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Domestic Violence (DV) in the Netherlands and Spain. Characteristics of the Perpetrators and Measures Implemented to Combat DV: A Comparative Study

Violencia Doméstica (VD) en los Países Bajos y en España. Características de los agresores y medidas implementadas para combatir la VD: un estudio comparativo

Dña. Julia del Carmen Bocatius

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AUTHORISATION FOR THE PRESENTATION OF THIS THESIS

Prof. Dr Samuel Rodríguez Ferrández is the Director of this Doctoral Thesis, titled "Domestic Violence (DV) in the Netherlands and Spain. Characteristics of the Perpetrators and Measures Implemented to Combat DV: A Comparative Study,' written by Julia del Carmen Bocatius, Department of Legal History and Criminal & Criminological Sciences (Faculty of Law). Prof. Dr Rodríguez Ferrández authorises the thesis's presentation to be processed since all formalities and requirements for eligibility for its defence have been met.

The signature confirms that the requirements of the Royal Decree 778/1998 of April 30, 2007, and 1393/2007 of October 29 have been fulfilled.

Murcia, Spain, September 2021

Signed Prof. Dr Samuel Rodríguez Ferrández

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Dedication

This PhD thesis is dedicated to my mother, who always encouraged me to follow my heart and ideals. She would have loved to be here together with me to celebrate this accomplishment. I like to think that she is cheering for me from heaven.

Abstract

Aims: This thesis highlights how menacing and costly domestic violence (DV) is for societies, not only monetarily but also as a representation of a global problem profoundly affecting individuals of both genders, physically and psychologically, in all age categories, social status, ethnic and sexual minorities.

This study's contribution centres on DV in two European countries: The Netherlands and Spain. It presents data on perpetrators characteristics, both male and female. It also compares the measures these countries apply to combat DV.

Design: The data was retrieved from relevant scientific search machines and other scientific information sources to respond to the research questions. The Dutch data was obtained from the *Dutch Criminal Courts* (period 2015-2018), filtering DV cases, which were treated by the *Prosecutor Office*. The result was a sample of 253 severe incidents from which nineteen perpetrators were females. The thesis presents anonymised real-life incidents of male and female perpetrators in the Netherlands, their psychopathology, and characteristics.

The data from Spain was collected from the *INE (Spanish Statistical Office), Ministry of Equality*, and research literature.

Findings: The results are in line with the asymmetric perspectives of DV: The number of female victims is significantly higher than the victimisation of men in both countries.

Practical implications: This thesis could be helpful for policy-makers because it draws on a broad spectrum of DV issues and recommendations to prevent this persistent problem.

Keywords: Domestic violence (DV), intimate partner violence (IPV), LGBT+, DV in Spain, DV in the Netherlands, symmetry and asymmetry of DV, DV risks factors, EU policymaking.

Abstracto

Objetivos: Esta tesis destaca cómo de elevados son los costes de la violencia doméstica (VD) para las sociedades, no solo monetariamente, sino como representación de un problema global que afecta profundamente a las personas de ambos géneros, en forma física y psicológica en todas las categorías de edades, estado social, minorías étnicas y sexuales.

La contribución de este estudio se centra en VD en dos países Europeos: los Países Bajos y España. Presenta datos sobre perpetradores de violencia, masculinos y femeninos y sus características. Hace también una comparación sobre las medidas aplicadas en estos dos países para resolver los problemas surgidos por VD.

Esquema: Los datos fueron obtenidos de los buscadores académicos más relevantes y otras fuentes de informaciones científicas. Los datos de los Países Bajos fueron extraídos de las Cortes de Justicia (periodos 2015-2018), filtrando los casos mas severos de VD que fueron tratados en las Fiscalías de los Tribunales Penales Holandeses, llegando a una muestra de 253 incidentes graves, de los cuales diecinueve eran mujeres. La tesis presenta casos reales anonimizados de hombres y mujeres perpetradores de los Países Bajos, sus psicopatologías y características.

Los datos de España fueron obtenidos del INE (Instituto Nacional de Estadística), Ministerio de Igualdad y literatura científica.

Conclusiones: Los resultados están en línea con la perspectiva asimétrica de VD: el número de mujeres víctimas es significantemente mayor que la victimización de los hombres en ambos países.

Consecuencias Prácticas: Esta tesis puede ser útil para las autoridades legislativas, porque presenta diversos aspectos de la problemática de VD y hace recomendaciones para prevenir este problema tan persistente.

Palabras claves**:** Violencia doméstica (VD)**,** violencia de parejas íntimas (VPI), LGBT+, VD en España, VD en los Países Bajos, asimetría y simetría de la VD, factores de riesgo de la VD, UE formulación de políticas.

Introduction

Domestic violence (DV) is a shadow that impacts the daily life of millions of people worldwide. In Western and developing countries, children, young people and older adults can become victims. According to the *World Health Organisation* (WHO), globally, 31% of women (around 852 million) experience physical or sexual violence perpetrated by intimate partners in their lifetime. In Europe, DV prevalence is approximately 26% (WHO, 2021). When violence occurs, the whole family is affected, the intimate partners and their children, and eventually, other close family members sharing that home (e.g. older adults, and pets).

In context, DV harms us all as a society due to people's suffering from their enchainment in violence. For governments, DV has a negative impact on their budgets because of massive financial costs (e.g. healthcare, loss of productivity, justice systems). For example, in Europe, approximately €228 billion are incurred annually on services caused by gender-based violence against women and men (Walby and Olive, 2014). A budget of that dimension could be spent on projects that actively prevent DV rather than reactively after the damage has occurred. Quality education for all is an excellent example of prevention. In itself, in the long term, education could preclude DV from happening, opening doors for more satisfying lives.

Nevertheless, other factors also maintain the circle of violence: Gender inequality, discrimination, social attitudes that justify violence, lack of education resulting in poverty and female's lower levels of employment than men, exposure to violence in childhood. None of these factors are a new phenomenon. In the past, women's movements had to fight against the invisibility of women's abuse at the hands of their intimate partners since there was no law to protect them. Women were considered the property of their husbands, who could rape or abuse their wives financially without fear of prosecution. Women had to fight against being considered second-class citizens without fundamental rights such as voting or equality to men in all fields of life. Fortunately, some progress has been made. DV is no longer considered a private matter but a denial of human rights. International organisations such as the *World*

Health Organisation, *UNICEF*, the *World Bank*, the *European Union*, and other prestigious institutions have raised their voices about the necessity to unite forces to stop violence against women and girls and other vulnerable individuals (e.g. LGBT+ people, refugees, migrants, and ethnic minorities). Children living in a violent environment is presently being considered child abuse.

In some countries, governments have included intimate partner violence as a crime in their penal code. In others, DV is still condoned because there are no protective laws. Alternatively, if laws exist, they are not implemented. Cultural traditions can also maintain harmful practices (e.g. honour killing, female genital mutilation).

This study aims to unveil the diverse faces of DV and how that violence profoundly affects people's lives where they should feel safe: Home. It also analyses how governments' (in)actions can have consequences and maintain circles of violence. Although many European countries ratified the *Istanbul Convention* compromising themselves to stop violence against women – for which they issue policies and laws to accomplish it – the hard reality is that the number of DV victims remain high. Why is that? This 'unbeatable' character of DV caught my attention. Did it give incentives to investigate DV to answer the following research questions:

1) Why would anyone stay in a relationship that harms physically, psychologically, and financially?

2) What kind of factors contribute to maintain the pervasive DV phenomenon?

3) What type of characteristics do DV perpetrators have?

4) Why we, as a society, cannot defeat the invisible but dangerous DV reality affecting many people globally, causing more deaths than terrorism?

5) What kind of measures take a Northern and a Southern European country - differing in their culture and representing old versus new democracy - to solve domestic violence issues?

The sources of information to write this thesis, including the answers to the research questions, required data which was obtained from scientific literature and literature reviews, except for question 3. For that question, I conducted my own research with data from the *Dutch Criminal Courts* (period 2015-2018), filtering DV cases, which were treated by the *Prosecutor Office*. The result was a sample of 253 severe incidents (Chapter 5, Sections 5.4 to 5.7, pp. 208-277).

The data from Spain was collected from the *INE* (*Spanish Statistical Office*), Women's Ministries, and research literature (Chapter 6, Section 6.2, pp. 285-297).

This study is divided into nine chapters that build upon each other, aiming at answering the "What's," "How's," "When's," and "Why's" of domestic violence in two European countries: The Netherlands (where I live) and Spain (where I am doing my PhD). The chapters are interrelated because the presence or the absence of certain factors can ignite violence in homes. The thesis is outlined as follow:

Chapter 1

Various sections explain domestic violence and its historical background: From a lack of rights to women and total impunity for the batterers, it became an issue treated globally. This chapter introduces the debates about the different perspectives existing about the asymmetry or symmetry of violence. It also explores DV in populations other than female (heterosexual) victims, to a rising phenomenon called *Hate Crime* that primarily affects same-sex couples and ethnic/sexual identities. It considered how the Covid-19 pandemic affected the health and wellbeing of millions of people worldwide and increased the number of DV incidents during confinement. Also, the high costs of DV and the negative consequences of violence on children were analysed.

Chapter 2

It is dedicated to exposing how some risk factors can exacerbate domestic violence in homes and may cause homelessness on women and their children. In this chapter, exposure to different kinds of abuse one partner can exercise onto the other (e.g.,

psychologically, economically, sexually) is explained. Also, how bodily and mental issues, drugs and alcohol dependency have harmful consequences in families. Finally, other DV high-risk factors are mentioned, such as poverty, lack of education, and the destructive influence community (condoning) violence has on people's lives.

Chapter 3

It is concerned with the strong link between psychopathology and DV. There are many personality disorders associated with DV, but only a selection of the most currently found among perpetrators was included: Antisocial Personality Disorder; Borderline Personality Disorder; Attention-Deficit Hyperactivity Disorder; Depression; Post-Traumatic Stress Disorder; Risk of Suicide, and the Battered Women Syndrome that explains the dysfunctional reactions a woman may have as a result of battering (e.g. the killing of her husband).

Chapter 4

Deals with DV legislation in Europe. Although the thesis is related to the Netherlands and Spain, Europe plays a crucial role in the fight against DV in its territory. There is increasing influence of *European Union* (EU) policies, initiatives and programmes introduced in member countries to break the barriers that impede society's development and equality among their citizens. This section analyses DV against women and men in Europe, giving extra attention to male victimhood.

Chapter 5

Shows DV in the Netherlands. It presents registered crimes, Dutch policies to tackle domestic violence and how the resources are allocated among the immense machinery of health, law enforcement and various social services interventions. The *Dutch Entrustment Act* (TBS Measure) is introduced. Sections 5.4 to 5.7 presents the data on male and female perpetrators. Besides, real DV cases obtained from the prosecution office (years 2015-2018) are shown.

Chapter 6

This chapter introduces DV issues in Spain and the changes in the country since the fall of Franco's dictatorship. From being a conservative society with rigid gender roles for men and women to a more open community (e.g. since 2009, Spain has a gay-friendly policy that recognises sexual orientation right for asylum). However, DV is still condoned in some circles, and national and international legislation has been issued to achieve higher levels of gender equality. In Section 6.2, the Spanish data on DV prevalence is presented.

Chapter 7

This chapter presents a data comparison between the Netherlands and Spain. Firstly, from the *FRA Survey* (2014) -*European Union Agency for Fundamental Rights (FRA*)- and secondly from the data on different forms of violence against women from the *United Nations Women* (2016).

Chapter 8

Section 8.1 explains which measures are taken to combat domestic violence in the Netherlands, the campaigns launched to protect children from maltreatment, the type of assessment tools used by professionals, and evidence-based policing.

Section 8.2 presents the measures taken to combat DV in Spain. For example, the legislation changes to protect women and other vulnerable family members; and the differentiation Spanish legislation makes between domestic violence and gender-based violence. Besides, issues of gender equality are exposed.

Chapter 9

It presents the results section. All research questions are answered in this section (for the reader's convenience). There is also a discussion on the limitations of this study.

"Violence against women and girls continues unabated in every continent, country and culture. It takes a devastating toll on women's lives, their families, and society as a whole. Most societies prohibit such violence - yet the reality is that too often it is covered up or tacitly condoned."

Former Secretary-General of the United Nations, Ban Ki-moon, 2007.

Chapter 1 General introduction to domestic violence (DV)

1.1 DV Historical background

Patriarchal systems are dominant, shaping societies and their traditions. Reforming settled ancient customs and principles is, therefore, difficult. In European civilisation and others worldwide, men did not consider women equal citizens. Women were believed to be creatures of feelings but not reason, or even their husbands' private property. This helps explain why, for centuries, justice systems did not treat marital rape as a crime. The lack of women's rights in the past can be explained by the traditional roles women were supposed to play, mostly in performing unpaid family labour activities, such as caring for their children and family. Due to these responsibilities, they concentrated on their domestic activities, while men were the breadwinners. This labour division created a generalised and persistent norm, implying that women's place is at home. Even thinkers such as Kant, Hegel and Rousseau assigned women the role of homemaker, which implied women's broad social and economic subordination to men. The resistance to changes in this status is predominant in many governments that should be upholding the rights of the unprotected and vulnerable (humans and non-humans) but fail to do so.

Gender roles across cultures are passed down to succeeding generations, so they continue to perpetuate differences and inequalities between genders. Although gender roles differ across societies, depending on cultural traditions and beliefs, politics, and women's access to education, the present reality is that DV is still very much alive worldwide, profoundly affecting the health and wellbeing of women and children.

This chapter describes how far DV issues are intertwined with a lack of rights for women, and how cultural motivations and traditions maintain as well as condone violence. It also discusses the hard battles of women's movements to make DV visible and obtain equal rights to men by challenging an extensive system of structural gender inequalities (with political roots) that considered DV a private issue, out of any government's purview.

The following topics will be discussed in this chapter:

1) Discriminatory policies against women.
2) Women's rights.
3) DV as a private problem.
4) Marital rape.
5) How institutions dealt with DV.

1) Discriminatory policies against women

When Ester Boserup (1970) published her pioneering book "*Women's Role in Economic Development,*" she provided, for the first time, comprehensive empirical data about women's contributions to agriculture and industry. She also highlighted the discriminatory policies, uneven opportunities, inequalities, and different forms of women's subordination (Beneria and Sen, 1981).

There have been many changes in the world since her writings. Nevertheless, her contribution remains prominent, and her work inspired the *United Nations Decade for Women* (1978-1986), research and enquiries on gender issues. Boserup gave an overview and compared the role of the development processes in 'female' and 'male' farming systems and how this process has changed the patterns of other non-agricultural activities, e.g. migration (Beneria and Sen, 1981).

Boserup argued that gender (female) and age (children) are factors in labour division in developing rural communities. For instance, the traditional economy of shifting agriculture in Africa was, and often still is, based on light tools (e.g. the hoe) which women can employ. When the industrial revolution took place, with the introduction of massive technology, women (being by nature on average physically weaker than men) were less wanted as labour forces than men. Women were not as vital to manage the heavy farm machines used (ploughs); to operate them requires arduous work (Beneria and Sen, 1981).

Women, therefore, only carried out primarily unpaid family labour activities such as the care for families and children. They also performed other activities such as preparing the soil for planting and caring for farm animals. Due to children bearing, rearing, and

caretaking responsibilities, women concentrated their activities within the home, while men were the breadwinners. This labour division created a generalised and persistent norm that implies that women's place is at home (Giuliano, 2017). Since gender roles across cultures are passed down to succeeding generations, they perpetuate differences and inequalities between genders, for example, in primitive rural agricultural communities, the oldest man in the family was the only ruler and the decision-maker; he assigned the amount, and the type of work women and children had to do to increase the family income and, therefore, men reduced their own work burden. In many cultures, females are expected to serve the male family members, care for the children, be responsible for all domestic duties, and work in the fields processing crops (Boserup, 1965).

In developing countries with pro-natalist governments, women were condemned to spend their lives (from puberty to menopause) being frequently pregnant and consequently regularly breastfeeding, for which they often paid with their own lives because of the burden on their health. Rural societies in Africa then responded to the resulting high mortality of children and women with polygamy. In areas with sufficient land to cultivate, the head of the family created wealth by saving manual workers' pay when their wives and children laboured the land. The result was an unequal burden on women and their children (Boserup, 1989).

The new technology introduced by the industrial revolution facilitated economic development, larger productivity, and the creation of surpluses that could be traded. The subsequent economic growth gave rise to new towns and the massive urbanisation of cities that demanded more services and industries; thus, factories arose, offering employment. Men had to migrate to work for a wage. They had the money to buy more land, while women did all the work in homes and the fields, unpaid (Boserup, 1989).

Women (e.g., unmarried, separated, without children to support them, and widows) migrated to the cities where the unskilled labour market was available.

Women were welcomed in the cities to work in factories, manufacturing products, domestic services, or other low standard work (Beneria and Sen, 1981). However,

those females who migrated to the city had not had access to education; simply because (when possible for their parents), only boys could receive an education. Girls had to help their mothers in the household and the fields instead of going to school. This new urbanisation of cities had a high price for women; they were exploited and received meagre wages lower than men's (Boserup, 1981).

2) Women's rights

In many civilisations worldwide, women have been deprived of their rights and were (and often still are) not regarded by men as equal citizens. Sometimes, women were believed to be creatures with feelings but not reason, or even their husbands' private property; and considered a means for sexual and reproductive matters (Rubio-Marín, 2014).

During the industrial revolution in Western countries, wage segregation was not the only disadvantage women had; they did not have legal rights. Social movements can call attention to relevant issues for societies that need to be changed and be considered in governments' agendas. Many policy scholars had identified how vital those social movements are (Weldon, 2011). Thus, women organised themselves and actively participated in campaigns to claim equal positions and the same conditions as men (e.g. the right to have the same wages for the same work). Unfortunately, this issue is still not an accomplished reality in many countries. Most of the rights women have achieved, such as voting, the right to higher education; egalitarian jurisprudence, and participation in prominent political positions, science, and labour markets, were once exclusively male domains; reflecting a dominant male viewpoint and their experience of the world (MacKinnon, 1983). Those rights were only acquired after heated public debates.

However, as Schneider (2000) noted, DV is an issue of gender subordination in the first place, and focussing entirely on traditional interventions or legal solutions for the problem of DV may distract our attention. There are incongruencies between claims

of equality and their practice because the role of laws in decision-making is inseparable from political contexts (which sometimes allows DV to happen) (Schneider, 2000).

Before the concessions of suffrage rights (which occurred in Europe only by the early to mid-twentieth century), married women were considered a sort of marital property (Doepke, Tertilt, and Voena, 2011).

Regarding the suffrage rights in Europe, in the Netherlands, those rights were stated in the Dutch Constitution of 1848. However, the Constitution did not explicitly affirm that the right to vote was only for men. In an amendment four decades later (in 1887), it expressly asserted that the right to vote applied only to men (Dutch Review, 2019).

According to Dutch laws, women were considered not as competent as men to have civil rights up to that moment. Separated and divorced women were vulnerable to the dominance of male authorities, and married women, in general, were subordinated to the domination of patriarchal systems. In the Netherlands, the full right to vote and be elected was first introduced in September 1922 (Dutch Review, 2019).

In Spain, those voting rights were conceded in 1931, after intense involvement of women's movements to obtain a democratisation process to achieve critical gender rights and better legislation for women, such as implementing rights to divorce, contraception, equal pay, and economic equality (Melo, 2017).

At a domestic and international level, DV had different legal treatment over time. The *United Nations Convention on the Elimination of All Forms of Discrimination Against Women (*CEDAW*)* states that men and women should have equal rights (Guruge, Jayasuriya, and Gunawardena, 2015). It is discriminatory to make any distinctions based on sex differentiation or marital status. That could impair women's fundamental rights in different social, economic, cultural, or civil rights domains (UNFPA, 2015).

Presently, DV is considered by the *General Assembly of the United Nations* a severe global public concern and an issue of human rights (Jacobs, White and Ovey, in Rainey, and McCormick, 2020). In its *Sustainable Developmental Goals*, the UN considers poverty and inequality as triggers for violence against women. Women can contribute to communities' progress when they access decent work, health care, and quality education (Baldry and Sargent, 2020, United Nations, 2020). Therefore, the

UN Declaration's Fifth Goal (2019) promotes "*The acceleration of gender equality and empowerment of all women and girls."*

We shall see in the following chapters how the empowerment of women can be a crucial issue to diminish domestic violence.

3) Domestic violence as a private problem

DV in America and other countries worldwide was for centuries not recognised as a legal problem. It was considered a private matter because it occurs in anonymity behind personal walls and was, therefore, thought to be of concern only to the married couple having relational problems and being outside of the justice system.

To illustrate the type of thinking reigning in the American culture at the time, Freeman and Mensch (1987) proclaimed that there should be a rigid differentiation between a public realm and a private realm because governments and their institutions should serve the public interests rather than interfering in personal matters.

However, the concept of marriage as an ideal and harmonic happening with only noble purposes is not a daily reality for many couples. The idea of privacy and freedom from state intrusion in-home violence only sustained and encouraged violent acts against women since men battering their partners were untouched by the law (Schneider, 2000).

Many forms of behaviour that we now condemn were a sad reality in the past - slavery is an example. Regarding DV, Barry (1979) proclaimed that women's sexual abuse by their partners should be considered a form of slavery.

Fortunately, there is a growing consciousness and recognition worldwide that DV, although occurring in homes, is not a private happening but affects whole communities and societies. Gender-based violence is now recognised as a human right violation (Asiapacific. UNFPA, 2015). Nevertheless, it was only in the nineteen-seventies when legal systems worldwide recognised DV as an issue worth to be considered.

4) Marital rape

Marriage was regarded already in ancient times as a sacred and respectable institution. Nevertheless, the safe haven (home) transformed itself for many women into a routine of abuse such as assault, marital rape, beating and stalking from present or former husbands or boyfriends (Schelong, 1994). There was enough evidence of spousal violence from men who forced their wives into sexual relations using physical force or intimidation (Gelles, 1977).

For a long time, the (American) justice system has legally overlooked the issue of marital rape as being a severe crime (Bennice and Resick, 2003). This rape exemption was based on a law dating from the 1736 Common Law Exception in which "*husbands could not be accused of committing the crime of rape against their wives"* (as cited in Bennice and Resick, 2003).

In the Hale doctrine, Sir Hale (1736) stated that "*The husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent and contract the wife hath given up herself in this kind unto her husband, which she cannot retract.*" (as cited in Russel, 1990, p. 17). This precedent justified the marital rape exemption for more than 300 years and was also applied in North America's colonies (Schneider, 2000).

Sir Blackstone developed the *'Marital Unity Theory*' in the USA, stating that "*women become their husbands' property during the marriage"* (Blackstone, 1765). Since the wife was considered the husband's property, he could not have committed a crime against himself. According to the doctrine of marital unity, marriage was the legal representation of husband and wife being one entity (Blackstone, 1765). Still, only the man had rights in that entity, and DV was tolerated (Schneider, 2000).

A husband could demand the obedience of his wife, and he was allowed to give "*corrections within reasonable bounds*" by the use of corporal punishment (also known as chastisement) if she denied his authority (Blackstone, 1765).

While the *Marital Unity Theory* supported women's view as a property of their spouses, another theory, the *Separate Spheres Theory*, undermined even further women's civil identity; in this theory, men represented the political/public sphere, and women the

family/private sphere (Small and Tetreault, 1990). Wives had no protective laws to stop their husbands' abuse, and husbands did not fear penalisation from criminal justice officials because the abuse was considered a private matter (Caringella-MacDonald, 1988).

However, for feminist advocates, marital rape was an essential issue. In 1974, the advocate Laura X started a crusade to make forced sex in marriage a criminal act. Two years later, In 1976, a typical case of forced sex in marriage went to trial. Mrs Judy Harttwell, the defendant, 28 years of age, was regularly severely beaten and sexually assaulted by her husband. On the day of the crime, the defendant stabbed her drunk husband to death when he tried to rape her. She claimed self-defence. The judge that presided the case stated that Hartwell had the right to resist rape (X, 1999).

Only late in the nineteen-seventies did the subject become increasingly of interest for researchers. In 1995 all UN represented countries voted in favour of considering marital rape a crime (X. 1999). Nevertheless, in practice, marital rape is not penalised as severely as rape by a stranger (X, 1999). The exception has benefited many marital rapists (X, 1999). The phenomenon of acceptance of marital rape can be explained by cultural validation that marital rape is not 'real rape.'

Eighty per cent of participants of the general population that took part in research studies about the subject victim-offender relationship believed that when a relationship becomes more intimate, the intimate partner's incident of forced sex cannot be defined as rape (Jeffords and Dull, 1982; Kirkwood and Cecil, 2001). Instead, the blame's attribution went to the victim because participants believed there was a tacit consent between victim and perpetrator (Monson et al., 2000).

5) How institutions dealt with the problem of domestic violence

In the past, police and criminal justice systems, prosecutors, and court personnel worldwide were unresponsive and unprepared for handling battering properly (Pastoor, 1984).

The police had inadequate training or no training at all. In police instruction manuals, officers were encouraged to adopt the role of a 'polite intruder' to arbitrate the situation.

They had no real protocols, experience or knowledge of the subject, and they were reluctant to intervene. Police acted more as counsellors than enforcers of the law, and they very rarely arrested men who battered women simply because police did not treat battering as a crime (Pastoor, 1984).

Family Courts, especially in the USA, proposed a mediator (when there was a history of DV), trying to reunite parents for custodial and visitation purposes, child support, or property division. However, when the abuser was used to control and dominate the other partner and used physical, emotional, sexual, and familial violence (including property damage) during the relationship, such a proposal could jeopardise the mother and her children's lives. The victim attempts to end the relationship to stop the abuse did not ensure that the control and domination would end; it escalated in some cases even more following separation (Fischer, Vidmar, and Ellis, 1992).

Due to the lack of knowledge by court personnel of legal standards applicable to family matters, and the representation of battered women by either pro bono advocates (legal representation without a fee) or voluntary law students, women were in some cases put at risk because the complex problems they were facing were not fully understood (Schneider, 2008).

Conclusion

This section aimed to show how far DV issues are intertwined with a lack of rights for women and how cultural motivations and traditions maintain and condone violence. In humanity's history, men did not consider women equal citizens. Women were believed to be creatures of feeling but not reason or even their husband's private property. The lack of women rights in the past can be explained by the traditional roles women were supposed to play, mostly in performing unpaid family labour activities, while men were the breadwinners. Since gender roles are passed down to succeeding generations, they continue to perpetuate differences and inequalities between genders, making it challenging to break the cycle of disparities.

Boserup highlighted the discriminatory policies, uneven opportunities, inequalities, and different forms of women's subordination in rural communities in Africa. Women and

children had to work in the fields, and girls did not receive an education because they were expected to carry out exclusively family labour activities; only boys were allowed to study. With the introduction of heavy tools in African economies, women without children or family members' support had to migrate to find work in uprisen cities where they were exploited in low-paid jobs.

In Western societies, DV was, for decades, invisible for governments, the police and the legal systems because it was considered an intimate life problem, that is, a private matter. The role of laws in decision-making was always inseparable from political contexts. Thus, claims of equality and the practice of those rights were subject to political decisions that sometimes allowed DV to happen.

Political neoliberal ideas of strict separation of state and private matters made it possible that marital rape was tolerated and perpetrators remained unpunished. Governments were reluctant to treat DV as an issue of human rights for which a private actor could be held accountable.

The situation remained unchanged until women's organisations brought the problem to light and encouraged justice systems to arrest wife batterers instead of acting as mediators. They also demanded laws that protect vulnerable individuals. Many women's rights (e.g. vote, education, participation in prominent positions in science and labour market) that once were exclusively male domain had now been achieved, especially in highly developed countries. Nevertheless, despite all the efforts of many international institutions and global governments that presently recognise DV as a problem and actively address women's rights issues, there is still a long way to solve inequalities and the unabated domestic violence problem.

1.2 Domestic violence - A global problem

The World Health Organisation (2018) affirms that DV is a widespread global crime. It includes physical and sexual abuse and stalking (Nicholls and Hamel, 2015) against women, perpetrated mostly by intimate partners. One in three women around the world becomes a victim of it. Despite its vast dimensions, it is the most minor reported human

rights abuse. This phenomenon occurs during times of peace and stability, but also during crises, conflicts or wars. For instance, in a women's survey in South Sudan about violent incidents committed by partners or ex-partners, more than half of participants said they had experienced DV (WHO, 2018).

DV is a broad terminology that includes various types of violence. It is related to abusive and controlling behaviour such as intimidation, threats of harm, physical injury and psychological aggression (WHO, 2010). Such behaviour can be directed towards any family member, taking diverse shapes and constellations (e.g. spouses battering the other partner, parents maltreating their children, among others).

In this chapter, the main objective is to display the all-embracing suffering of too many individuals confronted with violence from people who are most near to them, their intimate partners or former partners. Concerning child maltreatment or abuse, the violence comes from those supposed to protect them from harm.

In order to explain the global magnitude of DV, the following topics will be discussed:

1) DV in Western and developing countries.
2) The United Nations Refugee Agency and forcible displacements.
3) Violence against women: Honour Killing and Female Genital Mutilation.
4) Violence against children.
5) Restraining order: Lenahan Case - Lenahan vs the United States.
6) Government and organisations searching for DV solutions.

1) Domestic violence in Western and developing countries

Domestic violence in the USA

The United States Department of Justice (2017) issued a report concerning DV's police responses in 2006-2015. It was shown that the annual victimisation of all nonfatal DV incidents, including severe violence and simple assaults was, on average, approximately 1.3 million cases (Reaves, 2017).

From those victimisation cases, 889,012 were perpetrated by intimate partners; the other 425,480 cases were committed by other relatives (e.g. persons of authority or

other family members). This data was obtained from the *United States National Crime Victimisation Survey* (Cuevas and Rennison, 2016). The survey gathered information on nonfatal crimes of DV (e.g. rape, sexual assault, aggravated and simple assault, and personal larceny) (Truman, 2016) from reported and non-reported cases to the police (Truman, 2016). The survey participants represent US households aged 12 years or older (Cuevas and Rennison, 2016). Victimisations involving severe DV were mostly committed against female victims (38%) than male victims (12%) (Edwards, Sylaska, and Neal, 2015). Nevertheless, the estimation is that a percentage of severe DV cases, ranging from approximately 31%, are not reported to the police due to fear of reprisal (Reaves, 2017).

The problems caused by DV in the US are not to be overseen. Therefore, almost all police departments having more than 250,000 residents, currently have a full-time specialised DV unit that assists the victims (Reaves, 2017).

Domestic violence in Portugal

In Portugal, in 2017, approximately 22,599 cases of intimate partner violence were reported to the police. Fourteen women died due to the violence inflicted on them by an intimate partner in 2017. Thus, DV represents an extended problem within the total number of reported crimes in the country (Tenedório Abrunhosa, 2018). Since 2007, the Portuguese Penal Code considers DV a public offence, irrespective of the nationality, race, language, religion, disability, gender identity or sexual orientation of the victim according to the principles stated by the Istanbul Convention. The code includes violence against same-sex couples or relationships (Fernandes and Ramos, 2015).

To prevent violence against women, the Portuguese government launched public education and prevention campaigns using posters in major cities to raise awareness of DV and modify people's behaviour, from silence to intervention and condemnation (Cismaru, Jensen and Lavack, 2014). The messages ranged from "*Silence gives consent*" to "*Do not be silent. Speaking out can help you and others*" and other texts to encourage victims to report abuse to the police "*Step out of the shadows, do*

something" and "*Stop pretending that everything is fine*" (as cited in Moreno Martin, Alvarez, Ayllon Alonso, and Fernandez Villanueva, 2019). Campaigns are meant to make abused women aware of the institutional resources to help them (Wray and Wray, 2006). Besides, attitudes toward DV influence perpetration rates and women's responses to it (Harris, Firestone and Vega, 2005).

Domestic violence in developing countries

The United Nations Women and the *World Health Organisation* calculated that globally more than one-third of all women suffer from male intimate partner violence at some point in their lives (Tausch,2019). Nevertheless, there are countries where DV is still a taboo, maintained due to traditional attitudes that minimise the harms of violence against women, do not have laws to protect them, or there are laws, but those are not implemented. Below, there are some examples of countries that have to improve the situation of violence against women. The list is not exhaustive:

Armenia has a long history of gender stereotypes arising from cultural beliefs and patriarchal norms that dictate practices. Cultural beliefs and the ancient acceptance of DV are reflected in an Armenian saying, "*A woman is like a wool, the more you beat her, the softer she will be*" (as cited by Shirinan, 2010). Unfortunately, DV is under-reported and rarely prosecuted (Shirinan, 2010). One in four women in Armenia suffers from DV/IPV (Ishkamian, 2017). Due to the partnership with the EU, Armenia has only recently adopted a DV law (Zovickian, 2020) that is not in compliance with the Istambul Convention. Still, as women human rights activists state, a law can be amended and is better than no law at all (Matosian and Ishkanian, 2017).

Burkina Faso (West Africa) has a DV prevalence ranging between 4 and 29% (Ahinkorah, 2021).

DV is related to cultural factors that determine social roles that encourage specific patterns of violence in the marriage, influenced by living arrangements with the husband's family that are associated with the justification of violence (Alesina, Brioschi, and La Ferrara, 2020).

Egypt lacks reliable data on DV due to under-reporting and lack of reliable statistics; besides, the country does not count on a clear strategy for this problem (*Nazra for Feminist Studies*, 2016), neither are national DV laws to protect survivors. There are no efficient interventions or sufficient shelters (Magdy and Zaki, 2021).

