometime later, during Stephanie’s second abusive adolescent relationship, it was a neighbour that assisted her:

*[My] next door neighbour called the police because he heard me screaming and then erm, once Jim had left his missus came in and I was curled up on the floor and she was like ‘ah shit we’d better get you to the hospital.’*

Natalie identified a key missed opportunity to access support through a colleague:

*I had finger print bruises on my face and the most I got was, ‘oh your face is dirty what’s that on your face? Oh, it’s not coming off. Do you want some foundation?’ That was it. No ‘oh what’s happened?’*
This encounter could have provided Natalie with a confidant, but instead it left her feeling embarrassed and further isolated. Experiences like this highlight the necessity for a greater awareness of AIPV and how best to probe for information and offer support. Conversely, Rachel describes how she received positive support, and also how she has empowered others to provide appropriate support for colleagues who are experiencing IPV:

[...]

Rachel’s positive experiences at work, and her resilience in terms of passing on that support, identify inappropriate behaviour which could worsen someone’s experience of adolescent intimate partner violence. Whilst young adolescents are less likely than adults to be in employment, such support could also be provided by friendship groups at school, college, university, and other social groups, such as Girl Guides, sports teams, and other extracurricular clubs.

Eleven participants received support from parents, grandparents, or care givers. Whilst this support was similar to that provided by friends, it often had a (not necessarily successful) more authoritarian character. For example, Jemma’s mother joined forces with the Community Mental Health Team in an attempt to separate Jemma from Neil: “Mum used to come round with the mental health team and my mum said, ‘oh I’ll disown you otherwise, you’ll have no family’, erm, if I didn’t stop doing [amphetamines]”. This dual approach was unsuccessful. However, the welcome at her family’s home remained open, and was drawn upon approximately a year into Jemma’s abusive relationship: “[After] surgery on my leg I stayed at mum’s and dad’s for two weeks, they wouldn’t let me out now I’d finally come home”. Jemma viewed this two-week respite from Neil as a necessary step to get the mental health teamout of her life. Unfortunately, Jemma felt trapped in the house, and with Neil persistently offering her amphetamines, she subsequently returned to his flat to continue their relationship.

Eventually Emily’s grandparents had had enough of supporting Emily and banned Jimmy from their house. In response, Emily left as well:
As soon as he come [sic] off tag I had him stay at me nana’s. My nana found out and he was barred from the house … they thought he were bad for me. So they barred him. Cos that stops a teenage girl! [Laughs] Eventually I went ‘you kick him out, I’m going too’, she went ‘see ya later then’ … she found out where I was staying, started ringing me, ‘come home now’.

It would appear her grandparents’ strategy backfired and led Emily to spend more time with Jimmy, increasing their concern and demands for her to return home. Stephanie echoed Emily’s rebellion against her grandparents’ attempts to separate her from Neil: “they were trying to get me away from him but the more they were saying ‘no you can’t be with him’ the more I wanted to be with him”. Likewise, Sarah’s mother issued an ultimatum: leave Kieran or leave the house. Initially, Sarah chose Kieran, although several weeks later she returned to her mum’s following the escalation of violence whilst the couple were cohabiting:

Mum found out about him hitting me once erm, and she were angry that I didn’t tell her erm, and I was round and she was basically saying ‘you need to leave him and if you don’t then you’re out’. I think she was just trying to scare me really and get me to leave him. … [A few weeks later] I was going back home, begging my mum basically but she said she was fine with me being back.

Whilst Sarah’s initial choice to leave the family home appeared to be in defiance of authority, she quickly realised the error of her decision and returned home. This suggests that authoritarian ultimatums may be beneficial in ceasing a teenager’s abusive relationship. However, as Sarah disclosed, the risk to her health was vastly increased during those two weeks. Amy’s parents also banned Adam from staying at their house, although he was allowed to visit:

They obviously didn’t like him, they didn’t stop him coming round here they just stopped him staying over. My dad was angry and banned him staying here like after a bit cos I was getting too upset and stuff … and to be fair my mum did as well cos they obviously didn’t want to see me upset … my mum was trying to comfort me but she was trying to like, tell me in a calm way.

Amy went on to describe how, at the time, this strategy led to further conflict between her and Adam, and an increase in time spent with him away from her parents’ supervision. However, in hindsight she agreed it was the right thing for her parents to do in terms of demonstrating their unease with her relationship. This contradiction suggests that, as with Sarah, initially banning Adam from the house put Amy at further risk. Evidence suggests that cohabiting with a perpetrator increases the frequency and severity of AIPV (Manning, Longmore, and Giordano, 2015). Ideally, this risk could have been mediated, potentially by an external source, such as friends or college tutors. However, Amy accepted and approved of her parents’ intentions, suggesting that parental interventions do have a place in the prevention of adolescent intimate partner violence.
Milly-May had a fraught relationship with her mother. Having spent much of her childhood in and out of refuges in order to escape parental domestic violence, Milly-May had hoped for some support from her mother at her time of need. However, this was not the case.

_She just told me to [leave] and that were it. And then I asked if I could come back to them and they said no. So I had to stay [with Ricky]. I did want to leave but I didn't really have much option, kinda thing, so basically I was just stuck, they wouldn't have me back._

By refusing to accept Milly-May back into the family home she felt stuck. Despite previous experience of IPV interventions, she felt her only option was to remain in an abusive relationship. Unfortunately for Milly-May, this led to an increase in frequency and severity of AIPV, the loss of custody of her daughter, and her eventual referral to a women’s refuge. Milly-May’s story demonstrates how important familial support can be when a teenager is experiencing IPV.

Rachel also had negative experiences of familial support. Whilst her father was willing to take her on secretive food shopping trips at the height of Karl’s IPV perpetration, her mother and twin sister dealt with the situation very differently.

_Robyn used to make things worse, my sister. Cos we’re twins and, she used to make it worse by, knowing that he’d read all my text messages anyway, she’d text him, text me saying ‘are you still with that knob head, is he there?’ She thought it was funny. … Mum and dad had forgiven him, even though they, they didn’t want to but they did it, they did it for me. Robyn didn’t, she said she wouldn’t go [to a birthday party] if he was going. Then she ended up going but then she, she told everybody in the family … what he’d done before._

Rachel expressed at various times throughout the interview how disappointed she was in the lack of support from her twin sister, the person she felt closest to. Robyn’s provocation led to various incidents of physical violence and vast amounts of psychological abuse, including Karl’s insistence that Rachel move out of her flat with Robyn and back to her parental home. Rachel’s story demonstrates how siblings and those close to victims of AIPV may feel irritated by their choice to continue in an abusive relationship. It also demonstrates how directing that irritation at the victim may well put them at a greater risk of violence. Consequently, any preventative measures must include the education of those around the couple, as well as those in the abusive relationship.

The ability to access such vital support from informal channels had a considerable impact on the participants’ recovery from physical and psychological violence. Whilst some participants had more positive experiences than others, each example demonstrates the most effective support friends and family can offer: no judgement, patience, time to listen, a quick response in times of physical injury, and careful
consideration of the potential retributions for ill-conceived support. However, as demonstrated throughout previous chapters, adolescents are less likely to have the skills or experience in supporting others in this way, calling into question their ability to support peers in an appropriate manner.

7.4 Participant Experiences of Formal Support

Official support providers and prevention intervention services were accessed in various forms by all participants. Whilst Amy did not access such support through traditional routes, she did receive support from her best friend’s mother who was a staff member of a women’s refuge, potentially diverting her away from more formal routes of support. The formal interventions accessed by participants were schools and colleges, health services via GPs, hospitals, antenatal and postnatal health workers, therapists, IPV charities, Victim Support, the Freedom Programme, the National Domestic Abuse Helpline, IDVAs, the Community Mental Health Team, CAMHS, Social Services, women’s refuges, and the police and criminal justice system. This section will consider how each of these official interventions were accessed by the participants and how they were experienced.

Interestingly, no participants cited their school or teachers as a source of information regarding AIPV. Although, Lily cited her favourite teacher as a source of general support: “I would happily sit with my favourite teacher and talk and talk”. Lily’s first experience of AIPV came at age nineteen, so it was not possible for the said teacher to offer support in her case, yet her narrative demonstrates that teachers can offer positive support to adolescents. Natalie identified school as an escape from her experience of parental IPV. An initial attempt to provide her with support following the recognition that she was truanting failed when her mother threatened the teachers. Subsequently, she claimed that the school was unsupportive when she fell pregnant at fifteen years old:

School was my escape. It was where I could pretend everything was normal ... I think they picked up on truancy at one point. And I, I hadn’t told them any details, but I basically told them it’s all shit everything’s shit ... they got my mum in and my mum threatened the teacher so they refused to talk to my mum ... then I got pregnant in the fifth year and no one mentioned it. There was no support; no nothing ... I slipped through the net.

Although there was little evidence suggesting a link between teenage pregnancy and AIPV whilst Natalie was in her teens during the 1980s, there is now a growing body of literature (for example, see Wood and Barter, 2015). Natalie’s experience therefore
highlights a key opportunity for schools to identify truancy, misbehaviour, and teenage pregnancy as risk factors for AIPV, consequently highlighting the identification of such factors as an opportunity for formal support to be offered.

Nine participants had contact with medical services due to physical injuries. They suggested that they were not offered, nor did they seek, AIPV interventions. Participants narrated telling elaborate stories in order to reduce suspicion regarding the origin of their injuries. It appears the participants did not want to draw attention to their suffering for fear of judgement, potential police intervention, and/or risk of retaliation.

Psychological support was sought by five participants once they had exited their abusive relationship(s) and/or entered women’s refuges. For example, Sam suffered from depression and anxiety and often self-harmed. Her support worker from the women’s refuge chaperoned her to her GP: “I’m on antidepressants and I’ve been weight lifting instead of self-harming. It sounds weird but it causes like a good pain”. Medication plus a practical solution to her urge to self-harm has drastically reduced the frequency of suicidal ideation for Sam. Milly struggled to identify her psychological reaction to her experiences of AIPV. With the help of her support worker she recognised paranoid thoughts, insomnia, and anxiety, and sought assistance from mental health professionals:

*I’ve got, an appointment at the doctors cos there’s more anxiety kind of thing [K: Mm] I were, I was walking straight home and be like, oh this is going to happen to me and stuff so [laughs], and then I’m not, I were not sleeping, I was getting like 3 hours a night if I’m lucky [sigh].*

Similarly, following several months of support from her outreach worker, Jane reached out to her GP for help with anxiety and depression, but at the time of the interviews was waiting for a counselling appointment: “I’ve not had the referral to counselling yet but I went back to the doctors this morning cos I’m suffering with anxiety so they’ve all this heart burn and stuff, they’ve doubled my antidepressants now and I’m also on beta-blockers”. There is ongoing debate regarding the efficacy of antidepressants as the sole treatment for anxiety and depression (for example, Spina, 2016), however, Jane and other participants cited waiting ten or more months before receiving talking therapies. Jane’s story highlights the current issues with NHS mental health provision for abuse victims.

Mental health referral waiting times have been enforced since April 2015, however, they appear to have done little so far to address the disparity between physical and mental health waiting lists (NHS England, 2016; Murray, Richards, Newton et al., 2013). With vast evidence suggesting those who have experienced AIPV are
significantly higher risk of developing mental ill health (Salom, Williams, Najman et al., 2015), these failures are directly affecting victims of AIPV.

Nonetheless, when Stephanie was thirty-six weeks pregnant and at immediate risk of suicide, the support she received was satisfactory. After refusing antidepressants for fear she could not look after her young children, Stephanie was advised to admit herself to a psychiatric ward for recovery:

_I saw a doctor and she turned round and said ‘are you depressed?’ And I was like ‘depressed ain’t the word. I want to kill myself’. And she was like ‘right ok. We can’t actually allow you to do that’ so she turned around and said ‘right ok we got to err sort you out’. She gave me some antidepressants but within two days I stopped taking them cos I couldn’t function … went to the doctors, they turned round and said I can either sign myself in to what I call ward 10 or they can get a court order for it. Because I was pregnant so it was like right ok … I went for a week and with their help and everything else I got myself sort of sorted._

Whilst this can be seen as an example of NHS care working as it should, there is some doubt that Stephanie, or any other suicidal victim of AIPV, would have had this opportunity to access residential support had there not have been an additional risk to an unborn baby. The NSPCC report that one in three children who have been abused are unable to access mental health care (2016). The charity found that abused children often have to develop chronic mental health problems, be suicidal, or be self-harming before services become available to them. Furthermore, 78% of professionals surveyed felt there were significant insufficiencies in existing CAMHS provision (ibid).

As mentioned above, Jemma’s mother had assistance from the Community Mental Health Team (CMHT) when trying to separate Jemma from Neil. When Jemma refused to return home with her mother the CMHT considered sectioning her under section 3 of the Mental Health Act 1983:

_The mental health were guna section me [laughs] … my mental health workers were trying to get me out of the situation from taking drugs and getting me away from him … they were going to section me. Erm, because I was so underweight at the time from being on the amphetamines. It was about, I was, erm, seventeen, eighteen and I was only seven stone, maybe under. They tried talking to me first, then it comes across as if you don’t do it, I’m going to section you basically._

Fortunately, Jemma agreed to move to a women’s refuge in another town in order to detox and begin to recover from her mental and physical ill health caused by her experiences of AIPV. Whilst Jemma’s access route to IPV charities and women’s refuges was extraordinary, the majority of participants were also referred via other services, such as GPs, Victim Support, antenatal health workers, social workers and the National Domestic Abuse helpline.
When narrating their experiences of support, many participants conflated IPV charities, Victim Support, and the nationally available Freedom Programme offered by such charities to victims of IPV. Support from such sources was multi-faceted, with participants receiving support from an allocated case worker [N= 14], spending time in refuge [N= 11], attending the Freedom Programme [N= 7], and receiving support from other attendees of the Freedom Programme. Positive experiences were had by all, with some championing the support they received. Jane, for instance, narrated the following:

My [Women’s Aid support worker] she'd been really supportive, I can ring her anytime and I meet with her once a fortnight. She helped me get a cooker, a washing machine. Erm, so she helped me in that way. I was scared of going to the doctor even though I needed a sick note so she came with me and that’s when I ended up telling her about the drinking [K: yeah] and she’s referred me to [Substance Misuse Charity] so she’s been really supportive. I don’t know what I would have done without her really. And she’s still continuing to support me … going on that Freedom Programme helped me massively [K: Good] I still question myself, why, why, why? But after the Freedom Programme I can’t believe how widespread it is and it’s opened my eyes. I appreciated hearing others’ stories too … I wouldn’t mind doing the Freedom Programme again, could have a good cry in there … we’ve all got each other’s numbers.

Jane also identified specific practical things the IDVA at her local Victim Support were able to provide for her, whilst identifying an ongoing insecurity – her ex-partner knowing where she lived. Jane was put on to the social housing register, and due to her complex vulnerabilities, she was moved into a flat of her own in a location unknown to her ex-partner:

The IDVA lady came out to the house and it went alright actually, I felt as though she was dead supportive. I remember her asking me loads of questions and she mentioned having the locks changed and that was like, such a relief for me, and then she was talking about window alarms and then she looked and my smoke alarms wasn’t working so she organised for me smoke alarms to be fitted. Erm, she made me feel safe. It helped definitely, cos I knew that he couldn’t get past that door but it didn’t change that he still knew where I lived … I’ve got DV markers on [the flat] and window alarms.

The Freedom Programme was also championed by those attending it:

It was good me going on that meetings cos it did help … I wasn’t [confident] at first because I was thinking I don’t know anyone and it’s a bit embarrassing to, to tell people about yourself and, and, but then when I heard other people’s stories as well … It’s helped me get back to how I used to be and to know about future relationships and things like that. That’s really helped me. (Rachel)

Going on the Freedom Project [sic] has helped me open my eyes up to what actually he is doing and now it’s given me the confidence to turn around and say no. (Stephanie)

Three of the seven participants who had attended the Freedom Programme identified a significant weakness in the way it was delivered. For twelve weeks the group would
meet and discuss the tactics used by perpetrators. On the twelfth week a celebration meeting would be held before the group was disbanded. The women felt that they had been taught how to spot the signs of abusive behaviour, however, they had not been given the tools to continue life as independent women, as Molly describes:

Looking back, especially after going to the Freedom Group [sic], I can see the tactics and the way he did stuff … it’s been a real eye opener really … it’s a good couple of hours that you’ve got away from the kids because they’ve got a crèche so we like go and have a brew … the group were really good actually and they put me in touch with a few other people like Homestart and stuff … well, the course is like here’s how to spot one in the future good luck, off you go [K: mm] cos, cos, cos ev’ even though it’s done and we’ve learnt how to spot it in the future there’s nothing to help us with, how things are left, and a lot of people on the course were saying the same thing. Erm, you know like, if just like, support being strong enough to say look I don’t like that and if you don’t like something erm then stand up and say do you know what I mean?

Three participants knew how to access refuge support due to childhood experiences of them. One participant had a friend who was also staying in another refuge and had encouraged her to seek help. The remaining seven participants were referred to refuge by other sources, such as medical services, IPV charities, and Victim Support.

Of the participants who spent time in refuge [N = 11], seven did not have access to the Freedom Programme as their stay(s) in refuge did not coincide with the beginning of a new programme. However, they did receive support whilst in the refuge beyond the emergency housing offered to them and their children. Experiences varied for each participant, with some expressing their time spent at a refuge as negative: “I was in the woman’s refuge and that just done my head in cos that, I didn’t like being there. Like it was like ‘why am I here? I’m going nuts and I’m guna do somethi ng stupid’” (Stephanie); “I got massively bullied” (Ishara).

It didn’t help me cos of my depression and cos we had to talk about it … I was there for three weeks I think … I understand that they have to do, the one on one meetings, but I think it’s wrong that when you come out of the relationship they bring it all up what you’ve been through. Cos you’re trying to get over it but you’ve got to relive it [K: Mm] three times a week in these meetings. (Emily)

Others found the support from the other residents vital: “they’re like my new family” (Sam). The frequent one-to-one sessions with allocated support workers were often described as difficult to go through but important (Molly, Emily, Natalie, Sarah). Natalie was able to comment retrospectively about her time in a women’s refuge in the early 2000s:
Eleven months I was in the refuge for ... it was staffed twenty-four hours, which has its pros and cons. It’s a lot more structured because there’s someone there all the time ... the downside is its more institutionalised. The staff were good, so I got the support from the staff but then that was probably because I was there eleven months, whereas the average stay was three months ... counselling wasn’t great because the only room you could have was right next to the living room and all the kids are screaming ... and due to it being voluntary the person changed all the time.

The issues Natalie identifies here are echoed by the support staff at the refuges and IPV charities (discussed in more detail in Chapter 8). The refuges worked alongside local housing associations to re-house the young women following a ‘positive turnaround’. Sam, for example, stayed in the refuge for sixteen weeks before she was offered a house to move into. Likewise, Milly-May was offered the opportunity to pick an area in which she would like to move to and was able to be heavily involved in the process of relocation, essentially reinstating her autonomy over lifestyle decisions.

Many of the participants had not moved out of the refuge at the time of interview, and therefore were unable to comment on the support they received after a residential stay. However, Natalie narrated a decline in support once an adolescent had moved on: "[when you leave the refuge] that’s when the problems start and that’s when the support drops off". This lack of support post crisis intervention was previously identified by Molly regarding the disbandment of the Freedom Programme. It therefore appears that in order for any intervention to be experienced positively and have lasting benefits, it must be long term.

Once her local IPV charity was aware of the risk Emily was exposed to through her ex-partner, she was referred to a MARAC (Multiagency Risk Assessment Conference). She felt that they worked hard to ensure she was no longer at risk and ensured she was part of the decision-making process:

    MARAC have been fab', fabulous, I was [sighs] she was on the phone to me, had the police come check on me at the house, had alarms put in, had me in, if I wanted probation or an extra police or whatever at the meeting she’d make sure they were there … my MARAC worker was, I couldn’t have asked for anyone better.

Emily’s experience of her MARAC clearly demonstrates the positive effect multiagency work can have on victims of AIPV, especially when the person considered at risk is empowered to make choices about their own support.

Three participants were referred for therapy by the refuge they had accessed, medical staff, or their outreach workers. Ishara was referred by her postnatal health worker when she began having distressing nightmares:
[I] started getting repeat nightmares, and erm, I went to the weigh-in clinic and I said to the health visitor, ‘I can’t sleep, I’m having nightmares where I get killed and my daughter gets killed’, and I got a very, very good therapist [K: Hmm] who I was seeing for two years. I used to see this therapist every week and she made me realize for the first time in my life that women, women can live on their own and you don’t need men and you can do it on your own and she kind of put that into my mind over a year. She would say things like ‘it isn’t your duty to have sex with him, you don’t have to have sex with anyone you don’t want to have sex with’.

This long-term support (twenty-four months) enabled Ishara to change her patriarchal, gendered assumptions, and empowered her to make positive life-changing decisions.

The NHS now offers twelve-week blocks of therapy for those referred, but the waiting lists often run beyond twelve months. This means that refuge and outreach staff try their hardest to provide the missing support, but with minimal the resources to do so.

Natalie had first-hand experience of this:

*I spoke to my outreach worker cos she came round and she basically went ‘ooh this is all a bit above my head, erm, do you want me to refer you to someone else?’ ‘Erm no I’ve known you for eight months that’s the only reason why I’m telling you this stuff. Not going to tell a stranger’.*

Natalie’s experiences also demonstrate how vital consistent support is. With the average stay in refuge at three to four months, and the NHS offering just twelve weeks of therapy after significant waiting times, all of the participants experienced inconsistent and short-lived support due to major resource shortfalls.

As the participants’ stories demonstrate, the sources and quality of support experienced varied greatly. In order to draw conclusions from their narratives, the participants and gate-keeping staff were also asked to put forward suggestions for improving such support, as will be discussed below.

### 7.5 Improving Existing Prevention Interventions – Participant ideas

The participants of this study were asked three questions about their experiences of support and how they think prevention interventions should be designed and delivered:

1. How do you think AIPV could be reduced or prevented, if at all?
2. What do you think victims of AIPV need from interventions?
3. What could have helped you to recognise potentially violent behaviour in your teenage relationships?

Four main improvements were raised by participants: preventative education should be embedded in the curriculum; there should be greater awareness of AIPV within the
wider community; outreach support should be high quality, consistent, and empowering; and a review of how the criminal justice system and partnering agencies manage AIPV in practise, policy, and legislation should be conducted.

The participants felt that preventative education should be embedded within the curriculum, in an age-appropriate manner, throughout primary, secondary, further, and higher education:

To reduce it, it should be brought up in schools, in secondary school sex education, I, I, I think you should be informed about what’s right or wrong in a relationship cos you don’t you just get told about STIs and well yeah that’s great and all but if you’re in a relationship that’s violent and not knowing how to handle it, knowing about an STI clinic is not guna help you … I think you need more support out there. Erm, I know there is support but it’s few and far between, but people need to know about it and I do think there needs to be more support in certain areas. (Emily)

If I had this information in high school I would have been more aware … I definitely think it’s better for younger girls and boys to be taught stuff like this … I think it would bring out confidence in young people … like year six should go on the Freedom Course [sic] … I think there should be a confidence course. (Skye)

Participants felt that such education should be delivered to everyone, regardless of faith, location, or sex:

Rather than like, doing religious education lessons and stuff like that, they should do, you know, lessons on, you know, spotting signs of, control, domestic, stuff like that [K: Mm] I think that should be a subject at school. Not just for girls, for boys as well. (Milly-May)

Participants felt strongly that both sexes should receive such education concurrently to counter any myths one sex might have about the other, and to foster better group cohesion. The participants reported feeling strongly that prevention education should be more than simply raising awareness, it should aim to empower adolescents to make safe choices. It should include practical aspects, such as the opportunity to practice giving consent, which help to develop individual emotional maturity, confidence, and resilience: “there should be some sort of personal development work on the curriculum for boys and girls when it comes to relationships and emotional intelligence at an early age” (Natalie). Participants also felt especially strongly about such education reaching everyone, so that no matter what the official support available to them, friends would be able to offer initial informed support before AIPV escalates.

I hadn’t been in a relationship before, I didn’t know what to expect … but for someone I trust to actually say ‘no it’s wrong and it shouldn’t be happening, and if it does you shouldn’t be there. Don’t put yourself in that situation’. It probably would have made me realise a lot sooner. (Lily)
Awareness among adolescents is the foundation of what the participants felt needed to be increased in the wider community. Many adults view adolescent relationships as ‘trivial and fleeting’ (Collins, 2003), yet if they recall their own, many would agree they are not experienced in that way, and hence are important to the individuals involved. The participants argued that in order for preventative interventions to be experienced positively, those delivering them, whether formal or informal, should be aware of the phenomenon they are dealing with, and react to it with care and without judgment: “teachers should be trained in that, or it could be an outside organisation” (Lily); “With Jimmy, people were telling me what’s right and wrong and I think, people in domestic violence relationships, they know what’s right and wrong, they’re not stupid” (Emily). Whilst it was recognised that this will not happen overnight, many felt it must be tackled immediately and on an ongoing basis.

It was believed by five participants that AIPV is a normal phenomenon which occurs when two individuals clash, and hence cannot be prevented, yet interventions may help to minimise the harmful effects of AIPV. Whilst others disagreed that prevention is impossible, all participants believed that interventions should be high quality, long term, and consistent. Jane suggests there should be a walk-in centre for those seeking information or assistance: “fortnightly meetings, walk-in centre where I could just go to and speak to someone”. It was suggested that the focus should be on empowering victims of AIPV to become independent, confident, and resilient young women (or men), and should be deemed ineffective if these goals are not reached: “counselling, consistent support, self-worth and a support network. If you’re supporting someone they need empowering, they’ve got to stand on their own two feet and be able to make informed choices” (Natalie).

Two participants raised the highly topical debate about how the police, the wider criminal justice system, and partnering agencies react to and manage AIPV: “I don’t think there’s enough, you know, rules and laws and stuff against that. It needs to be out there as much as like, child abuse” (Milly-May). Whilst solutions were not suggested, it was strongly felt by Natalie and Milly-May that their experiences and the wider experience of IPV policing were highly unsatisfactory. Henceforth, any amendments to policy or legislation surrounding AIPV should involve those affected in the development stages.

All of these suggested improvements would require significant financial investment, which at this time of austerity, is unlikely to be provided. The potential adopted improvements and their potential impact will be discussed in Chapter 8, drawing on the thoughts and opinions of the staff in the gate-keeping agencies.
Conclusions
The narratives presented above demonstrate the wide variety of sources of support, both formal and informal, available to victims of AIPV. They have also demonstrated the varying quality of such sources. Many participants faced significant barriers in accessing support. Some participants had difficulty in identifying themselves as victims, and hence were not aware that support was available to them, and others felt they were not suitable victims either because of their age, marital status, parental status, or living arrangements. Lily, Jemma, and Molly shared narratives that suggest the source of support at the point in which their attention was drawn to their potential risk mattered greatly. Ex-partners were seen as untrustworthy, and hence were ignored. Others felt that their victimisation was necessary so that they could help or ‘fix’ their perpetrator. Interestingly, some participants struggled to identify AIPV behaviours in their relationships despite access to interventions.

Support varied in terms of quality and value to the participants and came from various sources both formal and informal. The favoured informal support sources were friends, neighbours, parents, and caregivers. The most reported source of formal support was via AIPV support organisations, although that may be due to the recruitment process of the study.

Informal support was usually from friends, family, colleagues, or neighbours. Such support was valued highly when it was non-judgmental, well informed, consistent, and encouraged the participant to realise their own autonomy using an unpressured approach. Participants also valued open door policies from informal sources of support, i.e. they could ask for support when they were ready rather than having it forced upon them. Informal support was criticised when sources provoke the perpetrator, thereby putting the victim at increased risk; and when the participant felt pressured to exit the relationship before they were ready. In addition, it was criticised when the source of support threatened to disown the victim if they did not leave the perpetrator, and when informal support sources ousted the perpetrator and subsequently the victim by telling others, or in some cases sharing images of the injuries sustained within a relationship. Furthermore, when sources of support did not take up opportunities to ask questions, for example when there was obvious bruising, support was also criticised. To avoid these negative experiences, participants suggested that a national curriculum-based prevention education and awareness campaign should be embarked upon to ensure that friends and family members can support one another appropriately and effectively.

No participants cited receiving information or support from their schools or colleges regarding AIPV. This highlights many missed opportunities as participants wanted
information and support from such sources. Medical support for injuries was received during the participants’ abusive relationships; however, participants went to considerable lengths to hide the origin of the injuries. As such, better and more comprehensive AIPV screening is required which can help health professionals to identify AIPV and intervene appropriately.

Many participants reported requiring psychological and mental health support. Participants were prescribed antidepressants, support for self-harm, and were referred for talking therapies. However, the waiting lists for talking therapies were often exorbitant, leaving vulnerable victims to fend for themselves often for months at a time. There are national ongoing attempts to reduce the waiting lists in mental health services (RCN, 2013). However, with more victims of AIPV coming forward as confidence in the supportive systems available increases, this particularly vulnerable group will continue to fight against long waits for the support they urgently require.

Due to the recruitment technique employed for this study, all participants (except Amy who received support from a gate-keeper as a friend) had experience of support from a formal source, such as Social Services, IPV charities, and MARAC. Participants narrated these experiences in similar ways to their experiences of informal support, as they varied greatly in terms of quality and efficacy. Sources of formal support included health professionals, IPV charities, Victim Support, IDVAs, the National Domestic Violence Helpline, CAMHS, Social Services, the police and the wider criminal justice system.

IPV charities were highly valued for their available support and signposting. The Freedom Programme was also valued highly for its guidance regarding perpetrator behaviour and support from other participants. However, many participants felt that after the twelve-week programme they were left to fend for themselves and would have benefited from further psychological and practical support. Participants with experience of refuge valued the emergency housing offered but felt that beyond this they struggled to get the support they felt was necessary to move on independently. It was suggested that improvements to outreach support in terms of consistency and quality could have remedied this.

Participants felt that existing prevention interventions could be improved in four ways. Firstly, healthy relationship education should be embedded across the national curriculum. This should be available to all young people in an age-appropriate manner. It was strongly suggested that such lessons should be taught to both sexes concurrently to explore topics affecting both sexes. Such a curriculum should aim to empower young people to make informed decisions regarding their sexual and
relational experiences. To do this, participants felt that practical skills, including giving consent and dealing with rejection appropriately, alongside developing individual confidence, resilience, and emotional maturity should be covered.

It was suggested that high quality, long-term, and consistent outreach should be a high priority to include regular community drop-ins for anyone requiring information and support. In conjunction with outreach should be a national campaign aimed to improve awareness of adolescents’ potential to be victims of IPV and how to support those experiencing it.

The fourth suggestion was for a review of the way in which the professional services, especially the criminal justice system, reacts to and manages AIPV. Participants felt that shorter waiting times, an empathetic and compassionate response, and a culture which offers help to all victims the first time they ask for it is needed. Ultimately, it was suggested that for these improvements to be possible, such support services and campaigns require long-term guaranteed funding and resources. Chapter 8 will discuss how these suggested improvements affect policy, legislation, and practise, examining the gate-keepers’ thoughts and opinions about existing prevention interventions.
Chapter Eight - Adolescent Intimate Partner Violence Policy and Prevention Efforts

AIPV is a significant drain on the UK economy, in terms of lost economic output and cost of responses (Walby, 2004), and to society in terms of human cost (Vos et al., 2006). This chapter will consider how the participants’ experiences of AIPV (Chapter 5), the impact of their experiences (Chapter 6), and their experiences of support (Chapter 7) affect the policy and legislation directing the quality, efficacy, and efficiency of existing AIPV prevention and intervention work.

Section 8.1 will introduce the Public Health Model of prevention, highlighting three complementary stages at which AIPV prevention work can be targeted. Staff participants’ experience-driven suggestions for improvement to AIPV prevention work will be explored in Section 8.2. This includes adequate resources for services to provide a professional and timely service to all victims of AIPV, regardless of their socio-demographics and the complexity of their needs; and sufficient refuge and follow-on housing provision to achieve efficient positive turnarounds. Further suggested areas for improvement include a national curriculum-based universal preventative education strategy, the development of a smooth multi-agency referral process, a twelve-point risk and needs assessment, and a focus on the professional development of staff.

To understand the context of AIPV prevention, the relevant UK policy and legislative framework is then be explored under the headings education, health, criminal justice, local authority, and multi-agency partnership working, in Section 8.3.

8.1 Preventing Adolescent Intimate Partner Violence

Age and gender have been highlighted throughout this thesis as significant intersecting factors associated with becoming a victim of AIPV (Potter, 2015). Furthermore, other factors interact with age and gender, including sexuality, disability and experience of care, to shape how individuals will experience AIPV (Collins and Bilge, 2016). Ellis argues that when identifying the causal relationships of AIPV it is vital to consider that “all children [and adolescents] are ‘at risk’ … they are either at high or low risk, but never at no risk” due to their age (2014: 30; Dean, 1999). She goes on to argue that risk is largely deterministic in that “… behaviour is abstracted from the social, political and economic context in which they live” (ibid: 31).
Subsequently, factors or circumstances in a child’s life can be viewed as precursors to ‘poor outcomes’ so that “what happened to a child sets in stone the pattern of his or her future life” (Waiton, 2001: 35). A positive outcome is therefore reliant on the successful prevention and intervention of these factors leading to children ultimately avoiding events and/or behaviours which have a detrimental impact on their outcome (Ellis, 2014). AIPV has been identified as one such factor which can affect an individual’s outcome, and therefore requires effective prevention.