Devries, Mak, Garcia Moreno, Petzold, Child, Falder, et al. (2013) conducted research using data on physical and sexual violence against females from 141 studies in 81 countries, giving a global estimate of the level of violence used. The percentages showed below indicate that one of every three females ever partnered aged 15 years and older had experienced physical and sexual IPV in their lifetime (Devries, Mak, Garcia Moreno, et al., 2013:

Andean Latin American	40.63%
Central Latin America	29,51%
South America	23,68%
East Asia	16.3%
South Asia	41,73%
Central Sub-Saharan Africa	65.64% (Devries, Mak, Garcia Moreno, et al., 2013)

(Mitchel, Wight, Van Heerden, Rochat, 2016).

2) *The United Nations Refugee Agency* and forcible displacements

The *United Nations Refugee Agency* calculates the number of persons presently being displaced worldwide because of violence and war situations to be approximately 67.7 million individuals compared with 22.7 in 1996 (Desai, Ramatowski, Marano, Madoff and Lessmann, 2020). Refugee families often have to live in crowded, unhygienic camps deprived of sanitation that disrupt their health, making them vulnerable to diseases (Altare, Kahi, Ngwa, Goldsmith, Burton, and Spiegel, 2019; UNHCR, 2020). The *International Rescue Committee* (IRC, 2020) warns that the Covid-pandemic makes the problem even more acute since only a reduced health service is available to help treat Covid patients or other infectious diseases like malaria and cholera (IRC, 2020). Alone in the twenty-seven member states in the European Union, there were 612,700 first time asylum seeker applications in 2019 from individuals of non-European

countries, an increase of 11.2% compared to 2018 (Euro Statistics, 2019). However, movements' restrictions due to Covid-19 resulted in a 38% drop of first-time asylum seekers in the fourth quarter of 2020 compared with 2019 (Euro Statistics, 2021).

A forcible displacement is especially dangerous for refugee women, girls and children because they are in acute danger of becoming the subject of sex trafficking, sexual harassment, and rape since they are often alone in containers in overfilled camps. Camps initially thought to allocate a maximum of 3,000 refugees now have 16,800 individuals living there (e.g. Moria camp in Greece) (Stamatis and Raptou, 2020). Those females who acquire a legal status as refugee or asylum seekers in any European country or elsewhere may still suffer from high pre-migration stress rates, e.g. depression, anxiety, PTSD or other psychological disorders (Stamatis and Raptou, 2020).

Female refugees are vulnerable to DV in host countries due to the lack of support from family or friends (Kaukinen, 2020). They sometimes stay with a violent partner for fear of being alone in an unknown environment and with an extra barrier: A different language. Sometimes, the asylum claim is linked to her husband; thus, she loses her refugee status if she leaves him. Once those traumatised people are in a new country, they may suffer from post-migration stress resulting from cultural and religious differences. They also suffer from difficulties adjusting to a new environment because they lack social support systems, family conflicts; racial or ethnic discrimination; neighbourhood segregation (refugees ghettos), and poverty. All conditions predict risks for mental illness and distress (Li, Liddell and Nickerson, 2016).

3) Violence against women: Honour killing and female genital mutilation (FGM)

Traditions that disempower women produce an unbalanced gender relationship, increasing the risk of violence against women (e.g. DV/IPV). Violence is perpetuated when societies do not condemn types of practices such as denying access to education for females; murdering them in the name of honour (also known as 'honour killing'); female genital mutilation (WHO, 2016). In many countries, when rape cases are reported, the victim is not believed, or the perpetrator is not punished (WHO, 2016).

More extensible, in armed conflicts or wars between countries or ethnic groups, women and girls are in real danger of being sexually abused or at risk of getting unwanted pregnancies and transmittable diseases (e.g. HIV/AIDS) (WHO, 2016).

Honour killing

The *European Union* Member States are confronted with diverse 'local' types of violence, but due to the globalisation and migration of people coming from different cultures which have their own traditions, beliefs and practices, Europe has now new challenges ahead; for example, how to combat more recent forms of violence as honour killing and female genital mutilations.

Female victimisation, known as honour killing, is a cultural form of a gender-related crime presently occurring mostly in migrant communities in Europe (Grzyb, 2016).

Honour derives from the Latin word 'honos', which signifies dignity and respect. In societies where honour is a key cultural value, being considered by others to be an honourable person is very valuable for one's social image. Thus, the family's reputation is critical, and it is believed that honour must be defended with violence and aggression if necessary. In those societies, females accused of breaking codes of honour are punished by family members either by killing or forcing them to commit suicide to restore the family's dignity and respect (Uskul and Cross, 2019).

The factors contributing to honour crimes are multiple and intertwined. Honour killing is mainly linked to religious concepts about women's position in a patriarchal society as property. Nowadays, honour killing is associated with Islam, but it is not exclusive of it. Roman Laws gave control to the head of the family over wives and children; their lives were at the mercy of male family members; husbands could kill women who committed adultery (Kaushal, 2020). In China (during the Ching Dynasty), males family members, such as fathers or husbands, could kill females that dishonour them (Kaushal, 2020).

Since 1984 the *United Nations* recognises honour killing as a severe human rights violation due to discrimination against women. It denies their rights to freedom and their rights to be considered equal to men (UN, 2009). Marital arrangements in honour

societies are patrilineal, and females are dependent on their husbands, frequently deprived of work or study opportunities, confined and veiled (UN, 2009).

Sometimes, women and girls living in Western societies refuse the marital arrangements made to weed a male of their own culture. Alternatively, women or girls do not follow their community's honour rules regarding 'appropriate sexual behaviour.' Appropriate behaviour is for those communities not to have sexual relations before marriage; the prohibition against having an extramarital affair; being 'too Western' in their lifestyle; seeking a divorce, or simply falling in love with an 'outsider'. In those cases, females are in jeopardy of being killed by a family member, primarily fathers or brothers, to save their honour (Korteweg, 2014).

Female genital mutilation (FGM)

UNICEF (2013) proclaims that 125.000.000 million young women and girls were submitted to female genital mutilations in African countries, reaching the highest rates in Somalia, Guinea, Ethiopia, Egypt, Eritrea, Mali, Nigeria, Sierra Leone and Sudan. However, female genital mutilation is also practised in other African and Asian countries. FGM is a new form of violence introduced in Europe by immigrants from those countries in the late 1990s (UNICEF, 2013).

FGM is a culturally related procedure that intentionally causes injury to female genitals "*involving the partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons*" (Low-Beer and Creighton, 2021). What is most alarming in FGM is the fact that children (girls) who are highly vulnerable and should be protected from any harm are submitted to such painful procedures by their parents or family. Many girls are circumcised before migrating to Western countries; others after the migration, even in second or third generations. The third group of girls at risk have not been circumcised but may still be at risk of circumcision (Kawous et al., 2020; Cottler-Casanova et al., 2020).

Children cannot consent; they cannot resist; children are just delivered to the madness called 'mutilation tradition' (my emphasis).

The evidence of physical and psychological risks associated with female genital mutilation is not to be overseen. The most common physical short-term health problems are excessive bleedings, shock, bacterial infections, tissue swelling, pain, and other issues. Among the known long-term complication is pain during sexual intercourse and obstetric complications when giving birth (Berg, Underlang Jensen, et al., 2014).

4) Violence against children

Women are not the only sufferers of violence. Every year millions of children below the age of eighteen die (Camaranesi, Ripat, and Piotrowski, 2020) either due to injuries, violence, abuse and neglect, or survive but sustain severe, long-lasting disabilities (WHO, 2012). There are higher risks for children of low-income families of becoming victims of violence or injuries due to socio-economic stress at home, increasing abuse risks. Other risk factors are mental problems and substance abuse of one or both parents. Structural violence against children and adolescents in Brazil's rural areas occurs mainly by deprived children who do not have access to education or decent housing because their parents live below the poverty line and are unassisted or poorly assisted. In 71% of maltreatment cases, violence occurs at the victim's home; in 57.14%, the perpetrators were male, and about 23% were drunk (Cunha Fernandes, Barauna de Oliveira, Souza Vieira, de Lima, et al., 2020). Nevertheless, DV is not a problem affecting only poor people from emerging countries. Other social strata and wealthy nations are also affected (WHO, 2005; Sholl, Korkie, and Harper, 2009).

Children who witness violence at home or lose a parent due to violence (Sholl, Korkie, and Harper, 2009) have severe emotional difficulties. Those emotional difficulties might be manifested in low school achievements, various types of disrupting behaviour, and diverse psychological problems such as depression, anxiety and concentration problems (Katz, Lalayants, and Lushin, 2021). Therefore, implementing protective measures to avoid escalating violence at home and protect the victims is paramount. Prevention programmes at a national or local level which are multi-disciplinary in scope (e.g. education, parent training programmes to prevent violence,

social welfare and good legislation), are proven to be successful measures to reduce violence (WHO, 2005).

5) Restraining order: Lenahan case vs United States

Governments legal systems can protect citizens, for instance, by issuing restraining orders. Restraining orders are, in theory, an ideal solution to stop the spiral of violence in dysfunctional families and protect women and children from further escalating violence, which may threaten their lives. Nevertheless, for restraining orders to be successful, they firmly rely on proper police enforcement.

The case Gonzalez versus United States (2010), as cited by Missari and Zozula (2012), shows how the misinterpretation of the meaning of a restraining order by the police ended in a fatality for three young girls who were killed by their father.

Jessica Gonzalez (now Lenahan) was a mother who lost her three daughters due to her husband's violence and the police's inefficiency and negligence.

The Lenahan case was the first case on human rights filed by the *Inter-American Commission on Human Rights* (IACHR). The IACHR claimed that gender and DV politics in the American justice system are not gender-neutral as it claims and ignores essential power issues involved in violence. The IACHR used human rights arguments on women's rights to sustain the case (Missari and Zozula, 2012).

The Lenahan case's tragic ending illustrates the issues that many women are confronted with in DV cases.

Jessica Gonzalez divorced her husband Simon Gonzalez after eleven years of marriage because of his threatening and abusive behaviour. Simon became even more erratic and unstable after the divorce, threatening the family 'someone will die;' he also tried (but failed) to kill himself in front of his daughters.

On May 21, 1999, Jessica Gonzalez obtained a temporary restraining order against her husband to protect herself and her daughters. A Colorado court made the restraining order permanent on June 4, 1999 (Missari and Zozula, 2012), containing instructions when Simon could see his daughters.

On June 22, 1999, Simon abducted (at 17:15 hours) the girls who have been playing outside, violating the restraining order imposed by the judge. From the moment that Simon left with his daughters, his whereabouts were unknown. Ms Gonzalez called the police - who arrived hours later - and showed them the restraining order. She requested that the police search for her ex-husband, arrest him, and return the children to her. The police refused to act immediately; they preferred to see if Simon himself would bring the girls home (Missari and Zozula, 2012).

At 20:30 hours, Ms Gonzalez spoke to her husband, who said that he and the girls were in an amusement park in Denver. Jessica alerted the police many times because she feared for the safety of her daughters. She went twice personally to the police station, but the police officers did not think Simon would harm his daughters (Senier, 2017) and even ridiculed her worries (Missari and Zozula, 2012).

At approximately 03:20 hours of the following day, Simon went to the Colorado Police Station and opened fire with a gun he has bought the same day he kidnapped the girls. The police shot Simon, who died as a result. When the police officers searched Simon's car, they found the dead bodies of the three girls Leslie, Katheryn, and Rebecca Gonzalez (as cited by Missari and Zozula, 2012).

Consequently, the mother sued the police department of Castle Rock and three officers for having failed to enforce the restraining order. The highest Supreme Court dismissed Ms Gonzalez's complaints; one of the judges argued: "*Simon Gonzalez constituted the primary danger, not the lack of police actions.*" Jessica decided to bring her case to the IACHR, which took it over and successfully proceeded against the *United States of America* (Missari and Zozula, 2012).

6) Government and organisations searching for DV solutions

DV's alarming global magnitude has lifted the subject to a priority matter for international organisations (e.g. UN, WHO, and other prominent institutions). Interested countries also aim at a unification of efforts to find solutions to this worldwide problem. As an example of this type of combined effort, the *General Assembly of the United Nations* has launched multiple publications to raise government and the public's

awareness regarding violence against women. In 2002, a publication focusing on DV and sexual violence called *"A World Report on Violence and Health"* appeared (Krug, Dahlberg, Mercy, Zwi, and Lozano, 2002). The report was a compilation of women's movements to address gender-based violence perpetrated in private and tolerated by governments (WHO, 2002).

In 2005, a United Nation's paper with the title *"Combating Violence Against Women in the Legal Domain"* highlighted the responsibilities legal systems have to improve government's legislation (e.g. allocation of resources, identifying and combating gender inequality, offer protection by restraining orders), to tackle any kind of violence towards women and girls, to ensure their security and empowerment. Presently, civil rights laws consider violence against women as discriminatory (UN, 2005).

The World Health Organisation (WHO) conducts surveys and organises campaigns to protect women from abuse. In a global survey study of women (organised by the WHO), more than 24,000 females participated. Their ages ranged between fifteen and forty-nine. Those females represented diverse urban and rural settings, cultural and geographical diversity from ten countries: Bangladesh, Brazil. Ethiopia, Japan, Peru, Namibia, Samoa, Serbia and Montenegro, Thailand and the Republic of Tanzania (Garcia-Moreno, Jansen, Ellsberg, and Heise, 2005; WHO International, 2005). The survey results confirmed that women are highly vulnerable to physical, sexual and psychological violence from male intimate partner's (Garcia-Moreno et al., 2005; WHO, 2013). Violence against females is worldwide, resulting in severe health deterioration (Cuevas and Rennison, 2016).

As a consequence of high levels of DV violence, this problem also brings emotional and high financial costs to the communities because physical injuries have consequences beyond visible physical damage (which may result in the hospitalisation of the affected individual). Examples of a financial burden for governments are: Health care and psychological services of all kinds, shelters, legal justice systems (Walby and Allen, 2004; WHO, 2014). More detail of other expenditures will be explained thoroughly in section 1.7.

Although each country has its own DV level, gathering experience on DV and the information resulting from researchers' data in different communities can help better understand and tackle the problem.

Governments do sometimes propose suitable measures to broaden civil rights for citizens to protect them. An example of this is the *European Parliament*'s ambitious plan called "*Charter of Fundamental Rights of the European Union,*" issued in 2000 (Peers, Hervey, Kenner and Ward, 2014).

Regarding non-discrimination, Article 21 proclaims, "*Discrimination on the ground of sex, race, colour, ethnic or social origin shall be prohibited*" (Kilpatrick, 2014).

Regarding equality between women and men, Article 23 states, "*The equality between men and women must be ensured in all areas, including employment, work, and pay*." (Peers, Hervey, Kenner and Ward, 2014).

All articles of the *European Union's Proclamation* (including those mentioned here) are necessary and well-intended. Sadly, many of the articles' proposals are not yet, twenty-one years later, a reality in practice.

Other governments in the world also have policies related to the health and wellbeing of their citizens. Those governments might be willing to promote gender equality by issuing legislation to protect and alleviate the suffering of individuals trapped in DV. Nevertheless, the enforcement of such legislation may sometimes be challenging to implement. This is especially the case when a whole culture (including religion) believes in traditions that empower men and disadvantaged women.

Conclusion and recommendations

The suffering of DV victims - adults and children - in Western and developing countries is devastating and costly for societies. DV also affects individuals psychologically. Violence at home negatively influences children in their school performance, and violence may cause them life-long traumas; thus, entire families are affected by the problem of DV.

Governments and other institutions at local and international levels are working hard to alleviate the situation of individuals suffering from violence, for instance, by declaring DV a crime in their penal codes and making perpetrators accountable for their criminal acts. Nevertheless, in some countries, DV is not recognised as a crime; therefore, no regulation had been issued to combat it; consequently, the problem persists. Other times, DV is recognised as a crime, but laws are not implemented, and often police take the side of the perpetrators instead of protecting women. Sadly, changes in the laws have not eradicated DV from homes because measures are in many countries challenging to implement due to political and cultural issues.

We saw that the *UN Refugee Agency* warns about the consequences of forcible displacement of individuals due to violence, war or conflicts. Refugee women suffering from DV often have to live in crowded, unhygienic camps deprived of sanitation that disrupt their health, making them vulnerable to violence from their partners.

Globalisation and displacements also result in people bringing their traditions to the new host country. Some of those traditions are very harmful, such as honour killing, which family members commit against a female, who has brought, in their eyes, dishonour on the family by breaking moral rules imposed on them. They are then killed to restore the family's honour.

Another harmful 'tradition' is female genital mutilation. Young girls are forced by parents or tutors to undergo painful cuttings in their genitals for no medical reasons, which is in itself a severe form of maltreatment against vulnerable children because they cannot consent or resist those barbaric practices (my emphasis).

Sometimes governments issue well-intentioned laws and measures that are meant to protect individuals and are effective. An example is a restraining order, which can be very useful if used correctly. In the Lenahan case, the judge issued a permanent restraining order to protect a mother and her three daughters from her husband's violence. The police misinterpreted the legislation and did not undertake action to find the perpetrator, who kidnapped his daughters and ended in the girls' tragic deaths.

Further research is essential to establish which policies effectively protect women and children from violence within the legal system. It is desirable to access services,

education, and training for all the parties involved in the legal system, such as police, prosecutors, judges, lawyers, and tailored laws to address female IPV and child maltreatment. Those measures can contribute to ending violence.

1.3 COVID-19 and DV

Covid-19 emerged in Wuhan, China, and has spread worldwide; declared a global pandemic in March 2020. Governments were confronted with an unknown virus and readily imposed staying at-home measures. Life changed for many adults and children; uncertainties and worries about what next started to appear. The pandemic has affected their lives with economic and social insecurities. Soon after the lockdown, calls to DV hotlines and police interventions lifted unprecedently.

These facts raise the question about how effective the policies employed during a pandemic are. Indisputably, the Covid-19 epidemic must be stopped. However, international organisations observed that well-intended social distancing measures have unintended negative consequences, such as increased DV worldwide.

How can the situation around violence against women, children, men (including the LGBT+ community) can be handled during any pandemic to avoid an outrageous DV increase? What kinds of measures are adequate?

We intend to answer these questions by analysing different aspects of this crisis and by discussing the following subjects:

1) The global Covid-19 pandemic and the increase of DV.
2) How the pandemic affects all aspects of daily lives.
3) Economic and social insecurities.
4) Effective measures.

1) The global pandemic and the increase of domestic violence

Usually, the term pandemic is used for global outbreaks of unknown viruses spreading across human populations. Nevertheless, the term 'pandemic' was already used in 2014 by the *UN Entity for Gender Equality and Empowerment of Women* in a very

different context, namely, to emphasise DV's pervasiveness, high morbidity and mortality rates, and the most severe violation of women's rights (Guidorzi, 2020). While governments consider Covid-19 a top priority spending gigantic monetary sums on healthcare and vaccines, the other silent 'DV pandemic' continues unabated and is under-resourced (Koshan, Mosher and Wiegers, 2020). Due to Covid-19, around three billion people worldwide sheltered in place (Hall and Tucker, 2020), and one-hundred-forty-two countries imposed stay-at-home measures (Hale, Angrist, Kira, Petherick, et al., 2020).

Since the Covid-19 outbreak, DV reports have increased in most countries: In the United States, DV has risen dramatically; some reports cite an increase of approximately 300% (Peterman et al., 2020). US Police departments provided insights into the rise of DV in many states during the pandemic. In Oregon, the police reported a 22% increase in arrests concerning DV; in Texas, 18%; in Alabama, 27%; and in New York City, 10% (Boserup, McKenney, and Elkbuli, 2020).

In Mexico, the calls related to violence against women made to the DV emergency line 911 have increased by 53% (Mexican Government, 2020). In France and Cyprus: 30%; Singapore: 33%; emergency calls in Argentina have increased by 25%. There has been more demand for emergency shelters in Canada, Germany, Spain, the United Kingdom, and the United States (United Nations Women, 2020). Several countries such as China, Italy, and Singapore reported an alarming increase in physical and verbal violence towards healthcare professionals (70% of whom are women). There was a rise in (sexual) violence in public spaces in the Philippines and India, both urban and rural areas, partly due to empty streets and public transport limited to essential services (United Nations, 2020). India has seen a high increase of complaints about violence against women during the lockdown, so implementing helplines for those affected by any form of DV is considered necessary (Chandra, 2020).

In the United Kingdom, organisations dealing with DV related issues reported an increase of 25% in the calls to its DV hotlines within the first week of stay-at-home measures (Bradbury-Jones and Isham, 2020). In Vancouver (Canada), the DV hotline had a 300% increase in calls (Daya and Azpiri, 2020).

In Peru, the level of intimate partner violence is high. There has been, though, a decrease in levels of DV from the year 2009 until 2019. The percentage of DV in 2009 was approximately 77%. By the year 2019, the percentage of women aged 15 to 49 affected by violence perpetrated by current or ex-partners was around 58%. At the time of the national lockdown, which started in mid-March 2020, nearly 60% of Peruvian women experienced violence (Agüero, 2020). In order to analyse the problem of DV during the pandemic, Agüero (2020) compared the numbers of calls (adjusted by population size) to the national helpline violence against women (Line 100) made in February 2019, and the ones realised in February 2020 (Agüero, 2020). He did not find considerable differences in the number of DV cases in February of both years, but the rise of calls rapidly increased by 48% in the following months of lockdown.

2) How the pandemic affects all aspects of daily lives

Globally, people's daily lives have changed during the pandemic. Individuals are isolated from essential others, have to adapt to social distancing; the social and educational support for children have been reduced since schools and childcare facilities had to close their doors to mitigate the pandemic (Kaukinen, 2020; Piquero, Riddell, Bishopp, Narvey, Reid, and Leeper Piquero, 2020). The confinement itself makes members of the family, especially mothers and their children, particularly vulnerable to the risk of DV. However, men and same-sex partners are affected by violence at home and should not be forgotten by social services or policy-makers even though they are less likely to disclose their partner's abuse. The pandemic has turned homes into unsafe places for individuals suffering from violence because there is no escape from the abuser (Warburton and Ranioli, 2020).

Global governments imposed quarantines, social isolation or restrictions to social gatherings to contain the infectious virus, and by so doing, social structures and regular activities were modified (Fong et al., 2020). According to Sharma and Bohra (2020), the pandemic conditions (mandatory staying in homes, layoffs, unstable work situations, loss of productivity) shape the ideal environment for a significant economic

and social crisis across the world to happen. Governments' measures to save lives are paradoxically comparable to the strategies used by abusers to isolate their victims from protective support networks such as friends and family (Xue, Chen, Chen, Hu, Zhu, 2020). Due to the pandemic, DV victims have to spend more time confined with their abusers (Van Gelder et al., 2020), exacerbating their fears and stress created by insecurity and economic worries (Sandler, 2020). Many women cannot safely connect with DV services to disclose abuse because the abuser closely monitors them. Unemployment and lack of women's resources put them in disproportionally unstable economic dependency on the abuser (Evans, Lindauer and Farrell, 2020).

3) Economic insecurities and social disruptions

A stressful situation such as the work loss of one or both parents creates economic insecurity and financial constraints that can ignite violent situations in homes, affecting children. Disruptive families that before Covid-19 were already trapped in abusive relationships or harmful behaviour have, due to the unavailability or discontinuity of social services during the pandemic, even more difficulties (UNICEF, 2020). Destructive behaviour can be triggered by mental health problems, personality disorders or alcohol and drug abuse. During a lockdown, there is an increased risk of substance use disorder which is accompanied by health deterioration and diminished wellbeing (Galea et al., 2020).

Covid-19 impacted disproportionately LGBT+ individuals and communities. Recent data shows that nearly a million LGBT+ adults living in California had, previous the pandemic, full time-work in private companies, non-profit organisations, foundations, or were self-employed. Still, most of them lost their jobs, or their income was reduced considerably (O'Neill, 2020). Economically, LGBT+ individuals struggle financially because 30.2% of (American) LGBT+ people became unemployed. Besides, the prognoses are that LGBT+ individuals with a global collapsed economy will have more difficulties finding work than their heterosexual counterparts (Human Rights Campaign, 2020a). Moreover, increased unemployment is associated with higher discrimination levels towards LGBT+ people and other vulnerable groups or minorities (e.g. migrants)

(Mattei, Russo, Addabbo, and Galeazzi, 2020). Unfortunately, data about the pandemic among LGBT+ persons are uncertain since public officials do not record sexual orientation or gender identity information to be able to help those communities (Johnson, 2020).

Gender-based inequality is highlighted during any pandemic. Females are more exposed to risks in the healthcare system than their male counterparts simply because most healthcare workers are female. In the United States, for instance, 76% of healthcare personnel is female. Women are the ones who have the closest and prolonged contact with patients and are, therefore, more at risk of contracting Covid-19 (US Census Bureau, 2020). Eleven per cent of women currently face under-employment compared to the four per cent of men (Connor, Madhavan, Mokashi, et al., 2020). For females, unemployment means dependency on spouses, loss of social contacts, and being with the perpetrator 24 hours a day (Schneider, Harknett, and McLanahan, 2016).

Another problem that has arisen with the US's pandemic is a large number of undocumented women (e.g. colour, immigrant, Latinas). Those working as domestic workers, caregivers of children or elderly, and other low-paid workers lose their jobs and fear losing their income or being exploited. They cannot claim benefits because they are without legal protection regarding health insurance, unable to be tested or receiving medical treatment (The Henry J. Kaiser Family Foundation, 2020). Domestic workers earn low wages, and their work overtime is not compensated; neither can they rely on paid leave (Díaz-Ordaz, 2010).

Foucault and Galasso (2020) used data from a cross-country survey from the project "*REPEAT*" (REpresentation, PErception and ATtitudes) in 12 countries about individuals' perception and behaviour regarding Covid-19 (Brouard et al., 2020) on public health measures that impacted households and labour markets. The survey used data such as gender, age, education level, status related to employment, and occupation type for comparability. They also included a question about participants' life satisfaction. The researchers found that in all participant countries (Australia, Austria, Brazil, Canada, France, Germany, Italy, New Zealand, Poland, Sweden, the UK and the US), there were visible gender gaps and inequalities (De Pedraza, Guzi,

and Tijdens, 2020). College-educated, white-collar workers and other high-income individuals had jobs that allow them to work from home (De Pedraza, Guzi, and Tijdens, 2020). Low-educated people with lower-income work were not working. They were employed in service-oriented work that cannot be performed from home (e.g. cooks, drivers, restaurant personnel, cashiers, housekeeping, cleaners). In these professions, employees are at an increased risk of becoming infected with the coronavirus (Foucault and Galasso (2020). Furthermore, due to the high costs of health insurance in the USA (The Henry J. Kaiser Family Foundation, 2020), nearly six million adults are estimated to have no health insurance coverage (Connor, Madhavan, Mokashi, Amanuel, Johnson, Pace, Bartz, 2020; Foucault and Galasso, 2020).

4) Effective measures

Learning from previous experiences is certainly a measure to be applied in new situations. Although Covid-19 represents a recent crisis with unprecedented challenges, it is not the first global infectious epidemic and probably will not be the last one if conditions for outbreaks are favourable.

The Ebola outbreak in West Africa in 2014-2015 already exposed the deficiencies and weaknesses of healthcare systems (Plot et al., 2019). Other factors such as endemic poverty; weak educational systems; destruction of the environment, and biodiversity, for the greed of a few (especially in wealthy Western countries) create favourable conditions for epidemics to flower; showing how fragile economic and political systems are when confronted with outbreaks (Piot, Soka, and Spencer, 2019; Piot, 2014; WHO Ebola Reviews, 2016).

Regarding the Ebola outbreak, women were the most affected. However, they seemed invisible in health policy or practice (Camara, Delamou, Millimouno, Kououma, Ndiaye, and Thian, 2020) in the emergency responses to the outbreak long-term planning on resilient health systems (Harman, 2016). Lessons that should have been learned from Ebola were not applied during the Zika virus outbreak in many Central and South American countries in 2016. Besides, other large scale natural disasters, conflicts, and crises also have a devastating impact on vulnerable women and children (Davies and

Bennett, 2020). It is not to be overseen that there is a persistent pattern of gender inequality in the world. Fragile health systems in low-resource countries are imbalanced when dangerous infections break out. Some of the countries affected by pandemics also have a history of civil wars, (domestic) violence, and political instability (Davies and Bennett, 2020).

The coronavirus pandemic can infect anyone, regardless of wealth and occupation, but, despite this appearance of equality of risks, socio-economic inequalities (income, education and wealth) procreate health inequalities because of the presence or absence of resources to avoid risk factors. For example, women living with an aggressive partner build up stress during confinement, which influences their physical and psychological health (also of their children), making them vulnerable to contracting any disease (Clouston, Natale and Link, 2021). Empowerment strategies such as self-support groups, access to psychological help, a universal basic income for the most vulnerable can alleviate poverty, access to food for children, safe places far from abusers, and improved health outcomes globally. However, (environmental) education since a young age to protect the only planet we have, and everyone living on it (human and non-human), is the most critical element (in my opinion) to stay alive and free from pandemics or natural disasters.

Conclusion and recommendations

Covid-19 is a new phenomenon, but DV is not, neither are some of the factors contributing to violence in homes: Increased levels of poverty, especially in low socio-economic countries, uneven distribution of wealth in highly developed countries; disruption in the social support services for vulnerable individuals (female, children, LGBT+) causing stress and suffering.

The chairman of the *United Nations*, Secretary-General Antonio Guterres, has called all nations to work on DV preventive plans. He emphasised the necessity to keep shelters open as they are an essential service and continue to offer emergency warning systems to protect women in danger (United Nations, 2020).

Guterres mentions that the Covid-19 pandemic is also becoming a 'child rights crisis' because of increased DV and child maltreatment, abuse, and supervision neglect. (children are being left alone in homes), witnessing (sexual) violence or being the victim of it during lockdowns or stay-at-home orders (UNICEF, 2020). Abuse has long-lasting harmful effects on children's lives because of increased traumas and suicidal thoughts. Besides, children who experience maltreatment have a lesser ability to deal with stress and are prone to antisocial behaviour (Piquero, Riddell, Bishopp, Narvey, Reid, Leeper Piquero, 2020). They have poor general physical health and higher mortality rates in adulthood (Kim, Wilderman, Johnson-Reid, and Drake, 2017).

A big crisis like Covid-19 should serve to find new solutions to old problems and not go back to 'business as usual' once the pandemic is redeemed. Governments should learn from previous mistakes to improve deplorable sanitary conditions for humans and animals that facilitate pandemics. Lowering DV levels against any vulnerable individual can improve the worrying DV situation reigning in too many countries worldwide.

Finally, it would be desirable to be more compassionate with the situation of the vulnerable. A new transformational agenda respecting rights for all (human and non-human) could be a promising start for a better world.

1.4 Gender perspectives

Early research on DV was framed under a gendered or feminist model known as *'The Gender Perspective*,' centring on structural gender inequalities. Feminists also emphasised the interplay between cultural constructions of femininity (e.g. nurturance). In that construction, women were supposed to try to 'heal' abusive men through their love, understanding, and patience, which was why they did not leave abusive relationships. In reality, women's lack of resources is the primary reason to stay with the abuser (Walker, 1984). The feminist views highlighted the relative importance of patriarchy in domestic violence's aetiology, proclaiming that gender and power issues were the ultimate DV roots (Dobash and Dobash, 1979; Yllo, 1993).

However, researchers of traditions other than the feminist model disagree with the statement that patriarchy is the most crucial variable to explain women abuse. For instance, researchers using a sociological lens to understand family violence argued that variables and constellations such as age, sex, cohabiting status, unemployment, and sociodemographic factors cause DV (Gelles, 1999).

These theoretical disputes are based on the different methodological approaches they use to study DV.

In this section, the following topics are analysed:

1) Victims of abuse and police intervention.
2) Cultural beliefs and the media's role in violence issues: Andrea Yates and Khoua Her cases.
3) Competing gender theories of DV

Finally, we present the positioning of research concerning DV committed by men and women and the two research theories that emerged from it:

In Section 1.4.1, The Asymmetrical Perspective, and

In section 1.4.2, The Symmetrical Perspective.

1) Victims of abuse and police intervention

A factor that may influence victims unwillingness to call the police for help in DV incidents is the uncertainty about how police officers will react and handle the situation. Will the police arrest the abuser? Are the officers understanding and helpful to the victim? (Berg Nesset, Bjørngaard and Nøttestad, 2017).

Gracia, García and Lila (2011) conducted research at the *Police Department Training* of Valencia, Spain. Three hundred and seventy-eight male police officers participated. The researchers wanted to obtain a psychosocial profile of the officers according to the methods they prefer to use:

-Conditional law enforcement (e.g. the victim wants to press charges) (Gracia, García and Lila, 2011); or

-Unconditional law enforcement (it does not matter whether the victim wishes to press charges or not).

The police training unit applies for a mandatory arrest warrant in DV cases, although the officers may use a discretionary option. The police officers' response varied from being tolerant of DV to disapproving of it and considered DV a severe crime.

Officers preferring unconditional law enforcement would file a crime report, lay charges and make an arrest independent of the victim's willingness to press charges (McCartney and Parent, 2015). These officers were empathetic, not sexists, and felt a personal responsibility to act against DV (Gracia, García and Lila, 2011).