The concept of preventing AIPV and violence against women and girls (VAWG) more broadly is based upon four assumptions:

1. VAWG is not an inevitable social phenomenon
2. VAWG is learned
3. Causes and causal relationships can be identified
4. It is possible to intervene in some way to ameliorate VAWG (Ellis: 2014: 23).

Situational Couple Violence is thought to be a symptom of humanity’s predisposition to conflict, whilst Intimate Terrorism is thought to be born out of an individual’s will to control their partner due to their contextual experiences, such as the holding of pro-violence attitudes (Johnson, 2006, 2008, 2011). Therefore, using Ellis’s assumptions of prevention it should be possible to reduce and eliminate AIPV. However, efficient methods for prevention are thought to be as complex as the issue itself (CDC, 2016).

The widely adopted Public Health Model of prevention categorises possible provision in terms of the point in time at which the prevention activity occurs in relation to the phenomenon, in this case AIPV (Ellis, 2014; Krug et al., 2002; Violence Reduction Unit, 2006; Department of Health, 2009). Primary prevention aims to stop AIPV from occurring at all by engaging in prevention activity prior to its onset. Primary prevention activity consists of universal services targeted at whole populations, with the aim of making small attitudinal and/or behavioural changes in as many people as possible (Ellis, 2014; Partnerships against Domestic Violence, 2003). For example, the entire student population of a school may engage in programmes with the aim of improving gender equality and reducing AIPV by reducing pro-violence and gendered attitudes. Primary prevention is vital and efficient; however, it does not provide support to those already victimised or reduce harm caused by AIPV. Therefore, secondary and tertiary preventions are also required (Fox, Corr, Gadd and Butler, 2013; Formby et al., 2011; Sex Education Forum, 2006; Ellis, 2014).

Secondary prevention consists of action to cease the occurrence or worsening of AIPV as soon as it is identified (Ellis, 2014). A school may react to a case of AIPV by alerting students to the warning signs of abuse, or by employing a local Non-Government
Organisation (NGO) to run a workshop with those deemed ‘at risk’. Such prevention alone is thought to raise awareness of the issues, but due to its reactive nature and focus solely on those at risk, it is not proficient at eliminating AIPV.

Tertiary prevention is employed when the phenomenon has already occurred and is required to reduce and/or overcome the harm associated with AIPV. It might include offering support services and refuge for victims. Whilst it is useful to identify the potential difference in requirements for prevention activities at the three points in a phenomenon’s life cycle, the process of victimisation in AIPV is rarely linear as the model suggests. It is more helpful to consider the three opportunities as complementary, especially when making policy and commissioning decisions (Ellis, 2014).

8.2 Professionals’ Suggestions for Improvements to AIPV Prevention Work

“Good quality interventions and support can make the difference between short-term safety, or simply surviving abuse, and living a secure and fulfilled life” (HM Government, 2016).

Several questions were put to the staff working in the gate-keeping organisations through a series of focus groups. The roles held by these staff included a young women’s domestic abuse outreach worker, an adult refuge and outreach manager, a children and young people’s support worker, an outreach support worker and helpline officer, and two young women’s domestic abuse accommodation support workers.

The focus groups were asked to discuss five key questions:

1. What service(s) do you provide to adolescent victims of IPV?
2. How do young people engage with your services?
3. What other services for victims of AIPV are available locally and/or nationally?
4. What improvements can be made to your service and the other services you work with to better protect and support victims of AIPV?
5. In a scenario where resources are unlimited, what would an ideal service which aimed to prevent AIPV at primary, secondary, and tertiary levels look like?

These questions were asked to establish the practical limitations of existing prevention interventions and how they might realistically be improved. The suggested improvements fell into four categories: resource-related content of the work; referrals; access to services, and improvements to enable staff to develop.
In terms of resources, the gatekeepers felt that they were currently operating on a skeleton basis, which could fall apart if demand increased or a member of staff became unwell. This was attributed to the issues with short-term funding cycles and disjointed local commissioning, often with very short turnaround times and an increase in demand for their services at a time when resources are decreasing.

Staff participants felt that several improvements could be made if their resources could be increased. For example, premises could be modernised, support could become consistent for all clients and long term where necessary, the staff’s expertise could be recognised allowing them to deliver CPD packages for other general services, and more staff could be employed allowing for specialist male workers, more children and adult women’s workers, and more administration and fundraising support freeing up time for existing staff to spend with service users.

Similarly, an increase in resources would allow for more staff development opportunities. Staff reported feeling undertrained, suggesting that they would relish the opportunity to professionalise themselves further by undertaking qualifications to better support their service users, particularly in the areas of mental health and crisis intervention. Due to the nature of the work, staff members were also keen to highlight that they would benefit from mandatory clinical supervision, as well as existing managerial supervision.

Due to the current housing system, the ways in which employed and unemployed women seeking refuge are charged differs. This inconsistency was raised during all three focus groups. Staff participants shared examples of employed women being charged substantial amounts for their services, whereas unemployed women were able to access it for free via housing benefit. This highlights a key opportunity for improvement in policy and practice whereby all women and children seeking refuge can have access to a space, regardless of their perceived ability to afford it.

Adolescent and adult women with children are also restricted with regards to where they can stay due to organisational policies dictating whether adolescent male children can stay with them, and whether the number of children staying with a mother is capped. In both gate-keeping organisations no males aged twelve years or older could stay in refuge. Whilst this is a protective measure for the other women and children in the refuge, it does highlight a gap in service provision. In addition, the number of children that could stay with their mother was capped at four due to capacity. Furthermore, this assumed that of the four children, one would be in a Moses basket, one would be in a cot, and two could go in bunk beds. This is clearly a significant limitation in provision for some service users.
Childcare availability affects the support available to victims of AIPV who are mothers. This was highlighted by all staff who voiced their concerns over the appropriateness of having young children present in one-to-one emotional support sessions, both for the service user and her children. As such, resources should be made available to ensure that all service users, whether in refuge or the community, have access to suitable childcare to enable their recovery.

The referral process was also discussed widely by staff participants, especially with regards to adolescent victims. Due to the lack of policy and legislation supporting victims under the age of sixteen, staff participants felt that at present referrals from other services were considerably lower than true requirement. Therefore, it was suggested that all pupils across England and Wales should have access to regular information and advice drop-ins, potentially during school hours. This should allow for more referrals to be made and for school staff to also have a contact for guidance where necessary. Similarly, staff participants felt that weekly community drop-ins at GP surgeries or other community venues would benefit those not in mainstream education.

It was unanimously agreed that effective preventative support should focus on twelve key areas (in no particular order):

1. Self-esteem and self-care,
2. Healthy sex and relationships,
3. Employment and training,
4. Physical health and nutrition,
5. Pregnancy and parenting,
6. Mental health,
7. Housing,
8. Keeping safe,
9. Drugs and alcohol,
10. Finance and budgeting,
11. Healthy boundaries, and
12. Digital dating and online safety.

Staff participants felt that for a service to be truly holistic and efficient every service user should have a needs assessment and plan of action which aims to improve their lives in each of the twelve areas. Furthermore, it was felt that existing services for adults, such as the Freedom Programme, needed upgrading and modernising to make them relevant to victims of AIPV.

The last question posed to staff participants aimed to determine what they thought was required to reduce and ultimately eliminate AIPV. They were asked to design an ideal service for preventing AIPV at primary, secondary, and tertiary levels, with
unlimited resources. Their responses demonstrated that existing preventions are already working towards the ideal.

Ideally, staff participants wanted all victims, regardless of age, gender, sexuality, disability, or ethnicity to be recognised, and therefore championed the inclusion of all adolescents in the Home Office definition of domestic abuse. Building on this, they felt that it is vital that the government recognise the avoidable harm and financial cost of AIPV. Staff participants reported that funds could be better directed into the design of a national curriculum which included appropriate preventative PSHE education at all key stages, and into further and higher education. After all, “relationships form the basis of people’s lives yet young people don’t receive any information about it and what’s the right way … people die all the time from IPV, why wouldn’t we want to prevent it?” (Young Women’s Support Worker).

In order that all schools feel supported in delivering PSHE education, and to ensure the quality and consistency of provision, it was also suggested that each school be partnered with a specialist local NGO which could support them by offering specialist sessions, awareness raising, support with identifying technological platforms for abuse, and supporting school staff who might be experiencing IPV in their own relationships.

In terms of secondary prevention to cease any identified AIPV and reduce harm and escalation, it was felt that specialist workers with expertise in AIPV, female genital mutilation, so-called honour-based violence, and male victims should be employed in all services to ensure any added complexity can be effectively responded to. Staff participants believed that specialist counselling should be available immediately to all those deemed at risk or who are already experiencing AIPV. They felt this could be provided by the partnered NGO. They felt it particularly worthy to note that such services must be available to every adolescent, regardless of their geographical location, and felt that local authority and governmental support to this end is vital.

In terms of tertiary prevention, staff participants reported that an ideal service would have purpose-built refuge provision for those under twenty-five years old, dispersed properties for those ready for more independent living, or with adolescent male children or complex needs, speedy access to social housing following a positive turnaround, twenty-four-hour access to mental health support, a designated space in all schools for young people to access, and long-term consistent support that meets the individual needs of all victims of AIPV. Ultimately, they argued, the associated cost with these improvements to preventing AIPV far outweighs the human and financial costs.
8.3 Existing Prevention and Intervention Efforts

This section will explore how the findings of this thesis affect the policy and legislation effecting AIPV, including education, health, criminal justice and the domestic violence sector.

Policy and Legislation

There are both national and EU laws and policies affecting the prevention of AIPV in England and Wales. Policy surrounding AIPV and VAWG more broadly has been in a state of flux for decades. AIPV is recognised in some policy documents (such as Call to End Violence against Women and Girls 2014, 2016), as well as national media campaigns (such as This Is Abuse), yet is neglected in other areas, e.g. child protection (Barter, Aghtaie, Larkins et al., 2015). This patchy coverage has meant that practitioners are unclear on what is expected in terms of supporting victims of AIPV, leading to a postcode lottery of provision.

As a result of successful campaigning the government updated their definition of domestic abuse to include sixteen and seventeen-year-olds and formulated the definitions of controlling and coercive behaviours for the first time in 2013 (Home Office, 2013). The inclusion of sixteen and seventeen-year-olds created some confusion among responding agencies, as the previous protocols for risk assessment were aimed at those over eighteen years of age. This thesis has highlighted that a majority of participants were victimised prior to age sixteen years. As such, many of their experiences are not recognised by existing policy and legislation. The staff participants felt that the inclusion of sixteen and seventeen-year-olds was a positive amendment, although they expressed concern that under sixteens are not receiving appropriate timely responses through child protection due to the hidden nature of AIPV. This appears to be supported by the lack of participant narratives of formal support prior to age sixteen. Therefore, further developments are required to ensure all cases of AIPV are appropriately risk assessed at the earliest opportunity.

Participants were clear in their desire for a greater awareness of AIPV in the wider community. As such, it would be beneficial to continue the Disrespect NoBody campaigns and supporting resources, whilst exploring additional measures to address awareness raising in the wider population. Since increased awareness is associated with increased demand on services, it is also important that AIPV services are adequately trained and resourced. This is particularly important given the negativity in the staff narratives around short term funding cycles, and opportunity to specialise in adolescence.
Education

Schools have been identified as ideal locations for the prevention and intervention of AIPV (HM Government, 2016). This is strongly supported by the findings of this thesis. Primary AIPV prevention education currently exists in the UK two forms – national curriculum-based PSHE education, and ad-hoc specialist sessions delivered in schools by NGOs. Both will be explored, followed by a consideration of the ideologically-favoured Whole School Approach (Thiara and Ellis, 2014).

National Curriculum-Based Preventative Work

Despite evidence suggesting that preventative education reduces the social acceptability of violence (Fox, Corr, Gadd and Butler, 2013) there is currently no statutory requirement for schools to educate pupils of any age about unhealthy relationships and IPV (House of Commons, 2008; Gadd et al., 2014; Formby et al., 2011). Consequently, schools are left to decide what, how, and by whom personal, social, and health issues are covered.

Teachers have reported concern over broaching sensitive topics (Thiara and Loy, 2014; Barter et al., 2015; Ellis and Thiara, 2014; Ellis, 2014; Siddiqui and Bhardwaj, 2014; Mahony and Shaughnessy, 2007), and eliciting disclosures as they are unsure of the protocols for managing them. Furthermore, some schools and individual teachers have expressed concerns about being accused of racism or being seen to be intolerant of minority cultures (Siddiqui and Bhardwaj, 2014). Others expressed a lack of confidence in talking about and using new technology and asking young people about their cyber lives (Barter et al., 2015). This is likely because AIPV and related issues are not currently addressed in teacher training (Barter et al., 2015). This highlights that teachers must be properly resourced and trained to deal with such issues, ideally supported by AIPV specialists from the domestic violence sector.

A key barrier to developing and improving the policy and practice response to AIPV within schools and beyond is the push to work on such issues using a gender-neutral approach (Firmin, 2014, 2011, 2013b). Young people live gendered lives, and AIPV itself is gendered, therefore, a gender-neutral response “runs in direct contrast to research on the gendered experiences of children and young people” (Firmin, 2014: 231). By recognising the gendered nature of AIPV, schools can challenge the everyday use of stereotypical misogynistic and homophobic language (Barter et al., 2015), engage young men to enable them to challenge abusive behaviours, tackle the existing gendered sexual double standard (Barter et al., 2015), and confront gender inequality and gendered power relations (Ellis and Thiara, 2014; Ellis, 2014; Pease,
2008; Carmody et al., 2009; Flood et al., 2009). Furthermore, by utilising an intersectional framework in preventative work, it can consider how gender intersects with other factors, including adolescence and sexuality, to mediate experiences of AIPV (Potter, 2015; Taefi, 2009; Collins and Bilge, 2016).

Some research reports that young males feel alienated and defensive when preventative work takes a gendered approach (Ellis, 2014; Friend, 2014). Friend (2014) found that having male staff present helped to diffuse any defensiveness, highlighting the role adult males can play in preventing AIPV and challenging hegemonic masculinity (Barter et al., 2015), which often presents as ‘lad culture’ in adolescent males (Flood et al., 2009). Habitually we ‘do’ male or female (Butler, 1990), reproducing norms which determine our socio-cultural identities and cultures, particularly heterosexuality and ‘appropriate’ femininities and masculinities (Maxwell and Aggleton, 2014). Therefore, young people’s gendered identities can be positively impacted upon by reimagining such femininities and masculinities during preventative education and practical skills sessions (Maxwell and Aggleton, 2014; Firmin, 2014).

There is some debate regarding the gender of the facilitator of preventative work (Bell and Stanley, 2006; Fox et al., 2014). Bell and Stanley (2006) found that some young males valued having adult males present to diffuse any defensiveness and offer an appropriate masculine role model. “Men can be a powerful force in challenging negative behaviours … [and] can be an integral part of preventions” (HM Government, 2016: 17). RESPECT (2012) argues that sessions co-facilitated by a male and female are best practice, as they can demonstrate gender equality rather than it remaining an abstract concept.

A move away from the ‘boys will be boys’ discourse will enable educators to tackle the highly pervasive ideologies that appear not only in the language used by perpetrators, but also in the public perception of sexual violence and in victims’ own understandings of their victimisation (Weiss, 2009). Such discourses encourage females to feel culpable for protecting themselves from these normalised manifestations of masculinity (ibid). Barter (2014) found that the ‘boys will be boys’ discourse is commonplace. Arguably, the presence of it in educative settings endorses the form of masculinity in which “boys try and persuade girls to engage in sexual activities even if they seemed reluctant”, and often describe it as just ‘messing around’ (2014: 76). Similarly, Barry and Pearce (2014) found that although girls did not recognise their experiences as abuse, many reported regularly experiencing pressure to engage in sexual relationships. This demonstrates that the sexual double standard persists: females are ‘slut shamed’, yet males are rewarded for sexual activity (Coy, 2013). Subsequently, a key aim for preventative education should be to unpick the power and
control ideologies founding this double standard, to re-imagine how young males and females might interact (Thiara and Coy, 2014). Firmin suggests that by educating adolescents in this way, young females will no longer feel culpable for protecting themselves from the violence and coercion used against them, instead redirecting the responsibility to the perpetrators of violence and coercion (2014).

There is wide agreement that prevention work should target both males and females (Carmody et al., 2009; Flood et al., 2009; Weisz & Black, 2001; Ellis and Thiara, 2014), with many adolescents, including the participants of this study, requesting mixed-sex discussions in which they can break down the misunderstandings and miscommunications regarding sexual relationships. After all: “its boys most us will be having sex with so what’s the point in talking about it without them?” (Barry and Pearce, 2014: 165).