Police attitudes are important because it allows the victims to decide whether or not, in future situations, they will report incidents and ask for help or not (Gracia, García and Lila, 2011; Apsler, Cummins and Carl, 2003). Victims can be at risk (when the batterer is not arrested) of exacerbating the abuser and becoming a target of retaliation, instigating even more violence (Reaves, 2017).

On some occasions, battered women do not collaborate with the police and enable them to incarcerate the abuser. The victim inhibits their cases' progress into the legal system because battered women occasionally refuse to press charges against the offender (DeJong, Burguess-Proctor, and Elis, 2008). Although it may seem paradoxical for the officers that the abused partner does not want to press charges, there are explanations for it: Victims must think about the consequences of their decisions, for instance, if the abuser is the only breadwinner at home, and he is arrested, then he can lose his work, and the only income for the household would vanish (Gracia, García and Lila, 2011).

Another important reason for the victim not to press charges may be that she has no family or friends 0to go to in an emergency. Thus she must stay home, especially if she has small children in her care. Finally, a third reason can be that the affected victim does not know where to find fast and adequate help (Gracia, García and Lila, 2011).

2) The influence of cultural beliefs and the media.

The Khoua Her's case

Culture plays a role in how governments deal with DV. As Elizabeth Schneider (2000) noted, DV against women may sometimes be comfortably and selectively linked to 'culture' by governments to mask their inadequate protection and denial of rights for women. For example, when a group outside of the mainstream Western communities is affected by DV, this problem is often linked with concepts of ethnicity and race to devaluate marginal groups (e.g. immigrants), and 'culture' will be the explanation (Easteal, Bartels, Nelson and Holland, 2015).

An example of created stereotypes in communities and media is the tragic story of a native Hmong immigrant named Khoua Her. She strangled her six children and then tried to kill herself because she did not see any other way out from a long history of DV (the police was called sixteen times in two years). Besides, she had lost her poorly paid job and could not, therefore, maintain her children. In desperation, she thought she would spare a miserable existence of poverty to her children and herself if they all were dead (Easteal, Bartels, Nelson and Holland, 2015).

This case's reactions in the media resulted in a massive blaming against Khoua Her's culture with comments such as 'immigrant's families' structured around male authority, privileges and superiority;' 'they have a different sense of family arrangements' or similar kinds of arguments.

Neither the government nor the media were eager to explain some important facts to the public. Why did the police not intervene to stop the violence? Why immigrant women are without protection from their batterers or deprived of access to financial help to support their children in case of unemployment? To blame a particular culture detracts attention from the government's failure to protect all citizens without exceptions.

Andrea Yates's case

The media's reaction in the case of Andrea Yates (a white American nurse living in Texas, married to a NASA engineer), who killed all her five children (drawn in the bath-

tap one by one) on June 20, 2001, was different. The bizarreness of the case could not be explained by the fault of a 'different culture'. Thus, it was psychologically explained: Andrea Yates suffered from postpartum depression and psychosis after her children's births. In 2002 a jury convicted Yates of capital murder and imprisonment for life (Denno, 2005). At the second trial in 2006, Yates plead not guilty for reasons of insanity. Twelve hours of jury deliberation resulted in a unanimous verdict of not guilty for reasons of insanity (Holman and McKeever, 2017).

4) Competing gender theories on domestic violence

According to Cannon (2020), early feminist literature has enriched understanding of the processes operating in (heterosexual) intimate partner relationships. For example, they proposed that women had the right to end their husband's abuse and that gender inequality influences gendered violence. Later waves of feminist thoughts embarked into a broader domain, including black feminist thought, poststructuralist and queer theories.

America, Europe, and other Western countries recognise intentional violence against women as a crime against humanity and state crime (Schmidt, 2010; Rose, 2015). Returning to the gender perspective on violence, since feminist activism made DV an urgent issue, protective laws and shelters were made available to improve battered women and children's situations. The copious research literature also asserted the asymmetric occurrence of DV affecting predominantly women (Dobash and Dobash, 2004). However, studies about men as DV victims (e.g. men as victims of spouse's violence) emerged around the nineteen-seventies. Those studies presented a different view on DV problems, supporting the notions of equal violence by women against male partners or the likelihood of women using even more violence towards their intimate partners (Straus, 2009; Hine, Noku, Bates and Jayes, 2020).

The emergence of new insights over men being DV victims started contemporary controversies related to research's results. Are women as violent as men? Do they involve in violence at the same level and frequency as men?.

Researchers agreed on the existence of certain similarities of the reasons why women and men perpetrate partner violence: Due to jealousy, anger, and because one of the partners wants to punish the other (Kernsmith, 2005). Females use violence in relationships (non-lethal or lethal) primarily in response to prior abuse (psychological and physical), such as retaliation or revenge. On the other hand, men use violence to obtain power and control (e.g. sexual or financial) (Johnson, 2009).

Ever since the emergence of men victimhood, there are two competing perspectives within the field of DV:

1) The *Gender Asymmetric Perspective* (also known as 'Feminist' or 'Violence Against Women'); and

2) The *Gender Symmetric Perspective*, or 'Family Violence'. This second perspective defends the view that both women and men perpetrate violence at equal levels (Mulroney and Chan, 2005).

The answers to the questions of who use violence, in which grade and frequency, is not just an academic contest. It has consequences for policy-makers and all the institutions active on issues of DV.

A possible explanation of why research shows different results on asymmetry or symmetry of violence can be due to the samples they use. The two primary sampling methodologies to gather data in DV are police, hospitals, courts, and shelters. This data is obtained from severe reported cases of violence, mainly concerning intimate heterosexual relationships and points to men as perpetrators.

The second methodology to gather data consists of surveys. Studies using general samples (surveys) contain items' lists intending to measure violence, conflicts or abuse. Nevertheless, the set of questions asked is too broad; they cannot differentiate the effect and certain behaviours' intent.

In the *Conflict Tactics Scale* (CTS), a man pushing his wife downstairs equates to a woman pushing her husband to defend herself or her children from abuse (Straton, 1994). For instance, if men and women are asked: "*Have you ever thrown an object at your partner?*"

If both partners answer with a yes, both will be considered to have acted violently. However, it is not the same to throw a heavy object at a partner as to throw a pillow.

The same can happen when participants are asked:

"*Did you ever hit your partner*?."

A yes answer from both partners does not have the same meaning because a corpulent male hitting his wife can fracture her jaw or produce other serious injuries, which require hospitalisation. In contrast, a slap from her will not have severe consequences. Considering 'acts' as proof that women are equally violent as men will erroneously indicate a gender symmetry in terms of perpetration (Johnson, 2010).

Survey data does not differentiate between (asymmetric) intimate terrorism from situational couple violence (Johnson, Leone, and Xu, 2014). Intimate terrorism is coercive controlling violence rooted in patriarchal attitudes (e.g. male dominance that attempts to exert general control over his intimate partner) (Johnson and Leone, 2005). Situational couple violence is practically gender-symmetric and occurs in daily family life conflicts, mostly in heterosexual relationships. Thus, sampling methodologies influence the conclusions of studies (Johnson, 2010).

Other scientists believe that the differences in research results are related to discrepancies in reporting styles of men and women: Men often under-report their own patterns of perpetration such as the use of heavy or massive objects as a weapon, kick body, punch, choke (Dobash and Dobash, 2004).

Regardless of who is reporting, some types of injuries are inflicted overwhelmingly by males, such as fractures of teeth or bones, beating up the partner until she gets blackout or unconscious, split lips, produce miscarriages due to force violence to their pregnant wives (Dobash and Dobash, 2004).

Females also perpetrate serious violence, although it is not the norm and often is reactive, self-protective, or self-defensive. Using qualitative data from interviews has revealed the differences between male and female violence (Dobash and Dobash, 2004), an example:

"*How serious would you say your violence was? Well, I suppose the fact that I stabbed him made it pretty serious. I was arrested for attempted murder, but he gets arrested for 'domestic'. It was dropped to 'assault', right enough, and I got eighteen months' probation. (women, 1082)".* Cited by Dobash and Dobash (2004).

Women underreporting may also be explained due to their tendency to downplay their partner's violence because of economic dependency, especially if they have young children. When dependent mothers seek to escape the violent relationship, they face another type of risk: losing custody of their children (Epstein and Goodman, 2018).

Next follows a short introduction of the two perspectives in research:

1.4.1 *The Asymmetric Perspective*

First and foremost, it is vital to recognise that both women and men perpetrate DV. Nevertheless, men in heterosexual couples are considered more likely to be perpetrators than victims (especially in what Johnson and colleagues named *'Intimate Terrorism*'). Men also use more often than women severe violence (Saunders, 2002).

A study by Stanko (2001) collected data from telephone calls relating to DV made on one single day in the UK in the year 2000. The calls were made to the police and other social services. Stanko established that eighty-six per cent of all callers were females attacked by males (Stanko, 2001).

The asymmetric perspective sustains what feminist activism voiced decades ago, which helped make the subject of DV visible (then also known as wives assault, battering, or spousal abuse). The asymmetric perspective maintains that sexism, the patriarchal nature of families and societies, gender inequality, and the coercion exercised by men (e.g. psychologic, economic, sexual) is the leading motive of intimate partner violence (Dobash and Dobash, 1998, 2001; Johnson, 1995; Ferraro, 2017; Expósito Jiménez, 2009).

Since DV was recognised as an issue affecting society from the 1970s onwards, social scientists with a feminist perspective were very interested in understanding its nature.

To accomplish that purpose, they interviewed female victims in shelters and other public agencies where victims of violence seek help, asking them to tell their stories, using quantitative and qualitative analysis. They also used data collected from hospitals, courts, and police logs. Over many decades, the arduous work demonstrated the differences in IPV patterns (Kelly and Johnson, 2008).

Johnson (2009) asserts that in the USA and other Western countries, there are subgroups of violent partners (Leone, Johnson, and Cohan, 2007), but the two most significant forms are:

1) *The Situational Couple Violence*:

It responds to a situationally specific conflict (Leone, Johnson, and Cohan, 2007). Intimate relationships inevitably involve disputes, tensions, and emotions that may lead couples to react with minor violence such as pushing or slapping the other, shoving, grabbing, throwing objects at the victim. These acts of violence are, in some cases, less likely to result in a medical hospitalisation or to have criminal justice consequences (Dutton, 2001). Nevertheless, in other cases, situational couple violence can be a chronic problem and life-threatening when violent outbursts happen from either husband or wife. Arguments may escalate to verbal or even physical aggression. The cause of escalation can be related to poor anger management, communication problems, or substance abuse (Johnson, 2006b, 2009; Leone, Johnson and Cohan 2007). Situational couple violence does not involve attempts to gain control over the other partner and is the most prevalent type of partner violence (Johnson, 2009).

2) *Intimate Terrorism:*

Patterns of power and control are representative of intimate terrorism (Leone, Johnson, and Cohan, 2007). Severe DV is not a rarely isolated phenomenon; women (and to a lesser extent, men) whose intimate partners seriously injure them often require to be treated in an emergency room. Unfortunately, those happenings are not unusual or rare. Copious research points to women as DV victims and the asymmetric nature of power (Kelley and Johnson, 2008). However, it is unquestionable that some women

terrorise their male partners; and that same-sex relationships of both males and females also experience intimate violence.

Diverse motivations trigger men to exercise DV or assaults against their female spouses or cohabiting partners, ranging from expectations about domestic work and economic resources to alcohol use by men; or issues related to children or household tasks (Dobash and Dobach, 1998). Factors such as low socioeconomic status, psychopathology, financial strains and conflicts all contribute to sustaining DV.

In some couples, women are terrorised by systematic male violence. Johnson called this type of violence firstly patriarchal terrorism, and later on, intimate terrorism.

Intimate terrorism is, according to Kelly and Johnson (2008), motivated by coercive behaviour to exercise control and power over the victim. Coercion means that someone threatens someone else to do something against their will with adverse consequences by refusal. This control can also be expressed by nonviolent tactics like threats, intimidation, or monitoring of their partner's behaviour.

Dutton (2001) points out that effective coercive control requires a second element: Perpetrators must make clear that they are willing and able to punish if 'necessary'.

A case example of intimidation: A woman told the researcher that she did not arrive home 'on time' on one occasion. " *At her arrival, her husband told her to go and lookout in the garage. She found that her husband had hung her dog*" (Kelly and Johnson, 2008).

Sometimes women must follow orders to avoid punishment: "*He allowed me half an hour to go up to the village and half an hour to walk back and ten minutes to get what I needed in the shop.*" (Kelly and Johnson, 2008).

The 'rules' are sometimes very vague, and the partners are insecure when they will get attacked: "*He would say, you made me hit you, you know, but I did not realise what I was doing to make him hit me*." (Kelly and Johnson, 2008).

Victims of intimate terrorism are women who had to flee their homes and search for protection in shelters, are found in emergency rooms, or in reports of severe DV

incidents made by law enforcement. The victims live in fear, seek help from the police, require protective orders, or ask for a divorce (Johnson, 2010).

Women (and a few men) victims of intimate terrorism use as a response to this aggression what is called violent resistance that emerges when a partner does not tolerate abuse and engage in self-protection (Johnson, 2009). In heterosexual relationships, women primarily use violent resistance (Johnson, Leone, Xu, 2014). Nevertheless, Hines and Douglas (2019) used a population-based sample of men who were IPV victims. These researchers asserted that Johnson's theory might be biased because of the examples he used; and that the approach needs revision since women are, they say, the primary perpetrators of intimate terrorism, while men primarily used violent resistance.

At some point in violent relationships, victims fight back physically as an instinctual reaction to being attacked. Others react after they see that the violence will not stop. Few victims of intimate terrorism may feel that after years of abuse and entrapment, the only way out is to kill the aggressor (Johnson, 2009). This subject is explained in chapter 3, section 3.5.

In some instances, Johnson claims, it is complicated to classify violence belonging to groups 1) *Situational Couple Violence* (Leone, 2004) or 2) *Intimate Terrorism* (Leone, 2004). The central distinction among DV types is the motivation underlying physical violence, rather than severity or frequency (Leone, 2004); it is related to patterns of power and control tactics, including physical violence (Johnson and Leone, 2005). Examples of nonviolent control tactics are emotional and economic abuse, threats, intimidation, and isolation (Pence and Paymar, 1993; Leone et al., 2004).

1.4.2 *The Symmetric Perspective*

Survey research on patterns of violence where only fifty-seven couples participated (in which four wives were seriously beaten, but none of the husbands) led Suzanne Steinmetz (1978) to introduce the term *'Battered Husband Syndrome*' (Straton, 1994).

With her finding of zero battered husbands, Steinmetz proclaimed that men just do not report the abuse committed by their intimate partners.

The voices of battered men were heard in various other studies and highlighted women's capability of using violence to inflict harm against their partners. Some researchers started to claim that if both partners are prepared to use violence against each other, both men and women should be considered accountable for their violent interactions (Stith, McCollum and Rosen, 2011).

According to the symmetric perspective, some studies show that female-only partner violence outnumbers the percentage of male-only partner violence (Straus, 2008; APA, 2009).

Straus (2009) claims that there is data available on partner violence's symmetry for over twenty-five years. Straus (2011) also asserts that more than two hundred research studies have found gender symmetry related to DV (that is, the percentage of women and men physically assaulting each other occurs in equal proportion). However, according to Straus, the evidence has been ignored, denied or misinterpreted as wrong by the advocacy (feminists) who fear undermining all the efforts made to support female victims (Scott and Straus, 2007).

Pengpid and Peltzer (2016) conducted a cross-sectional study to investigate female and male university students health behaviour; twenty-two countries in Africa, Asia and the Americas facilitated the project, and 16,979 undergraduate students living in a low or middle-income country participated in it. The results showed no impelling gender differences between males and females regarding physical and sexual partner violence. These findings are similar to previous studies, which showed an intimate partner violence victimisation of a similar proportion for females and males (Pengpid and Peltzer, 2016).

Conclusion

The early feminist movement aimed to gain rights for women and make abuse against females recognised as a crime by justice systems. They aimed at protecting abused women from the violence of their batterers. The research model known as '*The Gender*

Perspective' was centred on structural gender inequalities, on cultural constructions of femininity that made it possible for governments to masked their inadequate protection and denial of women's rights by tolerating men's dominance and control over their female partners.

We analysed why women sometimes stay in violent relationships, what reasons they have to remain by their batterers. The reasons they give varies from protecting their children or staying due to the lack of social and economic resources that prevent them from leaving the abusive relationship.

Other times they hope to receive help from police interventions to stop the violence at home. However, police officers are diverse in their reactions towards DV; some tolerate DV and use conditional law enforcement methods. Other officers are less lenient towards DV and use unconditional law enforcement; it does not matter whether the victim wishes to press charges or not; those officers score high on empathy.

We also exposed DV discourses by the media linked to 'culture' and presented two cases: Khoua Her and Andrea Yates.

Finally, we saw that decades later, after the feminist model of research, other researchers started to warn that women also perpetrate DV and are not the only victims of violence. The realisation that women could be perpetrators of DV opened up discussions about whether women are as violent as men (Hanson Frieze, Newhill, and Fusco, 2020). As a result, two competing research views on the nature of DV have emerged: The (feminist) *Gender Asymmetric Perspective*, on the one hand, asserting that men use much more severe violence than women (Hamberger and Larsen, 2015), and men coerce their partners (intimate terrorism) (Simmons, 2015). On the other hand, the *Symmetric Perspective* asserting that women are as violent as men (Simmons, 2015; Mazerolle, Eggins, Sydes, Hine et al., 2018).

1.5 Children exposed to domestic violence

The health, well-being, and functioning of children of all ages can be undermined when they are direct victims of violence at home or witness violence against one of their parents (mostly against their mothers). The literature on intergenerational violence signalises that DV perpetrators often were themselves victims of violence in their childhood. They have learned to resolve difficulties or conflicts by behaving aggressively against peers (e.g. bullying) and, later in adulthood, against intimate partners or children. The risk that violence will continue to be passed down to the succeeding generation is present when the child's living conditions are far from ideal: Deprived homes and neighbourhoods, interparental violence, lack of positive role models, insensitive parenting leading to insecure attachments, among other factors. Mothers play an essential role in children's lives. However, when women are physically, psychologically or sexually abused, they are impaired or unable to respond adequately to their infant's needs. As a result, children may develop dysfunctional attachments that may, once again, lead to maltreatment. Every step of childhood development can be challenging and has consequences in children's future lives. Helping parents break the intergenerational circle of violence at home could spare whole societies and future generations from the harms created by violence. This section aims to show that most DV perpetrators have themselves experienced abuse in their childhood and why multilevel factors associated with maltreatment can form considerable risks for DV's intergenerational transmission.

The topics that will be discussed next are:

1) Child maltreatment and its prevalence.
2) The repercussion of child maltreatment on children's lives.
3) Identifying factors leading to an intergenerational cycle of violence.
4) Theories that explain the intergenerational transmission of violence.
5) The WHO INSPIRE proposal to end violence against children.

1) Child maltreatment and its prevalence

Children witnessing physical or verbal violence between caregivers is considered a form of child maltreatment (World Health Organisation, 2016). In the family context, child maltreatment is often perpetrated by children's carers, e.g. parents or dating partners of one of the parents (Centre for Disease Control and Prevention, 2013). Maltreatment refers to harms inflicted on children during their developmental stages due to adverse interactions that parents or other persons with caregiving responsibility exercise on them or by the lack of interventions to protect children. According to Meinck, Steinert, Sethi, Gilbert, et al., 2016, maltreatment might take different forms, as we shall see below:

Physical abuse: Are acts that may be committed on one occasion or repeatedly. Emotional abuse includes denigrating, threatening, or other non-physical forms of aggressive behaviour (Meinck, Steinert, Sethi, Gilbert, et al., 2016).

Neglect: This is considered the failure of caregivers to provide the child with safe conditions at home, with proper shelter, nutrition, and supervision (Meinck, Steinert, Sethi, Gilbert, et al., 2016).

Another highly detrimental form of childhood maltreatment is sexual abuse (Lambie and Reil, 2020). The prevalence of child sexual abuse worldwide is 31% for females and 17% for males (Barth, Bermetzm Heim, Trelle, and Tonia, 2013). In Europe, child sexual abuse (CSA) is around 13.4% for females and 5.7% for males. However, there are indicators that 90% of sexual abuse cases go unreported (Sethi, Bellis, Hughes, Gilbert, Mitis, and Galea, 2013; WHO, 2013).

The prevalence of child maltreatment varies across countries and cultures (Sethi, Bellis, Hughes, Gilbert, Mitis, and Galea, 2013). The *World Health Organisation* proclaims that millions of young people experience abuse every year (WHO, 2016). *UNICEF* states that up to 1.5 billion children are victims of violent victimisation; children also suffer from emotional and psychological abuse, but these subjects receive less attention than physical violence; therefore, its prevalence is uncertain (UNICEF, 2008).

In the United States, one in every four children is exposed to DV; that means that 8 to 15 million children are affected, representing an enormous public health concern (Hamby, Finkelhor, Turner and Ormrod, 2011). The term 'exposure to DV' includes

visual, auditory or inferred DV risk (Black, Fallon, Nikolong, Tardis, Baird and Carradine, 2020). This term has broadened the definitions of 'witnessing DV' by including situations when children hear or experience the violence but never directly witness it (Latzman, Vivolo-Kantor, Clinton-Sherrod, Casanueva, and Carr, 2017; Black, Fallon, Nikolong, Tardis, Baird and Carradine, 2020; Hamby, Finkelhor, Turner and Ormrod, 2011). The report issued by the *United States Department of Health and Human Services, Administration for Children, and Families* (2018), states that children's early age is a high-risk factor for being maltreated. The report also says that the rate of victimisation of children decreases with the child's age. The most vulnerable children to be abused are very young ones. Nationally, 28.7% of children victims of maltreatment are three years old or younger. The highest rate of victimisation is found in children younger than one year (15.3%). The victimisation of girls is around 51.2%, while for boys, it is 48.5%. Victims are maltreated by mothers acting alone in 39.4%, and 21.5% by fathers acting alone.

In Europe, child maltreatment occurs in every country of the union. The *European Report on the Prevention of Child Maltreatment* (2018) (Sethi, Yon, Parekh, Anderson, Huber, Rakovak and Meinck, 2018; and the *WHO Europe* states that child abuse has decreased since 2005: In the 2015 survey, 1500 school children aged 13-15 participated, the prevalence of physical abuse was 20% compared with the previous rate of 35% in 2005.

2) The repercussion of child maltreatment on children's lives

Women are usually the primary caregivers of their children. When she is maltreated, there is a possibility that her children will also be physically or psychologically abused; perhaps not as the direct recipient of the maltreatment but indirectly experiencing the effects of DV (Anderson and Van Ee, 2018). Children as young as one year of age can already display clear signs of distress as a response to their parents' verbal conflicts (Øverlien, 2010).

Approximately twenty-two per cent of females in the U.S. are victims of severe physical abuse from their intimate partners; many of them have young children (Casanueva et

al., 2008). These high rates of abuse in families with young infants indicate that children are exposed to unacceptable rates of violence at home (Hamby et al., 2011).

According to Van der Kolk (2005), when parents are trapped in DV or have a history of traumatic experiences from their youth, they are unable to support their children. Living in a violent environment not only re-enacts past traumas on parents but also contributes to detrimental social effects on their children. It is not unusual for children exposed to chronic maltreatment to be at greater risk of the adverse impacts on their evolving brains and then develop traumas that can be pervasive and long-lasting. Those traumas can have potentially harmful effects on their future relationships and increase the possibility of correctional, medical and mental health services in adulthood (Van der Kolk, 2005).

Other disadvantages children with a history of maltreatment or who witness DV have are their difficulties in transitioning from childhood to adulthood resulting in insufficient behavioural adjustments, mental health problems, and poor school performance (Evans, Davies and DeLillo, 2008). This transition period represents a challenge to all young people, especially children exposed to conflicts between their parents, resulting in adverse outcomes during childhood and beyond (Kiese, Piescher, and Edleson, 2016).

Exposure to direct or indirect chronic violence harms a child's mental health and behavioural adjustments that can develop into a vicious circle of intergenerational DV in adulthood. This early-life exposure to trauma also affects adolescents' mental health in their present and future, including the risks of developing substance abuse dependency (Temple and Freeman, 2011). They may result in suicidal behaviour and depression (Costa and Canossa Gomez, 2018).

The severity of the abuse, its frequency and duration, is linked to increased psychological disorders (Trickett, Noll, and Putnam, 2011) and Post-Traumatic Stress Disorder (Iverson, Dardis and Pogoda, 2017). Other consequences for affected children and adolescents are the exhibition of dysregulated patterns of emotionality, their difficulty expressing emotions, and a tendency to be more reactive than children of non-violent families (Katz, Hessler and Annest, 2007).

3) Identifying risk factors leading to an intergenerational cycle of violence

The study of the intergenerational cycle of violence aims at understanding the factors associated with the continuation of maltreatment from one generation to the next.

A history of abuse in mothers can lead to depression and child maltreatment, negatively influencing their children's rearing. Those children are more vulnerable to emotional dysregulation (Warmingham, Rogosch, and Cichetti, 2020). Another problem abused mothers experience is that their parenting is characterised by high stress levels (Hugill, Berry and Fletcher, 2017) that lower their self-efficacy (Langevin, Hebert, Cabecinha-Alati, 2020; Fitzgerald, Shipman, Jackson, McMahon, and Hanley, 2005). Parental roles may turn abusive, inconsistent or chaotic, jeopardising the child's healthy development, increasing their vulnerability to victimisation (Cabecihna-Alati, Langevin, kern, and Montreuil, 2020).

Child sexual abuse (CSA) is a very harmful experience for children and a risk for society because such abuse has consistently been associated with negative consequences for the victims and their children. Longitudinal research shows that the harmful impact of sexual abuse on females may continue across generations. Children of sexually abused mothers are at a high risk of experiencing abuse themselves (Langevin, Hebert, and Cabecinha-Alati, 2020). Although mothers rarely perpetrate CSA against their own children, their past CSA traumas often develop into substance abuse; alternatively, unsafe conditions for their children might well result in them being removed from home (Trickett, Noll and Putman, 2011).

The link between the exposure to physical, sexual and emotional abuse in childhood and children's consequent violent behaviour in adulthood can be understood as a mechanism of the overlapping and consequent perpetration and victimisation. Accepting violence as a response to conflict also shapes distorted ideas of gender-role expectations in relationships, especially when families cannot give emotional support (Richards and Gordon, 2017).

Eriksson and Mazerolle (2018) conducted a study among three-hundred three male detainees who perpetrated intimate partner violence towards their female partners and who had themselves witnessed parental violence (father to mother or vice-versa).

Their findings suggested that partner violence influences children. These children may acquire attitudes (predictive of perpetration) justifying wife-beating, leading to the intergenerational transmission of violence. Nevertheless, the transmission "is gender and role-specific rather than the result of a generalised learning process" (Eriksson and Mazerolle, 2018).

The cycle of violence passing down to succeeding generations is very damaging. As we saw, abused children can become in adulthood batterers themselves (Frankling and Kerscher, 2012). They are prone to use violence against other people later in their adult lives, including their partners or children, generating an intergenerational transmission of violence and aggression.

4) Theories that explain the intergenerational transmission of violence:

Various theories explain the harmful mechanisms involved in the phenomenon of the intergenerational circle of violence. Here we will discuss

A) Bowlby's *Attachment Theory* (Bowlby, 1969, 1973, 1980) and

B) Bandura's *Social Learning Theory* (Bandura, 1977; 2001).

A) Bowlby's *Attachment Theory* states that attachment serves to create a powerful bond between the infant and the mother (or another primary caregiver), who gives the child comfort and protection. Caregivers' close emotional relationships, therefore, have an enormous life-long impact (Vicedo, 2020).

B) Bandura's *Social Learning Theory* emphasises that children learn how to behave socially from the essential persons in their lives (who are at the same time their role models). When children, both girls and boys, observe DV in their families of origin, they develop maladaptive beliefs and attitudes by imitating those dysfunctional patterns throughout their lives (Latzman, Vivolo-Kantor, Holditch Niolon, and Ghazarian, 2015; Foshee et al., 2015; Cameranesi and Piotrowski, 2020)

A) Bowlby's *Attachment Theory*.

This theory sustains that only a secure attachment meets the infant's emotional needs and their means for survival. Those securities are essential for a child's healthy development because it establishes an internal working model of its self, others, and the world, that will generalise to future (romantic) relationships (Bowlby, 1969, 1973, 1980). Children who have qualitative early experiences learn through their parents about security, about the social and emotional competencies needed to manage themselves with others (Mares and McMahon, 2020). High-quality parental caregiving that adequately responds to the child's signals is essential for their development and wellbeing (Vesely, Levine Brown and Mahatmya, 2013). For children to develop secure attachments, parents and caregivers must be sensitive and responsive to the child's needs. Sensitive responsiveness is acknowledged as a relevant quality of parental/caregiver behaviour for a healthy attachment's development (Helmerhorst, Riksen-Walraven, Vermeer, Fukkink and Tavecchio, 2014). However, many children are less fortunate and grow up in deprived environments and experience abuse and neglect. They live in dysfunctional families; some have single young mothers from whom they receive insensitive caregiving (Riva Crugnola, Ierardi, Gazzotti and Albizzati, 2014) or are maltreated (e.g. physical or emotional abuse). Violence, chaotic households and poverty can contribute not only to difficulties in regulating negative emotions but can also result in low educational progress and, consequently, a lack of qualifications (Berger, Cancian, Han, Noyes, and Rios Salas, 2015). Children are also in jeopardy of dropping out of school and subsequently have fewer chances to keep stable employment or training in adulthood (Coohey, Renner, Hua, Zhang, and Whitney, 2011).

Deprived children are thus at risk of developing an insecure attachment associated with fears of separation from the essential persons in their lives (Bowlby, 1984). Research has addressed the issues regarding the risks of a dysfunctional attachment for children exposed to deficient parenting, violence and fear since early life, and indicates a significant association between insecure attachment and intimate partner violence (Sommer, Babcock and Sharp, 2017). The attachments and bonds of a healthy child are vital because they predict a child's short and long-term psychological

adaptation and cognitive functioning. Insecurely attached children often exhibit disorganised behaviour and are at risk of psychopathologies such as eating disorders (Monteleone, Ruzzi, Patriciello, et al., 2019), poor cognitive performances, behaviour problems and stress dysregulation (Lyons-Ruth and Jacobvitz, 2008).

Hechler et al. (2019) proposed that teaching future parents to improve their parental skills at an early stadium, even before the child is born, could help prevent the known risks of low-quality caregiving, especially when parents are confronted with critical situations (e.g. baby constantly crying). Without such skills, their children are at a greater risk of being maltreated (Hechler, Beijers, Riksen-Walraven, and Weerth, 2019).

B) Bandura's *Social Learning Theory*:

Bandura suggested that children learn how to behave socially by observing the behaviour of crucial people (Bandura, 1977) in their lives, such as parents, siblings, caregivers, and teachers (Leveske, 2018). However, children living in an environment dominated by hostility, fear and control, witnessing interpersonal violence between their parents, are exposed to intense negative emotions (Weissman, Jenness, Colich, Miller, et al., 2020). Children can be traumatised by the evidence of violent assaults on one of their parents, for instance, bruises or other types of physical injuries, and to witness the intervention of police officers arresting one or both of their parents (Holden, 2003); or hear verbal abuse between them. They may associate abusive behaviour as 'normal' and 'appropriate' (Warenham, Boots and Chavez, 2009). Learning from violent modelling can instil children with knowledge of how to be cruel (Ehrensaft and Cohen, 2012; Harding, Morelen, Thomassin, Bradbury and Schaffer, 2013; Siegel, 2013).

Children's direct or indirect exposure to violence is associated with their behavioural expressions of emotional and social disturbances (Leveske, 2018), with negative consequences to their physical and psychological wellbeing (Miller, 2015). For instance, due to imitating aggressive responses and violent behaviour they witness at home, children may become the targets of anger from the battering parent when the

child tries to protect one of the conflicting parties. Children experience a crisis of loyalty when confronted with the dilemma of having to take sides of one or other of their parents because they depend on both for survival within the family (Van der Kolk, 2005).

Witnessing violence externalises mainly in difficulties, particularly aggression towards peers (Cullerton-Sen et al., 2008), using violence against other children (e.g. bullying) in pre-school, primary and secondary educational settings (Hymel and Swearer, 2015). Bullying perpetration is the uneven relationship of power between perpetrators and their victims (Naylor, Cowie, Cossin, De Bettencourt and Lemme, 2006). Bullying contains unsolicited, repeatedly, and intentional actions to inflict harm and coerce others physically (by shoving, kicking, pushing), verbally (name-calling), or by excluding peers socially, spreading rumours and by sharing compromising pictures or videos on social media (cyberbullying). Children who bully other children are at increased risk of becoming criminal offenders in adolescence or adulthood (Farrington et al., 2016). Besides, victims of bullying are themselves at risk of committing suicide, having adverse mental health outcomes (Armitage, 2021), emotional problems and depression, and of achieving poor results at school (Coperland et al., 2013).

5) *The WHO INSPIRE* proposal to end violence against children

Globally up to one billion children suffer from violence every year, which has long-lasting detrimental effects on their health, representing high costs for societies and undermine children's social functioning and well-being (Kury, Redo and Shea, 2016).

In 1990, the *Convention on the Rights of the Child* (CRC) marked a considerable shift away from traditional notions of children as passive beneficiaries of protection and welfare. The convention recognised children as right-holders who have the right to live a life without violence. This new perspective was essential to achieve the 2030 Agenda for Sustainable Development aims to construct a solid preventive plan to end violence against children.

The *WHO* and ten global agencies involving over 100 experts of diverse violence prevention sectors worked together to create that strategy, including ending all forms

of violence to children. *INSPIRE's* strategy is directed to governments, policy-makers, legislators, practitioners, funders, and advocates. *INSPIRE* is the acronym for*: "Implementation and enforcement of laws; Norms and values; Safe environments; Parents and caregiver support; Income and economic strengthening; Response and support services; Education and life skills*" (WHO, 2018).

Conclusion and recommendations

DV among parents can increase the risk of child maltreatment, whereby the adverse effects endure from childhood into adulthood, leading to damaging intergenerational cycles of violence. We often mentioned that DV's perpetrators were victims of abuse and learned to resolve difficulties or conflicts by behaving aggressively towards others (e.g. bullying against peers). Later in adulthood, they continue to use violence against partners and children.

The risk of violence passing down to succeeding generations is facilitated by harmful conditions, such as deprived homes and neighbourhoods, lack of positive role models, and insensitive parenting leading to insecure attachments.

Mothers play an essential role in children's lives. However, when women are physically, psychologically or sexually abused, they are impaired or unable to respond adequately to their infant's needs. As a result, children may develop dysfunctional attachments that may, once again, lead to maltreatment. Every step of childhood development can be challenging and has consequences in children's future lives. Helping parents break the intergenerational circle of violence at home could spare whole societies and future generations from the harms created by violence.

Qualitative parental modelling and healthy attachments are paramount to shaping and regulating children's behaviour in ways that contribute to healthy physical and emotional development. However, in highly dysfunctional families, parents may lack the competence to fulfil the adequate parental role, especially when they are too stressed by their own experiences as victims of violence and are, therefore, emotionally unavailable to their children.

Governments and policy-makers should implement effective measures that combine knowledge and know-how based on research to create interventions that break the cycle of violence. Interventions need to target risk factors that affect both parents and children in order to reduce the externalisation of problems. The promising seven strategies proposed by the *World Health Organisation (INSPIRE*), if implemented in every country worldwide, could end violence against children. Protecting children and their families from the harm caused by DV and offering them a safe environment to live without fear should become a reality as soon as possible.

1.6 Domestic violence among same-sex couples

Women's movements have fought to create laws to make DV a crime and to gain more rights for women - the beneficiaries were mainly heterosexual and white women. Unfortunately, other minorities (e.g. lesbian, gay, bisexual, transgender (LGBT+) were still invisible to the law and policymakers until the 1990s, when more rights were conceded (e.g. gay marriages). Nevertheless, intimate relationships of same-sex individuals continued to be considered an illness or mental disorder for some theorists (e.g. Freud; Le Vay) and for the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that only removed homosexuality from the diagnostic manual in 1973.

Mainly among high-income countries, attitudes towards LGBT+ communities were changing around the 1990s. LGBT+ gained visibility, recognition, social acceptance, and rights (e.g. legalisation of same-sex marriage, rights to child custody, the issuing of anti-discrimination legislation). Nevertheless, LGBT+ activists called attention to the limited protection of marginalised groups, including transgender women - those who were not born biologically female but identify themselves as female (Apsani, 2018).

Due to the LGBT+ ever-increasing visibility, researchers also showed interest in domestic violence in those communities – particularly its prevalence. The demographic census held every ten years in the USA has helped to calculate the approximate number of American households that are same-sex couples. Research is essential to

create new legislation to protect LGBT+ communities from DV/IPV and other types of violence such as hate crimes.

In section 1.6.1, we expose the phenomenon of *Hate Crimes*. In Section 1.6.2, we explain the changes in the law regarding hate crimes in the Netherlands. Section 1.6.3 provides an overview of hate crimes in Spain.

This section aims to increase knowledge of LGBT+ related issues by discussing the following topics:

1) LGBT+ from being a mental disorder to visibility and acceptance.
2) The US's demographic census's role in calculating same-sex couples' prevalence in America.
3) DV in LGBT+ Communities.

1) LGBT+ from being a mental disorder to visibility and acceptance

In humanity's history, having an intimate relationship with a person of the same sex had been viewed and explained by some theories (e.g. psychoanalytical, biological) as an illness or mental disorder. Freud's early psychoanalytic theory (written between 1905 and 1920) regarded same-sex relationships as a borderline condition, a personality disorder with patterns of unstable relationships and a distorted sense of self (Newbigin, 2013). Freud believed that same-sex object choice was narcissistic (Newbigin, 2013) and could be 'cured' by therapy (Price, 2020).

In 1993, Simon LeVay, a neuroscientist, proclaimed in an article published in the respected academic journal *Science* that the brain determines sexual orientation in men. LeVay suggested that homosexuality was biologically determined, not a choice, and therefore, immutable (McLaughlin, 2018).

Even the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) recognised same-sex relationships as an illness that could be cured by therapy. However, researchers could not find any empirical proof to support the relationship between homosexuality and mental illness. Therefore, the *American Psychiatric Association* decided to officially remove homosexuality from the DSM III onwards in 1973 (Drescher, 2015).

Since the 1990s in Europe, attitudes towards LGBT+ people have changed. At present, there is more tolerance and acceptance to their community. This tolerance comes from family structures across the industrialised world which have had significant changes in structure, organisation and composition, making possible the emergence of new forms of couple relationships, family patterns and dynamics (Doblhammer and Guma, 2018). In many countries, families formed by two people, whether they are heterosexual, same-sex, bisexual, or transgender, are recognised by law.

In the 1990s, gay marriages were not legalised anywhere in the world. However, a movement recognising gender identities other than heterosexual started proposing human rights concessions to these minorities. One of the first countries to legalise gay marriage was the Netherlands in the year 2000. Promptly other countries in Europe followed (e.g. Belgium, Denmark, France, Norway, Portugal, Spain, and Sweden). Countries outside Europe such as South Africa, Canada, Mexico and some states in the USA also began legalising gay marriages (Oppenheimer, Oliveira, and Blumenthal, 2014).

2) We shall now see how the American demographic census helps calculate the number of LGBT+ couples living in the USA, contributing to research into these populations.

The emergence of same-sex couples' visibility and prevalence in the USA also awakened researchers' interest in investigating and better understanding DV in all types of same-sex relationships among the LGBT+ community. Nonetheless, DV among transgender/gender or other nonconforming individuals remains understudied (Lasky, 2019) compared with DV cisgender heterosexual individuals (Rolle, Santoniccolo, and Trombetta, 2018; Scheer and Baams, 2019).

Although the LGBT+ community is present worldwide, it represents a relatively small sample of the whole population, and reliable demographic data is absent in many countries. There is also less research conducted on interpersonal violence among same-sex couples, possibly resulting from the difficulty of obtaining large and representative samples to draw general inferences. As a result, data on the incidence

and frequency of DV is quantitatively lower for this group than data gained from heterosexual couples (Edwards, Sylaska and Neal, 2015). Nevertheless, it is known that intimate partner violence occurs in LGBT+ couples and can be as invasive as in heterosexual couples (Miller, 2016).

The demographic census that takes place every ten years in the USA makes it possible to gather actualised data and calculates the number of same-sex couples in American territory. The census of the year 2000 showed that approximate 600,000 same-sex couples were living together in the USA. Mainly, but not exclusively, concentrated in urban areas with similar quantities of females and males (Gates and Ost, 2004). This census did not count single gay or lesbian individuals or those in a relationship with different addresses. Besides, some respondents might have been unwilling to identify themselves at the census; therefore, same-sex couples' numbers might be higher (Black, Gates, Sanders and Taylor, 1999).

The Census of 2010 established 313,577 male-male partner households (Spring, 2013) and 332,887 female-female households (Gates and Cooke, 2012). In this census and the previous one in the year 2000, no direct question about sexual orientation was asked. The number of same-sex partners might be higher since some participants might not disclose living with a partner of the same sex or identified themselves as roommates or non-relatives instead (Gates, 2010).

The increasing visibility of same-sex partnerships internationally and the upcoming rights these couples are acquiring (e.g. legal marriage, divorce, adoption) also make it necessary to know more about domestic violence in same-sex couples.

Why is this question relevant? Because research can better inform policing and legal matters on equal rights, combat negative societal prejudices and discrimination, and help find solutions for the problems embedded in DV (Peplau and Fingerhut, 2007).

3) Domestic violence in LGBT+ Communities

Domestic violence in lesbian relationships

Lesbian feminists and theorists in the mid to late 1970s were reluctant to admit power inequality issues and physical or emotional violence occurring in same-sex relationships. They did not want to divert the newly gained visibility from the subject of violence against women by men (e.g. rape and wife assaults). The positive image of harmony based on affection and egalitarian lesbian relationships created myths about the absence of violence in those relationships (which do not reflect reality). The positive side of this idealisation was that it helped modify the image of lesbians as being deviant or sick held by the public at the time (Ristock, 2011).

The prevalence rate of DV among LGBT+ people in Canada from *Statistics Canada Uniform Crime Reporting Survey 2007-2011* contains 99% of the incidents of intimate partner violence reported to the police in four years, reaching 346,565 cases (Whitehead, Dawson and Hotton, 2020), ranging from forced sex in current relationships to lifetime psychological, physical and sexual IPV (Edwards, Sylaska, and Neal, 2015).

The *Californian Health Interview Survey* showed that bisexual women were three times more likely to experience DV/IPV in their lifetimes (Cramer et al., 2012), and LGBT+ victims reported higher sexual assault rates than heterosexual victims (Cuevas and Rennison, 2016).

For a study of Canadian women in Toronto conducted by Chesley, Mac Auly and Ristock (1991), the authors distributed around 500 questionnaires among women attending a lecture given by a well-known lesbian writer in Toronto. Only 189 women reacted and responded to the questionnaire (participants were white, middle-class lesbians, employed, had a college or university education and ranged from 26 to 50 years of age).

The questionnaire contained questions about the prevalence of violence in women's relationships. One hundred and twenty-five participants (66%) claimed that they knew someone who experienced abuse in the relationship. One hundred and thirty-nine participants (73%) felt that abuse was an issue in the lesbian community. Thirty-seven of the participants (20%) said they were survivors of (psychological, physical or sexual violence) intimate partner violence (Cuevas and Rennison, 2016). Although the

participants were not reflective of other lesbians in Canada, for instance, working-class, indigenous or colour women, it did give a realistic image of the violence among lesbians.

Ristock (2011) claimed that the myths around lesbian relationships should be dismantled. Only when the general public, societies, governments, and policy-makers have access to accurate knowledge about the problems women experience in a same-sex relationship will it be possible to help them. Among those myths, we can mention:

- The assumption is that violence does not occur in lesbian relationships due to women's gentle, caring and nurturant nature. The reality is that lesbians are also victims of abusive relationships (Smith, Konik and Tuve, 2011).

- The myth is that partners adopt either a “butch” (male) or a “femme” (female) identity. That this identity equalises the stereotype heterosexual representation of men and women respectively, where the ‘butch’ is considered the perpetrator, is physically larger than the other partner, is masculine-looking and performing acts of aggression and dominance (butch) ((Renzetti, 1995). Smith, Konik and Tuve (2011) discovered that not all lesbian relationships have roles that dictate a power imbalance; sometimes, the ‘femme’ is the batterer.

- The myth is that both partners are involved equally in violence. Violent relationships among lesbians have, as in heterosexual couples, a perpetrator and a victim (Renzetti, 1988; Walters, 2009).

Domestic violence against Gay Men

Gay men are still subject to discrimination globally. In the USA, gay men have been criminalised since the founding of the country around the early 1600s. They were threatened with violent criminal prosecutions (e.g. castration) and stigmatised. British founders introduced the *Sodomy Laws* in American territory that defined sexual intercourse between two men as a capital offence punishable by death. Even today, some states still have sodomy laws that foster and condone violence against gay men (Scheer, Breslow, Esposito, Price and Katz, 2021).

Victimisation against gay individuals is also widespread in Europe. Gay men are being harmed through verbal insults, minor and severe physical assaults and threats because their sexuality violates the majority's social norms of heterosexual societies (ILGA-Europe, 2019).

Below we present the victimisation rates of gay and bisexual individuals and the attitudes towards homosexuality comparing Spain and the Netherlands. The data is from a study by Petrou and Lemke.

Country	Number of respondents	%	Verbal Assaults	Threats of Violence	Minor Physical %	Major physical %	Tolerance of homosexuality %
The Netherlands	2967	3.5	13.4	4.6	2.6	0.6	4.34
Spain	3670	4.3	10.6	2.2	1.4	0.5	3.92

(Petrou and Lemke, 2017).

Gay men are often victims of violence, approximately 26% to 33% report some form of IPV in their lifetime (Walters, Chen and Breiding, 2013). White gay men experience higher IPV rates than heterosexual men and women. Still, they are less victimised than young gay men of colour (aged 15-24) with a low level of education and HIV (Finneran and Stephenson, 2013). Gay men perpetrators of violence devaluate, undermine, and discredit their partner's sexual identity by devaluing and undermining them. They also use derogatory language (Woulfe and Goodman, 2018).

Domestic violence against transgenders

Research in transgender populations is under-researched. Both women and men transgenders often experience violence, threats and discrimination from present or former intimate partners, contributing to their harmful physical and mental health (Reisner, Poteat, Keatley, Cabral et al., 2016). Among trans women, there is an elevated rate of eating pathologies, such as purging, binge eating and body dysmorphic disorders compared with heterosexual individuals (Talbot, Smith, Cass, and Griffiths, 2019; Calzo, Blashill, Brown and Argenal, 2017). Boys in their adolescence have approximately 2.2-5 times greater odds of misusing anabolic

androgenic steroids (AAA) (Convertino, Brady, Albright, Gonzalez and Blashill, 2021) than heterosexual peers (Blashill et al., 2017).

The *U.S. Transgender Survey* (2015) showed that 35% of transgender individuals reported experiencing physical IPV in their lifetime (Cuevas and Rennison, 2016; James, Herman, Ranking, et al., 2016). Other studies have also obtained similar results (Cuevas and Rennison, 2016), where IPV prevalence ranged between 31% to 50% (Brown and Herman, 2015; Langenderfer-Magruder, Whitefield, Wall, et al., 2016). Rates of IPV are higher (31%) among transgender individuals (Edwards, Sylaska, and Neal, 2015) than cisgender individuals (20%) (Edwards, Sylaska, and Neal, 2015; Langenderfer-Magruder, Whitefield, Wall, et al., 2016). Transgender people are the most victimised among LGBT+ people; over 25% of them in the USA are victims of assaults (James et al., 2016) and rape (Jamel, 2018).

Another form of violence from intimate partners is economic withdrawal from support to buy the necessary hormones or surgeries. Also, verbal abuse, harassment, and threats to reveal their gender identity to employers, family, or friends are damaging and can only happen when gender identity is not disclosed (coming out) (Bry, Mustanki, Garafolo and Burns, 2017). Transgender people sometimes also experience difficulties at shelters when seeking a safe place to stay to escape the abusive partner, as we shall see in the case explained below: Cited by Rishita Apsami, 2018.

> "*I once worked with a woman who was transgender and whose partner had almost killed her. She had finally decided to leave the relationship, and she went to a shelter in Massachusetts. When she got there, the counsellors were confused about her gender even though she had previously explained that she was transgender and what that meant. The shelter staff asked her a set of intensive and gruelling questions about her body, including, "What is between your legs?"…after this humiliating treatment, they told her that she could not be housed there because they decided she was really a man. After being denied shelter, this woman went back to her batterer because she had no family, no friends and nowhere else to go.*"
>
> Emily Pitt, Director, Fenway Community Health's Violence Recovery Program

Shelters are places where transgender people are not understood. The National Transgender Discrimination Survey found that various formal support services where

transgender individuals seek help do not offer optimal help. Examples are the harmful discrimination or problematic interactions in medical settings, both in general primary care and in specialised areas such as mental healthcare (Henry, Perrin, and Coston, 2018), and substance abuse treatment (Stanton, Batchelder, Kirakosian, Scholl, et al., 2021). Besides, police and justice systems are not always well prepared to handle violence towards LGBT+ individuals, although they experience severe physical violence and forcible rape (Federal Bureau of Investigation, 2018; Oudekerk, 2019). Since LGBT+ individuals have negative experiences reporting crimes to the police, IPV incidents (59%) are under-reported (NCVAP, 2017a, b).

1.6.1 Hate crimes

Not all countries within the European Union have the same ideas about what a hate crime is. There is some unanimity among scholars about hate crimes and the message the perpetrator wishes to communicate to the victim and the victim's community. Prejudices about the victim's identity, behaviour, and cultural norms are crucial aspects of what constitutes a hate crime that may not necessarily be motivated purely by hate but by bias and hostility towards a minority group of ethnic, religious, and sexual identities like LGBT+ (Walters, 2011; Coston, 2020). Fortunately, recently there is an increasing awareness of LGBT+ rights in the *EU. Article 21 of the Equality Charter of Fundamental Rights of the European Union* "*Prohibits discrimination on the grounds of sexual orientation*" (FRA, 2010). *The European Court of Human Rights* ruled that "*European states are to recognise the post-operative gender of transgender individuals*" (Turner et al., 2009).

Nevertheless, despite the advances in diverse theoretical frameworks developed by research, hate crimes have become relevant to criminology in policy domains to address the rising level of different forms of violence directed towards vulnerable groups. LGBT+ individuals are overrepresented as victims of hate crimes, especially trans women. Perpetrators sometimes use only verbal abuse. Nevertheless, Rose

and Mechanic (2002) and Boeckmann and Liew (2002) suggest that verbal abuse can be as traumatic as physical violence.

Other types of violence used are threats, beating-ups, property damage, and sexual violence (Galop, 2016). In extreme cases, murder (Turner, Whittle, and Combs, 2009). The reasons for some individuals to commit hate crimes are the (irrational) fear, aversion or hatred for same-sex couples (homophobia), for feminine men or masculine females, and transgender people (transphobia).

According to *The U.K. Crime Report 2016*, 80% of LGBT+ individuals who participated in an online community survey carried out among 467 LGBT+ people said they had experienced hate crimes. Transgender individuals were the most affected by verbal abuse as part of hate crimes, some with 77%, followed by gay men with 75%, lesbians with 70%, and bisexuals with 67%. A quarter of the participants said they had experienced violent hate crimes. A third of the participants were victims of online hate crimes, while others experienced sexual violence (Galop, 2016).

In Canada, the *Trans PULSE Project* deals with the social exclusion of trans persons. Just because of their trans identity, twenty per cent of participants in their study said they had experienced sexual assaults or other physical assaults (Du Mont, Kosa, Solomon and MacDonald, 2019). Sexual assaults can have harmful physical, psychological and social consequences such as transmitting infectious diseases such as Aids, depression, post-traumatic stress, or unintended pregnancy. Affected persons need to receive adequate care from experienced health providers. Instead, the trans population are often confronted with discrimination and negative experiences by health professionals. As a result, they sometimes avoid seeking help at all. In emergency departments, transgender people who have suffered sexual violence are often denied services due to the lack of trained health professionals able to carry out medical examinations of trans persons. Over 73% of nurses working in 35 different hospitals in Canada completed an online survey indicating that they did not have expertise in the proper care for sexually assaulted trans clients (Du Mont, Kosa, Solomon and MacDonald, 2019). Moreover, some police officers position those assaults on LGBT+ individuals as consensual (‘they ask for it’), blaming the victim

(primarily men) because some officers have a stereotypical idea that gay men are promiscuous (Javaid, 2018b).

The European Union is making progress in stopping human rights violations against LGBT+ minorities. Nevertheless, sexual and gender minorities are still being discriminated against and have unequal rights compared to heterosexual EU citizens (ILGA Europe, 2019; Rainbow Europe, 2020; European Commission, 2020).

1.6.2 Hate crimes in the Netherlands

In many Western societies, hate crimes are a social problem (Pezzella and Felzer, 2021). Registered cases are rising due to the hardening of the political climate characterised by polarisation, prejudices, stigmatisation of outer groups, or intergroup conflicts (Castanho Silva, 2017).

The Netherlands is a secularised country, although there is a representation of religious parties in the parliament. In general, Dutch governments have fewer constraints in issuing policies not directly affected by religious moralities, such as abortion and the legalisation of same-sex marriage (Siegel and Wang, 2018). The Netherlands also has within the police a special corp called (in Dutch) Roze in Blauw / Pink in Blue (PiB), which deals with all reported gender violence-related incidents occurring in the LGBT+ community.

A survey study by Feddes and Jonas (2020) with PiB's collaboration, the police academy, COC Amsterdam, and the Amsterdam-Pink-Panel was conducted in which 391 LGBT+ participants took part. From those participants, 16% said that they had experienced hate crimes in the previous 12 months; from the participants who reported the hate crime to the police, only 10% expected to be taken seriously; to obtain recognition and empathy in the short term, and to receive feedback on their complaint in the longterm. Individuals who sought social support instead of isolating themselves were less affected by depression and stress and had higher well-being levels. Nevertheless, LGBT+ individuals do not always report hate crimes to the police. The

most mentioned reasons for it are their low expectation that the police would take incidents seriously and solve them, feelings of shame, and fears that the perpetrator would retaliate (Rainbow, 2020).

1.6.3 Hate crimes in Spain

The phenomenon of hate crime is not new. Still, in recent years, governments in some European countries acknowledge the problem and start to issue legislation to make it unlawful (Hall, 2005).

The Spanish Constitution (Section 10) emphasises explicitly that "*Respect for individuals dignity and the free development of personality are the foundation of political order and social peace*." Section 14 establishes equality among people. Although affective-sexual orientation and gender identity are not explicitly mentioned, the discrimination and violation of human rights are well stated in the constitution (Martin Aragon, 2020).

In Spain, there is a Prosecution Office specialised in hate crimes (Salazar and Giacomelli, 2016). The Spanish Criminal Law considers these crimes as being against the non-discrimination rights expressed in the Constitution. The hate element is an aggravating circumstance of the offence. Nevertheless, Gimenez-Salinas et al. (2011) remark that the aggravated hate element is not applied in almost half of the cases.

In 2017, there were 271 reported cases of hate crimes on sexual or gender orientation identity. The official statistics for the year 2017 showed an increase of 17% compared to 2016. However, unofficial numbers of cases were as high as 629 incidents according to research conducted by the *State Federation of Lesbian, Trans and Bisexuals* (FELGTB).

Regarding police reports, Spain has 1% over the European average on physical and sexual attacks. Nevertheless, copious numbers of victims do not report crimes to the police (82%). Victims consider the facts not grave enough (48% against the average of 43% in other European countries). Seventeen per cent report to other institutions

such as LGBT+ associations, hospitals or health services, offices dealing with victims of crimes, or other organisations) (Martin Aragon, 2020). The number of cases in police reports can show a biased reality that minimizes the seriousness of the issue and does not reflect policies involving criminal investigations and prosecutions (Aguilar Garcia, 2014).

Conclusion and recommendations

Violence and abuse perpetrated by an intimate partner is a severe global problem, and LGBT+ minorities are not an exception.

In the past, intimate relationships with same-sex partners were considered an illness. LGBT+ people were invisible to the law and policymakers until the 1990s, when more rights were conceded. From the 1990s onwards, attitudes towards LGBT+ communities changed. They gained greater visibility, recognition, social acceptance, and rights (e.g. legalisation of same-sex marriage, the issuing of anti-discrimination legislation). With upcoming visibility, researchers also showed interest in investigating domestic violence in those communities helped by data, among others, of the USA's demographic census. Research information was and still is essential to understanding LGBT+ issues and creating new legislation to protect communities from (hate) crimes. Despite gained rights, we saw that all LGBT+ individuals suffer from stigmatisation, discrimination and violence. Transgender women and men are the most at risk of victimisation for serious sexual assault or other forms of violence. Transgender women also have difficulties being accepted in shelters for battered women because sometimes shelter personnel are confused about their 'real' gender. Other services such as police and justice systems do not signal openness or understanding of LGBT+ concerns, resulting in the under-reporting of crimes that affect policy-making.

Justice systems in the European Union and elsewhere worldwide have issued legislation to protect vulnerable populations. Still, transgender populations are at the highest risk of discrimination among all LGB people.

Hate crimes are presently more visible and get the attention of justice systems and policy-makers in many countries because of rising levels of hate crime incidents. In

this section policing concerning hate crimes in the Netherlands and Spain were presented. In both countries, victims' reluctance to report incidents to the police was high because they believe reporting a crime would be a waste of time or because they fear retaliation from the abuser.

Equality, dignity and non-discrimination for LGBT+ individuals in societies are the first steps to respecting their identity. Education, visibility of DV in this population, better training for personnel in healthcare settings, the creation of medical guidelines in transgender care to execute appropriate interventions (e.g. in cases of sexual assault), and justice systems that are well-informed of DV issues in LGBT+ communities and respond appropriately could be a positive input to improve the situation of this population.

1.7 The costs of violence

Violence against females and their children (also against men and sexual minorities) in low, middle and high-income countries is now recognised as a human right violation. As a result of violence, governments have high economic costs because abused individuals use healthcare resources more intensively than non-battered populations.

DV is financially detrimental for governments due to healthcare systems' expenditures, loss of productivity, and the negative impact on individuals well-being. Besides healthcare costs, there are also institutional budgets related to DV such as police, justice systems, and other public services for the survivors (e.g. costs for shelters, civil legal costs, housing, refugees, welfare) and the perpetrators (treatment, probation, prison), which are high.

DV is harmful to victims, their families, and society, irrespective of where it is happening.

This section calls attention to the economic costs of violence and the consequences it has in the lives of DV affected individuals

1) DV costs in the USA,

2) The costs of DV in Europe (UK, Spain, Iceland).

1) Domestic violence costs in the USA

In the United States, many children and adolescents (around 20-25%) witness DV with deleterious consequences for their lives (Finkelhor, Turner, Shattuck and Hamby, 2015). According to the calculations of costs made by Holmes, Richter, Votruba, Berg and Bender (2018), exposure to violence in young years correlates with intensive use of social and healthcare services, productivity loss, or even criminal behaviour. The economic burden per victim is around $55 billion nationwide (Holmes, Richter, Votruba, et al., 2018).

The USA is a country with a long history of mass immigration. It is estimated that approximately eleven million undocumented migrants live in the USA (Passel and Cohn, 2016). The number of victims of physical and sexual violence among them is unknown. Women who are illegal in a foreign country are not readily going to report their situation to the authorities for fear of deportation. To have an accurate size and magnitude of DV cases in the US, the Congress funded the *Centres for Disease Control and Prevention* to conduct a study to estimate the national incidence, prevalence, and healthcare costs resulting from IPV and recommend strategies to prevent its serious consequences.

The Data was collected via the *National Violence Against Women Survey (*2010) (Cuevas and Rennison, 2016). Respondents to this survey said to have suffered from rape, physical violence or stalking by partners or by ex-partners in their lifetime. Of those surveyed, 35.6% were women, and 28.5% were men (Fair, 2018).

According to Peterson et al. (2018), the lifetime economic costs of IPV among US adults amounts to approximately $3.6 trillion, with $1.3 trillion attributed to productivity losses (Erten and Keskin, 2021). With a mathematical model, Peterson et al. (2018) estimated the lifetime costs of intimate partner violence with data from the US National Intimate Partner and Sexual Violence Survey. She arrived at the following costs: $103,767 per female victim. Per male victims, the calculated costs were $23,414, based on forty-three million US adults with victimisation history. The *US Centres for*

Disease Control and Prevention (2006) estimate that the cost of DV, including medical and mental health and loss of productivity, is around $8,3 billion a year (CDCP, 2006).

The *National Centre for Injury Prevention and Control* (2014) states that more than five million incidents of DV against women occur each year in the United States, having severe negative psychological consequences for the affected women (e.g. substances abuse, depression) (Connelly, Hazen, Baker-Ericzen, Landsverk and McCueHorwitz, 2013). From those DV incidents, around two million are injuries, consequently producing a loss of eight million paid-work days (*National Centre for Injury Prevention and Control*, 2014).

3) The costs of domestic violence in Europe

The costs of DV in the European Union (EU) are high. A report from the *European Institute for Gender Equality (EIGE*), written by Prof. Walby and Dr Olive on the costs of violence in the EU, estimated that the expenses incurred on services due to gender-based violence against women and men were approximately €228 billion annually (Walby and Olive, 2014).

Although suffering and pain inflicted towards the victims cannot be counted monetarily. Still, for countries' economies, DV matters because it impacts economic terms in creating extra expenditures and loss of work productivity, representing a considerable burden (Walby and Olive, 2014). DV affects victims' health negatively and represents additional costs due to injuries and hospitalizations. Abused individuals are affected psychologically, requiring expensive, long-lasting therapies or interventions. It also burdens countries enormously with institutional budgets such as police, justice systems, and other public services. For instance, services for survivors are shelter and welfare. Public services for perpetrators are treatment, probation, and prison.

The EU countries strive for better protection for victims of violence in all member countries and emphasise that to achieve that purpose, it is essential to eliminate gender-based violence and implement effective policing on gender and social equality (Walby and Olive, 2014).

Domestic violence costs in the UK

The taxpayers in the UK pay for healthcare, education, residential, and crime costs for children and adolescents' support service, £1.4 billion (Pro Bono Economics, 2018).

According to Walby and Olive (2018), the United Kingdom's data about the economic output due to working time losses produced by health damages (serious wounding, assaults, rape and sexual assaults) and poor health (incapacity or sickness absences in paid and unpaid work) were estimated in €4,214 million per year (ratings for 2012).

The UK Criminal Justice System, including the police, prosecution, probation, prisons and legal aid, costs the state €4,739 million per year.

In 2012, civil legal system costs were €405 million (plus self-funded €230 million). For instance, these services include legal action for separation or divorce, disputes over finances and child custody, protection orders, civil legal representation, and other expenditures (Walby and Olive, 2018).

Social welfare in the UK includes different kinds of help, such as family support, children look-after and housing aid. The costs for 2012 were €1,296 million. Other specialist services costs such as accommodation, housing benefit, helplines, independent advisers on DV and sexual assault, rape crises centres, represented an output of €210 million (Walby and Olive, 2018)

The mental health services for abused women in the UK range from dealing with harsh treatment (less invasive forms of injuries caused by partner violence, e.g. name-calling, belittling, mocking) to the use of long-lasting psychological or psychiatric treatment such as traumas, stress and fears. Other conditions which require long terms treatment are: Depression, suicidal intentions, anxiety, use of alcohol or drugs, among other harmful behaviour. The costs for mental health visits for women subjected to DV/IPV are four times higher than those women not subjected to DV/IPV (Walby, 2004).

It is estimated that 3-8% of the UK population identify as LGBT+. The most researched topics among LGBT+ people are sexually transmitted diseases such as HIV/AIDS among gay and bisexual men and the transitioning process for transgender people.

However, the LGBT+ community has a wide variety of other physical and mental issues. Meads (2009) found that LGBT+ people suffer from high breast cancer rates, eating disorders, mental health problems (e.g. depression, suicide attempts or self-harm), and poor health behaviour due to smoking, unhealthy diets, and illegal drugs. Meads proclaims that the mental health of LGB is worse than the general population and should be given more attention than it has until now to combat all those preventable diseases that increase healthcare costs.

Domestic violence costs in Spain

Europe is currently being exposed to an unprecedented refugee crisis. The number of undocumented migrant women in Spain who experience intimate partner violence is high. Regarding the survey *Violence Against Women (VAW,* 2015), thirty-six per cent of participating women aged sixteen or older from non-European countries reported physical or sexual violence victimisation, compared to seventeen per cent of Spanish women. Among migrant women, there were twice as many cases of severe violence compared to the Spanish population (De Miguel Luken, 2015).

According to a Spanish government survey called "*The Impact of Gender-based Violence in Spain, an Evaluation of its Costs in 2016,"* each European citizen pays between 20 and 60 euros to provide social services to gender violence victims. The total cost of gender-based violence within the EU is estimated to be €288 billion (1,8% of the Gross Domestic Product) (Borges Blázquez, 2020).

In Spain, to reduce the expenditure on healthcare costs, the Spanish parliament proposed on the 20th April 2012 to reform the, at that moment, current healthcare law, which was universal and free, to be replaced by a more restrictive one. According to the government, reforms were needed to maintain the health system affordably and prevent 'healthcare shopping tourism in Spain' (Moreno Beltrán and Ballesteros Peña, 2014). Since the implementation of *The Royal Decree-Law 16/2012*, in September 2012, healthcare cards from 873,000 individuals were cancelled except for pregnant women and children under eighteen (De Durana and Moreno-Fuentes, 2016). The previous healthcare system, which permitted access to a healthcare card for foreign-

born (undocumented) women experiencing intimate partner violence under the same conditions as the Spanish population, expired (Rice and Vall Castelló, 2018).

According to Rice and Vall Castelló (2018), there is a link between cutting budgets and restricting access to healthcare for certain minority groups and the decline of help-seeking behaviours among minority battered women. In practice, the implementation of this more restrictive law resulted in a lower level of reported violence. Requests for protection orders have declined by 16% or by 19% in more restrictive regions. The incentive to report violence in Spain has fallen not because violence has diminished but because minority groups now have no access to social insurances for healthcare services and cannot be monitored or counted for in statistics (Rice and Vall Castelló, 2018).

Domestic violence costs in Iceland

In a study realised in Iceland by Jonasdottir, Thorsteinsdottir, Argeirsdottir, et al. (2020), the researchers used data from medical records at the LUH (*Landspitali National University Hospital*) in Reykjavik. They were interested in knowing the prevalence of intimate partner violence and the costs (in Euro) incurred by the health system due to violence against women. They found that the actual partner of the victim committed violence in 48.8% of cases. In comparison, 33.1% of the violence was committed by an ex-partner. The data corresponded to the year 2005-2014.