It can be argued that there is value in both single-sex and mixed-sex sessions. There may be some topics which it might be beneficial to explore with each sex separately before mixed-sex sessions. One argument for separate sessions highlights the differing ways each gender interacts with the sexualisation of popular culture (Thiara and Coy, 2014; HM Government, 2016). Studies suggest that without the opportunity to discuss sex and sexual relationships, young males will look to the internet and pornography (Thiara and Coy, 2014), creating unrealistic sexual expectations of sex and relationships. Therefore, prevention work should be aware of how such sexualised media informs adolescents' self-identity and gendered expectations (Thiara and Coy, 2014).

**Specialist Services Delivered by the Domestic Violence Sector**

Much of the AIPV focussed work conducted by the domestic violence sector to date has focussed on outreach education. However, Maxwell and Aggleton (2014) found that the positive impact of sessions covering issues related to AIPV often dissipated when students returned to the pervasive heteronormative culture of the rest of the school, hence the scope of such programmes are limited. Similarly, Holland et al. (1998) found that providing young people with this preventative information did not necessarily translate into them putting it into practice, i.e. attitudinal change does not equate to behavioural change. This highlights the difference between intellectual and experiential empowerment. It has been suggested that a Whole School Approach (discussed further on page 197) would overcome these limitations (Barter et al., 2015; Lundgren and Amin 2015; Ellis and Thiara 2014).
Nicola Harwin, then CEO of Women’s Aid, told the House of Commons in 2014: “there is a lot of work being done on developing tools. That is not so much the problem. It is the will inside schools to deliver it and creating time for teachers” (ibid: 34). There are currently many projects across England and Wales working to create tools for use in schools and by NGOs. However, the lack of commitment from the Department of Education means they are not necessarily being utilised effectively.

Despite their success, the domestic violence sector often faces barriers in reaching young people. Schools themselves have been reluctant to recognise the issue (House of Commons, 2008; ONS, 2016; Moore et al., 2015; Barter et al., 2015) and focus their limited resources on something that is often viewed as a social care issue (Ellis and Thiara, 2014). Furthermore, whilst providing preventative education in schools ensuring access to most young people, those in Alternative Provision are likely to miss out (Radford et al., 2011; Ellis and Thiara, 2014). This group of young people are likely to include those living in the care system, those with a history of school exclusion, or those whose school attendance is minimal (Corr et al., 2013). Each of these factors has been linked to an increased risk of experiencing AIPV. Therefore, alternative methods of reaching such individuals need to be explored as a matter of urgency. In addition, there is much debate about the age at which to begin prevention work (O’Brien 2001; Tutty et al., 2005), with some favouring age-appropriate work at all key stages, and others focusing on those already in adolescence (Foshee et al., 2009). This said, there is growing agreement that preventative work should build across the trajectory of childhood into adolescence. However, until a clear mandate is set following the current Domestic Abuse Bill consultation, such education is unlikely to be provided (Home Office, 2018).

There is currently little evidence pointing to the most effective form of preventative education in the UK, both in terms of providing lasting change and reducing AIPV, and finance. Existing UK programmes such as Zero Tolerance, Trust, and Tender have mainly been evaluated using qualitative methods (Stanley, Ellis & Bell, 2011). Such evaluations have highlighted good practice suggestions and the challenges of service delivery, but rarely use methods deemed appropriate to assess attitudinal and behavioural changes. This highlights the need for further research into the efficacy and sustained preventative nature of such programmes, ideally from an intersectional perspective.
The Whole School Approach to Preventing Adolescent Intimate Partner Violence

The Whole School Approach (WSA) was developed in response to concerns that the positive impact of prevention work would dissipate when adolescents return to the highly gendered culture of schools. It was established by Womankind Worldwide and is considered the most valuable approach to preventing AIPV and adversity (Mahony and Shaughnessy, 2007; Siddiqui and Bhardwaj, 2014; Thiara and Coy, 2014). As schools are sites for the production and reproduction of gendered values associated with AIPV (Kehily, 2002; Reay et al., 2007; Allan, 2009; Maxwell and Aggleton, 2010b), they can also be sites for the transformation of such values (Horvat and David, 2011). Hence, AIPV and VAWG more broadly are viewed as issues the entire school should address.

The WSA utilises Pierre Bourdieu’s concepts of ‘habitus’, ‘field’ and ‘social agent’, whereby the ‘field’ represents the school, the ‘social agents’ represent the staff and students, and the ‘habitus’ refers to the field’s social environment shared by the social agents. Bourdieu argues that social agents within a habitus, in this case a school, share “an open system of dispositions that is constantly subjected to experiences and therefore constantly affected by them in a way that reinforces or modifies its structures” (1992: 133). Thus, social agents within the field have the power to make, reaffirm, and sustain change in the shared habitus. In other words, the staff and students (social agents) within a school (habitus) have the power to make sustained change in the school’s pro-violence and gendered social environment (field) by implementing policies which promote an environment which is non-violent and gender-safe.

Stein argues that to achieve gender-safe schools we must “employ multiple, simultaneous strategies to ensure sexual harassment and gender-based violence will be located and identified, accurately named and prevented” (2014: 237; Stein and Mennemiere, 2011). Subsequently, Ash argues that for such transformation to occur, a WSA must be adopted in which the transformation occurs on three levels (2011; Maxwell and Aggleton, 2014):

1. Action at institutional and policy levels
2. Work involving school staff
3. Programmes of education and support for young people.

The first level of a WSA sits with the institution and its policy makers. Institutional and policy level change must aim to create a school’s culture in which gender equality is key, and which creates an ethos where violence, including AIPV, is not tolerated (Ellis and Thiara, 2014; Flood et al., 2009; Ollis, 2011). Such institutional changes highlight the role of adult social agents. They are key in implementing the social and cultural
processes they are engaged with, for example by challenging misogynistic language via bystander interventions. However, such an ethos should also hold to account the perpetrators of violence, whilst removing the burden placed on potential victims to protect themselves. Ideally, institutional change would include the explicit promotion of gender equality, ensuring preventative education is integrated in the curriculum, policies, and budgets, and is a standard component of child safeguarding (Lundgren and Amin, 2015).

All staff in a school adopting the WSA, including teaching and administrative staff (Friend, 2014), should be trained to have a full understanding of gender equality and other sociodemographic factors that intersect to create privilege, inequality, and AIPV (Maxwell and Aggleton, 2014). Such an understanding enables staff to engage with the new policies, priorities, and rules to ensure the now gender-safe culture is adopted by all (Ash, 2011; Maxwell and Aggleton, 2014). Greenwood (2014) argues that staff should also be trained to have the readiness to deal with sensitive issues and disclosures, which have the potential to moderate risk of harm to the children that are in locus parentis.

The third aspect of the WSA is the engagement of young social agents. As research suggests adolescents want information regarding sex and relationships in a respectful and non-judgemental format, which fosters a dialogue between themselves and adults (Barter et al., 2015), this should not be problematic. Adolescents should also be encouraged to conduct bystander interventions, facilitated by staff where necessary.

Bourdieu’s concept is particularly powerful when considering a WSA to preventing AIPV, as it demonstrates how policy level change can filter down and disrupt unequal power dynamics across the field, making room for a gender-safe environment, all the while preventing AIPV (Maxwell and Aggleton, 2014). The WSA is widely valued for its flexible nature, as it can be applied to primary or secondary schools, colleges, universities, workplaces, families, police departments, and ultimately nationwide. The WSA can also be seen to represent the wider societal change required to eliminate all VAWG.

The Health Sector

As the participant narratives demonstrated, various health professions are in a unique position for identifying and intervening in AIPV, as victims are likely to turn to them when injured or unwell, and through routine healthcare when pregnant. GPs, midwives, health visitors, mental health, drug, and alcohol services, sexual health, and
A&E staff are particularly well placed to become agents for AIPV prevention (HM Government, 2016).

As discussed in Chapter 7, participants sought medical help when injured, although they often hid the origin of their injuries. This highlights the necessity for health staff to be rigorous when screening for AIPV. A move away from just ‘asking the question’ is required (Fox et al., 2013), instead focusing on developing a rapport with patients which allows a comprehensive and accurate clinical history of the patient to be gathered. This is highlighted in the Home Office (2016) review of domestic abuse services, which found that 85% of victims seek help from professionals at least five times before receiving the help they need. This could be overcome by specialist training of staff.

Waiting times for mental health support was a key theme emerging from the focus groups with staff. There is a chronic issue with the ability for mental health services to deal effectively with patients experiencing AIPV or with a history of abuse. Not only are waiting times unacceptably long, the Royal College of Nursing (RCN) found that CAMHS services were inadequate (50%) or highly inadequate (20.1%) due to too few nurses, too few beds, too few doctors, and the criteria for services being set too high (RCN, 2016). In addition, too many young people are being sent out of area for a bed, complicating their recovery by disrupting any support network they may have. Furthermore, on confirmation of funding increases to CAMHS, the Chief of NHS England raised concern that the “increased funding will only be enough to reach a third of children who need help”. Despite some positive developments, there is much more to do to ensure every victim gets adequate support from health professionals the first and every time they ask for it. This could include training domestic violence sector staff in mental health first aid and triage.

**Criminal Justice**

Whilst the new policy and legislative changes are welcomed, further amendments to policy, practice, and legislation are required to ensure that all victims of AIPV are protected from all forms of harm, including AIPV, as directed by the UNCRC. Such amendments should aim to increase victim confidence in the criminal justice response to AIPV. Participants felt this could be achieved in part using technology, such as body-worn cameras, and better communication throughout the criminal justice process with regular updates regarding case(s) (HM Government 2016). This can be achieved through appropriate commissioning decisions by Police and Crime Commissioners (PCCs), local, and national government. The prosecution of adolescent perpetrators
of AIPV should be avoided where possible. However, a throughout consideration of intersectionality and risk is required on a case-by-case basis to ensure that criminal justice responses are used as a last resort or in circumstances in which the perpetrator is deemed likely to cause serious harm. Ideally adolescent perpetrators would be diverted into interventions which promote stable and supportive relationships, help young people to develop self-awareness, self-management, and healthy relationships. However, this should not come at the expense of victim safety and should be managed by multiagency panels of which education should be present.

**Local Authority**

The staff participants felt strongly that a clarification of safeguarding responsibilities for adolescents is required. This should make it clear to organisations and professionals operating within the local authority that each victim of AIPV should be identified at the earliest opportunity so that they can be signposted towards specialist organisations promptly, whilst effective multi-agency partnership work should ensure that this process is seamless.

**Multi-Agency Partnership Work**

Over the last decade, governmental policy has changed the response to high-risk domestic violence cases exponentially (HMIC, 2014). Specialist Police Domestic Violence units and risk assessments have been created to capture high-risk victims and ensure they receive effective support via Independent Sexual Violence Advisors (ISVAs), Independent Domestic Violence Advisors (IDVAs), and Multi-Agency Risk Assessment Conferences (MARACs) (HMIC, 2014).

In addition to the potential risk an adult victim of IPV might face, adolescents might also be facing sexual exploitation, gangs, honour-based violence, forced marriage, and online stalking and abuse. To capture this in their risk and needs assessments, CAADA (now Safe Lives) has developed a DASH-RIC-YP for young people (YP) to reflect these additional risks\(^\text{11}\). However, the staff participants were not aware of this, but were interested in using it in the future.

Those under eighteen are protected by existing child safeguarding policies. However, the use of the DASH-RIC-YP aims to develop local care pathways which integrate the

\(^{11}\) Available at: http://www.caada.org.uk/practice-support/resources-identifying-risk-victims-face
existing safeguarding practices and expertise from domestic violence professionals, including MARACs, essentially bridging the gap between children’s social care, young people, and adult social care. Reflecting the government’s addition of sixteen and seventeen-year-olds to the definition of domestic violence, sixteen and seventeen-year-olds who answer yes to fourteen or more of the DASH-RIC-YP will automatically be referred to a MARAC, as an over-eighteen-year-old would. Thirteen, fourteen and fifteen-year-olds will instead be referred to the individual agencies as per the risks they face, and the policies put in place by child safeguarding. In addition to the agencies present at an adult MARAC, Children and Adult Mental Health (CAMHS), youth offending teams (YOTs), and children’s safeguarding teams will be present at a young person’s MARAC. However, for these adolescent specific procedures to be utilised further, the domestic violence sector and public sector must be aware of them and encouraged and support to employ them.

Conclusions
This chapter has located AIPV prevention interventions within the existing context of policy, practice, and legislation in the UK. Using Ellis’ framework of prevention, it has determined that AIPV is able to be prevented as it is not inevitable; instead, it is largely a learnt behaviour with identifiable causes which can be intervened in to eliminate AIPV (2014). Using the Public Health Model of prevention this chapter has highlighted various existing attempts to prevent AIPV, and the ways in which they can be improved.

Primary preventions include those which are universal and occur prior to the onset of AIPV. This includes policy and legislation, and education strategies. The existing environment in which prevention interventions sit is fraught with difficulties. Legislation and policy makers are beginning to acknowledge the potential for adolescents to become victims and/or perpetrators of IPV, yet there is little consistency across relevant policy and legislation.

Recent policy developments regarding high-risk victims of IPV demonstrate the government’s willingness and ability to better protect victims, which must be replicated to better protect low- and medium-risk victims, of which many victims of AIPV are. The Serious Crime Act 2015 has identified those aged ten years and above as potential victims of IPV. Consequently, for adolescents to be properly safeguarded, legislators and policy makers must make explicit the protocols for policing, preventing, and intervening in all cases of AIPV.
The existing system of NGO ‘buy-in’ services is fundamentally flawed, as the services they offer are usually short lived, often one-hour sessions over six weeks, with specifically designated ‘at-risk’ pupils. Whilst this is a positive move forward, this approach fails to reach those not yet identified as ‘at risk’; it removes the ‘face’ of support and information once the programme is over, and often focuses on girls or boys rather than exploring how the genders relate to one another on an issue that is existentially gendered. This said, the alternative PSHE approach has been described as ‘patchy at best’ due to the lack of government directive regarding the delivery of such education (OFSTED, 2013).

Research commissioned by the Home Office (Hester & Westmarland, 2005) evaluated preventative education in schools. The findings suggest that to achieve gender inequality, by challenging pro-violence attitudes, and IPV, they should be embedded across the curriculum and be at least a core and substantial feature in PSHE lessons across the country (Hester and Westmarland, 2005; Ellis and Thiara, 2014). Similarly, it has been recommended that AIPV and VAWG be taught as part of the national curriculum due to their ‘lifelong impact’, and contrary to the government’s current policy, PSHE should be mandatory. Ideally, it would be linked with material on bullying, conflict resolution, and healthy relationships (House of Commons, 2008). Integrating IPV, conflict resolution, bullying, and healthy relationships into other core curriculum subjects, such as history, English, art, and drama gives young people the opportunity to explore their experiences, thoughts, and feelings about the subject in safe spaces and in ways that allow them to project their experiences on to tasks, subsequently not requesting excess time from the PSHE allotment (Corr et al., 2013; House of Commons, 2008). This is supported by more recent research, including this PhD, and by the From Boys to Men Project (Fox et al., 2013; Corr, Gadd, Butler & Fox, 2013; Gadd, Corr, Fox, & Butler, 2013) and other organisations such as the Family Justice Council, NSPCC, Women’s Aid, Refuge, and Respect (House of Commons, 2008).

The Home Office (2005) states that it is crucial that teachers are appropriately trained and feel able to educate and support young people in addition to feeling supported themselves (House of Commons, 2008). Therefore, it is vital that such a sensitive and wide-reaching topic is not handed over to teachers and subjects that do not have the capacity to deal with the likely disclosures, and perhaps difficult conversations it may elicit. Therefore, the potential of co-facilitated sessions by teachers and NGO experts should be explored, particularly in lead up to the start of the compulsory SRE in September 2019 (Home Office, 2017).

Secondary prevention includes efforts to cease the occurrence of AIPV and/or reduce the worsening or escalation of AIPV. This chapter has argued that health professionals
are in an ideal location to identify abuse and intervene promptly to reduce the likelihood of AIPV continuing or escalating. However, such individuals must be properly trained and confident to do so to ensure that victims of AIPV get the right help they need the first time they seek it. Mental health services continue to face a significant challenge in dealing with victims of AIPV and abuse more broadly. Significant financial investment is required to ensure CAMHS can overturn its ‘inadequate’ status and offer all victims timely and consistent support.

The criminal justice system also has a vital role to play in preventing AIPV. By policing cases appropriately, rather than trivialising cases due the victims’ age, there is huge potential to reduce the likelihood of escalation and the chance to improve victims’ confidence in the criminal justice system. A move towards recognising the benefits of focusing on standard- and medium-risk cases, as well as high-risk cases, will also have a significant effect on the number of cases reaching crisis point. Underpinning an effective strategy to secondary prevention of AIPV is truly effective, and efficient multi-agency partnership work for all cases, regardless of the current risk status. The existing practitioner and commissioner ambiguity in such instances should be overcome with the implementation of the National Standards of Excellence. However, evaluation of its impact will be required in the coming months.