The researchers found that female victims of IPV had, on average, 34 years of age; the majority, 72%, were aged within the reproductive ages 18-39 years old and having a history of repeated violence against them. Although the injuries were multiple, they were of low severity. As high as 37.8% of all visits were not first-time visits.

The number of new visits at the LUH was 1,454, of which 92.6% were at the Emergency Department. The prevalence of IPV per 1,000 was 1.69.

Here below are mentioned the average costs of a hospital's treatment due to IPV:

The average cost per visit	EURO	258
The total cost for visits	EURO	375,431
The average cost per admission	EURO	8,678
The total cost for admission	EURO	407,899
The total cost for hospital treatments of IPV	EURO	783,330

Data from the study by Jonasdottir, Thorsteinsdottir, Argeirsdottir, et al. (2020).

Conclusion and recommendations

Women who experience violence and abuse from intimate partners often have poor physical and mental health that requires specialistic care, which is expensive. Mental health services range from dealing with less invasive forms of injuries such as name-calling, belittling or mocking to long-lasting psychologic or psychiatric treatment for traumas, stress, and fears, requiring long-term treatments.

The *European Institute for Gender Equality (EIGE*) report, issued in 2018 on the costs of violence in the European Union, estimated the expenses incurred on services due to gender-based violence against women and men to be approximately €228 billion annually (Walby and Olive, 2014).

According to a survey from the Spanish government called "T*he Impact of Gender-based Violence in Spain, an Evaluation of its Costs in 2016"*, each European citizen pays between 20 and 60 Euro to provide social services to gender violence victims. The total cost of gender-based violence within the EU claims 1,8% of the Gros Domestic Product (Borges Blázquez, 2020).

The costs of battered women's mental health visits are four times higher than for women not subjected to IPV. Government budgets on police, the justice system, welfare, and other services incurred from DV against women and girls, men and boys, and LGBT+ people worldwide support the urgent need to find effective measures to prevent DV. A possible way is via education, by promoting gender equality, empowering people to intervene when they witness unacceptable behaviour. All of

these measures can help. Nevertheless, laws that effectively protect victims are needed, and those laws must be enforced.

Chapter 2 Core issues of domestic violence

Identifying significant risk factors for DV can help pinpoint the most vulnerable individuals who require protection in both high and less developed countries to stimulate programmes to safeguard the victims and prevent violence from happening. Many factors affecting the maintenance or escalation of violence within families and relationships have been identified. They are considered core problems of DV (e.g. poverty, low level of education, violence in the communities, and homelessness).

However, DV is a complicated phenomenon with different faces. Each DV case can be different from another; that is why researchers use interdisciplinary knowledge to develop risk assessments tools to estimate, for instance, whether a woman is in danger of being re-victimised or killed. Those tools have different degrees of validity and reliability (Messing and Thaler, 2013).

Although most common risk factors are mentioned in the assessment tools, it is not easy to rely on fixed stereotypical actions because not all situations or nuances in DV can be written down. Assessment tools are traditionally used in clinical settings by psychologists or other health systems practitioners. Nowadays, using tools with empirical value is also implemented by police officers dealing with DV and might be subjected to interpretations by users other than clinical staff.

For some years, police in the US and the UK use risk assessment tools to recognise common risk factors for DV's re-abuse and potential lethality risks. Officers are expected to be aware of the risks situations present in DV to act effectively.

Since the year nineteen-eighty-nine, police forces in the UK have at their disposition a risk assessment tool called "*Domestic Abuse, Stalking and Honour Based Violence*" (DASH). This tool has been recommended by the *Association of Chief Police Officers* (Robinson, 2010), but in practice, police officers interpret the meaning of what a risk

factor is differently. This differentiation in meaning can be explained by the fact that police officers are also moulded by their social and cultural environments and can have different interpretations of what signifies DV risk. Besides, police officers will react according to their training and DV experience, probably influencing how they respond to incidents beyond the classical' physical assault (Pérez Trujillo and Ross, 2008).

Considering that not all DV incidents are reported to the police, victimisation rates are considerably higher than the official number of cases in statistics. Researchers can reach with surveys a more significant number of participants who otherwise would disappear in statistical anonymity (e.g. minorities and marginalised groups). Researchers can obtain information on various themes of their interests; for instance, they can calculate the prevalence of common mental disorders in young women who suffer abuse or know about crime and victimisation rates in a population, among other subjects. Unfortunately, not even surveys can reach most marginalised groups (e.g. homeless people, minority and underground groups). Besides, many factors influence the responses given in surveys. The way the question is made can alter the answers obtained and, therefore, the final results.

2.1 Domestic violence's risks factors

DV affects millions of victims who suffer from physical or sexual violence (Klugman, Hammer, Twig, Hasan, McCleary-Sills, and Santamaria, 2014). Many reasons facilitate DV to happen, as we shall see in the following subsections.

However, the most common primary risk factor for a victim of DV is a previous assault, whether the victim is in the separation process because (ex)partners who used violence before often stalk, injure, or even kill their victims (Walby and Myhill, 2002).

Conflicts about child custody or access to their visit regulations are also the main reasons for violence. Therefore, professionals working with battered women who are separating or divorcing must consider this risk factor to recognise who is in danger of becoming victims of aggravated violence or being killed.

Offering help to those women and allocating them to emergency shelters or providing affordable social housing to facilitate escape is helpful (Walby and Myhill, 2002). However, this violence coming directly from partners is not the only risk. DV risks factors are manifold.

Here below, only a selection of four risks factors will be explained more extensively:

2.2.1 Poverty.

2.2.2 Lack of Education.

2.2.3 Community Violence, and

2.2.4 Homelessness.

2.1.1 Poverty

Family poverty is a sad reality, and even rich countries have this problem. Prominent global and local institutions and governments commit themselves to noble strategies. For instance, one key policy in Europe was the '*Europe 2020 Strategy'*, aimed at '*lifting 20 million people (and their children) out of poverty and social exclusion by 2020*.' The goals have not been met.

The *United Nations Convention on the Rights of the Child (UNCRC*), first held in 1989, promoted universal children's rights to healthcare and lives without poverty or maltreatment. But, unfortunately, the goals have not yet been met.

Achieving these noble aims is vital because financial strains have adverse outcomes in parents and children's interactions. Indicators that the proposed goals by governments have not been met are, for example, when there is still any household that cannot afford to heat the house in winter; is unable to buy a new washing machine when the old one is out of order; have difficulties in paying all the debts on time. Alternatively, when parents can never take children on holidays, there is stress caused by financial motives. Parents are in such situations more prone to have conflicts with their intimate partner, leading to poor parenting or even maltreatment.

This section shows that many countries, governments, and institutions propose ambitious plans to end poverty, but poverty is still flowering despite all well-intentioned efforts. We analyse the following topics:

1) Child poverty.
2) Disabled children in poverty.
3) The *European Union* and poverty.
4) Children poverty and healthcare issues in Western countries.

1) Children poverty

Everyone agrees that children deserve to be full participants in society and live free of poverty (Mont, 2014). *The United Nations Convention on the Rights of the Child (UNCRC)* promotes children's rights. The UN defines a child as a person under the age of eighteen years. The *UNCRC* contains three principles: Protection, Participation and Provision in the family (e.g. children should have a decent standard of living, opportunities to study, and be free of disadvantages). The best way to reach well-being goals for children is achieved when children are raised in caring family environments which protect and provide them with all they need (UNCRC, 1989).

The *United Nations International Children's Emergency Funds* (UNICEF, 2014) reported in 2014 a decline in children's well-being due to the recession in national economies with a markedly high number of children living in material deprivation. The unforeseen Covid-19 pandemic starting in 2020 has also produced less favourable economic periods. Even wealthy countries have persistent child poverty due to parents' instability or below-average income in individual households. Globalisation and deregulation in the labour markets worldwide (e.g. jobs insecurities and low salaries) negatively affect citizens' health and well-being.

The lowest poverty rate in Europe is in Denmark (around 4%) (Thévenon, Manfredi, Govin, and Klauzner, 2018).

In the Netherlands, seven per cent of individuals are living in long-term poverty. Most children in these families live in a single-parent family that relies on welfare benefits (Dutch News, 2019).

In Spain, the most vulnerable child population under eighteen years of age has a high poverty rate, approximately 32.9%, as measured by "*At Risk of Poverty or Social Exclusion" (AROPE)* based on income, work intensity and material deprivation (González, Estarlich, Murcia, Larrañaga, et al., 2021).

Understanding the poverty situation of the mother and her children can improve the detection of children at high risk of poverty and disadvantage. Though, child poverty measures are influenced by or linked to political views and rhetoric's of governments, policies, and labour market changes. Vulnerable groups such as young single mothers, ethnic minority groups such as the Roma, Sinti, and children of recent migrant families, are portrayed by neoliberal or conservative governments as the cause of their children's poverty (Main and Bradshaw, 2016). Poor parents are said to take wrong decisions about their children due to laziness, neglect and dependency (Main and Bradshaw, 2015), although little or non-evidence is found to support these theories. Instead, the reality is that due to the unwillingness to contribute with financial assistance to the ones in need, neoliberal or conservative governments in industrialised countries neglect to introduce a better distribution of resources, housing benefits for low-income families, better education, and availability of employment. Consequently, vulnerable groups are in jeopardy of becoming homeless, continuing to live in poverty, or acquiring traumas that lower their well-being even more (Bartlett and Sacks, 2019).

2) Disabled children in poverty

Families with disabled children are fifty per cent more likely than families without disabled children of getting into debt and experiencing poverty and severe material deprivation (Horridge, Dew, Chatelin, Seal, et al., 2018). Parents of disabled children face adverse political responses during recessions that reduce budgets on education, training, social care, welfare support, a reduction in employment and support allowance for work-related activities. In the United Kingdom, raising a child with disabilities costs three times more than a child without disabilities (Gordon, Parker, Loughran and Heslop, 2000). *UNICEF* Report (2014) states that since the great

recession in Europe (from the year 2008 onwards lasting almost a decade) and now with the Covid-19 pandemic, young adults and children are at risk of poverty, surpassing for the first time the elderly, which often is the most vulnerable group (UNICEF, 2014; 2020).

Parents with children are often relatively young, and they incur in extra expenditure, which has economic consequences for their budget because raising children is costly. Children are to be fed, clothed, housed, and educated. Thus, parents' financial resources decrease because their income may stay the same, but all living costs rise. Families with children often have less wealth than families without children (Pfeffer and Schoeni, 2016). According to Townsend (1979), poverty is when economically insecure families have insufficient resources to provide healthy food, an adequate standard of living for their children, or being unable to participate in any activity that represents extra expenses. As a result, those families are excluded from ordinary living patterns and, therefore, isolated. These types of situations may bring stress which impedes healthy, nurturing interactions to happen (Rothwell, Ottusch and Finders, 2018).

Economically insecure families are families having debts, unemployment and other material hardship, including lack of food. These families are more prone than secure economic families to maltreat their children. Children are then three to nine times more at risk of physical or psychological maltreatment (Yang, 2015).

From 2008 onwards, most countries opted (instead of investing in combating poverty, especially child poverty, to rescue the global economic system during the great recession. Governments helped the institutions that started the crisis in the first place by making massive cuts in public spending and privatising public services (Emejulu and Bassel, 2018). According to the *National Audit Office* (2017), Britain allocated £1,162 billion to save financial institutions from collapse. Nations implemented austerity measures. Again, others saw new opportunities presented by the crisis to change and roll back their welfare systems altogether, resulting in local services disappearing and benefits becoming more stringent (Goodhart, 2017).

Parents with disabled children face an even cruder reality across Europe because their children are often excluded from their community's economic and social lives (WHO/World Bank, 2011).

In times of economic crisis, many governments adopt severe austerity measures such as cuttings in benefits for disabled children and public services available to them. In recent years, families and professionals agree on the negative effect of austerity measures on disabled children's care, especially for those with learning disabilities and mental health conditions (Horridge, Dew, Chatelin, Seal et al., 2018). According to McGrath, Griffin and Mundy (2016), austerity policies damage individuals psychologically because they have to live in fear, distress, and insecurity, increasing the risk of mental health problems. Consequently, women and their children are in danger of becoming socially isolated and living in poverty (Showalter, 2016), resulting in adverse developmental effects. For instance, disadvantaged children are more likely to suffer from tensions within the family and low-quality housing and malnutrition. Due to a lack of resources, they cannot participate in social and out-of-school cultural activities, share pastimes with peers, and have fewer friends to engage in social interactions (Ridge, 2011).

3) *The European Union* and poverty

The *Organisation for Economic Cooperation and Development (OECD) is an economic organisation* founded in 1961. Nowadays, thirty-six member countries participate in it. This group is formed mainly by developed countries with high-income economies. These countries share mutual social and ecological problems, and together they try to find sound solutions for the issues at hand, for instance, child poverty in all its dimensions. In almost two-third of OECD countries, the poverty level has risen since the great recession caused by financial institutions in the U.S., the U.K., and then extended worldwide. The employment status of non-wealthy parents is very significant in determining child poverty. Child supplements, social assistance, and housing allowances can decrease child poverty over time (Thévenon, Manfredi, Govin, and Klauzner, 2018). The measures mentioned above (social service, child supplements and housing allowance) are necessary because persistent poverty, DV, and

community violence can severely affect children's experiences. Deprivation also produces physical and mental health problems and influences education achievements which are children's life chances for their future (Bartlett and Sacks, 2019).

Member States of the *European Union* are committed to eradicating child poverty by implementing measures at a national and local level to meet the targets they set to improve children's situation. One key policy in Europe was the "*Europe 2020 Strategy*," proposed by the *European Commission* in 2010, a ten-year growth strategy plan with the intention of "*lifting 20 million people and their children out of poverty and social exclusion by 2020.'"* The then-year target of getting children away from poverty has not succeeded. Statistical evidence indicates that none of the EU countries has reached their aim (Grimaccia, 2021). In 2012, the rate of poverty peaked at 28 per cent and stayed unchanged until 2014. Around 24.8 million children in the EU were in 2016 at risk of poverty and social exclusion.

Around 40 million citizens were at risk of poverty and social exclusion due to low work intensity in the European Union. Those citizens had (or still have) only part-time work, flexible contracts, or have jobs on-demand that equal no work, no pay. Another risk for poverty is income poverty: The person has a job, but it is not enough to cover all living expenses, or they suffer from material deprivation: A person cannot afford to buy the necessary things to live (Eurostat, 2020).

Financial strain in the household also harms the interactions between parents and children. Examples of financial pressures are when families cannot buy a new washing machine when it is out of order; cannot afford heating to keep the house warm in winter; have difficulties paying all the debts on time; can never take children on holidays. Under stress caused by financial motives, parents are more prone to have conflicts with their intimate partner, leading to poor parenting of their children (Shank and Robinson, 2013).

Poverty plays a significant role in why victims of DV stay with their abusers. Women's socioeconomic status (e.g. economic dependency) and family size influence the level of poverty. Most poor children share their home with one or two siblings, and more than twenty per cent of poor children live in families with three or more children that

have only one working parent. When the mother works, she often does it part-time. In some cases, due to the violence in homes, women are often unable to keep up with their jobs because of poor health or visible signs of battering (Moe and Bell, 2004). This situation provokes work disruptions and creates a risk for those women of losing their jobs.

Consequently, women and their children are in danger of becoming socially isolated and living in poverty (Showalter, 2016). Besides, childhood poverty can adversely affect children's social development and their future lives as adults. For instance, poor children are more likely to suffer from tensions within the family and low-quality housing and malnutrition. Due to a lack of resources, they cannot participate in social and out-of-school cultural activities, share pastimes with peers, and have fewer friends to engage in social interactions (Ridge, 2011).

4) Children poverty and healthcare issues in Western countries

In the last forty years in the US, the level of childhood poverty has stayed very high. Around one in five children lives in a household with an income below the poverty threshold. Children from low-income families are four times more likely to have fair-to-poor health than children from higher-income families. For instance, forty per cent of poor children are significantly more likely to be overweight or obese. They often suffer from bullying, low self-esteem, and diverse organic diseases such as diabetes, fatty liver disease, hypertension, insulin resistance, excessive visceral adiposity, and shorter life expectancies (Mazer and Morton, 2018).

Concerning healthcare issues, the 1948 *Universal Declaration of Human Rights* proclaimed healthcare as a fundamental right. Almost all high-income countries have made arrangements for their citizens (including the low-income population) in the form of national healthcare insurances to make medical care affordable and accessible for everyone (Korenman, Remler and Hyson, 2017).

Since the 1970s, childhood obesity rates in the US have almost tripled in marginal groups where socioeconomic disparities are evident (e.g. racial or ethnic minorities). Childhood obesity goes in approximately eighty per cent of the cases from obese

children becoming obese adults, which has become a severe public health concern (Ogden et al., 2016).

Childhood obesity has also reached an epidemic proportion in the United Kingdom. Seventeen per cent of eleven-year-old children are obese, requiring enormous financial and health services capacity because of the psychological problems and organic diseases that obesity causes (Rudolf, 2004). Children of low-income families are thirty per cent more likely to suffer from asthma which affects their quality of life because it reduces physical activity, and children may miss school days, affecting their school performance (Lozier, Zahran and Bailey, 2019).

Here below, a case of a thirteen-year-old girl with asthma will be presented, which is illustrative of the interrelation between DV, poverty and poor health:

"The girl has visited three times in ten days an emergency department before her follow-up by the paediatrician because of her difficulty with breathing. Although the mother reported having complied with all medications (antibiotics) for her daughter, the girl's situation worsened. Further questioning to the mother resulted in the information that she and her two children live in a shelter with no heating. The family has moved several times from one shelter to the next. Still, none of the apartments she was sent to had a functioning heating system, which made the asthma of her daughter worse, besides the girl missed eight days of school during that period." cited by Stein Berman, Patel, Belamarich and Gross (2018).

In the end, societies that do not do enough to combat poverty pay a high price due to expensive extra healthcare systems expenditures (Ferri et al., 2005). (See section 1.7).

Conclusion and recommendations

Prestigious institutions and governments propose strategies to combat poverty. The *United Nations Convention on the Rights of the Child* proposed already in 1989 universal children's rights to healthcare and a life without poverty or maltreatment.

The EU launched in 2010 a ten-year target plan to take 20 million citizens and their children out of poverty but failed to accomplished the aims.

Family poverty makes parenting very challenging, especially for families with young children, because children's impoverishment is associated with developmental and educational problems. Children living in poverty can develop healthcare problems (e.g. organic diseases) due to unhealthy lifestyles, poor housing, bullying, low self-esteem, and the stress of witnessing violence at home. Besides, children of economically insecure families are three to nine times more often victims of being physically or psychologically maltreated

Parents of disabled children are fifty per cent more likely to get into debt and experience severe poverty than families with non-disabled children. Those families see, in harsh times, that governments make massive cuts in public spendings and welfare, privatising public services resulting in services for their vulnerable disabled children disappearing or becoming more stringent. Financial strain in households exacerbates negative interactions between adults and their children. Parents are prone to have conflicts, leading to poor parenting or even child maltreatment.

We mention the case of a 13 years old girl with asthma, who, together with her mother and siblings, have fled home from violence against their mother and had to live in a shelter without heating, which made her medical condition even worse.

Neoliberal governments worldwide deregulate labour markets even in times of economic prosperity, causing job insecurity due to temporary work contracts and low salaries. Vulnerable families with children may have a job but do not earn enough to afford necessary things. In recessions or pandemics, the same neoliberal governments dismantled social welfare destined for (disabled) children to save the economy, maintaining or even enlarging poverty. In most countries, governments are democratically elected; citizens freely choose their governments and thus their destiny. A qualitative education system teaching equality, solidarity and compassion from childhood onwards could make a difference.

2.1.2 Lack of Education.

In an ideal world, homes are the haven, and families provide for children's needs; parents teach their children how to behave in the social world; they are also protected from pain or suffering. Later they go to the right school with a quality education system. Schools are alert to detect maltreatment cases and work together with other instances in suspected anomalies that can hurt the child. Globally, governments consider family and education an investment for the country's future. Education represents not just academic learning and getting a diploma. It is the most reliable basis for children to broaden their social and cognitive development, make friends for life, have better opportunities in the labour market when they reach adulthood, and help make a nation prosperous.

In the real world, the situation is different. The WHO estimates that one out of three females (35%) worldwide experience physical and sexual violence from intimate partners. Women with low education are more at risk of being victimised. Their homes are not safe. According to the *UNESCO* programme *Education for All's Global Monitoring Report 2015*, over 56 million children in primary education in developing countries drop out of school before reaching the secondary school level. Of which 55% are girls,.especially in countries where poverty is endemic and social and economic inequalities are high. The goals of gender equity by 2015 have not been met in education; there are still 796 million illiterate adults, of which two-thirds are women (EFAGMR, 2015).

In this section, we aim to explain:

1) Why do many young people drop out of school. We give arguments for the possible reasons to stop education and mention protective factors that help them get a diploma.
2) We expose the case study of Daniel Pelka in the UK and the role of school personnel who ignored key signs of maltreatment and neglect, ending in Daniel's tragic death.
3) We explore the educational systems in Sweden to signal DV related maltreatments.

1) Many young people drop out of school for reasons related to the circumstances of their lives and environments. Traumatic life events trigger stressors that threaten their psychological and physical health and wellbeing. Among those stressors, it can be mentioned: Repeated abuse, family instability; parental divorce; incarceration or the death of a parent; parents mental illnesses. The psychopathology of young persons can also affect their functioning. These stressors are some of the many known risk factors that might precipitate school dropout (Dupere, Leventhal, Crosnoe, et al., 2018).

Before completing their secondary school diploma, young people who exit education are in jeopardy of being excluded from the labour market. If they find a job, they earn lower salaries than the ones who graduate (Sweeten, Bushway, and Paternoster (2009) and are, therefore, at risk of coming in contact with crime and delinquency due to resource attainment by illegal means (e.g. theft, selling of drugs). In Sweden, individuals who drop out of school are five times more likely to be sentenced to prison by the age of thirty than non-dropouts (Bäckman, 2017; Bäckman and Nilsson, 2013).

The World Health Organisation (WHO, 2002) indicates that many children and adolescents in developed countries have some addiction. One in five young persons aged between thirteen and fifteen years smoke cigarettes. In the USA, approximately 9.7 million adolescents aged twelve to twenty years drink alcohol, of which 6.6 million are binge drinkers. In Europe, the consumption of substances such as cannabis, ecstasy, alcohol, cocaine, and others contributes to dropping out of school. According to the *European Monitoring Centre for Drugs Addiction* (2016), many young people in Europe use illegal drugs, for example, cannabis use among adolescents ranges from 37.5% in the UK and 3.8% in Portugal; ecstasy use in Ireland is around 9%, and 1% in Sweden; cocaine in Spain is approximately 4.3% (EMCDDA, 2016).

In homes where a harsh, controlling parental style predominates, parents tend to be authoritarian and highly demanding. They give preference to obedience and conformity to strict rules. Parents exhibit low trust and engagement levels in this parental style, and children do not receive sufficient warmth or healthy development support. Parental control and warmth are, thus, essential factors during childhood and adolescence. When these elements are absent in the rearing of young individuals,

adolescents might turn to the use of readily available substances such as alcohol and drugs to compensate for emotions and feelings of bonding that they do not receive from their parents (Hancock Hoskins, 2014).

Other developmental risk factors facing the children of neglectful parents (e.g. parents are punitive, errant, indulgent) are adverse family environments and inappropriate learning guidance. Failure at school by children of harsh, controlling parents may exacerbate parent-to-child violence; it can also lower the self-esteem of the affected children. Controlling parents delay and interfere with children's psychological maturity (e.g. empathy, self-competence, emotional stability, regulation of emotions) (Garcia and Serra, 2019).

Children who experience violence at home may act out their problems by inappropriate behaviour at school, not matching their teachers' expectations of good performance, or by not adjusting to the requirements schools demand on them. These circumstances can contribute to school failures and, consequently, drop out of school (Ibabe, 2016). Exposure to DV almost triples children's likelihood of conduct disorders (Evans, Davies, and DiLilo, 2008). Dropping out of school has further negative consequences for young adolescents since work level and earning potential is reduced without a school diploma. Lower salaries mean living in more impoverished neighbourhoods, low-quality housing and even increases the likelihood of juveniles coming into contact with the criminal justice system. Why is that? A possible answer is that adolescents are often influenced by peer pressure to act asocially, try addictive substances, engage in irresponsible sexual activities, or display antisocial behaviour. If parents cannot serve as role models and protect them, children and adolescents are at risk (Ibabe, 2016).

Sometimes academic achievements are less successful because of violence occurring in homes where children and adolescents witness violence or become victims themselves. DV affects academic performance in several ways. For instance, children and adolescents affected by DV have more difficulty concentrating and focussing. Due to the problems in homes, they are usually preoccupied or suffer from sleep deprivation (Buckley, Holt and Whelan, 2007).

Protective factors

Family stability is a necessary protective measure that can reduce the risks causing school dropout.

Parenting is a decisive element in children's and adolescents lives. Good parenting can protect the well-being of children. From birth onwards, parental practices significantly impact children's physical, psychological, and behavioural development (Frosch, Schoppe-Sullivan and O'Banion, 2021). Autonomy-supportive parenting (e.g. parental involvement, responsiveness and warmth, inductive reasoning, consistency) is linked with positive developmental results for children of all ages. It promotes social competencies, self-regulation, and improved concentration in academic contexts (e.g. learning) (Block et al., 2009). This autonomy-supportive type of parenting is only possible when parents, especially mothers who are generally the primary caregivers, are free from very stressful situations such as DV, substance abuse, psychological problems or earlier traumas (Farrar, 2018).

Children who grow up in protective, stable, and positive environments where parents show interest in their school performance, encourage them and celebrate their school successes have a lower risk of dropping out of school. Such children benefit from family stability because it influences their psychological and emotional development. Parental education and socio-economic level can be relevant protective factors against children's academic failure (Ibabe, 2016). Other protective factors for maltreated children with traumas are academic achievements, meaningful activities, competence and self-esteem (Whitaker, Dearth-Wesley, Herman, Nagel, et al., 2020).

2) The case study of Daniel Pelka

Fraser's report (2013) on the case of Daniel Pelka makes us aware of the chain of assumptions and mistakes made by one small school in the West Midlands, UK, which ended in the tragic death of Daniel Pelka.

Daniel was four-year-old. He was abused, maltreated, and suffered from starvation for at least six months. He died from an acute head injury in March 2012 inflicted by his

mother and step-father. Daniel's parents were both convicted and received a 30 years prison sentence.

This case exposed the painful reality resulting from the lack of information exchange between schools and other institutions that should protect children. On the one hand, the police, health and social services knew about the long history of DV and substance misuse of Daniel's mother and his step-father, but neither communicated with the school about these issues.

On the other hand, signs of severe abuse against the child were not recognised by school personnel. Daniel showed (in their eyes) disruptive behaviour (he took food and fruits from other children's lunchboxes on several occasions and once even from the trash bin), but he increasingly lost weight. On several occasions, the school's nurse noticed bruises in different parts of Daniel's body (they could not be overseen). Still, neither the school nor the nurse recorded the observations or reported those anomalies to the authorities. They took all the mother's explanations at face value: An eating disorder caused Daniel's obsession with food, and the bruises were caused by falls or other reasons (Fraser, 2013).

These types of failures by schools and institutions that should protect children may result from over-reliance on explanations at face value given by parents or due to school staff's inadequate training in their ability to recognise signs of maltreatment. The school staff had not considered the possibility that neglect or abuse was an explanation for what they had seen (Fraser, 2013).

3) Sweden and child maltreatment.

In Sweden, living with DV is considered child abuse. Sweden was also the first country in the world to ban corporal punishment of children already in nineteen-seventy-one. Schools are legally responsible for reporting any maltreatment of children (Jembro, Tindberg, Lucas and Janson, 2015).

The *Swedish Education Act (ASF,* 2010) expects schools, teachers and other professionals at schools (e.g. counsellors) to report to the *Child Protection Service* (*CPS*) known and suspected cases of child abuse (e.g. children living with DV).

Nevertheless, school personnel find DV a complicated issue to deal with, especially when they believe they do not have sufficient knowledge about the subject or how to identify children suffering from DV, despite the training they received (Uitto, Joikikokko, and Estola, 2015). School personnel claim that there is no clear guidance or references on how to deal with this problem effectively (Eriksson, Bruno, and Näsman, 2013a).

Exposure to DV can happen when children see the effects of DV, hear or overhear violent acts between their parents even when the violence is not directed directly at them. Children might be hurt when trying to intervene to protect their mothers from assault. In both cases, DV incidents cause stress reactions in children, forming a serious threat to their lives (Münger and Markström, 2019). Although no statistics are available from Sweden on the number of children affected by DV, it is estimated that one in twenty children live with DV (Annerbäck et al., 2010).

A study by Kiesel, Piescher and Edleson (2016) showed that exposure to DV negatively affects children's cognitive and emotional development, which shows in their school achievements. Children exposed to DV have the most unsatisfactory school outcomes (e.g. school attendance, language competence, reading and arithmetic level) when compared to matched comparison groups.

Carrell and Hoekstra (2009) reported that children from families where DV is prevalent exhibit lower levels of reading skills and maths scores, and they tend to misbehave in the classroom. As a result, children from violent homes can influence the school performance of their peers at the school and increase misbehaviour by other students. This behaviour increases disciplinary infractions by fifty-one per cent (Carrell and Hoekstra, 2009) and causes reductions in test scores by approximately two points (Carlsson, 2008).

Conclusion and recommendations

Family stability and harmony are vital for children's healthy development. Schools and schooling are also essential to children and adolescents in preparing them for the future as full participants in the community and a globalised world. Unfortunately, some

young people cannot complete school and obtain a diploma because they are trapped in traumas caused by bullying at school, DV in homes, or other family dysfunctions.

Parents could also benefit from guidance on how to break the spiral of violence occurring between them in order for their children to have a normal life without traumas.

Regrettably, the educational targets for young citizens that many countries aim for cannot always be realised because many children and adolescents stop school too early before completing their courses and obtaining diplomas.

It is necessary, even imperative, for governments to take measures and assume responsibility to improve the protection of DV victims, prioritize school safety, improve the level of knowledge of school personnel about DV, and recognise children who suffer abuse.

In the fatal case of Daniel Pelka, school personnel did not intervene to save the child. Because they comfortably believed the mother's argument that everything was fine with Daniel, the school and the police did not communicate with each other, there was a succession of mistakes that cost a young child's life.

The *Swedish Education Act* obliges schools, teachers and other professionals at schools to report to the *Child Protection Service (CPS*) known or suspected child abuse cases. Although it is a sound measure, school personnel find DV a complicated issue to deal with, especially if they do not know the subject or how to identify children suffering from DV.

Societies should take responsibility and proper actions to protect children from violence and make it possible for children to stay at school and obtain a diploma to flourish in their future.

2.1.3 Community violence

Violence in communities occurs worldwide, although some neighbourhoods are more affected than others. Industrialised nations have seen a decline in homicides rates since the 1990s. On the contrary, disadvantaged areas characterised by a lack of social organisation and control have increased poverty and violence. According to the *Social Organisation Theory*, the problem of rising crime in disadvantaged communities can be explained by the lack of informal social control that is central to crime regulation. In addition, communities of ethnic heterogeneity, low socioeconomic status, and unemployment have more difficulties establishing social ties to maintain order in their neighbourhood. Disorder and violence predict higher DV victimisation rates.

Some ethnic minorities (e.g. the American aboriginal community) are at high risk of DV victimisation due to a devaluation of ancient cultural values of respect for women since colonisation. Presently, IPV tolerance is the new norm.

In this section, the following topics will be explored:

1) The American aboriginal communities and DV.
2) We explain the *Social Organisation Theory* and risk factors for DV.
3) Violent neighbourhoods and DV.

1) The American aboriginal communities and DV

The United States have five-hundred and sixty-seven federally recognised tribes (Bureau of Indian Affairs, 2016). From the social and historical perspective, indigenous women have been respected and protected in their communities; they had almost a sacred status. Many of the tribes were matrilineal and female-centred. Violence against women was rare, and DV perpetrators were severely sanctioned (Weaver and Congress, 2009).

The present DV level of rape, physical violence, and stalking by an intimate partner in tribal communities is disproportionably high, around 46% compared to other ethnic groups: Non-Hispanic black women: 43.7%; non-Hispanic white women: 37.1%

(Burnette and Figley, 2016). The *National Intimate Partner and Sexual Violence Survey* collected this data that has caught national attention (Black, Basile, Breiding et al., 2011; *Centres for Disease Control and Prevention*, 2013).

Since DV affects females and children's lives, it is crucial to investigate violence in a cultural framework, separate from other ethnic minorities. To explain, predict, and prevent DV, it must first be determined how it is experienced by indigenous people (Burnette and Figley, 2016).

Indigenous women in the South-Eastern United States who have experienced intimate partner violence, and the professionals who work with them, participated in a critical ethnographic study on DV. The study aimed at identifying community risk factors using a theoretical framework of historical oppression (Burnette and Hefflinger, 2016).