Building on excellent primary and secondary prevention, education, health, and multi-agency responses to AIPV should be swift, accessible, and ultimately supportive. After all, “every point of interaction with a victim is an opportunity for intervention and should not be missed” (HM Government, 2016: 12). Multi-agency work should be fine-tuned to allow smooth transitions between organisations, accurate and timely sharing of appropriate information, and innovative ways of working, especially in complex-needs cases.

Ultimately, to provide the best victim-focused primary, secondary, and tertiary prevention, NGOs require secure and increased funding, ideally on a three-year cycle. This will allow a consistent provision of specialist services in a way which reduces the pressure on other services, such as mental health. Staff could become more professionalised and specialise in areas such as HBV or FGM, ensuring provision across the country. Secure and increased funding would also allow access for victims requiring the service, regardless of their location, age, complexity of needs, or number or gender of children. As suggested by the staff participants, refuge provision would ideally be purpose built, with a focus on dispersed properties in the community, rather than communal living, to minimise the conflict and trauma experienced by residents and their children.
In times of austerity, the likelihood of increased funding to NGOs or public-sector departments is greatly reduced. Therefore, improvements to preventions at primary, secondary, and tertiary levels must be designed in a way that maximises the potential impact of each penny of funding. However, thirty-two refuges have closed since 2010, and further anticipated cuts to benefits are pushing victims into poverty and making them even more vulnerable, distinctly increasing the improved investment required to prevent AIPV. The implications of these findings will be explored further in Chapter 9.
Chapter Nine - Conclusions and Recommendations

This thesis has provided an original contribution to the field by applying an intersectional approach (Potter, 2015; Collins and Bilge, 2016) to AIPV. The intersectional theoretical framework, presented in Chapter Three, was explored through the examination of the lived experiences of seventeen female victims of AIPV collected via the Free Association Narrative Interview Method (Hollway and Jefferson, 2000). The original contribution of this thesis can be explored under three themes. The first addresses the gap in the conceptualisation of AIPV; the second recognises AIPV as a significant public health and human rights issue; and the third explores AIPV prevention interventions. Each theme will be explored in this chapter, which will conclude with four recommendations for further work.

This thesis has examined the nature, aetiology, prevalence and definitions of AIPV, through existing literature and analysis of the participants' narratives. Adolescence has been defined as between the ages of ten and twenty-five years of age (Connolly and McIsaac, 2011; Blakemore, 2012). For the purpose of this thesis, AIPV is defined as “any incident or pattern of incidents of controlling, coercive, or threatening behaviour and/or psychological, physical, sexual, financial or emotional violence” (Home Office, 2013), perpetrated by someone whom the victim is currently or has in the past been intimate with, regardless of gender or sexuality, whilst one or both partners are between the ages of ten and twenty-five years.

Analysis of the ONS data was presented in Chapter 1, clearly highlighting adolescence as a significant period of risk for experiencing AIPV. Those between the ages of sixteen and twenty-five are four times more likely to victimised that those over twenty-five years old (ONS, 2016). However, comparable statistics are not available for those aged ten to fifteen. To gain a more complete picture of the prevalence of AIPV in England and Wales, three seminal UK (and Europe) based studies were explored in Chapter 2.

The NSPCC (Barter et al., 2009) study was the first to explore AIPV in England and Wales. The report’s findings identify AIPV as a significant child-welfare, human rights and public health epidemic. Prevalence statistics varied for the type of violence and gender of respondent, although it was reported that between 1% and 87% of adolescents in the UK had experienced at least one facet of AIPV (Barter et al., 2015). Furthermore, there was a significant gendered divide in the impact of these experiences, with females significantly more likely to report a negative impact, especially with regards to sexual violence. Interestingly thirteen to fifteen-year olds
were as likely as those aged sixteen and over to experience AIPV. This suggests that the CSEW data for those aged sixteen to twenty-five can be expected to reflect those in under sixteen-year olds, suggesting significant prevalence. Although this requires further exploration, to allow a greater level of evidence to be collected which could be used to better identify funding and support requirements for adolescents. The prevalence of AIPV uncovered by the NSPCC study also suggests that prevention work should start before the age of thirteen, with secondary and tertiary interventions also available from early adolescence (ibid).

The From Boys to Men project took a different approach to studying AIPV, focusing on why some adolescent males perpetrate whilst others do not (Gadd et al., 2014). The project found significantly higher prevalence of AIPV than expected, especially in comparison with prevalence in adulthood. Interestingly, and in contrast to the NSPCC study, the From Boys to Men project found a largely gender-symmetric and unilateral form of AIPV. The only exception to this was sexual violence, in which males were most likely to perpetrate against females, with females reporting a significantly more negative impact than males.

The From Boys to Men project also uncovered a complex relationship between victimisation and perpetration within the sample of thirteen and fourteen year olds. Male respondents appeared to under-report both their victimisation and perpetration of AIPV, whilst females appeared to over-report their perpetration (ibid). This highlights the requirement for a better understanding of the nature of AIPV across adolescence and how gender might influence victimisation, perpetration and the self-reporting of each phenomenon. Furthermore, help-seeking behaviours were mediated by gender and previous experience of DVA or AIPV, in that those with previous experience were least likely to seek help from an adult; similarly, males were much less likely than females to seek help (Gadd et al., 2014). This highlights the necessity for prevention interventions to recognise that many participants will have previously or may be currently experiencing DVA or AIPV.

The most recent study of AIPV in the UK also included an analysis of data from four other European countries – Bulgaria, Cyprus, Italy and Norway (Barter et al., 2015). The STIR project was the first to consider the interconnectedness of adolescents’ on- and off-line lives, highlighting significant recent technological developments. The project found that AIPV victimisation was most prevalent in England, with 40% of females experiencing online and offline control and coercion, one in five respondents experiencing physical violence (compared to one in ten in the other countries), and 41% females and 25% males experiencing sexual violence. In contrast to the From Boys to Men study there was a significant gendered impact of AIPV. Eight-one per
cent of females who experienced sexual violence reported a negative impact, compared with 60% of males reporting a positive impact or no effect. This reflects the gendered sexual double standard (England and Bearak, 2014) and the requirement for significant shifts in adolescent culture towards gender-safety (Siddiqui and Bhardwaj, 2014). The STIR project also found complexity in the self-reporting of perpetration, supporting the requirement for additional research to explore this further. Whilst it was rare for AIPV to occur solely online, the project found that the presence of technology, particularly social media, had a hugely negative effect on the wellbeing of victims. This suggests that technology, the internet and smart phone applications must be considered in any prevention or intervention work. Furthermore, research examining the ways adolescents’ use this technology will be vital in ensuring the prevention work is accurate and relevant to those it is aimed at.

**Addressing the Theory Gap**

Knowledge regarding the prevalence, aetiology and nature of AIPV in the UK has been steadily growing over the past decade (Barter et al., 2009; Gadd et al., 2015; Barter et al., 2015). This study builds upon the existing literature, presented in Chapters 2 and 3, by highlighting the cultural, structural, disciplinary and interpersonal power dynamics associated with adolescence, and how they intersect with those associated with gender, religion, disability, sexuality and so on, to create a context in which AIPV thrives (Potter, 2015; Collins and Bilge, 2016). Furthermore, these factors have been shown to mediate the participants’ experiences of AIPV, as shown in Chapter 5, as well as the participants’ recovery and help seeking behaviours, as explored in Chapter 7.

Chapter 3 has demonstrated the multiplicative ways in which the context of adolescence interacts with interpersonal power dynamics to encourage male domination over females (Teitleman et al., 2008). Adolescents are more likely than their adult counterparts to hold pro-violence attitudes (Barter et al., 2009; Gadd et al., 2015), which have been linked to an increased likelihood of IPV. Furthermore, pro-violence attitudes are produced and reproduced through language and behaviour endorsing the hyper-masculine ‘lad culture’ associated with adolescence and young adulthood (Farvid et al., 2017; England and Bearak, 2014; Ridgeway and Cornell, 2004). These interpersonal dynamics intersect through the ‘special vantage point’ of adolescence to create a context in which adolescents experience these power relations more acutely than adults (Collins and Bilge, 2016). Furthermore, due to their age, adolescents have a lack of experience in the romantic domain (Taefi, 2009;
Collins and Bilge, 2016), are more likely to have poor and/or unpractised conflict resolution skills (Johnson, 2008, 2011) and are more impulsive and likely to take risks than adults (Blakemore, 2012). As a result of these interacting factors, adolescence has been identified as one of the major social axes of power and oppression in which an intersectional analysis of IPV is concerned (Collins and Bilge, 2016; Potter, 2015).

Each facet of AIPV was experienced by the participants before age 16 years, suggesting that adolescence does indeed interact with gender, and other factors, to create a context in which abusive relationships take place. The participants narrated experiences of AIPV which were shaped by the intersection of age and gender, along with sexuality, religion, lower economic backgrounds, and experiences of being in care, teenage pregnancy, lower educational attainment, and disability.

Natalie (16), for example, shared how Ken (26) convinced her to commit to a relationship with him. Once they had begun cohabiting, Ken took control of the caring responsibilities for Natalie’s daughter, and began to make Natalie feel that she should minimise contact with friends and family, instead focusing her time on Ken. Within a few months, Natalie was pregnant with Ken’s child and felt she had no option but to leave college. This highlights how Natalie’s age (16), parental status, low economic background and forced reliance on Ken, who was ten years older than Natalie, intersected to create a context in which Ken had power and control over her (Potter, 2015; Collins and Bilge, 2016).

Furthermore, Sam is a seventeen-year-old British Muslim (now renounced), whose father was a respected member of the local Muslim community. She was forced into an Islamic marriage with Ali (36), who was considerably physically and psychologically violent. During the seven-week marriage, Ali would “call [Sam] a slut, call [her] a prostitute, and he went round [sic] telling people [she’d] slept with doctors at the hospital”. These were particularly significant threats for Sam due to her father’s position in the Muslim community and the potential for the backlash to fall on her wider family. This mediated her experience of AIPV and worked to reduce her perceived escape options. As such Sam’s age, gender and religion mutually shaped her experience of AIPV.

Facebook was used to monitor and publicly humiliate Lilly (19) by her first girlfriend Leanne (24): “she put all these horrible things like under interests she put licking cunt … people could see, and it was all to do with lesbians and sex like stuff”. This was particularly traumatic for Lilly as this incident meant she was outed to the family members on her account (Donovan and Hester, 2015). This demonstrates the privileged access perpetrators have to victim’s personal information (Villalonga-Olives
and Karachi, 2017) and the added level of complexity experienced by LGBT adolescents (Donovan and Hester, 2015).

The participants of this study narrated experiences of all three of Johnson’s typologies (2006, 2008, 2010). Situational Couple Violence (Johnson, 2008, 2011) is motivated by conflict, rather than control. It was hypothesised that Situational Couple Violence would be prevalent within the participants’ narratives due to the participants’ ages and associated lack of skills in the romantic domain (Johnson, 2005; 2008; 2011; Collins, 2003; Blakemore, 2012; Sawyer et al., 2018). However, Situational Couple Violence occurred in just 10% of the participants’ narratives. This is significantly lower than found in the adult literature (Johnson, 2008; Dixon and Graham-Kevan, 2011), which has found Situational Couple Violence in up to 50% of cases (Straus, 2008; Whitaker, et al., 2007). This is perhaps due to the methods of recruitment – via support services which may have filtered the cases available for sampling (Johnson, 2006, 2008, 2011). However, it may also be because such aggression does not occur as frequently during adolescence as in adulthood. In addition, the experiences of Situational Couple Violence narrated appeared to be predominantly unilateral rather than bidirectional as expected (Johnson, 2006, 2008, 2011). Further research is required to explore this.

Intimate Terrorism aims to reduce the victim’s will to resist the perpetrator’s demands and instil the perpetrator’s perceived right to control and punish the victim (Stark, 2007; Johnson, 2008). Perpetrators of Intimate Terrorism use a pattern of coercive behaviours to control their victim. Contexts which favour male dominance of females are thought to be most conducive to the development of Intimate Terrorism (Johnson, 2008, 2011; Tomlin et al., 2003). Therefore, it was hypothesised that Intimate Terrorism was likely to prevalent in adolescence, since adolescence is hyper-gendered (Sills et al., 2010; Amin et al., 2018; Klein and Milardo, 2000; Tomlin et al., 2003) both culturally and interpersonally (Potter, 2015; Collins and Bilge, 2016).

Intimate Terrorism was experienced by participants in multiple ways. They described how their perpetrators’ jealousy lead to isolation and control. Threats and intimidation were widely narrated. This included threats to damage or steal property belonging to the participants and/or their families, threats to physically hurt them and their family members, and threats to commit suicide or abandon the participant. Furthermore, attempts to disrupt the participants’ identity were common place, with perpetrators controlling what they could wear, what they could do and who they could see. Such attempts were implemented through monitoring and surveillance, including surveillance using technology such as FindMyFriends. In addition, participants narrated degradation and psychological attacks which worked to wear down their will to resist the control. Perpetrators employed a range of acts, including mind games,
jealousy, cheating, monitoring, and putdowns, to make the participant subordinate and/or dependant on them, and to minimise resistance to their controlling demands (Stark, 2007; Johnson, 2008; Barter et al., 2009; Fox et al., 2013; Gadd et al., 2013; Murphy and Smith, 2010). All participants described incidents of physical force (including pushing, slapping, hitting, and being held down), and severe physical force (such as punching, kicking, strangling, being beating up, or attacked with a weapon), and sixteen (of seventeen) participants narrated experiences of sexual violence, including rape.

As hypothesised, there were some examples of Violent Resistance within relationships experiencing Intimate Terrorism (Johnson, 2006, 2008, 2011). Five participants (Emily, Skye, Molly, Jessica, and Sam) disclosed their own perpetration of violence towards their male partners. The self-reported context for each of their offences was in response to male violence, most frequently in retaliation or self-defence (Dobash and Dobash, 2004; Stark, 2007; Johnson, 2008; 2011), representing Johnson’s Violent Resistance Typology.

This suggests that an intersectional approach to understanding IPV, using Johnson’s typologies, can indeed account for the prevalence of cases during middle, late adolescence and into young adulthood. Furthermore, it identifies that significant factors intersect with age to provide the context for such violence to occur and mediate the participants’ experiences of IPV. This has considerable implications for policy and practice, as discussed on page 213.

Establishing Adolescent Intimate Partner Violence as a Public Health Issue
The World Health Organisation has reported that AIPV victimisation has a severe and profound negative impact on its victims, which can last a lifetime and cross generations (2012). AIPV has been found to ‘profoundly damage the physical, sexual, reproductive, emotional, mental and social wellbeing of individuals’, families, and partnerships’ (WHO, 2010:3). Furthermore, AIPV victimisation has also tentatively been associated with an increased risk of poverty, unemployment, and low educational attainment (WHO, 2010; 2012).

Chapter 6 utilised the Radiating Impact of IPV model to explore the impact of AIPV on the participants (Riger et al., 2002). The impact was categorised according to which aspect of their lives were affected by their victimisation. First order effects refer to the direct impact to the victims’ health and wellbeing; second order effects refer to
Participants narrated their experiences of AIPV and the impact of their experiences during two free association narrative interviews. Narrated first order effects included significant psychological and emotional impacts. Internalised effects such as depression (APA, 2013; Barnow et al., 2002), self-harm, suicide ideation and anxiety (Coker et al., 2002 Wright et al., 2015), and externalising behaviours such as risky sex, alcohol and substance misuse and survival sex were repeatedly narrated (Hair et al., 2009; Conner, 2015). A further four participants developed psychiatric conditions (Paranoid Schizophrenia, PTSD, Bulimia Nervosa, and Body Dysmorphic Disorder) (Nelson et al., 2014) as a direct result of their victimisation. Impact to participants’ physical wellbeing were also narrated, including injuries, bruising, lacerations, burns, broken bones, scarring, partial blindness, and ongoing pain and discomfort (WHO, 2012; Whitaker et al., 2007). Furthermore, there were considerable pregnancy related impact, including pregnancy (WHO, 2012), rapid-repeat pregnancies (WHO, 2012; Jacoby et al., 1999), pregnancy-complications and miscarriage (Stephenson et al., 2006; Asling-Monemi et al., 2008; Boy & Salihu, 2004; Reza et al., 2009), fear of negotiating contraception (Pearson, 2006), and abortion. This also reflects the findings in the literature on adult victims of IPV, suggesting that significant work is required to prevent and respond to such victimisation in adolescence (Wathen et al., 2016).

The impact of AIPV narrated by participants was severely detrimental and long lasting, adding to existing evidence suggesting that AIPV is a public health epidemic requiring vast investment in order to deliver universal prevention programmes and minimise the harm experienced by victims (WHO, 2012; Barter et al., 2015).

AIPV victimisation also affected the participants’ relationships with friends, family and their children. Participants felt that the mutual trust and respect between themselves and family members had been corroded by their victimisation. Furthermore, whilst some friends remained loyal and offered sanctuary, the majority lost patience with the participants and abandoned them. This added to their isolation and the cumulative impact of their victimisation, especially as many participants suggested that friends would be their preferred source of support. Nine of the participants were parents themselves and narrated difficult relationships with their children as a result of their victimisation.

The participants’ ability to function in their community and wider society was also affected by their victimisation (Riger et al., 2002). Participants narrated high levels of truancy, poor educational attainment and early exit from education as a result of their
victimisation. Furthermore, those who had part- or full-time work, or who were attending college felt significant pressure from their perpetrator(s) to leave, as a result of their jealousy and monitoring. Those who continued to work went on to narrate experiences of financial violence, essentially removing their resources and ability to engage in their community. The participants’ narratives suggest there is a link between AIPV victimisation and educational and employment attainment, however further exploration would be beneficial.

During the analysis of the participants’ transcripts it became clear that there was also an impact on those around the victim, including their parents, children and wider friends and family. Using Riger et al’s model, several third order effects were identified. Participants narrated acute impact on their children, with incidents of direct abuse, exposure to their mothers’ victimisation, and subsequent signs of distress and internalising and externalising behaviours. This is particularly concerning as the participants are themselves also young and vulnerable, highlighting a vital potential opportunity for intervention(s) with adolescent parents.

Direct impact on parents and wider family members were sparingly narrated. However, Amy’s mother was very keen to share her experiences of stress and disordered sleep. Furthermore, participants narrated parental property damage, increased demands on their parents for child care and secondary traumatisation. There is very little literature considering the impact of AIPV on those around the victim, highlighting a potential area for further research and intervention.

The participants’ narratives have highlighted several significant health and wellbeing, social, and financial costs of experiencing AIPV, reflecting the adult literature (WHO, 2012). Furthermore, due to the developmental phase in which the violence is occurring, victims of AIPV appear to be particularly vulnerable to long-term negative effects, including psychological disorders, attachment issues, physical health conditions and potentially neurological issues. Further research into the long-term impact of victimisation at this vulnerable developmental phase is urgently required.

These are significant mental, physical and reproductive health issues, at a life phase which holds considerable weight over future outcomes (Collins, 2003; Sawyer et al., 2018). Arguably, due to the developmental significance of the age at which the IPV is occurring, AIPV victimisation is a particularly acute public health issue (Howell, Barnes, Miller and Graham-Bermann, 2016; Cisler, Begle, Amstadter et al., 2012; Park, Smith and Ireland, 2012) requiring immediate recognition and response (WHO, 2010).
Identifying the impact of AIPV highlights multiple opportunities for prevention interventions. Ideally, appropriately targeted preventative work will account for the complexity of adolescence and the intersecting factors likely to shape the context and experience of AIPV (Potter, 2015). The experiences narrated by participants highlight the requirement for all young people to have knowledge and understanding of their own wellbeing and how to maintain it, so that they can seek help from appropriate sources if, and when, required.

In addition to the significant impact resulting from participants’ experiences of AIPV highlighted above, participants also identified many barriers to seeking help. Foremost was the difficulty in recognising their victimisation. This appeared to be because their experiences did not fit with the stereotypical ‘real IPV’, in that they were not cohabiting, married and/or did not have children with their perpetrator. When these scenarios were realised, participants found it somewhat easier to recognise their victimisation but there was still considerable reluctance to seek help. The desire to rebel against parental advice was narrated by many participants and was reflected in participants’ narratives when an ex-partner or ex-wife attempted to warn them off the perpetrator. This suggests that a greater awareness of AIPV, alongside clear referral pathways for support are particularly important. Arguably this is most important for those under sixteen who are less likely to identify as victims.

Participants narrated their experiences of support from both formal and informal sources. Overall their experiences were considerably mixed. Informal support came from friends and family. Friends were the often the first person the participants would turn to with positive experiences of support including being listened to in a non-judgemental manner, consistency, and offering sanctuary when the participant was ready to leave or have a break from the abusive relationship. Those who were well informed seemed to provide the most valued support, because they understood the issues the participant was facing. Less positive experiences included being judged, talked down to, and blamed for their victimisation. Participants felt that some friends were inpatient and easily frustrated when dealing with them, as they couldn’t understand the participants’ situation. This was worsened for two participants when their friends shared images of their injuries or told others about their victimisation without their consent. Arguably, universal preventive education will go some way to minimise these negative effects.

Family members, including parents, attempted to support the participants in the way they thought best, although the authoritarian edge to this support promoted a...
of rebellion in some participants. Parents were cited as having banned the perpetrator from their house and forbidding the participant to see them. This appeared to lead to participants taking significant risks to spend time with their perpetrator. Furthermore, the added conflict at home caused considerable additional distress for the participants. Support for parents and families as a whole may work to minimise these experiences, although further research is required to explore the form and function of such work.

Interestingly, none of the participants cited teachers or school staff as sources of support for AIPV specifically. It seemed that there were several missed opportunities in this regard. Truanting and pregnancy were cited as key red flags that appeared to be missed by education professionals. Participants felt that there was considerable potential for national cross-curriculum sex and relationships education and additional support from a tutor or school nurse. This is supported by the Children and Social Work Act which has provided the government power to make SRE compulsory from September 2019. The consultation regarding the format and content of this work is currently being analysed, with the government response due imminently.

Support from formal sources such as the health professionals and victims’ services were regarded by participants as useful but in need of improvement. Many of the participants sought assistance from a health professional for contraceptive advice, pregnancy care, and accident and emergency admissions. In addition, many of the participants sought help from their GP due to depression and anxiety. Whilst such healthcare professionals were reported to screen for DVA, the participants felt that such attempts were minimal. Once participants denied their victimisation, there appeared to be no further enquiries made. This suggests that an awareness raising campaign among all frontline healthcare staff which highlights that adolescents may be victims of IPV, the signs to look out for, how to build rapport with adolescents, and how to refer them for specialist support is required. Following the success of the IRIS project (Health Foundation, 2011), there is evidence to suggest such a scheme could have considerable positive impact.

A range of victims’ services were accessed by the participants, including refuge, outreach, counselling, the Freedom Programme and practical support from IDVAs. However, the quality, length and consistency of this support varied depending on the participants’ age and location. One participant was deemed high risk using the adult DASH-RIC and was referred to a MARAC. She felt that the added wrap-around support this provided was excellent, although she also narrated several escalating incidents of physical violence after the MARAC, suggesting it was not entirely successful at removing her risk.
One the most valued forms of support cited by participants was that offered by and received from other attendees of the Freedom Programme. Whilst participants cited issues with the content and length of the programme itself, they felt that the collegiality and bonds built within the group were instrumental to their recovery and ensured their ongoing attendance. Several participants also noted that without the free child care their attendance would not have been possible, highlighting the necessity for longitudinal practical and emotional support. However, there was some concern raised by staff participants regarding the Programme’s suitability for adolescents. Further work should explore this.

The criminal justice response to participants' victimisation was sparingly narrated but generally regarded as insufficient. Restraining orders and perpetrator removal were deemed to be short-term and largely ineffective. This suggests that a review of criminal justice responses to AIPV is required. As cited by Gadd et al. (2014) this review might include a move towards containing responses rather than purely punitive responses, particularly for perpetrators who are adolescents themselves.

Conclusions and Recommendations
This thesis has brought together the existing policy, legislation and research on AIPV in the UK. The empirical element of the thesis has contributed original knowledge of the lived-experience of AIPV victimisation. This data has highlighted the impact of the intersecting nature of age and gender on experiences of IPV, alongside the additional impact of further intersecting factors such as sexuality and disability (Potter, 2015). Whilst the majority participants of this study were White British, the findings presented in this thesis build on the intersectional literature (for example Crenshaw, 1991; Potter, 2015; Collins and Bilge, 2016) suggesting that experiences of AIPV will be significantly mediated by experiences of race and/or ethnicity. Additional research which explores this link further would be beneficial.

Furthermore, this thesis has firmly located AIPV as a significant child-welfare, public health and human rights issue. Participant and gatekeepers' suggestions for improvements to the existing prevention intervention efforts have been explored in Chapters 7 and 8. Whilst the application of the intersectional theory to the participants' narratives is original and insightful, there are limitations due to the sample and recruitment biases. As such further application of the intersectional framework is required, to include female and male participants, and ideally longitudinal data sets which allow the theory to be tested across adolescence. The recommendations that follow consider those suggestions alongside the evidence presented throughout the
thesis.

- If the age parameters of the cross-governmental definition of DVA are to remain the same significant investment is required to improve the child protection response to victims under sixteen, including continued investment in the Disrespect NoBody awareness campaign. This will help to raise awareness of the issues in early adolescence and encourage criminal justice, health, education, and victim service responses which are more attuned to adolescents' risks, needs and experiences.

- The national sex and relationships education (enabled by the Children and Social Work Act 2017) should ensure that on and offline contexts for abuse are covered, including the risks associated with intersecting factors such as age, sexuality and teen parenthood so that all young people, rather than only those deemed 'at risk' have the knowledge and opportunity to improve their skills.

- Significant investment is required in mental health support for victims of AIPV. Such investment should significantly reduce waiting times for adolescents, ensuring that the currently patchy CAMHS service (RCN, 2013) is standardised and waiting time quotas are effectively managed to ensure victims receive support as soon as possible.

- Further research which tracks participants' experiences of AIPV across adolescence from an intersectional perspective will enable a greater understanding of the ways in which Johnson’s typologies interact with adolescence and improve our understanding of the phenomenon.

Adolescent intimate partner violence is a significant public health and human rights issue, which links to many additional phenomena, particularly for marginalised groups. This research contributes to the body of knowledge in this area by highlighting the voices of victims of AIPV and those who work with them in a supportive capacity. The intersectional analysis begins to highlight new ways of understanding their experiences and responses to them.
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Appendices

Appendix One – Information Sheet

Victims of Adolescent Intimate Partner Violence: Prevention and Intervention

Participant Information Sheet

You are being invited to take part in a research study [as part of a postgraduate student project]. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

Miss Kirsty McGregor

Department of Criminology, School of Law, Williamson Building, Oxford Road, Manchester, M13 9PL

Title of the Research

Victims of adolescent intimate partner violence: Prevention and intervention.

What is the aim of the research?

The aims of this research are 1) to find out how adolescents define their intimate relationships, and 2) to find out what victims of adolescent intimate partner violence need from prevention and intervention strategies.

Why have I been chosen?

You have been chosen to take part in this study because between the ages of 10 and 25 you had (or are having) an intimate relationship. In total, twenty people will be taking part in this study.

What would I be asked to do if I took part?

Each participant will meet with Kirsty McGregor twice for approximately an hour on each occasion to discuss adolescent relationships. It is possible that you may discuss topics that could be upsetting; however you do not have to talk about anything you are uncomfortable with.
What happens to the data collected?
The conversations will then be typed up by Kirsty McGregor and analyzed according to the research aims.

How is confidentiality maintained?
You will be assigned a pseudonym, so that only you and Kirsty McGregor will be aware that the text relates to you. Any information given that could lead to someone being able to identify you in the text will be removed. Each document will be saved on an encrypted USB drive and accessed through a password secure University of Manchester computer or Kirsty McGregor’s personal password secure laptop. The recorded conversations and transcripts of the conversations will be stored securely until they are no longer of use, at which point they will be destroyed.

What happens if I do not want to take part or if I change my mind?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself.

Will I be paid for participating in the research?
You will be given a £10 High Street Gift Voucher for participating in this research.

What is the duration of the research?
One hour interview on two occasions.

Where will the research be conducted?
The research will take place either at the University of Manchester or your home, which ever you would prefer.

Will the outcomes of the research be published?
The outcomes of this research will be published in the thesis and in an academic journal article.

Contact for further information
Email: kirsty.mcgregor@postgrad.manchester.ac.uk
Telephone: 07572 871152

What if something goes wrong?
There are many organisations that can provide help and support to people who have experienced intimate partner violence. Please contact Kirsty McGregor for a list of those in your local area.
If you want to make a formal complaint about the conduct of the research please contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.
Appendix Two – Consent Form

Victims of Adolescent Intimate Partner Violence: Prevention and Intervention

Consent Form

If you are happy to participate please complete and sign the consent form below

1 I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily

2 I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving reason and without detriment to any treatment/service

3 I understand that the interviews will be audio recorded

4 I agree to the use of anonymous quotes

I agree to take part in the above project

Name of participant ___________________________ Date ___________________________ Signature ___________________________

Name of person taking consent ___________________________ Date ___________________________ Signature ___________________________

Please initial each box
Appendix Three – Interview Schedule

Interview One

Introduction:
I am conducting a study on adolescent’s experiences of unhealthy intimate partnerships. I hope to gain a better understanding of how people define their relationships during their teens and into young adulthood, and what young people want and need from healthy relationship services. Thank you for agreeing to discuss this with me.

I want to assure you that this interview is confidential and is being recorded by this audio device with your permission so that I can type it up. The recording will then be destroyed. Your participation is entirely voluntary and you are free to stop at any point.

To start with I will ask you some general questions.

1. RESPONDENT DETAILS
   (a) Name________________________________________________________
   (b) Age________________________________________________________
   (c) Nationality___________________________________________________
   (d) Ethnic Background____________________________________________
   (e) Immigration Status____________________________________________
   (f) Religion_______________________________________________________
   (g) Sexual Orientation____________________________________________
   (h) Disability_____________________________________________________
   (i) Marital Status_________________________________________________
   (j) Do you have any children? YES NO_____________________________
   (k) What are your current living arrangements? (E.g. private rented with two friends)
       ________________________________________________________________
   (l) Did you finish school? YES NO
   (m) Did you go to College (YES/NO); University (YES/NO); Other____________
       ________________________________________________________________
   (n) Did you grow up with
      i. Both parents
      ii. Single mother
      iii. Single father
iv. Grandparents
v. In a care establishment
vi. Other

Details

(o) How many brothers and/or sisters do you have?
Brothers       Sisters

(p) What was growing up like for you?

(q) Did your parents
   a. Finish school? Mother (YES/NO) Father (YES/NO)
   b. Go to College? Mother (YES/NO) Father (YES/NO)
   c. Go to University? Mother (YES/NO) Father (YES/NO)

(r) What sort of work do your parents do?
   Mother                                      Father

(s) Do you have a supportive network of friends and family?

2. SQUIN (partial)

Please tell me about your experiences of intimate partnerships.

Include all the events and experiences which were or are important for you, and how it all developed up to now.

You can start around the time you began thinking about relationships, or the period in your life when they became personally important.

We've got about an hour, so please take all the time you need.

I won't interrupt. I'll just listen and take notes of the experiences which have been important for you.
Thank you for telling me about your experiences. Now is a good time to take a break. How was that for you?

Interview Two

I’d like to ask you a few questions about the information you told me in the previous interview/earlier.

3. Questions deriving from primary analysis:

I would also like to ask you some questions about specific areas of your life, such as your relationships and your thoughts and opinions.

4. You and Your Relationships

   (a) How old were you when you first started going out with girls/boys? _____

   (b) How old were you when you became sexually active? _______________

   (c) How old were you when you had your first girlfriend/boyfriend? _______
a. What was their name/how would you like to refer to them?

(Ask respondents to expand on this relationship. For example: how did it start? How did it feel to be in the relationship? How did it end? How old were they? What was their religion? Evidence of the princess effect? Etc)

d) Have you had any other relationships? YES/NO

(Ask respondents to expand on each relationship. For example: how did it start? How did it feel to be in the relationship? How did it end? How old were they? What was their religion? Evidence of the princess effect? Etc)

e) Did you have any shorter term or less serious relationships in between the ones you have already mentioned? YES/NO

   a. If yes, can you tell me more about them?

Considering all of the relationships we have discussed, I would like to ask you some specific questions about adolescent intimate partner violence behaviours. They are split into three parts: physical force, sexual activity and psychological factors.

(WHERE A BEHAVIOUR IS PRESENT IN MORE THAN ONE RELATIONSHIP, ASK THE RESPONDENT TO BREAK IT DOWN FOR EACH)

5. Physical Force (4 questions)

Have any of your partners:

   (a) Used physical force such as pushing, slapping, hitting or holding you down? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (b) Used more severe physical force such as punching, strangling, beating you up, or hitting you with an object? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (c) Have you ever used physical or more severe physical force against a partner? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (d) Are there any experiences that we haven’t already discussed of this type of behaviour which you could tell me more about?

   ______________________________________________________________________________________

   ______________________________________________________________________________________

6. Sexual Activity (5 questions)

Have any of your partners:

   (a) Pressured you into kissing, touching or something else? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (b) Physically forced you into kissing, touching or something else? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (c) Pressured you into sexual intercourse? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)

   (d) Physically forced you into sexual intercourse? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
7. Psychological Factors

Have any of your partners:

(a) Made fun of you (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(b) Shouted at you/screamed in your face/called you hurtful names? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(c) Said negative things about your appearance/body/family/friends? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(d) Threatened to hurt you/family/friends unless you did what they wanted? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(e) Told you who you could see and where you could go? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(f) Constantly checked up on what you were doing e.g. by phone or text? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(g) Used private information to make you do something? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(h) Used mobile phones or the internet to humiliate or threaten you? (NEVER/ONCE/A FEW TIMES/OFTEN/ALL THE TIME)
(i) Have you ever used these behaviours against a partner? What were the circumstances? ____________________________
(j) Are there any experiences that we haven’t already discussed of this type of behaviour which you could tell me more about? ____________________________

The final section of questions is about your thoughts and opinions regarding adolescent intimate partner violence and related issues.