Interviews with these indigenous women showed that they suffer an almost double rate of physical victimisation from their intimate partners (1.7 times) than non-Hispanic white women (Breiding et al., 2014). DV has become a cultural disruption in indigenous communities because violence has been internalised as a structural norm. Before colonisation and oppression took place, tribes knew an egalitarian way of governance, a cohesive and united community, elements that are known to be protective factors against DV (Bubar and Thurman, 2004). After colonisation, the tribal system was replaced by Western political governance forms that eroded indigenous cultural values (Burnette, 2015b). Gender roles changed from matriarchal to rigid patriarchal structures (of male dominance and exploitation of women). Besides, dehumanising ancient belief systems about women made it possible that violence against women was tolerated and normalised (Matomonasa-Bennet, 2014).

Community fragmentation, norms perceived as exacerbating inequality, lack of cohesion, and acceptance of DV as 'normal' affect the occurrence and maintenance of community violence, not only for communities with traumas of colonisation. Many disadvantaged communities struggle with problems of violence and its negative consequences for their youths and adults.

2) We explain the *Social Organisation Theory* and risk factors for domestic violence.

In many industrialised nations, levels of serious violent crimes such as homicide have declined in their communities since the nineteen-nineties (Cooper and Smith, 2011; Truman and Morgan, 2016). However, disadvantaged neighbourhoods characterised by a lack of social organisation and control have seen a rise in the levels of poverty and violence.

The *Social Organisation Theory* explains the problem of rising crime in disadvantaged communities through the lack of informal social control, which is central to crime regulation (Bursik and Grasmick, 1993; Sampson, Raudenbush, and Earls., 1997). According to Warner (2007), informal social control consists of actions that can prevent undesirable behaviour from occurring, such as drugs, public drinking, loitering, youth getting into trouble due to school non-attendance. Other examples of social control are the surveillance of property by neighbours, calling the police when needed, or resolving emerging problems (Warner, 2007; Bellair and Browning, 2010).

Communities with low socio-economic status, unemployment, many welfare recipients, residential instability, not optimal education standards, single-parent families, and ethnic heterogeneity have more difficulties establishing and maintaining order in their neighbourhood. One of the reasons is that there are fewer social ties and control among the residents, resulting in poor social connections, cooperation and social networks among neighbours. Other reasons are that individuals are cautious in intervening in conflicts or violence occurring in public spaces or homes (e.g. DV, child maltreatment). Disengagement with a neighbourhood can result in adverse outcomes for the community. Examples are rising levels of criminality, school dropouts, and teenage pregnancy (Hall, Beauregard, Rentmeester, et al., 2018).

3) Violent neighbourhoods and domestic violence

When compared to their Caucasian peers, predominantly urban, African-American youth living in neighbourhoods characterised by poverty, violence, and elevated rates of criminality are more exposed (both as witnesses and victims) to higher risk levels of

violence in their communities (*Centre for Disease Control and Prevention*, 2010; Gibson, Morris and Beaver, 2009).

Victimisation risk for severe crime such as homicide, rape or aggravated assault is, for African Americans, twice as high as for Caucasian youths (*Bureau of Justice Statistics*, 2006). In addition, exposure to community violence is also linked to disadvantages in other fields in the lives of juveniles. For example, in academic functioning (Henrich, Schwab-Stone, Fanti, Jones and Ruchkin, 2004). Dropping out of school before receiving a diploma is more likely for African Americans than Caucasian students (Chapman, Laird, and Kewal-Ramni, 2011).

According to Busby, Lambert and Lalongo (2013), teenagers who witness violence in their community show psychological symptoms such as PTSD, depression, and anxiety, as well as disruptive behaviour. Aggressive juveniles spend too much time arguing or fighting at school, resulting in disciplinary measures (e.g. suspension), which also has adverse outcomes because many young persons may avoid going to school. By missing classes, they learn less. Targeting youth's aggressive behaviour affected by violence can positively affect behavioural adjustment at school and improve their academic performance (Busby, Lambert and Lalongo, 2013).

Bagley, Tu, Buckhalt et al. (2016) cite that adolescents who live in violent communities or homes are often exposed to violence (e.g. experiencing or witnessing assaults). As a result, they have concerns about their safety; therefore, at risk of developing a state of chronic hyperarousal that might provoke sleep deprivation, especially in girls, which may negatively affect their health.

Fowler et al. (2009) suggest that witnessing or hearing about violent events in a neighbourhood such as drug dealings, robberies, stabbings, and shootings can have harmful effects on children and adolescent behaviour even when the violence is not directly directed at them.

In dysfunctional communities, many families are involved in DV issues due to psychiatric or substance abuse problems. Children and adolescents are thus exposed to harmful, violent or conflictive interactions between their parents, a non-biological transient caregiver at home, or the other parent (e.g. mother’s male partners). Besides,

youth aggressive, rule-breaking behaviour such as vandalism, burglary, and school bullying thrives because of peer pressure or other adverse life events in children's lives (Ferguson, San Miguel and Hartley, 2009).

According to Cunradi, Mair, Ponicki and Remer (2011), there is a connection between social disadvantages and risk for DV. Couples at risk of DV with easy access to alcohol (especially off-premise alcohol outlets) can be trapped in a vicious circle of alcohol consumption and violence. Since alcohol affects behaviour, its use often results in frequent calls to the police, who must then intervene to stop further violence.

Conclusion and recommendations

We started this section by mentioning that community violence occurs worldwide, but the problem is more extensive in some neighbourhoods than in others.

Regarding DV in aboriginal tribes, before colonisation, tribes had an egalitarian way of governance. Most were matriarchal, and women were highly respected. Presently, DV has become a cultural disruption in those communities because violence has been internalised as a structural norm.

Communities with low socio-economic status, unemployment, many welfare recipients, residential instability, inadequate education standards, single-parent families, and ethnic heterogeneity have more difficulties establishing and maintaining order in their neighbourhood.

The *Social Organisation Theory* explains that problems in disadvantaged communities are a lack of informal social control to prevent undesirable behaviour such as drugs, public drinking, and youth school absenteeism. In addition, a lack of social connections, cooperation and unwillingness to intervene in conflicts (e.g. DV, child maltreatment) or violence occurring in public spaces or homes is harmful to the community.

Protective factors that can effectively lower the adverse effects caused by exposure to community violence are family factors such as strong parental support and protective,

warm family relationship. A good school climate, including school safety, can also alleviate the distress caused by living in a violent environment.

Youths living in violent neighbourhoods are disadvantaged compared to other children or adolescents. Young people can be helped with measures that promote problem-solving strategies, enhance social skills, and prevent aggressive behaviour rather than punishing after the violence.

2.1.4 Homelessness in victims of domestic violence

"*We lost our home because of my ex…I did try to resolve and get back together with him, but he was still abusive. I was not only hurting the kids, like he was swearing at my daughter and my older son.*"

Mary

Cited by Milaney, Lee Lockerie, Fang, and Ramage (2019).

Women and their children can be regarded as fortunate when they have stable, adequate homes that can be considered a refuge, a place that brings them a sense of security. Unfortunately, that is not a reality for all women, as sometimes home can be dangerous when women are battered. In many cases, DV victims cannot remain in a relationship because of injury threats or lack of safety for themselves and their children. When women finally decide to sever the abusive relationship but do not have a family or a network to support them, they can suddenly become homeless - sleeping in cars, public spaces or overcrowded shelters. Ending an abusive relationship means a significant life transition, from having a home to being homeless. Due to their gender, females and children are exceptionally unsafe for sexual exploitation and assault while homeless.

In this section, we analyse the following topics:

1) The invisibility of female homelessness.
2) Data on female homelessness in Europe.
3) Responses to female homelessness in different countries.

1) The invisibility of female homelessness

Most Western countries have social programmes to assure their citizens a minimum level of resources to keep them from poverty. However, many homeless people do not claim or do not receive benefits because they are not recorded in any administrative data that might have protected them from entering homelessness. That invisibility to the authorities and the lack of policies to improve social conditions for people in need result in an unfair redistribution of assistance programmes.

Homelessness by males and females is different. Homeless men are more visible than females; men live in public places, on the street or use night shelters. Women who become homeless tend to use all the informal support available from relatives, friends or acquaintances to provide accommodation for themselves and their children. When they have exhausted those resources, then they use welfare services (Mayock and Sheridan, 2012).

Due to the invisibility of homeless women in official registrations as recipients of help or as rough sleepers (for security reasons, women try to hide), much European research into homelessness has not included women in its data. The reasons were:

A) Researchers have for a long time viewed homelessness as a social problem that affects primarily lone adult men (Bretherton, 2016).

B) Women fall outside the focus of homelessness definitions (e.g. rough sleeping, single homelessness). Only relatively low numbers of homeless females who live on the streets, in temporary housing for homeless people, or in emergency shelters are counted as homeless (Pleace, 2016; Busch-Geertsema et al., 2014).

C) Women who are homeless but temporarily staying with family or friends are invisible in existing data systems.

D) Women who do not have a home anymore as a result of male violence (having to use a refuge or shelter) are not counted or researched as being homeless but as being victims of violence (Baptista, 2010). Countries in the EU have a different definition of female homelessness. Nevertheless, what still counts as

female homelessness is long overdue for review if a better understanding of all

In the United Kingdom, there are specific homelessness laws designed to assist lone parents who suffer from DV, 0which is one of the major causes of statutory homelessness.

Approximately 13% of homelessness by women and their children results from men committing DV against women (Jones, Bretherton, Bowles and Croucher, 2010). Although women's refuges can provide temporarily for a safe place (and for a structured and organised space for families), women report that living in such type of accommodations is stressful for various reasons: They live in fear of the perpetrator tracking them down in their new address; refuges are generally located in an unknown location for the safety of the women, but a new address represents changes to be done to known and trusted places such as schools for the children and health services; being away from support from friends or family. Besides, women and their children might have to spend a long time in such accommodation before they can be re-housed (Jones, Bretherton, Bowles and Croucher, 2010).

2) Data on female homelessness in Europe

Since the first published European data on females homelessness, carried out by the *European Federation of National Organisations Working with the Homeless (FEANTSA,* 2001), more publications have followed: *FEATNSA,* 2017, 2018 a,b. They contained chronic homelessness issues, including more actual ones, such as providing adequate housing for asylum seekers.

The reports highlight the extent of female homelessness in several countries in Europe, the impact of policies and services provision and services' effectiveness to vulnerable women experiencing homelessness (Baptista, 2010).

Recent research conducted by the *European Typology on Homelessness and Housing Exclusion* (Edgar, 2012) acknowledges that family homelessness is a gendered experience that mainly affects young women who are lone parents. Homelessness is

0often linked to DV economic marginalisation. However, compared to long-term homeless men, women present fewer signs of severe mental health, poor health or drug use, neither have they criminal records (Busch-Geertsema et al., 2010).

3) Responses to female homelessness in different countries (Canada, USA, Australia)

Canada

Every five days, one woman is killed by her intimate partner (Roy and Marcellus, 2020). If women are not killed and run away for their lives, they can become homeless.

The population in all provinces and territories is approximately 27.3%, including black, gender diverse, disabled, poor, LGBT+, and other vulnerable women such as sex workers, newcomers, young and old. However, the number is probably much higher since homeless women with children try to remain off the street and out of shelters, moving from place to place and "couch surfing" at friends or family. More recently, immigrant women and refugees are located in unsuitable overcrowded accommodations. In addition, too many families with different cognitive and psychological disabilities live in crowded locations (Andermann, Mott, Mathew, Kendall, et al., 2021). Sometimes, women are forced to engage in 'survival sex' and are vulnerable to human trafficking, others sleep in cars for safety, and those are not counted in statistics of female homelessness (Schwan, Versteegh, Perri, Caplan et al., 2020) or tents, on floors or sidewalks (Whitney and Basloe, 2019).

In Canada, social welfare fundings and programmes (e.g. housing, education, employment) to help homeless women have been reduced. Since the crisis in the 1990s, the federal government withdrew investments in affordable housing, exposing even more Canadians to the risk of homelessness (Gaetz and Dej, 2017). Approximately 25% of the adult homeless population are females. Between 2005-2009, women and children's homelessness has grown around 50% in the length of stay in shelters across the country. Compared with the adult male homeless population, women and children tripled their lengths of stay in shelters (Segaert, 2012).

USA

DV is a leading cause of homelessness for women and their children (Baker, Niolon, and Oliphant, 2009). Children who experience housing instability or homelessness are at higher risks of abuse, neglect or witnessing violent events than housed children (Gilroy. McFarlane et al., 2015).

The *US National Network to End DV (NNEDV*, 2020) reports that daily more than 40,000 IPV survivors and their children stay in emergency shelters, which have an essential role for survivors seeking immediate safety. Survivors receive supportive services that offer the victims safety assessments, legal support, and long-term housing when available (Baker et al., 2010; NNEDV, 2020).

Homelessness is traumatic for any person, especially for children, because its impact can be traumatic and pervasive for their future relationships and health. Until recently, infants and toddlers' needs were not considered by family services providers in the US. These agencies acted as if children were invisible in the whole process and, therefore, negated the exceptional support young children need and disregarding children's vulnerability (Witney and Basloe, 2019).

Around half a million individuals experience everyday sheltered and unsheltered homelessness, from which a third are mothers with children (Henry, Watt, Rosenthal, and Shivji, 2016). Many of those women are young and have one or more children (Guo, Slesnick and Feng, 2016).

Women in the U.S. are confronted with similar difficulties faced by women worldwide because of the non-availability of affordable housing and employment possibilities to sustain themselves and provide for their children without external intrusion. Despite the goodwill of the shelter's personnel, women feel as if they are monitored continuously about their parenting style, increasing their feelings of inadequacy and a loss of independence that negatively influences the mother-child relationships (Barrow and Laborde, 2008). These shelter experiences result in even more tension for the mothers who are already experiencing, for instance, poverty, exposure to violence and an uncertain future (Azim, MacGillivray, and Heise, 2018).

Mothers living in shelters are expected by the social services to learn how to become independent, which is a positive quality to enhance their self-confidence. However, this is a challenging task for immigrant women, especially when they do not speak well the host country's language and do not know the procedures to follow or who is the right person to contact to solve the problems they are facing. Besides, there is no coordination among social services. Women must go to multiple places that deal only with one issue (e.g. health care card in one office, subsidised housing in another place, and child support again in a different location). To complete all the necessary administrative paperwork to receive support takes a long time and greatly extending the time they must stay in shelters. Sometimes the women's (ex) husbands are more than willing to have them deported to their country of origin to access children's custody. Many immigrant women are uncertain of their future, whether they can obtain subsidized housing or remain in the country.

Australia

According to Flanagan, Blunden, Valentine, and Henriette (2019), DV in Australia is complex. To secure funding to address homelessness, counting and profiling people at risk is critical (Horsel and Zufferey, 2018) for issuing policies and interventions (Busch-Geertsemna and Fitzpatrick, 2016) to prevent, reduce or in the best scenario to end homelessness (Gaetz and Dej, 2017).

Policymakers and social services that help DV survivors are confronted with complex and varied situations; women who make the difficult decision to leave home could be confronted by their (ex) husbands, who might often have a history of violence, stalking or harassment. Besides, appropriate and affordable housing is not readily available. The women lack the financial resources to access a new home, making them vulnerable to abuse by staying in a violent relationship. Another serious problem is the shortage of affordable housing for women suffering from DV. Sometimes women have no choice but to accept accommodation in poor conditions that may represent a health risk for their children or take housing in disadvantaged neighbourhoods.

Women who reject a housing offer, for whatever reasonable reason, can be perceived by social services as declining support, which can then have consequences for future offers (Flanagan, Blunden, Valentine, and Henriette, 2019).

Conclusion and recommendations

Homelessness caused by DV is harmful to any individual, especially mothers, who suddenly are in the street with their children, and of course, the situation is traumatic for the children.

The knowledge of females' homelessness in Europe is not accurate because there is no consensus among European countries of what counts as homelessness. Women who use informal arrangements, stay with family, friends, or acquaintances do not count in the official data. Therefore, they are invisible to social services that could have prevented or resolved homelessness.

Ideas on gender and homelessness impact the policies that will be issued (e.g. welfare, housing) and the services offered (e.g. social assistance programmes) at the European level. We saw that in Europe, homelessness is present but not accurately counted, and the risk factors are similar in other Western countries (e.g. Australia, Canada, and the USA). Besides, affordable housing for women who fled home is unavailable or insufficient.

Due to violence, women (and their children) who left their homes are often trapped in poverty and unequal access to social support systems such as education, employment, and affordable housing. It would be desirable to develop efficient, evidence-based interventions for abused women who become homeless due to violence and live in shelters.

To make housing a human right for all should not be just a dreamer's project. It is a compassionate idea to alleviate many people's situations and rethink the present systems of support to make them more accessible to those who need that help most - the weakest in our society. A European network of academics and lawyers from various countries is making advances in establishing the '*Housing Rights Watch'*. The organisation promotes housing's rights across Europe and internationally. The

objective is to position housing as a fundamental human right, where homelessness would be considered a denial of those rights (*Housing Right Watch*, 2010).

2.2 Psychological abuse

When DV against women started to be visible to research and the public, laws and regulations changed to adjust to new realities. At the beginning of the 1990s, scientists researching physical abuse among battered women's samples also identified non-physical forms of abuse. Women told the scientists that physical assaults were not as destructive as isolation, humiliation, and domination that affected them the most. Paradoxically, decennia's later, police, courts and the justice systems in many countries classify these types of coercive behaviour as 'minor' because no signs of physical violence are evident. The justice system has no clear definition of what DV contains, nor do health practitioners, who cannot recognise abuse symptoms other than physical. Therefore, they cannot help the victims effectively. Even among the public, controlling behaviour is not considered abusive because of cultural beliefs and gender roles.

In this section, the following topics will be discussed:

1) The development of the meaning of psychological abuse.
2) What counts as psychological abuse?
3) The attitudes of acceptance towards DV.
4) New legislation on psychological abuse.

1) The development of the meaning of psychological abuse

The study of physical and sexual violence in intimate relationships have been well researched by scientists and have also received close public attention. This interest may be explained because the physical consequences of violence are visible (Ruiz-Perez and Plazaola-Castano, 2005).

Since the beginning of the 1980s, scientists researching physical abuse among samples of battered women they were studying have also identified non-physical abuse forms. Battered women very often reported that "physical assaults are not the worst of it". Patterns of psychological battering such as isolation, humiliation, and domination were what women said "broken them down the most" and "robbed them of their lives" (Capezza, D'Intino, Flynn, and Arriaga, 2017).

The researchers noted that psychological abuse (e.g. emotional abuse) is widespread and is even more common than physical and sexual violence (Follingstad and Edmunson, 2010). Nevertheless, it has received less attention than physical abuse despite the negative consequences on female's health and well-being (Babcock et al., 2008).

According to Stark (2007), males' coercive control towards their female partners in the United States affects eight to ten million women (from a population of 14.5 million) who are psychologically abused by their partners. Patterns of coercive behaviour and oppression might be classified as 'minor' abuse by police, courts and the justice system. Although emotional abuse occurs as a systematic pattern of behaviour, no signs of physical battering are visible. Consequently, those acts of psychological abuse are often trivialised, rendered invisible or normalised (Stark, 2007).

2) What counts as psychological abuse?

Health practitioners and justice systems unmistakeably recognise physical abuse because physical force leaves visible signs. However, other types of DV abuse do not involve physical forms. For instance, coercive or controlling behaviour is used to subordinate the partner, taking the other partner's money; commit certain forms of stalking, monitoring, or surveillance (Buzawa, Buzawa, and Stark, 2017). Other examples of coercive behaviour are preventing the partner from seeing their family, not allowing the partner to work but at the same time not giving the necessary money to cover expenses in the household. Coercive behaviour is as harmful and detrimental to affected women's health and well-being as is physical violence. The only difference is that it is physically invisible (Roberts and Price, 2018). These acts of illegitimate use

of power and coercion to maintain control and subjugate the other partner are dangerous because they harm women's autonomy and personhood and limit their liberty and rights, reinforcing gender inequalities (Stark, 2010).

There is some agreement among researchers that psychological or emotional abuse is not yet rigorously defined. This issue can be explained by the fact that there are no parameters to measure the consequences of psychological maltreatment compared to physical or sexual violence. Besides, women react differently to this kind of psychological maltreatment, and its impact on their lives also vary from one woman to another (Follingstad, 2009). Though, there is some consensus on the meaning of psychological abuse, which is defined as any pattern of behaviour committed by one intimate partner against the other to harm, by using verbal violence such as criticising, giving denigrating comments, cursing, continuous devaluation, and manipulation in order to maintain control even without resorting to physical violence to reach their aim. Examples of coercive control methods to keep dominance are threats and verbal aggression (Zavala and Guadalupe-Diaz, 2018; Breiding et al., 2015).

Coercive control sometimes inflicts fears even after the abusive relationship has ended, especially if the couple have children in common and women have to co-parent with their abuser (Crossman, Hardesty and Raffaelli, 2015). Male partners often threaten to harm or kidnap the children, manipulating and controlling their partners (Hardesty and Chung, 2006). After the union dissolves, mothers who were exposed to psychological abuse are still under stress because they fear the uncertainties of the transition to single-motherhood, future employment, financial consequences; the most problematic is the stress of having continuous physical and psychological threats from their ex-partners. More than a third of women continue to experience physical abuse (Pallini, Alfani, Marech and Laghi, 2017), and 95% experience emotional abuse after divorce (Hotton, 2001).

3) Attitudes of acceptance towards domestic violence

Attitudes of acceptance towards DV are not surprising since cultural ideals of gender in a given society create expectations of ‘proper’ roles for males and females. Feminist

sociologists and anthropologists have emphasised the social construction of gender. They highlight different scripts that families and society prescribe for individuals to follow. They consider the imprint of gender inequalities in structural patriarchy as the macro framework of socializing mechanisms. After all, gender socialisation aims at transmitting the concept of gender hierarchy to be accepted as natural and normal for both men and women (Ganesh and Phookam, 2018).

Margaret Mead (1949), a pioneer of cultural anthropology, explains that conformity in women is part of the gender roles they have acquired or are imposed from their childhood onwards. Girls learned that behaviour determines their gender roles (e.g. expected to listen, obey, and not stand out independently).

Research has shown that gender matters when dealing with psychological abuse (Roberts and Price, 2018). Many young girls (aged 15 to 18) who participated in a survey study wrongly associate coercive behaviour (e.g. jealousy, control) as a sign of care. Not surprisingly, many young women normalise such behaviour (McCarry, 2010), leading to its general acceptance (Stark, 2007).

Evan Stark (2012) proposes that the present DV policies and the legal responses by the criminal justice system for acts of DV in the US are based on erroneous assumptions. The 'violent incident model' recognises the damage that has occurred to victims only when the severity of the physical injury is visible. Considering that coercive control patterns are common in abusive relationships, police paying attention only to severe (visible) partner violence will not bring real solutions in the long term for battered women. The current system must be modified, and laws should include different coercion types to protect victims effectively.

Research by McCarry (2010) reports that individuals normalise DV. Therefore, identifying coercive behaviour as part of DV is not easy for many males and females who support domesticity's traditional gender roles.

In Wilcock's (2015) research, female participants did not regard psychological, emotional, financial or even sexual violence as DV. Instead, those women justified forced sex with friends or husbands to appease them or reduce their jealousies.

Gender roles can perpetuate culturally harmful controlling behaviour or entitle men to believe they have power over women.

4) New insights on psychological abuse.

Official definitions of what DV is and what types of behaviour are considered abusive are modified and expanded according to the latest research insights. For instance, the UK government (2020) now defines psychological abuse as follows:

Any behaviour directed at the victim, children or another individual that "*would make the victim dependent or subordinate to the perpetrator; isolated from friends, relatives or other sources of support; control, regulate or monitor daily activities; deprive the freedom of action; and frighten, humiliate, degrade or punish the victim.*" *Domestic Violence and Abuse Bill* (2020).

Research on psychological abuse and the overwhelmingly negative consequences on health issues in all age categories are being studied in the USA and other countries because psychological harm increases by 2.7 times the likelihood of somatic symptoms (Afari, Ahumada, Wright, et al., 2014). However, DV's definition has expanded and includes emotional and psychological abuse (*Office of the Administrative Rules Coordinator Division of Financial Management*, 2020).

In section 1.7, we saw DV's detrimental consequences for individuals and governments due to high healthcare costs.

Conclusion and recommendations

The subject of DV and specifically psychological abuse, is complicated. There is no consensus or undisputable definition of psychological abuse - neither for healthcare practitioners nor justice systems. It is challenging to prove psychological violence in court when no physical signs of violence are visible.

Another complication is the mentality of people who continue to believe in gender superiority and male 'rights' over females minds and bodies, maintaining and condoning violence.

Gender issues should be present as a mandatory subject in all schools worldwide. Governments ought to have special ministries or portfolios exclusively for DV because we can see that violence against women is present everywhere, including rich and 'advanced' countries.

The ultimate solution for DV's global problem might reside in high-quality education for all, legislation that understands the damage caused to the victims even if they do not have externally visible marks such as broken bones or a black eye to prove their suffering. A real concrete and all-encompassing support system for victims would also help enormously.

2.3 Economic abuse

Financial resources are essential for any individual to survive, but it is paramount for women to gain independence from their abusers. One way to gain independence is by working and by being able to maintain employment. Unfortunately, many battered women are unsafe at work due to harassment, threatening or sabotage by their (ex)partners. Abusers try to maintain control and exercise power against their intimate partners by using tactics of economic governance, that is, any behaviour that aims at impeding women to use and conserve financial resources, undermining their security, independence, and self-sufficiency

In this section, we will discuss the following topics:

1) The tools the batterers use.
2) The characteristics of abused women.
3) Gender inequality and economic abuse.
4) Financial Abuse through Consumer Credit' - The case of Emma.

1) The tools that batterers use

Typical forms of economic abuse which harm women's lives are employment sabotage, financial control, and economic exploitation.

Economic sabotage means that the victim is prevented from obtaining or maintaining employment (Postmus, Plumer, et al., 2015). Examples of employment sabotage are when perpetrators forbid, actively interfere with their partner's career, or discourage them from searching for work or further studying opportunities (Alexander, 2011). Perpetrators can use different techniques to reach their aims. For example: Destroying the victim's car so that she cannot go to work; threatening to inflict physical injuries; stealing car keys or money so that the victim cannot pay for other types of transportation; refusing to give her a lift to work; inflicting facial injuries; harass the victim and her co-workers at the workplace; disseminate lies at her workplace such as saying that she is a psychiatric patient or a drug addict, and so on.

Economic control can happen without violence, for instance, when perpetrators do not allow the victims to know or access the joint finance status and keep them out of financial decision-making (Postmus, Plumer, et al., 2015). Perpetrators often deny access to food, medication and clothing (Anderson et al., 2003); and lie about shared properties and assets (Anderson, 2003)

Economic exploitation is when perpetrators aim at destroying the victim's financial resources or credits (e.g. refusing to pay bills, using the couple's joint money for gambling, stealing money, checks or credit cards (Postmus, Plumer, et al., 2015).

2) The characteristics of abused women

A high percentage of women (between 79% and 99%) engaged with DV services (Adams, Sullivan, Bybee, and Greeson, 2008; Postmus et al., 2012b), are welfare recipients, live in poverty or participate in support groups for intimate partner violence survivors. Most experience also economic abuse (Kutin, Reid and Russell, 2018).

Most of the women who are being battered have low education levels and are only employed in low-skill jobs that do not pay sufficiently to maintain themselves and their

children. In a study of women living in a shelter conducted by Moe and Bell (2004), they included in their sample women who completed high school or had at least some college education, who had before their experience of violence a successful career. All the women in the sample had in common that they were mothers. The types of abuse varied, but there were similarities in their experience of fears for their partners. Other similarities were the impossibility of keeping their work because of violence and the uncertainty of their future and that of their children (Moe and Bell, 2004).

3) Gender inequality and economic abuse

Gender inequality exists in poor and rich countries. In developing countries, the education level for men and women is unequal. In highly developed countries, women surpass men at universities, but they do not receive the same pay for the same work.

In some developing countries, the marriage age for women and girls is extremely low. They are pressured due to cultural reasons to dedicate their lives exclusively to child-rearing and cannot access education or employment, are thus dependant on their husbands (*World Health Organisation*, 2013).

Due to abuse, women show visible physical effects and are at risk of losing their jobs as a consequence. Others stop working and flee to another city so that their abusers cannot find them. Sometimes, when employers incur in extra costs due to absenteeism at work and the lower productivity of their employees, they often decide to terminate women's employment (Moe and Bell, 2004).

Economic abuse is also possible where there are inadequate or non-existing welfare programmes to help women become financially independent of their husbands' dominance. Besides, many countries have no protective laws for women, or those laws are not being applied or enforced (Klevens, Ports, Austin, Ludlow and Hurd, 2018).

4) Financial abuse through Consumer Credit - The case of Emma

A relatively new phenomenon related to economic abuse among couples is emerging as an area of research. Effective laws are not yet answering individual illegal acts,

which affect predominantly females (especially in the US). This type of abuse is called '*Financial Abuse through Consumer Credit'*, also known as 'Coerced Debt'. Women are made accountable for their partner's wrong-doings (e.g. men can take loans or credits easily on their wives' names without permission).

Adams (2019) makes us aware of the coercive nature of that type of economic abuse, resulting in the victim's lives being financially ruined.

Here follows Emma's real case (a fictitious name), showing the devastating consequences of abusive control: Economic and personal.

"*When Emma first met Andrew, she was a successful real estate agent who was financially independent. At first, Andrew supported her success. Shortly into their marriage, the dynamics of their relationship changed drastically. Andrew took complete control over Emma's life. He limited her time with family and friends, restricted her computer and phone access, and fully managed the couple's finances. He alone had access to her bank accounts, giving her a small, set portion of her paycheck each week for spending. He depleted her savings. Emma tried to leave the relationship five times before she exits for good. Later, she learned that Andrew had spent tens of thousands of dollars on her credit cards and had taken out several loans in her name, saddling her with substantial debt that she alone was responsible for.*" Cited by Adams (2019)

As it became clear in Emma's case, abusive partners misuse the US's complex credit system to obtain loans or buy expensive goods with their partners' credit cards without their knowledge. Alternatively, trick or force the partner to sign contracts to authorise them to make financial decisions and transactions.

The problem of coerced debt –a non-consensual credit transaction - resides in the legal uncertainty of whether a couple is one economic unit or two and when one partner has the authority to make financial decisions for the couple.

Historically, only in the mid-1800s women were recognised as independent economic actors; before that time, they were considered one economic unity with their husbands. Only men could administrate and dispose of those assets. When those fault legislations were changed, it was no longer permitted for the state to concede economic rights based on gender. Presently, marriage continues to exist as a

monetary institution, and both partners act as financial partners. Unfortunately, too often, men are believed at face value that they are acting in consent with their partners to ask for a loan or credit. Besides, it is difficult to recognise when a transaction is fraudulent and when it is coercive. Coerced debt damages the victims' creditability, but it also makes leaving the abuser even more problematic since landlords, employers, and companies do not desire to have newly single survivors as house renters, employees or clients (Littwin, 2012).

Men who use violence against their partners also use other kinds of abuse. For example, the perpetrator uses emotional abuse to undermine the victim's sense of value, while financial abuse destroys the victim's economic resources.

The combination of abusive tactics causes severe and long-lasting consequences for women because they lose their self-esteem, their health deteriorates, and they are ruined financially. Sometimes the only way out for women is to seek medical or psychological care, which is very expensive to the community.

Besides, women have great difficulties deciding to leave their abusive partners to become free of emotional and financial pressures and be self-sufficient. Some forms of abuse are acknowledged (e.g. coerced debts), but there are no yet juridical solutions. As mentioned in other sections, many of the problems women face related to housing instability and disadvantages in the workplace are structural inequalities maintained by governments in poor and rich countries. Examples are low pay, part-time employment, insecurities in the labour market, expensive child-care facilities.

To alleviate and revert the damages caused by an abusive partner targeting the financial security of the victim by creating economic dependency (Adam et al., 2008) require that social services providers and scholars better understand such damages to improve policies to help the victims. Besides, introducing a new social system that values human capital instead of greed could be precious.

Conclusion and recommendations

The economies in Europe are generally based on neo-liberalism ideas of growth and its redistribution. The neo-liberal system is characterised by free-market trade, individualism, and the shift away from state welfare. In most European countries,

women are expected and encouraged to work outside the home. Nevertheless, the prices of child-care centres are very high, discouraging women from working only to pay for those facilities. Besides, up to now, there is a wage gap between males and females (to the disadvantage of females), lack of jobs for non-highly qualified personnel, thus the choice to stay home to care for young children primarily relies upon the one who earns less: Women. During and after economic recessions, neo-liberal systems fail to protect the most vulnerable in society (e.g. children, women, unemployed, disabled) who are dramatically affected through social exclusion, cuts in social services and social securities budgets. The dismantling of social security contributes to elevating DV risks (Walby, 2018).

Walby (2018) proposes a refreshing, exciting idea about creating a new knowledge economy that could reduce inequalities and promote gender equality. Because, she argues, by creating institutions that promote the public interest under strict democratic and transparent public control and elevating social justice, growth also increases. For instance, valuing individuals' labour instead of aiming at paying as little as possible, or use cheap labour, excluding specific populations, does not promote equality. Preventing violence, which is already known to be devastating and very costly to societies, would save women from a life of abuse, harm and poverty (Walby, 2018).

2.4 Alcohol dependency

It is estimated that globally 237 million men and 46 million women suffer from alcohol-use related disorders, such as neglect of family, work, education, social life, changes in behaviour, and propensity to risky behaviour. High-income countries are the most affected by this problem. The European Union has the highest alcohol consumption per capita in the world: Excessive alcohol use by men is calculated to be around 14,8% and by women 3,5%. Worldwide 27% of all 15-19-years-old are current drinkers. By the same age range of current drinkers in Europe, the percentage is calculated by 44%. In some European countries, alcohol use starts at the early age of fifteen, with almost no difference between boys and girls (*World Health Organisation*, 2018).

The World Health Organisation (2018) says that more than three million people died in 2016 due to excessive alcohol consumption. These numbers represent one in twenty deaths, from which more than three quarters are men. It is known that alcohol increases aggression and reduces self-control because it affects cognitive functions. In distressing situations, individuals who drink excessively are less capable of employing non-violent resolutions to solve conflicts within the relationship. Diminished self-control can lead to physical and sexual violence against their partners.

This section exposes the consequences that alcohol dependency has on DV by discussing the following topics:

1) The harmful effect of alcohol on individuals' daily lives.
2) Alcohol dependency among LGBT+ individuals.
3) Alcohol consumption and perpetration of DV.

1) The harmful effect of alcohol on individuals' daily lives

High levels of alcohol consumption are very closely related to DV, which is a severe global public health problem perpetrated chiefly by men against their female partners (e.g. sexual violence, rape, and extreme physical violence) (WHO, 2013).

Men tend to perpetrate more severe assaults than women, mainly when they have mental disorders and substance use disorders as principal or comorbid diagnose (Yu et al., 2019). Women also commit violence against men. Female violence is often motived due to a dependence on one or more harmful substances (alcohol use often co-occurs with drug use). Women are often involved in unhealthy alcohol use when they cohabit with abusive partners who drink. These women drink three or more drinks on any single day, seven drinks per week, or over that quantity (*National Institute on Alcohol Abuse and Alcoholism*, 2015).

Comparing women in the general population with women using substances, the last-mentioned group experiences higher intimate partner violence (Gilchrist, Blazquez, and Torrens, 2012). When women are intoxicated, they are no longer capable of using safe strategies to solve problems. Alternatively, they are reluctant to participate in treatments that could help them manage their behaviour and emotions, seek social

support, or interpret their experiences in more meaningful ways (Iverson et al., 2013). Alcohol also affects teenagers. Excessive drinking is one of the risk factors for dating aggression by teenagers. Alcohol abuse is a risk factor for sexual violence (percentages ranging between 30 and 40%) (Breiding, Chen and Black, 2014).

Considering the early age at which adolescents start drinking can be problematic. At that age, adolescents are in the middle of a critical transition period to adulthood, where new romantic relationships and experiences of emotion and passion occur. Thus, alcohol use negatively impacts their lives (Reyes, Foshee, Gottfredson, Ennett, and Chen (2020).

2) Alcohol dependency among LGBT+ individuals

Alcohol dependency can create different types of conflicts among partners, for instance: Financial difficulties, marital tensions, alcoholic jealousy, also known as alcoholic paranoia – A psychotic disorder characterised by delusions of unfaithfulness, of making unfounded accusations leading to violence between the partners; and childcare problems such as child neglect or maltreatment. Observing violence in childhood is associated with the long-lasting emotional and psychological impact on children, with violent and delinquent behaviour in childhood and alcohol dependency later in life (WHO, 2018).

Davis, Kaighobadi, Stephenson, Rael, and Sandfort (2016) researched, among the 189 participants, the association between alcohol use and IPV among gay men. They found that 48.7% of the participants perpetrated IPV to a steady partner in the last twelve months. They also found that alcohol consumption is undoubtedly associated with physical, sexual, and HIV-related IPV victimisation and emotional and controlling IPV perpetration against a casual dating partner.

3) Alcohol consumption and perpetration of domestic violence

Perpetration of DV under the influence of alcohol during conflict situations between partners, especially antisocial personality disorder (ASPD), is well documented. Individuals with mental issues are at an increased risk of alcohol abuse, exacerbating

their already present tendencies to disregard and violate others' rights (Maclean and French, 2014). Therefore, the involvement in distorting interactions, conflict escalation, and the use of violence towards their partners is more likely to happen in men who are alcohol dependent than in men with mild or no alcohol use (Gil-Gonzalez et al., 2006).

In the following paragraph, the reader will be introduced to the real case of Joanne, who had a partner with alcohol abuse problems. Joanne clearly and recognisably illustrates some of the dilemma's women are confronted with before they finally decide to free themselves from an abusive partner. Joanne left her husband and searched for help from a women's support group.

"He had a drinking problem, but he said he wanted to get sober. And I believed that once he would stop drinking, he would stop abusing me, and we would have a great life together…. I moved out a couple of times. He would make promises, and I really wanted to keep our family together. It kept getting worse. Finally, one night after he had beaten me up, I knew I couldn't take it anymore.. and called the police….I am angry at myself that I didn't wake up sooner. Why didn't I leave and stay gone? Why did I keep coming back? I know the answers, but it still doesn't make sense to me."

Cited by Vera Anderson (1997) in "*A Women like You. The Face of DV"*

Living in constant stress due to excessive alcohol consumption is associated with severe health problems for all family members. Excessive drinking has other collateral issues involving poverty, housing instability, maternal mortality, children's exposure to DV, inadequate supervision or neglect. It also has consequences for many children who must then be separated from their families and placed in out-of-home care due to violence or neglect in homes (Sandison/Australian Institute of Health and Welfare, 2017).

Some researchers hypothesise that DV is more likely to happen when individuals have low-stress tolerance skills or maintain negative, maladaptive behaviour: Alcohol misuse, Irritability, impulsivity, and aggressivity that reinforce other destructive behaviour (e.g. DV) (Cummings et al., 2013).

Violent male partners who were in treatment for substance dependency reported having elevated feelings of anger and being more inclined to react aggressively in response to provocation (Finkel and Eckhardt, 2011).

Therefore, governments and policymakers must consider restrictive measures proposed by the *World Health Organisation* (2018). The *WHO* believes that the indiscriminate easy access to alcohol for young people is a barrier to a successful future as adults. Starting misusing alcohol will have devastating consequences for their health and well-being and their partners and children.

Conclusion and recommendations

We saw that millions of men and women suffer from alcohol abuse-related disorders globally, from which high-income countries are the most affected. For instance, the *European Union* has the highest alcohol consumption per capita in the world: In some countries, alcohol use starts at the early age of fifteen, with almost no difference between boys and girls.

Alcohol and gender-based violence are strongly associated with the perpetration of DV/IPV in all populations irrespective of gender, age, and sexual preferences.

Alcohol dependency creates conflicts among partners, such as financial difficulties, marital tensions, alcoholic jealousy (alcoholic paranoia), characterised by delusions of the partner's unfaithfulness, leading to violence towards the partner or creating childcare problems, such as child neglect or maltreatment. Observing violence in childhood is associated with the long-lasting emotional and psychological impact on children, with violent and delinquent behaviour in childhood and alcohol dependency later in life.

We showed Joanne's case, a woman who had a partner with a drinking problem. Her case is not unique; many more cases are similar to this one, but Joanne could stop the battering by leaving the abuser.

The WHO proposes that issuing policies that help decrease alcohol consumption among young people can reduce dating violence among teenagers. Such measures can spare much suffering for many adults and children as well.

2.5 Drugs dependency

According to the *World Health Organisation* (2019), diseases caused by drug use at a global scale are calculated to be approximately 1.3% (WHO, 2019). Worldwide, circa two-hundred-seventy-five million people use illicit drugs (one out of twenty from the age range of 15-64 years). One out of ten individuals suffers from drug use disorders, including drug dependency. Around half of the people with drug dependency share syringes, making them vulnerable to acquiring HIV (ca. 10%). The majority are infected with Hepatitis C.

Drug use represents a significant global health problem, implying high healthcare costs to societies and have very negative social consequences for the affected persons and their environments (WHO, 2017). Annually, the deaths attributed to drug use are estimated at 500,000 (including those produced by drug use disorders). Deaths attributed to injection-drug use is around 23% caused by global hepatitis C incidence, and 33% due to injection drug use (WHO, 2019). Only one in six persons with drugs dependency has access to a treatment that is effective. In Latin America, the scale is 1 in 11, and in Africa, 1 in 18. This low number of people who receive treatment is caused by stigma and discrimination or lack of knowledge. Worldwide, people with drug use disorders are seen as a criminal justice problem instead of a health problem. Therefore, individuals are not sent to recovery programmes for rehabilitation (WHO, 2017).

Excessive drug consumption directly activates the brain reward systems, producing feelings of pleasure (known as being 'high'). Individuals who use psychoactive substances are at risk of developing substance use disorders that are manifest in social impairments, lessened control, and they may exhibit risky social behaviour (*American Psychological Society*, 2013).

There is a relationship between substance misuse and violence caused by pharmacologically induced violence, or when drug-dependent individuals must attain drugs and do not hesitate to use violence for that purpose. Drugs affect cognitive

control and the capacity for underlying planning or behavioural strategies (Hoaken and Stewardt, 2003).

In this section, the effects that illicit drugs can have in the perpetration or victimisation of DV are analysed:

1) Drugs dependency in females.
2) Drugs dependency in males
3) Drugs dependency among LGBT+ individuals

1) Drugs dependency in females

Many abused women are addicted to one or more substances. In a report based on interviews with 42,000 women across the European Union (EU) (up to now the most comprehensive survey in the EU), researchers asked female participants about their DV experiences. The results presented by the *European Union Agency for Fundamental Rights* (FRA, 2014) concluded that "*one in five women aged fifteen or older had at some time in their lives experienced DV.*"

Among Latina and African American women in the US, the prevalence of rape, physical violence and stalking by intimate partners is much higher than experienced by white women (Breiding, Chen, and Black, 2014). Almost 70% of adolescent women are at increased risk of experiencing DV before they reach the age of twenty-five. A quarter experience partner violence before reaching their eighteenths (Black, Basile, Breiding, Smith, Walters, Merrick, et al., 2010). Pregnant adolescents have higher rates of physical DV victimisation than non-pregnant girls or older mothers (Saltzman, Johnson, Gilbert, and Goodwin (2003).

The drug use among female DV victims who participate in drug treatments ranges between 25% and 57%. Compared to community-based samples, the difference is considerable: 1.5-16%. Nevertheless, it is not yet clear whether there is a causal relationship between the consumption of drugs resulting in DV, or alternatively, experiencing DV leads to increased use (El-Bassel, Gilbert, Wu, Go, and Hill, 2005).

Early scientific literature considered that the excessive use of drugs was mainly a male problem, and accordingly, studies were conducted using male participants. However, subsequent studies revealed that women have as many substance use disorders as men. In fact, the number of female users increased steadily (Tuchman, 2010), and DV can explain that rise.

There is also a relationship between drug misuse, DV, and health problems affecting all family members. Addictions and violence occurring during pregnancy signify high risks for mothers and negative implications for unborn children (Siegel and Brandon, 2014); it affects the relationship between parent-children, especially mother-child, which has consequences for the child's development.

From a young age, women with histories of victimisation experience severe traumas and violence in relationships throughout their lives. The abuse of drugs (e.g. opioids and tranquillizers) can be a mechanism for coping with these traumatic experiences or self-medication for various body/mind pains (Andrews, Motz, Bondi, Leslie and Pepler, 2019). Recently, pain management during pregnancy and the postpartum period involves a high dosage of oral opioids (e.g. by a caesarean delivery) that exposes women to addictive medications. Doctors quickly prescribe large numbers of pills that may be misused for purposes other than they are meant for and might lead to daily use and addiction (Ecker, Abuhamad, Hill, Bailit et al., 2019).

Considering that women are generally children's primary caregivers, the devastating consequences on entire families and societies due to women's use of illicit drugs cannot be underestimated. Unfortunately, dysfunctional relationships where violence is present may trigger drug abuse or relapse. Some of the dysregulations that may occur due to drugs taking in combination with DV are that DV during pregnancy increases miscarriages, pre-term deliveries, and stillbirths. Prenatal substance abuse is related to adverse gestational events, complications in delivery, and babies born with low weight (Alhusen, Lucea, Bullock, and Sharps, 2013). Some studies have found associations between deficient birth weight babies (VLBW <1500 g) and psychopathology during the developmental cycles up to adulthood. For instance, depression (Alati et al., 2007; Gale and Martyn, 2004; Hack et al., 2004; Wiles et al.,

2005), and Attention Deficit Hyperactivity Disorder (ADHD) (Franz, Bolat, Bolat, Matijasevich, Santos et al., 2018).

In the post-partum period, mothers who use drugs and experience DV show a lowered attachment to their infants and reduced parental functioning. Mothers can become overly permissive, show a lack of emotions, or give insufficient protection and support to the child. Alternatively, they may act hyper-vigilant and controlling because their psychological functioning is impaired (e.g. difficulties in emotion regulation) (Cataldo, Azhari, Coppola, Bornstein and Esposito, 2019).

Children living in violent households with drug-dependent parents are at risk of being abused or neglected (Murphy, Harper, Griffiths and Joffrion, 2017).

2) Drugs dependency in men

DV and substance use co-occur in every culture, having severe emotional, physical, and psychological effects on individuals and their families. In a meta-analytic review from 285 studies, researchers found that men's drug use is significantly related to DV perpetration and victimisation (Belanger, Mathieu, Dugal, and Courchesne, 2015). Problematic drug use was robustly correlated with DV perpetration. Surprisingly, the types of drugs used were not significant (Cafferky, Mendez, Anderson and Stith, 2016).

The *US Department of Health and Human Services*, in their *National Survey on Drug Use and Health* (NSDUH, 2013), reports that males are more likely than females to abuse marijuana, cocaine and hallucinogens. Drug dependency in men almost doubles that of women (men 10.85 against 5.8% in women). Between 40 to 60 % of intimate partner violence episodes involve alcohol or drug abuse (Soper and Jones, 2014), but only 20 per cent of males admit to using drugs. Drug abuse may increase aggression that leads to legal or family pressures to seek treatment. Behavioural treatment is favourable because it guides new coping mechanisms to deal with anger, risk-taking behaviour, and aggression (NSDUH, 2013).

3) Drugs dependency among LGBT+ individuals

Illicit drug dependency among sexual minorities, both adolescent and adult groups (e.g. LGBT+ individuals), is high across all ages. There is an over-representation of Black gay men having an HIV diagnosis in the USA (CDC, 2019); these men are also more likely to live in poverty and not utilise healthcare services. They find barriers to access the system compared to other gay (white) men when they do. Sometimes HIV is not detected, and lack of diagnostic means that they are not virally suppressed (Peterson et al., 2008). The combination of substance abuse and intimate partner violence affects their vulnerability to HIV.

In a qualitative study of 30 participants by Maiorana et al. (2020), researchers found that many participants in the age group 19-29 had not completed high school and had limited employment skills. Some participated in the sex economy and other street economies, such as dealing drugs, selling stolen merchandise, and shoplifting. Only a few of them had a steady job. They lived in precarious homes and had dysfunctional family environments (e.g. parents had addictions or a history of incarceration).

Young adult lesbians are two to five times more at risk of having problems with drugs abuse or dependency than heterosexual peers. It is not yet clear why women rather than men from minority sexual groups are at most significant substance abuse risks. According to the theory of minority stress (Meyer, 2003), individuals of minorities groups experience repeatedly harmful interactions, often lifelong social stress due to stigma and discrimination. Those stressors can cause adverse mental health outcomes like depression, anxiety and sometimes psychosis because the self-worth of the affected persons diminishes, making them susceptible to poor mental health, sickness, or substance abuse (Bhui et al., 2005).

Conclusion and recommendations

Worldwide, one in ten individuals suffers from drug use disorders, including drug dependency that implies risks to their health due to sharing syringes, making them vulnerable to acquiring HIV or Hepatitis C infections. However, only one in six persons with drugs dependency has access to a treatment that is effective. In many countries

globally, people with drug use disorders are seen as a criminal justice problem instead of a health problem and are not sent to recovery programmes for rehabilitation

We know from research that drug dependency in any population of women, men and LGBT+ people of all ages influences their lives. Individuals with histories of severe victimisation in relationships throughout their lives have traumas. Drug abuse can be a mechanism for coping with traumatic experiences or as self-medication.

For pain management, doctors prescribe too quickly large numbers of pills that may be misused for purposes other than they are meant for and might lead to addiction. During pregnancy and postpartum high dosages of oral opioids expose women to addictive medications. Mothers suffering from DV and having substance abuse problems cannot care responsibly for their children.

It would be convenient to offer direct support and an efficient assistance network for women and their children to avoid further victimisation, (sexual) harassment, or stalking from abusive partners and ex-partners. For men, detoxication programmes, psychological help, and behavioural treatment can help them avoid risky behaviour and control their anger and aggression. LGBT+ populations can also use all these measures to help end drug misuse and violence affecting whole societies.

2.6 Victims health problems

Millions of women globally are affected by the violence that intimate partners inflict on them. Many female victims have been abused or maltreated as a child, are survivors of other crimes or cultural victimisations, have presently, or had in the past mental health problems. Among the severe mental problems victims of DV suffer, we can mention post-traumatic stress disorder (PTSD) (Hanson Frieze, Newhill, and Fusco, 2020).

In this section, the following topics are analysed:

1) Mental health problems

2) Health problems treated in emergency rooms (ER)

1) Mental health problems

Violence escalating to life-threatening levels, forced intercourse, or other physical severe harms and coercive behaviour can lead to traumas. Women with PTSD are often diagnosed with other lifetime traumas such as sexual violence, neglect and maltreatment during childhood (Warshaw, Brashler and Gil, 2009).

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) considers terrorising behaviour a 'traumatic event' (APA, 2013). An overwhelming quantity of women who require urgent shelter protection are victims of such traumatic events (Bargai et al., 2007).

From data gathered for research purposes in different studies, it comes to light that female survivors of DV have more mental health problems than non-abused females and are susceptible to chronic pain, depression, substance abuse, somatic complaints, and suicide (Black et al., 2011; Iverson et al., 2012). Exposure to trauma influences the victims' physiological and psychological functioning. Abusive relationships increase the likelihood of mental health symptoms. At the same time, having mental problems also increases the risk of being abused or revictimized (e.g. a husband threatens his wife to take custody of the children and send her to a psychiatric facility) (Oram, Trevillion, Feder and Howard, 2013). Although the medical community in Western countries responds adequately to female patients' somatic public health problems suffering from DV, psychiatric health treatments are not always available for vulnerable individuals, not even in wealthy countries. There is also a lack of programmes to systematically screen DV survivors. Sometimes, victims do not search for help because of economic reasons. In many countries, mental healthcare is expensive due to cultural stigmas about psychiatric patients or simply because they have other more urgent priorities than counselling (e.g. safety, housing, childcare) (Simmons, Lindsey, Delaney, Whalley and Beck, 2014).

As Simon et al. (2014) warn, there could be negative implications for using psychiatric diagnostic labels by high vulnerable populations. DV perpetrators can potentially use

psychiatric labelling to discredit the victim in custody battles, by police and the court, or even by co-workers and family.

2) Health problems treated in emergency rooms (ER)

Healthcare systems, especially in emergency rooms (ER), are where DV victims are provided support for their injuries that can vary in severity. Research by Singhal et al. (2021) found that from 2012-2016, there were 10,935 DV related visits to the ER in Ontario, Canada (Singhal, Orr, Singh, Shanmugarantha, and Mason, 2021): 81.2% by females and 18.8% by males. These results are consistent with other international studies' findings (Boyle, Robinson, and Atkinson, 2004)

The visits due to physical injuries were primarily body injuries, for instance, craniomaxillofacial (50.5%); injuries to the neck, thorax, abdomen, spine and pelvis; limbs; injuries in multiple body regions; and a small per cent corresponded to burns and corrosion, N= 21 (0.6%).

The cases reported to the police are estimated to be much lower than the actual occurrence of violence. Still, victims do not always ask authorities for help due to fears of retaliation or shame (Perreault, 2014).

Conclusion and recommendations

The high prevalence of DV and the visits to hospitals' emergency rooms or clinical settings give us an idea of the problem. Injuries to the victims and the costs incurred by health institutions are visible in statistics. However, it is worth noticing that not all cases of violence are reported to the police, and many women do not disclose their problems to healthcare personnel. Patient-physician encounters are troubled by a lack of communication from both sides. The patient and the doctor make a barrier to identifying DV/IPV issues and solutions. Although there are training possibilities and interventions to help patients, none of those efforts has yet sustained improvements. Either because of the reservations women have to disclose their situation openly or

because physicians' lack of knowledge of DV does not equip them to give non-judgemental support or provide the victims with the help they need.

Chapter 3 Psychopathology associated with domestic violence

Every survivor of DV responds differently to what they have experienced (e.g. physical injuries, psychological abuse, sexual violence, coercion). The implications of such violence are widespread and involve health problems, and violate human rights (World Health Organisation, 2014). Besides, children who witness DV are affected. They show emotion dysregulation and social dysfunction, creating long-term problems when confronted with emotions such as avoidance or withdrawal (Morris, Silk, Steinberg, Myers and Robinson, 2007).

This chapter will discuss the most common health disorders experienced by victims of DV. Among those disorders, we can mention:

3.1 Attention Deficit Hyperactivity Disorder (ADHD).

3.2 Antisocial Personality Disorder.

3..3 Battered Women Syndrome.

3.4 Borderline Personality Disorder.

3.5 Depression.

3.6 Post Traumatic Stress Disorder (PTSD), and

3.7 Risks of Suicide.

3.1 Attention-Deficit/Hyperactivity Disorder (ADHD)

Both adults and children can be diagnosed with ADHD when they manifest problematic behaviour that interferes with their academic, social, and occupational functioning (APA, 2013).

ADHD exists in all cultures (approximately 5% of children and 2.5% of adults worldwide) and often co-occurs with delays in motor, language and social developments, as well as with cognitive problems. By young children (toddlers) before the age of four, it is difficult to diagnose ADHD because children have elevated motor activity at that age. ADHD is easier to identify during elementary school because children's inattention is prominent (APA, 2013).

Worldwide, ADHD is a common childhood psychiatric disorder with prevalence rates ranging from five to seven per cent (Du Rietz, Pettersson, Brikell, Ghirardi et al., 2020; Polanczyk, Willcut, Salu, Kieling, and Rohde, 2014). When bodily or psychological impairments limit daily activities such as school or work, individuals' social participation in society is negatively affected. A lack of self-control and impulsivity characterise the interaction of children with ADHD with other children or adults. Children also show difficulties paying attention or complying with adults' directions (e.g. teachers, parents). At school, children with ADHD are at risk of educational underachievement due to learning problems that may cause them to repeat a grade or leave school without achieving a degree that has deleterious consequences in their lives (Loe and Feldman, 2007).

Several studies have demonstrated that the impulsivity and hyperactivity components of ADHD in childhood accurately predict future delinquency (Zinkstok and Buitelaar, 2014). ADHD is, therefore, a risk factor for delinquency, especially when the individual also has problems related to conduct disorder (CD) and has an antisocial personality disorder in adulthood (ASPD) (Pardini and Fie, 2010).

In the general population, males are more often than females diagnosed with ADHD (approximately a ratio of 2:1 in children and 1.6:1 in adults) (APA, 2013). Nevertheless, Biederman, Kwon, Aleardi, Chouinard, et al. (2005) assert that the possible

explanation for the smaller number of girls diagnosed with ADHD might be explained by the fact that girls show lower levels of disruptive behaviour and learning disabilities (e.g. mathematics or reading) than boys. These differences in behaviour between girls and boys may cause referral biases, especially in the boys paediatric ADHD population (ratio 10:1) (Biederman et al., 2005).

According to APA (2013), females are more likely to present only the attention deficit features. The *Diagnostic and Statistical Manual of Mental Disorders-5th Edition* (DSM-5) stipulates that to be diagnosed with ADHD, symptoms are to be manifested in various settings (e.g. home, school, work) for at least six months (APA, 2013).

The main characteristics for both adults or children with ADHD are:

1) Inattention:

Individuals have a lack of accuracy at work or school (e.g. make too many mistakes). Have difficulties in keeping the attention in what they must perform and with organising or planning activities. In their daily activities, they are easily distracted and often forgetful (e.g. returning calls, keeping appointments, paying bills, meeting deadlines), are not keen on engaging in tasks requiring arduous mental efforts (e.g. preparing reports and reading lengthy papers. They lose things necessary for the performance of activities (e.g. keys, eyeglasses, school material, paperwork, mobile phone) (APA, 2013).

2) Hyperactivity and Impulsivity:

Individuals with ADHD are unable to stay quiet (as if they are “driven by a motor”); as a result, they exhaust others with their hyperactivity (APA, 2013). Hyperactivity such as climbing and running, often seen in young children, sometimes decreases during adolescence. Nevertheless, restlessness and impatience usually persist into adulthood (APA, 2013).

Individuals with ADHD have difficulties in waiting for their turn. They act restlessly in situations that require that the person remains seated or pays attention. They interrupt others in conversations; talk excessively; complete people’s sentences or give

answers before the question is finished; jump into conversations without being invited to do so, use other people's belongings without consent or permission (APA, 2013).

Genetic factors are considered to be one of the leading causes of ADHD. Research shows that genes play a significant role in ADHD's aetiology (Adler, 2020) and other broad spectra of neuropsychiatric conditions (Lahey, Van Hulle, Singh et al., 2011). Twin, family and adoption studies support the heritability component (70-80%), while studies using self-ratings show a lower heritability (<50%) (Faraone and Larsson, 2019; Franke et al., 2018). Nevertheless, environmental factors such as malnutrition, alcohol exposure in the uterus, smoking during pregnancy, history of child abuse, foster placements, neglect, infections (e.g. encephalitis) are all risks factors (APA, 2013). Children's exposure to environmental toxins (e.g. lead and pesticides) increases the risk of developing ADHD (Nigg, 2006).

ADHD is considered a risk factor for DV (Buitelaar, Posthumus and Buitelaar, 2015). Managing conflicts and compromising are essential elements in any romantic relationship, but individuals with ADHD, both men and women, lack those qualities. Adults with ADHD also have difficulties listening or paying attention to their partners. They often react with physical and verbal aggression, making them vulnerable to perpetrating DV or being victims (Wymbs and Dawson, 2014). The combination of ADHD sensitivity to partner provocation, behaviour characterised by hyperactivity/ impulsivity and a lack of anger management often results in high separation or divorce rates (Kessler et al., 2006).

A study found that approximately 74% of DV's offenders with ADHD had not been diagnosed with ADHD before (Buitelaar and Ferdinand, 2016). The missing diagnostics might be explained by the fact that only around the 1980s, the diagnosis for ADHD was possible when it was first published in the *Diagnostic and Statistical Manual of Mental Disorders 3rd Edition*. Therefore, older individuals have never been diagnosed with ADHD before this date.

The missed ADHD number of clients in forensic settings of outpatient samples is calculated to be around 56 per cent. This lack of diagnosis for DV perpetrators has

clinical implications for possible future treatments for ADHD individuals with other comorbid psychiatric disorders (Buitelaar and Ferdinand, 2016).

Several studies have demonstrated that the impulsivity and hyperactivity components of ADHD in childhood accurately predict future delinquency (Zinkstok and Buitelaar, 2014). ADHD is, therefore, a risk factor for delinquency, especially when the individual also has problems related to conduct disorder (CD) and has an antisocial personality disorder in adulthood (ASPD) (Pardini and Fie, 2010). ADHD, in particular, is associated with impulsive or reactive violent aggression (Retz and Rosler, 2009). Some studies have found an association between childhood and adult ADHD and adult IPV, sometimes mediated by ASPD (Zinkstok and Buitelaar, 2014; Gonzalez, Kallis and Coid, 2013).

3.2 Antisocial Personality Disorder (ASPD)

In the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5*), ASPD is grouped in Cluster B of Personality Disorders (American Psychiatric Association, 2013).

Although the precise aetiology of ASPD is unknown, some researchers try to explain its aetiology as a behavioural pattern learned in childhood. ASPD diagnosis is linked to severe adverse childhood experiences (ACEs) such as neglect, physical and sexual abuse, or childhood psychopathology, affecting the (mental) health and behaviour across the lifespan. ASPD has a biological and environmental basis (DeLisi, Drury and Elbert, 2019).

ASPD is a severe personality disorder associated with a persistent disregard for others, and the violation of other's rights, including failing to conform to social norms (e.g. lawful behaviour) (Armenti, Snead, Babcock, 2018). Individuals with ASPD are manipulative, characterised by irresponsibility, lack of remorse, recklessness for self or others; they are deceitful, impulsive, irritable and aggressive (DeLisi, Drury and Elbert, 2019). They also have increased risks of alcohol and drugs abuse. Men with ASPD traits and substances abuse are at an increased risk for DV/IPV perpetration.

They tend to be violent towards intimate partners (Armenti, Snead, Babcock, 2018) and use aggression to resolve conflicts and maintain power and control in their relationships (APA, 2013; Badcock, Jacobson, Gottman and Yerington, 2000).

The disorder is more common to be diagnosed in males than in females; in many prisons settings, ASPD is over-represented, 50% for men and 20% for women (Fazel and Danesh, 2002).

ASPD individuals can be irresponsible as parents. For instance, by malnutrition of their children, children contracting illnesses due to a lack of minimal hygiene; relying on others for food or shelter because they repeatedly spend the money required for household necessities on something else, or by leaving children alone when absent from home (APA, 2013). The prevalence of ASPD is the highest in samples of low socioeconomic (e.g. poverty) or socio-cultural factors (e.g. migration) in clinics, prisons, or other forensic settings (over 70%), among severe samples of males with alcohol use disorder and from substance abuse.

3.3 Battered Women Syndrome

The clinical psychologist and feminist Dr Lenore Walker (1979; 1992; 1999; 2012; 2017) started more than forty years ago her research on the psychological effects that severe and frequent violence causes on abused women. Although her investigation is still in progress using new facts and instruments, the original studies presented here give a good insight into how psychology can help understand and assist women suffering from traumas and victimisation.

Walker conducted interviews during three years (July 1978 to June 1981) with four-hundred and thirty-five abuse victims from the USA's Rocky mountains area. With that ground-breaking data, Walker identified mainly sociological as well as psychological factors associated with DV. It also permitted her to test Martin Seligman's '*Learned Helplessness Theory*' (which was an extension of Seligman's interest in depression). Seligman's theory (1967) was initially tested on animals in

laboratory conditions. The animals in the experiments received electric shocks and reacted, after some exposures to the shocks, as if they were giving up, accepting passively the traumatic situation they were experiencing. The heavy traumatised animals became paralysed and unable to escape the painful conditions they were submitted to, even when escape was possible.

Meier and Seligman (2016) proposed that learned helplessness occurs in humans and animals, but the psychological processes are different. The experiments with humans did not use electric shocks; that would have been unethical, but sounds.

This section focuses on human learned helplessness (a cornerstone in Walker's original research), specifically related to battered women's perceptual distortions in feelings. For instance, due to experiences learned in childhood occurring without their control, some women might under-develop a sense of self-efficacy when confronted with violence. Pessimistic thoughts can hinder effective responses when women believe they cannot control what is happening to them (Walker, 2017).

Based on the insights gained from Seligman's theory, Walker hypothesised that women who are battered for extended periods react passively or become hyper-vigilant on avoiding the batterer attacks. By using that tactic, they fail to abandon their attackers (Walker, 1979).

Walker introduced the term "*Battered Women Syndrome*" (BWS) in the late seventies. Presently, BWS is considered a *subcategory of PTSD, also known as 'Battered Spouse Syndrome' and 'Domestic Abuse Syndrome*' to explain the behavioural and cognitive patterns of victims of abuse (McMahon, 1999; Fair, 2018). BWS could also explain the psychological mechanisms involved in violent relationships, and the symptoms of a woman exposed systematically to verbal, emotional, and physical violence (Craven, 2003).

The Battered Women Syndrome (BWS) could account for why a woman, after long periods of exposure to psychological and physical maltreatment, intends to kill or actually kills her abusive partner. BWS does not constitute a criminal defence of itself, but psychologists and psychiatrists are occasionally permitted to instruct the jury and

judges at the Court about the syndrome. A mental health expert can explain the woman's state of mind at the time of the violent incident (Walker, 2012).

Since there were at the beginning many myths and misconceptions about battered women among jury members and judges, which hindered the application of self-defence criteria, expert testimony was therefore crucial to explain the circumstances under which some battered women resorted to lethal force in order to make a successful assertion of self-defence.

BWS explains why battered women may have acted in self-defence to protect themselves and their children when they use violence resulting in their partners' death, even though the circumstances were not the expected confrontational self-defence. For instance, the husband was at the moment of the (deadly) attack not directly battering her, but he was, for example, asleep (Walker, 1992). This phenomenon can be explained by the fact that when a battered woman is so highly traumatised by her abusive partner, she believes herself to be in danger even when she is safe (Orenstein, 2014). One example of the use of the BWS as a defence in a New York court was the case of Barbara Sheehan in 2008, who shot her husband Raymond Sheehan, a retired police officer, with his gun as he was shaving in the bathroom (the gun was next to him on the vanity). Barbara suffered DV for many years (e.g. head injuries, he threatens repeatedly to kill her, he became progressively more violent and menacing). Although he was not battering her at the moment, she shot him dead. She claimed to be acting in self-defence, protecting herself from his violence. The jury found Barbara Sheehan not guilty of second-degree murder, and she was acquitted of the homicide charges (Colb, 2011).

The *Battered Women Syndrome* became a new tool to highlight the devastating emotional distress that violence brings into women's and children's lives. Lawyers use the syndrome to defend their female clients (Walker, 1999). Before the BWS appearance, a woman who killed her husband was encouraged to plead guilty to murder to lower her sentence. Only in a few cases could women use insanity as a defence. The BWS's psychological explanations on homicides made it possible to meet the legal standard of self-defence (Walker, 1999).