8. Thoughts and Opinions

(a) What are your thoughts about traditional gender roles in the family? For example the woman is a housewife and the man is the breadwinner.
(b) Describe to me your ideal relationship.
(c) Do you think it’s ever ok to use violence (physical, sexual or psychological) in a relationship? Explain your answer.
(d) What are your thoughts on the way women and girls, and violence against women and girls are portrayed in the media? i.e. TV, film, pornography, news coverage etc.
(e) How do you think adolescent intimate partner violence could be reduced or prevented, if at all?
(f) What do you think victims of adolescent intimate partner violence need from interventions?
(g) What could have helped you to recognise potentially violent behaviour in your adolescent relationships?
(h) What have you learned from your relationships to date?
(i) Is there anything you would have done differently?
(j) Is there anything you would like to add or ask me?

Thank you very much for your time. How was that for you?

____________________________________________________________

____________________________________________________________

Give participant details of support services; confirm that I am available to contact for additional information; and give participation voucher.

This interview schedule has been adapted from Barter and McCarry (2012).

**Interviewer Notes:**

**Interview One**

Length of interview:  _______________________________________

Impression of respondent: _____________________________________

Comments about the interview: __________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_______________

**Interview Two**

Length of interview:  _______________________________________

Impression of respondent: _____________________________________

Comments about the interview: __________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_______________
Appendix Four – Case Study: Milly-May

Milly-May is a 23 year old White British woman, currently living in a women’s refuge for under 25 year olds. She is heterosexual and single. Milly has a two and a half year old daughter who currently lives with Milly’s mother. After school Milly joined the Navy as a Warfare Specialist. Due to an accident in the Armed Forces, Milly has occasional mobility issues arising from a hip and lower back injury.

The second oldest of six, Milly’s childhood was traumatic. Her mother and biological father were together until she was seven years old. This relationship was extremely violent and occasionally Milly’s dad was violent towards the children. Milly’s mother was forced to take Milly and her siblings to stay in women’s refuges on several occasions. This relationship ended when Milly’s mother met her step-dad. Milly’s step-dad was strict but fair. Milly’s mum suffers with mental health problems leading Milly to take “on the mum role and [3 second pause] sort us out”. Milly feels she has no support from her family.

When Milly was 14 she joined the sea cadets, where she met her “first love” Steven. They were together for two and a half years, and “lost [their] virginity” to one another at 16. Shortly after this, they were posted to different locations with the Navy and so the relationship “broke down because like the distance”.

At 16 years of age Milly met Simon (21) and was in a relationship with him for four years. Simon controlled Milly and “he was abusive, erm but not as severe as my previous partner [Ricky]. He just like pushed and, but there were occasions where he stood on me throat and stuff like that”. Milly describes this relationship as mildly abusive, however the examples of ‘mild abuse’ Milly offers, for example “he stood on my throat’ would more accurately be described as severe direct physical force, an example of how Milly minimises and normalises her experiences of AIPV. Milly and Simon lived with his parents and Milly began working for the family’s taxi firm. Towards the end of their relationship Milly and Simon bought a house together. Milly hypothesises that the stress of the house purchase meant that Simon began “getting heavy handed”. Milly recounted one episode in which she retaliated against Simon by hitting him with a pool cue. Described as having “an obsession with porn”, Simon began forcing Milly to watch it with him and perform sexual acts she wasn’t comfortable with. This escalated when Simon took control of her wages and began making Milly earn her money again by performing sexual favours; including “on one occasion he made me erm, give him oral sex while he were on the phone to a sex line, which degraded me, you know made me feel like a prostitute”.

Following the breakdown of her relationship with Simon Milly “turned to drinking, you know partying and stuff” and had several one night stands and “fuck buddies”. She views these sexual experiences as immoral and on several occasions says “I lost all self-respect … I’m not proud of it”. After a while, she moved back home to her parents’ and “got my life on track, got a job”. Then Milly (20) met Matthew (22), her daughter’s father.
Matthew and Milly fell in love quickly: “it were just like a big whirlwind”, but the honeymoon period didn’t last long: “he were a bit like obsessive over me, you know like. He always wanted to be with me”. Within one month Milly found out she was pregnant. Matthew was a soldier and often worked away, so Milly found herself paying for him to visit her at weekends, however “he would just be interested in going out with his friends, you know, taking weed and … cocaine”. Matthew would often get drunk and take drugs and start arguments in which he’d start “pushing and shoving” Milly. When Milly was four months pregnant, there was an incident in which Matthew put “his hands round me throat and, you know, thumped me basically”. Milly found this unacceptable so she left him. He has not been involved in her daughter’s life since.

Towards the end of Milly’s pregnancy she grew closer to a friend, Ross. Milly (20) and Ross (23) had previously “dated at school kinda thing”. Milly reported no abuse within this relationship. Ross was at the birth of Milly’s daughter and took her “daughter on as his own”. They moved to a cottage in Wales for a new start. However, four days after the birth, Milly discovered Ross had been cheating on her with several different women so she “packed her bags,[and] moved back home”. In October 2012 Milly got a house for her and her daughter. Four months later (January 2013) she met Ricky.

Ricky is a year younger than Milly and in her younger brother’s class at school, although they met through Milly’s neighbour. After one night together Ricky “basically just moved himself in, stayed over mine one night, and just never went home [laughs]”. To begin with everything was “perfect, you know, for the first month … he was the most perfect guy”. His cannabis use began to impact on his mood “cos he he smoked cannabis, so erm and then he started like shouting all the time”. When Ricky didn’t have money for drugs or Milly wouldn’t give him any “he would just steal it”. This quickly escalated into physical violence: he started “pushing me, you know, thumping me”.

Milly found out she was pregnant three months into the relationship. This seemed to compound Ricky’s aggression and violence. Throughout the relationship Ricky would demand sexual intercourse up to ten times a day, which Milly would agree to, “to keep peace and calm”. On the 3rd of April 2013 Ricky and Milly “had a stupid argument, and umm, he beat me in front of me daughter, erm. Then he attacked me with a hammer. Umm. Which then resorted in me, erm miscarrying [sic] the baby cos he obviously attacked me with a hammer, and threw me down the stairs and threw me against the door”. Ricky “blamed me for losing the baby”.

Then, on the 8th of April Milly’s “daughter got took off me and placed with my mum, because err, she had bruises all over body”. On a visit to her paternal grandmother, Milly’s daughter was found to be covered in bruises and so her grandmother took her to hospital. It transpired that in the three months Ricky had known them both, he had demanded complete control over the care of Milly’s daughter because he was jealous of their relationship: “he would insist on bathing her and dressing her, putting her to bed and everything”. He had been physically abusing her. The police were involved but the case was dropped due to insufficient evidence: “basically I lost two babies in five days … I’ve not got any justice for her”. A month later Milly
discovered she was pregnant again, but this time decided that with the state of the relationship it would be best to have a termination without Ricky knowing.

This was just the beginning of the abuse Ricky inflicted on Milly. Once Milly’s daughter was out of the house the abuse escalated and became a daily occurrence. Ricky “punched, kicked, erm, ragged around by me hair”. Milly estimates that the longest the couple went without a violent argument was approximately two weeks. Ricky quit his job and “stopped me going out, seeing my friends” unless it was to work. He began to control what Milly wore and ate “because he liked curvy women so he were like a feeder, basically”. He took control over Milly’s finances and began selling her personal possessions to buy drugs, including her car. At the end of April 2013 Ricky attacked Milly with a new level of violence. He attacked and held her hostage for four hours. During this time he removed her access to telephones so she couldn’t call for help. He stamped on her, dragged her down the stairs and threatened her with a knife. When Milly tried to run out of the house he dragged her back by her hair, causing her to have multiple bald patches, whilst covering her mouth to muffle any screams. He was arrested and charged with four counts of assault by beating and had a restraining order placed against him.

The police intervention and break down of the relationship appeared to aggravate Ricky further. He breached his restraining order several times by walking up to Milly’s house and “stalking [her], erm, posting letters through [her] door saying he was sorry, knocking on [her] door at stupid o’clock when [she] was in the house on [her] own … putting his ears to [her] windows to listen to everything [she] was doing in the house, following [her]”. Milly’s experiences here reflect the widely reported increased risk of IPV and stalking following a relationship breakdown. The increasing pressure from Ricky and his constant promises that “he would never hurt [her] again” led Milly to take him back: “I had no choice, or he just wouldn’t go”. Within days Ricky had beaten her, requiring her to call the police and break off the relationship again. On one occasion, Ricky broke into Milly’s house: he “kicked my door down. Erm, begging me to take him back, cos I said I didn’t want to be with him anymore. He beat me”. Ricky strangled her and beat her black and blue. The cycle of police removing him from the premises and later bailing him only for him to return to Milly’s house continued for some time.

Milly spoke candidly about her reasons for staying with Ricky: “I still, I still loved him. And I thought I could help him, you know. I wanted to help him, come off the drugs and stuff cos he was a nice lad. We did have good times”. Immediately following this statement, Milly began recalling the first of two rapes by Ricky. Ricky’s dad bought him a flat to live in. Milly joined him there and they had a relatively calm first week living together. Then Ricky started hitting her again: “if I didn’t do what he wanted me to do or if I didn’t wake him up if he fell asleep and I just go to bed without him”, this extended into sexual violence: “… err, there was one occasion where he raped me, umm. At his flat. Erm, I just, I said I didn’t want that, you know, sex, but he still insisted on you know, having it. So we did anyway … I just laid there crying and he was like, you’re my girlfriend, I’ve got rights”. The next morning, Ricky beat Milly again, but this time in front of one of his friends. This prompted Milly to call the police, and Milly moved to a women’s refuge.
Milly was at the refuge for one week. During that week, Ricky kept ringing her and “threatening me, telling me he was going to burn my mum’s house down with my daughter in” Ricky changed tactics when threats weren’t successful. He began ringing and apologising, suggesting Milly could collect her things. Milly agreed to meet him and “he did something he had never done before and that was like, he bought me this teddy. Erm, saying I love you loads and a rose, and he’s never done, you know shown any affection like that before”, so Milly left the refuge and moved back in with Ricky. One of Ricky’s neighbours was particularly unhappy about the frequent police visits to the flat, so Ricky and Milly moved to one of Ricky’s friend’s caravans in their back garden. The violence became more frequent and more severe once in the caravan: “he just started, you know, beating me every day, in the caravan”. Milly spoke in detail about one particular incident which led to the second brutal rape:

_We went out one night. Ricky had had some cocaine. Come back to the caravan and erm, he just flipped. There was, no, it, it, it started because I was dancing in town and split my drink on him, by accident. [K: Hmm] so he hit the, umm. He left me, you know, took all me money off me in town, erm, walked off so obviously I followed him cos I had no way of getting back. Erm, we got back to the caravan you know, carried on arguing. He started hitting me and threw me against the wardrobe, erm … I tried to get out of the caravan. He, he wouldn’t let me out … and then he wanted sex. I told him I didn’t want to have sex with him, and he was like, well you wanted it this morning, and I was like, well that was this morning, I’m not having sex with you while you’re in this mood. Well he didn’t take no for an answer, so erm. He brutally raped me, erm. Tried screaming he bit my mouth. Erm he tried to suffocate me, erm, when I tried to fight him off. He punched me. He erm, you know pinched me, there were a bruise on every part of my body. Erm, and then when I tried to fight him off he like, turned me over and shove my face into the pillow and raped me from behind. Erm. And once he finished, erm, he still kept hitting me and stuff … because I wouldn’t let him come near me he kept dragging me, you know, towards him to cuddle him”._

Milly confided in the female partner of the caravan owner, who made the decision that the police should not be called. Following this incident, Ricky promised that “he had gone too far this time” and he would never treat her like that again. A week later there was a further incident in which Ricky was “hitting me, grabbing me by the hair and pushing me about”. One of Ricky’s friends became aware of the ongoing incident and helped Milly escape. Later, when Ricky returned, he hit her a further four times, at which point the owner of the caravan physically restrained him until the police arrived. In October 2013 Ricky was charged with two counts of assault and breach of a restraining order, and sentenced to seven months in prison. This hasn’t stopped Ricky from contacting Milly. He regularly writes and calls her from prison claiming to have changed and asking her to consider taking him back: “he’s still messing with my head. Like, I still love him".
Appendix Five - Case Study: Jemma

Jemma, aged 18, is white, Christian and self-identifies as working-class. She has recently moved back to her parents’ house with her two younger sisters in the same council house the family have shared her whole life. Neither parents finished school and have spent their adult lives without work, supported by the welfare system. Jemma has “learning problems” and epilepsy. She is currently at college and is single. Jemma has good memories of her childhood, although she spent a significant amount of time in the hospital due to her epilepsy.

Described as “proper decent”, Jemma’s first boyfriend Paul (25) was 11 years older than Jemma (14). They met through a mutual friend: “we met, err, well we started going out when we went to the park basically, and we just got on so we started going out”. Together for 23 months, they had arguments but “only silly arguments”, until Paul met a drug dealer, Neil, and started injecting amphetamines, at this point the relationship “went down the pan”. The arguments became more frequent and Jemma “began to not love him anymore”, so they separated. However, Neil began to take an interest in Jemma and she “got sucked under like, you know like sucked. Erm, I like got pulled in”. Neil has not worked since leaving school and is currently in receipt of job seekers allowance. Jemma was warned off Neil by several acquaintances: “she tried to warn me about him, how violent he were. He apparently locked her in a cupboard and smashed her phone up … apparently she said that he err, he slit her wrists” but Jemma “didn’t put the connection on, erm, and then I got with him”.

In the beginning of their relationship Neil was “nice” but “a bit controlling”; with evidence of the princess effect “he would buy me presents and stuff like that”. Neil began to control who she could speak to and what she could wear: “I wasn’t allowed to go out with my mates”, “I wasn’t allowed to speak to lads … he was controlling what I was wearing as well. I couldn’t wear anything that like, showed my stomach or anything like that”. If Neil disapproved of something Jemma was wearing or someone she was speaking with, he would start an argument. Neil took control of Jemma’s access to technology by monitoring her mobile phone and demanded to see all text messages and call histories, eventually banning her from using her phone all together “I wasn’t allowed to text anyone”. He also demanded to know her Facebook password and “he wouldn’t let me be tagged” in photos or in friend’s Facebook status updates. Several months into the relationship Jemma went to her school prom. Yet his controlling behaviour meant that when “he saw me talk to this lad, he’s like, ah what you talking to this lad for? And I was like, I’m not. So I had to come back from the prom early, which got me, well in a load of shit with all me mates really”.

Neil would also use insults and put downs to affect Jemma’s self-esteem: “he would tell me I was mad all the time. When he got with this 14 year old, he just sent me this text, oh she’s got bigger boobs than you anyway, and err, he would just mess with my head all the time”, “he made you feel proper unwanted … he would criticise me and say I was ugly and everything, erm, and that hurt, quite a lot”. He also used sleep deprivation as a strategy to loosen Jemma’s resolve: “The problem with Neil is he just kept on all the time, shouting, giving me the gob all
the time and, he wouldn’t stop, even if I wanted to sleep, he would still be gobbling at me, but
nurr narr, all day and it’s like, so exhausting”.

The arguments worsened if Neil had been drinking alcohol, quickly escalating into Neil hitting
Jemma, and other forms of direct and indirect physical violence: “he used to throw his stuff
about before he used to hit me”. On one occasion Neil was in a “mard” so he grabbed Jemma
around the throat and pushed her down the stairs, “he’s smacked me round the face, he’s erm,
kicked me in my legs, he’s thrown stuff at me, erm, he’s grabbed hold of me”. On another
occasion Jemma locked herself in the bathroom to escape Neil but “he’s there, having mards,
smashing through the bathroom door”.

The couple began cohabiting as soon as Jemma was legally allowed out of her parents’
custody: “I moved in with him soon, straight away when I was 16”. However this wasn’t a natural
development in their relationship, Neil coerced Jemma into moving in with him: “he blackmailed
me with that, he was like well we’ll split up if you don’t move in, err, if you don’t move in with
me then we’re going to split up”. Jemma hypothesises that this was so that Neil could have
more control of her, enabling him to force her into intravenous drug use: “so, but I moved in
with him and that’s when he could, get me hooked on drugs [laughs]”.

Within two months Neil was forcibly injecting Jemma with amphetamines, “I was 16 years old
and I had never tried it before and Neil was like, try amphetamines. I was like; oh they’re proper
dodgy, no I don’t want to”. Despite her protests, Neil administered Jemma’s first amphetamine
dose “… when he had the needle in my skin, I, I, I changed my mind and said no. But he,
injected me with it anyway”. Neil also encouraged Jemma to take other drugs: “I kind of injected
amphetamines and then did pills and M-CAT, everything really”. This continued in secret for
two years: “I kept on taking it, I kept on having bruises on my skin cos I was injecting it but, I
felt ashamed … I kept it secret for two years, from my parents”. Jemma’s relationship with Neil
and her drug use led her parents to ban her from the family home, “my mum said, oh I’ll disown
you otherwise, you’ll have no family”, so she felt forced to stay with Neil. Eventually, Jemma
learnt to inject herself: “I kept on doing drugs because he kept pumping it into my system cos I
couldn’t inject myself and he was injecting it for me … I learnt to do it myself, when I was about
17”. The catalyst for the couple’s most volatile arguments was drugs; where they would get
them from and how they would pay for them. Eventually they began shoplifting together to fund
their habits.

Jemma lost contact with her friends “I wouldn’t go out with my mates after that, I was just stuck
in those four walls of that flat all the time, just taking phet”, Neil’s attempts to isolate Jemma
were successful. After some time Jemma’s amphetamine use put her in hospital “I got a bit
worse for wear on the drugs, because he got me into them and I was in hospital all the time …
I had a heart monitor on, on me and all sorts”. It is suspected that Jemma’s amphetamine use
has caused her to develop paranoid schizophrenia: “in some situations that I find dis-
distressing I find, completely schiz out. I think there’s someone out to get me; I think there’s
cameras, people watching me, cars following me”. Jemma is medicated and compliant with
help from her parents: “my mum gives ‘em me”. Jemma’s relationship with Neil and subsequent
drug use has also meant she’s developed depression and anxiety. She has suffered from suicidal thoughts and self-harm: “err I used to err, razors, umm slit my wrists”. She has tried to take her own life on more than one occasion: “I just tried to jump out of a, err car. Err yeah I jumped off a bridge as well umm [K: Mm] I jumped into a train tracks to try and kill myself [laughs] … whilst I was on the drugs [K: what sort of thoughts were you having?] [6 second pause] just that I wanted to go really [laughs] just, yeah, I weren’t normal”. She directly attributes these suicidal thoughts, self harm and suicide attempts to her drug use “most of them when I was on drugs to be honest”.

The first time Jemma sought hospital treatment during her relationship with Neil was due to a Grand Mal seizure: “I had a massive fit and I banged my head on the table. The table went upside down”. Rather than being caring and concerned “Neil starts having a mard about how I’d tipped his baccy [tobacco] over, so I had to go all the way over to the shop, buy some baccy for him. He didn’t care about me. I were nearly dead like [laughs] … then I went to hospital and had a heart monitor put on … I’d discharged myself, and I was going to walk from there to [home town]”. Jemma was prepared to walk for over five hours through the Peak district to get back to Neil and perhaps more importantly the amphetamines.

Jemma suspected Neil of cheating on her, however Neil managed to manipulate her thoughts and emotions in an attempt to deny her accusations: “he got with me best mate, but he denied it for years and years until I found texts on Facebook that he did actually do it, and he had been telling me that he didn’t, so he did cheat on me ... he was bringing young girls back to the flat while I was there. Err, basically seeing other young girls while he were there with me. Bringing them round the flat and making out I were mad, saying I was not seeing these girls when I was”. These techniques of minimisation and denial worked to silence Jemma by turning her against herself and making her doubt her sanity.

On one occasion, Jemma attempted to break up with Neil and escape from Neil’s flat by kicking through a glass door. Following hospital treatment Neil “was supposed to be looking after” Jemma but instead refused to let Jemma rest and continued to force feed her amphetamines against medical advice. This eventually led to her stitches ripping and the wound becoming infected. At this point Jemma sought advice from her parents, who, on discovering she was still taking drugs, “wouldn’t let me out for two weeks”. Unfortunately, this failure to comply with medical advice has left Jemma with a permanent scar 5 inches long and 1.5 inches wide on her right lower leg.

There was also financial violence within Jemma and Neil’s relationship: “He made me sell my mobile phone … he made me spend my bursary, I had £1200, and he made me spend it all on drugs”. He frequently stole money from Jemma’s account after she told him her PIN so he could take out money for drugs. “We was going to get some drugs recently and I told [him] to draw a tenner out and he said his gyro had come through, and he nicked, he put me in £80 worth of debt. So I couldn’t buy my four year old sister a present”. 

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In September 2013 Jemma was sexually assaulted by unknown perpetrators, although Jemma suspects it was Neil and his friends: “I come back from my grandma's and I didn’t take any drugs that day or anything, and, I remember just drinking a cuppa tea, blacked out, ended up in bed, upstairs with bruises, got up in the morning with bruises all over my legs, like handprint bruises, and I was limping and I get flashbacks to what happened. Someone carrying me upstairs, erm. So I reckon it might have been him but he denies it so I reckon it’s his mates that have done it basically”. Neil was not supportive of Jemma at this time: “When it happened I went to Neil, and I was crying, I was like, ohh I’ve been raped and then all of a sudden, and he just called me a liar and booted me out the door basically … I was hysterical, I needed to tell someone, Neil, and, he called me a liar”. Neil’s reaction meant Jemma didn’t notify the police for several days. The police investigated the incident but could not identify any suspects. She has since been diagnosed with Post-traumatic Stress Disorder and frequently suffers with flashbacks of the assault, nightmares and anxiety.

Jemma’s mental health workers were attempting to encourage her to leave Neil and stop taking drugs: “they tried, me get, talking to me first” but when that didn’t work: “they were going to section me. Erm, because I was so underweight at the time from being on amphetamines [K: Hm] it’s about, I was, erm, 17, 18 and I was only seven stone, maybe under”. Social services were also involved. After 2 years, Jemma, aided by her mental health workers, moved into a refuge for under 25s and was weaned off the drugs. She was clean and away from Neil for five months before he concocted a story about him dying so that Jemma would return to him: “I had split up with him completely until he said he was dying [K: Mm] so, which made me think, oh right he really is dying, but he wasn’t, it was just a thing to try and get me back basically [laughs]”. Jemma was concerned that Neil might die, so she returned to his flat. Within three days she was then forced into using amphetamines again: “he just used to do me head in, ah do you want some, do you want some, do you want some? Pushed in my face really”. In those three days Neil and Jemma began “talking and it were fine … it were like a new relationship again” and “then after three days it just, turned upside down again”. Neil began having his “mards” again, and was extremely jealous and controlling. Two months later Jemma left Neil and has now been clean and single for three months with the support of her family and the outreach branch of her local domestic violence charity.
### Appendix Six – Coding Framework

<table>
<thead>
<tr>
<th>Theme</th>
<th>Nodes</th>
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<tr>
<td>Catalysts</td>
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| Support – formal/informal | Criminal justice              | Mental health                |
|                          | Treatment for injuries        | Pregnancy                    |
|                          | Family                        | Friends                      |
|                          | Restrictions for accessing    | Improvements                 |
|                          | Technology                     |                              |
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ref: ethics/13015

10 June 2013

Dear Kirsty

Research Ethics Committee 1

McGregor, Deakin: Victims of adolescent intimate partner violence: prevention and intervention (ref 13015)

I write to confirm that the amendments to the ethics application form, the participant information sheet, advert and the research disclosure policy satisfy the concerns of the Committee and that the above project therefore has ethical approval.

The general conditions remain as stated in the letter of 7th May 2013.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by June 2014, whichever is earlier. When completing this form, please reference your project as:

‘McGregor, Deakin: Victims of adolescent intimate partner violence: prevention and intervention (ref 13015)’

Yours sincerely,

Katy Boyle
Secretary to University Research Ethics Committee
Appendix Eight - Recognising Sexual Violence: The Case of Rachel

Conversely two participants did recognise their experiences as sexual violence: Rachel and Milly-May. Rachel, who we have already met, was in a relationship with Karl, a fire fighter, for approximately 20 months. Described as good looking and charming, within three weeks Karl began demanding to know Rachel’s whereabouts 24 hours a day. He used technology to monitor her whereabouts, her communication with others and her finances. Approximately one year into the relationship, Karl and Rachel separated because he had forced her to have a pregnancy termination at 18 weeks. The first incident of sexual force described by Rachel occurred the day she had the termination:

I just wanted a bath and then I didn’t feel very well and then, because he’d come in and seen me in the bath then he wanted to be doing things and I didn’t want to [K: yeah] I didn’t think it was appropriate anyway but because I was just tired, I was so tired that I just had to. I felt that he had been good taking me there [to his brother’s house], so I didn’t have to go back to that house [the refuge] and, that he was looking after me so I just did it so that I wouldn’t make anything funny or cause any trouble.

Around this time Rachel felt that without Karl monitoring her she return to a flat of her own from her parents’ house. When Karl found out she was living alone he began monitoring her again. Eventually he located her address and began pursuing Rachel again. Before long their relationship was as abusive as it had been previously, with one further development. Karl began demanding that Rachel viewed pornography with him, claiming that if she truly appreciated him, her ‘only friend’, then she would do anything for him. When she refused on one occasion, Karl poured a fresh cup of tea on to her lap causing severe burns which required hospital treatment. She was terrified of the physical violence escalating so she did as he demanded (Ullman and Filipas, 2005). This then escalated to him forcing her to dress up in lingerie and masturbate on Chatroulette to other men whilst Karl pleasured himself. Rachel described feeling particularly confused at this demand as Karl was so jealous of any potential interaction she had with other males. This demonstrates Karl’s desire to be powerful and have control over Rachel, rather than the sexual violence being driven by sexual urges (Teitelman et al., 2008; Tolman et al., 2003; Brownmiller, 1975).

This sexual violence escalated into multiple perpetrator rapes. Without warning, Karl arrived at Rachel’s flat on one occasion with two other men she did not know. When Rachel was told what was going to happen, she tried to refuse, however Karl threatened her with physical violence. She felt that as there were more of them she would be overpowered if she tried to resist: “I was so scared”. During the first multiple perpetrator rape, one of the men asked Rachel why she was “just lying there like a corpse”. Rachel suggested during the interview that this individual must have been aware that she wasn’t there by choice and struggled to understand why he would continue to rape her anyway. Karl beat her up after this occasion because of the man’s comment.

Going forward, Karl would regularly make threats that men would be arriving at Rachel’s flat any minute so that she was always on her ‘best behaviour’. Rachel was always petrified that the men would return and on one occasion Karl told her to put on her best underwear because they were going elsewhere for a similar incident. When she refused he put her in the car and stripped her naked. They physically fought in the car for a while, until he drove down a country lane and threw her out of the car shouting and screaming that some men would be with her in a few minutes to have sex with her. Rachel was visibly shaking and close to tears when recalling how scared she was at this point and how the time she was there, alone and naked, felt like an hour. Ten minutes passed before Karl returned and picked her up claiming she had

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12 Chatroulette.com is an online chat forum which pairs users from around the world randomly for web-cam based conversations. Despite user terms and conditions Chatroulette has received vast criticism with respect to the offensive, obscene or pornographic material that some users of this site were exhibiting. According to a survey carried out by RJMetrics, approximately 1 in 8 of feeds from Chatroulette involved ‘x-rated’ content (http://techcrunch.com/2010/03/16/chatroulette-stats-male-perverts/).
saved her from the men because they ‘looked really mean’. Rachel didn’t think that these men existed in hindsight, and wondered if it was all an attempt to make her so fearful of repercussions that she would do whatever Karl suggested.

This severe psychological and sexual violence continued to escalate. On the second occasion when three men turned up at Rachel’s flat and she refused to take part, Karl punched her in the face and forcibly stripped her naked in the bedroom, whilst the other men waited in the living room. After the second rape, a friend saw the bruising Rachel had obtained during the attack and called the police. Karl had videoed the incident on his mobile phone and sent it to her family in revenge for going to the police, further adding to Rachel’s psychological trauma. On our last meeting, Rachel confirmed that the Crown Prosecution Service had dropped the charges (of rape and sexual assault) against Karl due to a lack of evidence. Whilst she was grateful for the confirmation that she would not have to stand up in court, she did display concern for Karl’s future victims and a want for justice. The inclusion of other men in Karl’s sexual exploitation of Rachel led her to feel compelled and coerced into giving up her sexual sovereignty in order to minimise the potential physical violence she would face.

This case study provides key evidence for the extremity and severity of sexual violence that young people face, made worse by the existence of technologies allowing easy access to pornography and the instantaneous exploitation of adolescents.
Appendix Nine - Recognising Sexual Violence: The Case of Milly-May

At age 16 Milly-May met Simon (21) and began a relationship with him of four years. Milly-May and Simon lived with his parents and Milly began working for the family's taxi firm. Described as having “an obsession with porn”, Simon began forcing Milly-May to watch pornography with him and perform sexual acts she wasn’t comfortable with: “he made me, erm, give him oral sex while he were on the phone to a sex line, which degraded me, you know made me feel like a prostitute”. This escalated when Simon took control of her wages and began making her earn her money again by performing sexual favours. However Milly-May did not see this as particularly abusive as there was no physical violence (Leen et al., 2013; Barter et al., 2011).

Her third relationship with Ricky however was different: “Ricky always used to say he had high testosterone levels so he always demanded sex all the time. I used to do it to keep the peace and calm”. Continually having sex to avoid an argument, Milly-May felt used. This was exasperated when Ricky forced himself on Milly-May claiming he had “rights to her body” for sex because she was his girlfriend:

I’d just finished work. I’d been on a shift and, I didn’t get in to about half 11 in the evening. And, I kept on trying to like push himself on me, and I was like Ricky, I don’t want it. But it ended up happening anyway. I just laid there crying and he was like, you’re my girlfriend I’ve got rights.

Milly-May, under duress, forgave this incident and their relationship continued. The physical and sexual abuse escalated however, and on one particular occasion in which Ricky had been drinking and taking drugs it came to fruition:

We went out one night. Ricky had had some cocaine. Come back to the caravan and erm, he just flipped. There was, no, it, it, it started because I was dancing in town and split my drink on him, by accident. [K: Hmm] so he hit the, umm. He left me, you know, took all me money off me in town, erm, walked off so obviously I followed him cos I had no way of getting back. Erm, we got back to the caravan you know, carried on arguing. He started hitting me and threw me against the wardrobe, erm … I tried to get out of the caravan. He, he wouldn’t let me out … and then he wanted sex. I told him I didn’t want to have sex with him, and he was like, well you wanted it this morning, and I was like, well that was this morning, I’m not having sex with you while you’re in this mood. Well he didn’t take no for an answer, so erm. He brutally raped me, erm. Tried screaming he bit my mouth. Erm he tried to suffocate me, erm, when I tried to fight him off. He punched me. He, you know pinched me, there were bruise on every part of my body. Erm, and then when I tried to fight him off he like, turned me over and shoved my face into the pillow and raped me from behind. Erm. And once he finished, erm, he was still kept hitting me and stuff … because I wouldn’t let him come near me he kept dragging me, you know, towards him to cuddle him.

On the advice of an adult female friend, Milly-May decided not to involve the police at this stage. A further physical attack in front of others prompted her to seek hospital assistance which led to police involvement. Ricky was later convicted of rape and at my last meeting with Ricky was awaiting sentencing. This particular incident could be interpreted as Situational Couple Violence as it appears to be as the result of an argument (Johnson, 2008). However, a more detailed analysis highlights the coercive control Ricky subjected Milly-May to suggesting her experiences fit with Johnson’s Intimate Terrorism typology (Stark, 2007; Johnson, 2008). Ricky removed Milly-May’s access to money and subsequent ability to get to the isolated caravan he had moved them to; his extreme reaction to a mundane drink spilled on him; his excessive reaction to Milly-May’s refusal to have sex with him; his infliction of injuries to “every part of [Milly-May’s] body”; and his demands for intimacy and forgiveness following the incident all suggest that this was an intentionally brutal attack on a victim already ground down by his persistent and escalating abuse.

Rachel and Milly-May both recognised their experiences of rape and sexual violence as such. As previously mentioned I believe this is because of the physical violence (Leen et al., 2013) and the intervention by health services and criminal justice agencies. The process of accessing the health services will likely have meant that Rachel and Milly-May recognised their physical
injuries and will have explained their origins to triage and treatment staff. Secondly, the criminal justice process will likely have meant that they will have had to repeat their experiences to multiple police officers, sexual violence support professionals and potentially forensic medical examiners. This telling and retelling of their narratives and input from professional is likely to have reframed their experiences from 'normal' adolescent sexual activity to rape and sexual violence. Whilst they may have previously been aware that this behaviour was wrong, both Rachel and Milly-May did not use the terms sexual violence or rape until narrating their more extreme incidents. The analysis of data collected for this thesis found that 94 per cent of the participants experienced sexual violence during adolescence at least once. However, just 12.5 per cent of these participants recognised their experiences as such. This suggests that we need to educate our young people about the subtleties and difficulties surrounding sexual activity, emotional maturity, power relations, consent and coercion.