In recent years, many courts have become increasingly interested in the *Battered Women Syndrome* when a woman is repeatedly subjected to long-term abuse and commits murder or manslaughter against her abuser. Courts accept expert testimony when it confirms that the act was reasonable because it resulted from the exposure to continuous threats of serious harm to her (Weskalnies, 2018). Nevertheless, in many situations, some women will have difficulties in establishing a claim of self-defence due to the traditional interpretation of what self-defence is - often the idea of a woman facing imminent death by the hand of her husband, so she strikes out at the last moment before being killed and kills her attacker - (Faigman, 1986).

For a long time, there were several myths and beliefs about battered women as uneducated, unskilled, coming from a low class, and deserving to get beaten (Walker, 1979). In her study, Walker (1979) found that all ages, education levels, and socioeconomic status were represented in the sample of battered women participating in her research. However, those women had common characteristics such as having low self-esteem, suffered from guilt, experienced a passive view of the world, believing that no one would help them, and tended to downplay or minimalize their husbands' responsibility (Walker, 1979).

Nevertheless, many of the interviewed women were intelligent, competent and well-educated, and they felt relieved when they terminated the violent relationship (Walker, 2017).

Myths also existed about battering men; if they beat women and children, they were considered psychopaths or alcoholics (Walker, 1979). In reality, the best predictor of future violence by those men is a history of past violent behaviour such as violence against animals (pets), other people, having criminal records, and having shown previously violence against women (Walker, 2017).

Walker also established that the husbands of those battered women came from violent homes themselves, were extremely jealous and possessive, had a history of temper tantrums, were manipulative, charming and seductive to get what they want it but were very hostile when they did not succeed (Walker, 2017). Besides, those men often had strict and punitive fathers and inconsistent mothers (Walker, 2017).

Walker (1979) proposed that wife battering occurs in three stages:

Phase 1) "*The tension-building phase"*: Tension builds up slowly, and the conflicts are low-level; minor verbal or physical episodes occur. The victim avoids escalation of violence, trying to calm her husband down for short periods of time. By so doing, she keeps the peace at home, giving her the feeling of control over the batterer's behaviour. In this cycle, she believes that she will not be beaten up if she behaves 'better'. She becomes extremely alert to her husband's moods, and she places his needs above hers.

Battered women report that the psychological battering they are submitted to is even more damaging than the severe physical harm their husbands inflict on them. Eventually, due to chronic stress, she withdraws and avoids any situation that may set off his explosion of anger. The abuser may feel angry or neglected and tries to find justifications for his actions.

Phase 2) "*The acute battering incidents*": In this phase, frequent serious conflicts culminate in out-of-control physical, psychological, emotional, and sometimes sexual abuse. The batterer goes into a blind rage and inflicts severe injuries against the other partner. All that anger explodes suddenly. The victim's only purpose is to survive: She lives in fear of his unpredictable but yet inevitable coming attack. Escape is not her primary goal. Many battered women love their husbands, and they do not want to leave the relationship for fear of loneliness. Besides, they often blame themselves for the violence their husbands inflict on them.

The final stage of this repetitive cycle is:

Phase 3) "*Period of (loving) contrition or 'Honeymoon period'"*: After a severe abuse that might end for the battered woman in a hospital room due to serious injuries, the battering partner may try to win her trust and affection, for instance, by delivering flowers and gifts to the hospital, or by promising her to seek professional help, professing love, being apologetic and remorseful. This phase makes it possible for the victim to develop an emotional attachment once again, and she does not leave the relationship. The battered partner sees only the good side of the batterer and makes excuses for his aggressive behaviour. Inevitably, the period of loving contrite ends and

once again merges into a period of minor battering. The cycle begins again (Walker, 1979).

According to Walker (1979), only if the cycles of violence are repeated many times (at least twice) can it be claimed that someone is suffering from BWS.

Some people would ask, firstly, why did she kill the husband instead of just leaving him? Secondly, why did she not involve the police or ask for help from friends and family? Regarding the first question, in many cases, the battered woman has indeed contacted the police before the deadly incident, but the officer was reluctant to intervene.

The second question can be answered by the fact that severe battering affects the perception of women about their social network, and those perceptions can be biased, resulting in uncertainty for her whether she can rely on her network for support in a time of need or not (Coohey, 2007). There are also other reasons for women to stay in the relationship, for instance: Fear that the abuser, as a means of retaliation, might harm the children or other family members, friends or work-colleagues if she leaves him. From previous experiences, she might know that she will be severely beaten up if she tries to leave the relationship. Economic dependency is also a factor to stay. Instead of leaving, the victim develops strategies to avoid making him angry; she may become hyper-vigilant at any signs that could be the start of another assault.

Although it is difficult for most laypeople to understand the unusual bond battered women have with their batterers and the reasons they give for not leaving the relationship, it would be desirable that personnel working with these women (e.g. social workers, shelter's employees, healthcare providers) do understand the dynamics of intimate partner violence to be able to give appropriate responses to battered women's needs.

Members of the justice system and policymakers ought to be aware of the long-term effects that complex traumas resulting from DV have on women. Women suffering from violence should be protected and offered the security they need by facilitating legal, psychological and economic help. Making therapy readily accessible has the advantage of learning new skills to free themselves from violent relationships and begin

a ‘new and normal’ life without battering or fears, leaving behind their feelings of helplessness, guilt or low self-esteem.

3.4 Borderline Personality Disorder (BPD)

BPD is a relatively highly prevalent psychiatric disorder associated with compelling psychosocial impairments, affecting approximately 2-6% of the general population (Michael, Chennells, Nolte, et al., 2021). BPD is characterised by emotional instability, disrupted self-image and identity, fear of abandonment, unstable relationships, self-injurious behaviour (e.g. self-mutilation by cutting or burning; suicide attempts or suicidal ideation), and marked impulsivity beginning by early adulthood (Euler, Nolte, Constantinou, Griem, Read Montague, and Fonagy, 2019).

BPD in males is associated with interpersonal violence and other criminal behaviour (Bayes and Parker, 2017).

BPD is also associated with significant impairments and disabilities. Males and females who come in contact with justice systems due to DV or other criminal behaviour and suffer from BPD tend towards risky behaviour (Sijstema, Baan, and Bogaerts, 2014). Mainly they act out emotional distress with violent behaviour because they have difficulties regulating their emotions and use maladaptive ways of responding to emotions (Dixon-Gordon, Weiss, Tull, DiLillo, et al., 2015). Therefore, it is convenient to explain the triggers to social impairments in individuals suffering from BPD to improve interventions for these populations. The source of social deterioration in relationships is already known to be associated with a biased manner to process information (Roepke, Vater, Preissler, Heekeren and Dziobek, 2012; Niedfeld, Renkewitz, Medäbach, Hillman, Kleindienst et al., 2020).

In most clinical settings, BPD is less diagnosed in males than in females (APA, 2013). Nevertheless, studies in forensic settings have found high prevalence rates in males (Wettenborg, 2015).

3.5 Depression

In a global context, the number of individuals suffering from depression (females, males and children) is estimated to be 322 million (in 2015). The number of affected individuals is growing, especially in low-income countries. Approximately 4.4% of the total world population suffers from depression, and its occurrence is more common in women (5.1%) than in men (3.6%) (World Health Organisation, WHO 2017).

Depression is characterised by changes in somatic and cognitive levels and sad, empty, and irritable moods (American Psychiatric Association, 2013), affecting individuals' functioning. Substance abuse, prescribed medications and physical conditions are also associated with depressive disorders (APA, 2013).

The topics discussed in this section are:

1) Prevalence of depression.
2) The association of depression and domestic violence.
3) Depression in mothers during pregnancy.
4) Depresion in adolescence.

1) Prevalence of depression

The WHO (2017) considers depression the most significant contributor to disability and the cause of suicide deaths (estimated at 800,000 a year). Although depression affects people of all age ranges, the incidence is highest in older female adults (7.5% among females aged 55-74 years). By males, the percentage lies above 5.5%. Depression affects all social strata. However, it is believed that poverty, unemployment, bereavement (e.g. due to the death of a loved one), physical illness, and addiction problems (e.g. drugs and alcohol) are the most frequent causes for the manifestation of this mental health in both men and women. Depression is often accompanied by other mental disorders (e.g. anxiety); females (4.5%) are more affected than males (2.5%) (WHO, 2017). There is compelling evidence about the relationship between abuse in relationships and depressive symptoms (Al-Modallal, Peden, and Anderson, 2009).

2) The association of depression and domestic violence

Depression is consistently associated with DV and is manifested by the loss of interest or joy in daily-life activities (Flint, Green span, and Kendler, 2020), diminished concentration, low self-worth, decreased energy, sleep disturbances, eating disorders, and suicidal thoughts (WHO, 2017).

Females exposed to chronic traumatic stress due to violence experience fears, hopelessness, feelings of despair and isolation, which increase the risk of developing symptoms and disorders related to depression. Suicide attempts among battered women are more likely than non-abused women (Reviere, Farber, Tworney, Okun, Jackson and Zanville, 2007).

There is evidence pointing to a link between DV and depression. A possible explanation is that there are different constellations in the relationship between DV and depression. Sometimes DV causes depression in women (that elevates either the ideation of suicide or the suicide attempts); in other cases, women who experience depression are at an elevated risk of DV victimization. A third explanation is that suicidality is a common risk factor for DV and depression (DeVries, Mak, Bacchus, Child et al., 2013). If battered women do not receive proper treatment for depression, there is the risk that they might see suicide as the only way out (Khodabandeh, 2019).

3) Depression in mothers during pregnancy

Women with histories of violence during their prepartum period, predominantly low-income pregnant adolescents, are at the most significant risk of depression and poor mental health in the period of postpartum, also called postpartum depression (Kendall-Tackett, 2007). *Postpartum Depression* in mothers is associated with parental deficiencies towards their children, negatively affecting children's cognitive, emotional and behavioural development (*Centre on the developing child at Harvard University*, 2009).

Depression in mothers during pregnancy, dysfunction in families, and harmful living environments (e.g. conflictive relationships, mental illness and substance misuse of one or both partners) often co-occur, resulting in adverse effects on children, who are

at risk of being neglected or maltreated. Both have harmful long-term effects on mental health as adolescents and adults). Compared to the impact of family dysfunction, maltreatment has an invasive adverse effect on children's lives (Atzl, Narayan, Rivera and Lieberman, 2019; Narayan et al., 2017). Nevertheless, children with adverse childhood experiences (ACEs) and chronic stress are likely to suffer physical and psychological damages. Consequently, their mental health across their lifespan worsens (De Bellis, Nooner, Scheid and Cohen, 2019).

A history of ACEs increases the risks of DV perpetration in adulthood (Roberts, McLaughlin, Conron and Koenen, 2012). Men with high ACEs are 8.8% more likely to perpetrate DV compared to men with no ACEs. The percentage of perpetration by women with high ACEs is around 14.3% compared with 2.5% in low-level adversity groups (Roberts, McLaughlin and Koenen, 2011).

Individuals who have experienced at least four adverse childhood experiences in adulthood show impaired cognitions, violence, problematic substance abuse, and low social and emotional functioning than individuals without ACEs. ACEs also represent a risk for future generations (Hughes, Bellis, Hardcastle, Sethi, et al., 2017).

4) Depresion in adolescence

Western societies are confronted with a growing number of adolescents suffering from depression, which has become a growing worldwide problem because it affects their mental health and well-being. Depression in adolescents implies frequent physical and psychological health problems, which diminishes their quality of life (Bertha and Balazs, 2013), it is costly to the healthcare services (Wright et al., 2016), and represents a high risk for suicide attempts (Lewinsohn, Rohde and Seeley, 1994).

The number of adolescents who develop major depressive disorders (MDD) before reaching adulthood has increased by 23% between 2005 and 2014 (Mojtabai, Olfson and Han, 2016). Depression also affects adolescents school attendance. The more depressed individuals are, the fewer school achievements they will realise (King and Bernsterin, 2001), negatively impacting mature adulthood (Costello and Maughan, 2015). It is estimated that in the UK. 2.1% of children and adolescents suffer from

depressive disorders (Sadler, Vizard, and Ford, 2018). Disorders usually have adverse psychosocial outcomes such as low educational attainment (e.g. failure to complete education; poor grades at school), having long-term negative consequences predicting unemployment, risks of homelessness and poor health (Almquist, 2013) that might result in suicide attempts (Sörberg, Zeebari, Lager, et al., 2018).

As mentioned earlier, the spiral of violence occurring at dysfunctional homes where mothers are battered, or otherwise, couples use violence against each other, often results in harmful consequences for all family members.

Mothers who are depressed due to intimate partner violence are less available to their children or use inadequate parental strategies that negatively affect their children's development. Adverse childhood experiences (ACEs) are predictors of mental health disorders like depression, susceptibility to the use of drugs or alcohol, increase risk of DV perpetration in adulthood, to name just a few disadvantages of having experienced ACEs. Poor performance at school caused by depression or other mental health problems is acted out by children and adolescents through diverse problematic behaviour and low grades, resulting in further negative impacts on their lives.

3.6 Post-Traumatic Stress Disorder (PTSD)

In the nineteen-eighties, the *American Psychiatric Association* (APA) formalised PTSD as a diagnostic category, acknowledging the impact of trauma or other life-threatening, stressful experiences on people's functioning. The diagnostic category also stimulated research on psychological trauma and possible treatments for PTSD since traumas can lead to chronic dysfunction. The latest version of the DSM-5 states that PTSD can be present in adults, adolescents and children when they have experienced traumas or witnessed traumatic events occurring to loved ones or close friends. For a distressing event to be considered a PTSD, the following symptoms are deemed to be present: Involuntary and recurrent memories related to the traumatic event; distressing dreams about the event; flashbacks where the person re-enacts what has happened to them; they suffer psychological stress when cues that resemble the trauma appear;

the individual avoids distressing memories or external reminders of the trauma (e.g. people, places, situations). PTSD is also associated with alteration in moods, harmful emotional modifications, and cognitions such as anger, guilt, shame, feelings of detachment and the inability to experience joy or love (APA, 2013).

The following topics will be analysed here:

1) The criteria to diagnose PTSD.
2) Prevalence of PTSD.
3) Psychological, physical, and sexual DV and PTSD among ethnic minorities.
4) PTSD in immigrant women.
5) PTSD in women staying in shelters.

1) The criteria to diagnose PTSD

There was already at that time a consensus about aversive events causing psychological traumas ranging from mild to severe, lasting a short time (several months) or many years (Bonanno and Mancini, 2012). An example was the case of earthquake survivors who presented signs of PTSD ten years after the earthquake (Bland et al., 2005). Nevertheless, controversies remained about trauma's definitional and etiological issues, especially war-related dysfunction (Lamprecht and Sack, 2002).

According to Mahoney, Lynch, and Benight (2019), although 90% of adults experience one or more traumatic events in the course of their lives, only 8% meet the PTSD criteria introduced in the DSM-5. Women are the most affected by PTSD concerning sexual violence (e.g. any non-consensual sexual advances) compared to other types of trauma exposure that are not interpersonal such as traffic incidents or a natural disaster (Cloitre et al., 2009). PTSD is the most frequent mental disorder among women who have experienced sexual trauma exposure (Mahoney, Lynch, and Benight, 2019). PTSD can also occur after traumatic situations of various kinds such as war, torture, sexual trafficking, threatening illnesses, natural disasters, violent crimes (APA, 2013).

In this present section, PTSD will be explicitly explained regarding DV victims (mothers and their children) who show symptoms of PTSD.

Females abused by their intimate partners may show symptoms of depression and PTSD. In the United States, 40% of battered women report having depressive symptoms. The percentage of PTSD ranges from 19 and 84% (Hellmuth, Jaquier, Swan and Sullivan, 2014). Mothers with PTSD experience maladaptive emotional regulation and depressive moods, showing behavioural and cognitive impairments that predict harmful effects on their children's development and heighten PTSD in children (Leen-Feldner, Feldner, Knapp, Bonaciu, Blumenthal and Amstadter, 2013).

2) Prevalence of PTSD.

Approximately one million children in the US have witnessed DV in their lifetime. Children of battered mothers are present in homes during those assaults in around half of the DV incidents (Finkelhor, Turner, Shattuck and Hamby, 2015). Children living in violent homes often witness their mothers' battering and are, therefore, at a high risk of being traumatised because of the constant state of psychological and physical tension (Adams, 2006). Besides, the danger exists for children witnessing abuse to become victims or perpetrators of DV in adulthood. Adults with adverse childhood experiences might also submit their children to child abuse and neglect (Assink et al., 2018).

Lünnemann et al. (2019) conducted a study with families that receive help from the child protection services in the Netherlands, where 101 fathers and 360 mothers participated. Those families had 426 children, whose mean age was seven years, and 50% were boys. This study found that trauma symptoms in either of the parents can be transmitted to their children. Thus, from one generation to the next, especially from battered mothers to their children. This transmission mechanism from fathers to children is not yet very clear since little research has been completed. The explanation could be that mothers who are traumatised due to DV might develop mental health problems (e.g. PTSD) (Van der Kolk, 2000), affecting their children's mental health. This phenomenon is known as the intergenerational transmission of family violence

(Fredland et al., 2015). Understanding the impacts of this phenomenon in entire families is paramount to develop effective interventions to stop the intergenerational circle of violence and offer children effective trauma treatment at an early stadium (Lünnemann et al., 2019).

3) Psychological, physical, and sexual domestic violence and PTSD among ethnic minorities.

Research studies have found a solid relationship between DV (e.g. psychological, physical, and sexual) and PTSD among various populations such as ethnic minorities, immigrant women, and women staying in shelters. The link has been demonstrated in the literature.

Ethnic minorities:

African Americans, First Nation People, and Asian American women are disproportionally affected by DV. They suffer higher rates of PTSD, depression, low self-esteem and suicides when compared to other ethnic minority women who are not abused or with white women suffering from DV (Bryant-Davis, Chung, Tillman and Belcourt, 2009).

For some ethnic minority groups in Australia, family cohesion is highly valued; when DV and child maltreatment happens in homes, the victims sacrifice their own personal safety to protect their culture (they do not rely on external support). Their name and reputation's safety is so crucial for them that they prefer to remain silent about the battering. This type of conduct makes it hard for social services or child protection bodies to intervene (Sawrikar, 2019).

4) PTSD in immigrant women.

Immigrant women experience higher DV levels and PTSD than non-immigrant women. A possible explanation is that the lives of immigrant women are more stressful due to their circumstances. For instance, they have to adapt to a new culture, quite often do not speak the host country’s language, their level of poverty and social isolation is high,

they have fewer social resources, and, in addition, they do not know their legal rights (Cho, 2012).

5) PTSD in women staying in shelters

Women are in shelters because they have been exposed to severe DV. Most of them have a history of victimisation either in childhood or adulthood (Assink et al., 2018) and display higher levels of PTSD than women who do not report past victimisation (Becker, Stuewig, and McCloskey, 2010). Assault, sexual abuse, repeated and extreme exposure to traumatic experiences, or witnessing violent and threatening situations directed at close family members (e.g. her children) often result in a PTSD diagnosis (American Psychiatric Association, 2013).

A study by Nixon, Resick and Nishith (2004) on the prevalence of DV in women who stayed at shelters found that PTSD and major depression disorder (MDD) correlate positively with each other. Both disorders can increase women's social isolation and decrease their social networks. Among the women in their sample, 75% of the victims were diagnosed with PTSD, and 54% with MDD. When women experience various alterations in mood and cognition, such as irritability, sleep disturbance, reckless or self-destructive behaviour, and concentration problems, the affected individual's physical and psychological condition worsens. These impairments can produce disruption in many areas of the individual's functioning.

Conclusion and recommendations

Post-traumatic stress disorder is a global problem, frequently diagnosed in battered women and their children due to trauma. PTSD is highly prevalent among various populations such as ethnic minorities, female immigrants, and women staying in shelters, sharing psychological barriers that prevent them from leaving destructive relationships. Children are vulnerable, and they ought to be protected from maltreatment or abuse because they do not have the choices adults have, for example, to leave the violent home. They are trapped in a world of violence. All societies must

protect children, offer them a future without violence, and opportunities to thrive and be happy children.

3.7 Risk of Suicide

The *World Health Organisation* (WHO, 2019) states that suicide is deadlier than sicknesses, such as malaria, breast cancer; war; and homicide together. Yearly, approximately 800,000 individuals worldwide die as a consequence of suicide. The majority of the world population, eighty-four per cent, live in low and middle-income countries, where the percentage of suicides is the highest. For young people of both sexes aged 15-29 years, suicide is the second leading cause of death after road injury (WHO, 2019). The risk of suicide is highest for persons who have been physically, psychologically or sexually abused in childhood. The *WHO* (2014) reports that male perpetrators' lifetime prevalence of sexual abuse ranges from approximately 18% for girls and 8% for boys. Sexual abuse happens either in homes or institutions that are supposed to protect children.

In this section, we discuss the following subjects:

1) Children and adolescents at risk of suicide
2) DV and suicide rates in Europe

1) Children and adolescents at risk of suicide

Children and adolescents with childhood traumas due to sexual abuse are at risk of suicidal ideation and non-lethal behaviour (e.g. suicide attempt; non-suicidal self-injuries) later in life (Brodsky, 2016).

The risk exists that young people might go further than having only suicide ideations and consider taking their lives to stop the abuse. As a society – from governments to all civil organisations - we are obliged to free children and youth from all forms of violence by creating safe environments for them, by giving support to parents or caregivers, by offering efficient support/help services, and by improving the economic

conditions of families allowing them an adequate income without poverty. In addition, education should be accessible for all and, of course, it is our duty to keep on reminding governments that they have committed their countries (at least in global conventions) to reinforce the protection of children as stated in the *Convention of the Right of the Child* (WHO, 2014).

Societies ought to find an effective way to stop any kind of child abuse in the first place. Secondly, we need to identify the most prominent risk factors of suicide to prevent children and adolescents (or adults for that matter) from suicidal thoughts to actually taking their own lives.

The *Centres for Disease Control and Prevention* (2013a) claim that there are many more suicide attempts than suicide deaths. That might sound positive, but the hard reality is that individuals who attempt suicide already suffer from severe mental health issues such as anxiety disorders, PTSD, and often also from drug/alcohol use disorders. By also attempting suicide, which might result in severe disability or injuries (e.g. head injury, fractures, internal injuries), their interpersonal relations suffer because it creates even more burdens/difficulties due to a loss of autonomy (May and Klosky, 2016).

2) Domestic violence and suicide rates in Europe (Netherlands, Spain, and the UK)

DV victims are another vulnerable group; females are more at risk of experiencing interpersonal violence than males (WHO, 2019). Suicide rates in Europe are high; to give an example, here follows data from two countries: The Netherlands and Spain:

The Netherlands is a high-income country (according to the WHO) with high-quality data. The numbers of suicides of all ages for the year 2016 were: Both sexes: 2,140; Females: 771; Males: 1,369. Crude suicide rates for all ages (per 100,000): 12.6 (WHO, 2019)

Spain is also a high-income country (according to the WHO) with high-quality data. The numbers of the suicide of all ages for the year 2016 were: Both sexes 4,028;

Females: 1,057; Males: 2,971. Crude suicide rates for all ages (per 100,000): 8.7 (WHO, 2019).

The risk of having suicidal thoughts is three times higher for women suffering from DV; those women also have a four-time higher risk of attempting suicide compared to females who are not battered by their partners (Ellsberg et al., 2008).

Data from women and men in the UK - the *Adult Psychiatric Morbidity Survey* - was used to study the long-term consequences of interpersonal violence and abuse and the risk of suicide (NatCen, 2013). Researchers divided the survey population into six groups with Latent Class Analysis' statistical system to identify people with similar profiles.

The results were very revealing: Group 1 was formed by three-quarters of the (English) population (76%) in the survey. This group had experienced only a low level of violence and abuse. However, 3% had been restricted by a partner on when they could see friends or family. 2% had no access to household finances, and 14% had been bullied (NatCen, 2013).

The other quarter was divided into groups according to the type and level of violence they experienced. According to NarCen (2013), these were:

- Group 1 – 76% of the participants in this group had experienced little violence or abuse. Nevertheless, partners prevented 3% from seeing family or friends, 14% experienced bullying, and 2% were withheld from household finances (NatCen, 2013).

- Group 2 - 81% were kicked, bit, pushed, slapped or suffered from a partner's coercive control. Neither sexual abuse nor severe physical abuse or serious threats was reported (NatCen, 2013).

- Group 3 - Experienced physical violence and coercive control. 81% have received death threats, 53% with weapons. Almost all reported being kicked, pushed, slapped and experienced coercive control by the partner. There was non-significant sexual violence (NatCen, 2013).

- Group 4 - Experienced sexual abuse in childhood. 85% of this group were addressed in a sexual manner. 66% had been (sexually) touched. 13% experienced non-consensual sex. 13% were severely beaten by parents or caregivers (NatCen, 2013).

- Group 5 - Experienced sexual abuse in adulthood, to a lesser extent, suffered from childhood sexual abuse, 3% of the surveyed population were in this group, and 99% had experienced in their childhood non-consensual sexual contact (NatCen, 2013).

- Group 6 - Experienced in childhood and adulthood physical and sexual violence, high levels of coercive control and severe sexual abuse (38% non-consensual sex in adulthood and 23% as a child). 1 in 25 (4%) belonged to this group (NatCen, 2013).

In groups with high physical and sexual violence, females were overrepresented compared to men; however, men were represented in every group (NatCen, 2013). In this group (high physical and sexual violence), divorced and separated individuals, including low household incomes and low education levels, were in the majority. They resided, it should be noted, almost exclusively in poor neighbourhoods. However, 29% of the participants of this category group live in households with the highest income levels (NatCen, 2013).

More than half of the survey participants had clinical mental disorders, e.g. depression or anxiety, confirming a solid relationship between DV and mental disorders. However, only a small percentage (10%) received a specialised treatment or therapy for those mental disorders (NatCen, 2013).

Regarding suicide attempts, those groups characterised by severe violence were 15 times more at risk of committing suicide or self-harm than the control population (NatCen, 2013).

Other studies have arrived at similar results concerning the claim of an existing connection between childhood abuse and increased vulnerability for depression and anxiety, self-harm and suicidal behaviour in adulthood. Individuals with a past with

ACEs attempted suicide more often in their lifetime than those experiencing only verbal abuse or assault (Joiner, Sachs-Ericsson, Wingate, et al., 2007).

Psychiatric patients with a history of suicide attempts had often experienced trauma in their childhood (Sarchiapone et al.,2009). Childhood traumas are a high-risk factor for suicidal behaviour since, as it is known, childhood is a crucial period in children's development. In this period, the human brain moulds and regulates diverse domains (e.g. emotional, behavioural, cognitive), social skills, and interactions with others. Nevertheless, childhood physical and sexual abuse creates a risk of psychopathology in adulthood and suicide attempts (Joiner et al., 2007). Experiences of traumas due to DV can precipitate suicidal ideation or even the completion of suicide.

Suicide is a burden for societies. Identifying specific risk factors for suicide in vulnerable populations of children, youth, and adults suffering from psychiatric conditions (e.g. depression and PTSD) resulting from DV experiences would help. Then could we improve their lives and give them the protection and care they need to prevent loss of lives or disabilities resulting from failed attempts. A further improvement of the existing prevention strategies both in rich and developing countries is desirable.

Male perpetrators' lifetime prevalence of sexual abuse ranges from approximately 18% for girls and 8% for boys. Sexual abuse happens either in homes or institutions supposed to protect children (WHO, 2014).

"*Gender-based violence is understood to be a form of discrimination and a violation of the fundamental freedoms of the victim and violence in close relationships, sexual violence (including rape, sexual assault and harassment), trafficking in human beings, slavery, and different forms of harmful practices, such as forced marriages, female genital mutilation and so-called 'honour crimes*."

Recital 17

EU Legislation

Chapter 4 Domestic violence legislation in Europe

Although violence against women is not a new phenomenon, the magnitude of the problem has been recognised by the international community as a human right violation only in the last decades. Europe has issued new legislation to protect women from any type of violence. Several legal instruments and resolutions are applied to reach this aim. However, as Sartre 1964 said, conservative institutions and right-wing movements in Europe advance their own patriarchal conservative political agendas that minimise the severity of male-to-female violence and disguise control and domination under the umbrella of "gender-neutral policies" (DeKeseredy, 2020).

This section shows the improvements performed at all levels by the European Union (EU) to stop the harmful impact of violence. Here, we analysed the following topics:

1) The European Union against gender inequality.
2) European legal instruments to protect victims of violence: Protection Orders.
3) Needed improvements in European policies.

1) The European Union (EU) against gender inequality

The EU has committed to eliminating gender inequality and domestic violence in its territory because of the harmful impact violence has on societies in broad spectrums. The European Commission (EC) is vital in the EU decision-making political system; it proposes legislative initiatives and monitors laws that ensure equal rights between the sexes (Herbinger, Neunkirchner and Leonhardmair, 2020).

Policies to fight DV must encompass European and international standards. Although the EU intends to protect DV victims and propose implementing equality among all citizens regardless of gender, sex, origin and religion, not all states embrace that legislation. Twelve countries have not yet ratified the Istambul Convention, and therefore, human rights are not guaranteed in every country (Tentoni,2020).

There are also very positive developments in Europe. Some European countries have added domestic violence as a criminal offence in their Penal Codes: Portugal since 2007 (PPC; Law Nr. 59/2007, 4 September). Slovenia under the term Family Violence since 2008 (Art. 191, PC-1, OG RS, Nr. 55/08 and 66/08) (Herbinger, Neunkirchner and Leonhardmair,2020).

Another good example is Scotland that made DV a specific criminal offence in 2018. The new Scottish legislation issued on 1 April 2019 criminalises DV psychological abuse and coercive and controlling behaviour. This new penal legislation is meant to warn abusers that "*All forms of domestic abuse are presently considered a criminal act, and perpetrators will face the full consequences of their abusive behaviour*" (McDonald, 2020). Besides, this legislation penalises harm against children due to DV (Domestic Abuse Act, 2018).

The advantage of including DV as a criminal offence in Penal Codes is that it can create more clarity in statistical records on its urgency and actual prevalence. Governments at a national and international level could allocate adequate fundings once DV is separated from other types of violence. For instance, violence committed by strangers instead of intimate partners (Herbinger, Neunkirchner and Leonhardmair,2020). Such division could correct the misconceptions of gender-symmetry resulting from surveys (Myhill, 2017).

Other countries such as Austria, France, Germany and Finland do not include DV in their penal code. Still, they have adopted strategies to improve DV responses by implementing policies that respond more effectively to such acts of violence (Herbinger, Neunkirchner and Leonhardmair,2020).

In an ongoing fight against DV, Europe is issuing policies to protect women from violence incorporating measures to alleviate their situation since the perpetration of severe violence against women is mainly committed by males (Van der Aa, Niemi, Sosa, Ferreira, and Baldry, 2015). Nevertheless, there are also some points of critique. DV, sexual harassment, and stalking or crimes related to interpersonal or domestic spheres between spouses or former partners are not exclusively a female problem; other populations, such as LGBT+, are to be considered as well.

2) European legal instruments to protect victims of violence: Protection Orders

A legal instrument used to protect victims of violence is the protection order, also known as a protective order or a restraining order. The order is issued with the intent to restrain a person from, for instance, attacking, stalking, threatening, harassing the victim in homes, school, or workplace, and it can be extended to protect children (Women Law. Org, 2021).

The different names given to this protection measure relate to the differences between one judicial system and the other. In general, a protection order is a restriction imposed on an individual (for instance, the condition to contact the victim) to protect another person (Van der Aa, Niemi, Sosa, Ferreira, and Baldry, 2015).

In Spain, protection orders for DV cases were introduced by article 544 to the Code of Criminal Procedure, facilitating DV victims to obtain precautionary protection orders until a definitive decision is reached. There is also a comprehensive protection measure against gender-based violence that enhances the existing protective order, providing women with complete and integrated protection against the abuser and allowing the court to include civil, social and criminal measures. The Code of Criminal Procedure regulates these protection orders issued utilizing a simple judicial procedure before the specialised Courts for Violence Against Women (within 72 hours after application). These Courts have the competence to act in civil and criminal matters (Van der Aa, Niemi, Sosa, Ferreira, and Baldry, 2015).

In the Netherlands, protection orders are applied in criminal cases and civil or administrative matters. Protection orders are regulated by laws, except for emergency orders that ensure safety for short periods to DV victims' (Van der Aa, Niemi, Sosa, Ferreira, and Baldry, 2015). During the barring period, both victims and perpetrators are provided with help. For the victim, assistance is provided by the social service. For the perpetrator, by probation services (Government of the Netherlands, 2021).

Nevertheless, despite a move towards mutual recognition of judicial decision-making in domestic protection orders in the EU, there is a lack of coordination at a European level concerning protective measures against gender violence. For instance, in the first trimester of 2019, 9,530 protection orders were issued in Spain, of which 32.4%

concerned non-Spanish citizens. Presently, a victim who moves out of the country of origin to another EU country cannot count on the protection order's implementation. A perpetrator that moves to another country is not monitored anymore and represents a danger for the victim. Although on paper everything is under control, in practice, it is not because of lack of coordination (Borges Blázquez, 2020).

Member States keep, up to now, national differences in approaching protective orders. Therefore, standardised criteria would be desirable to serve the victim's interest.

3) Needed improvements in European policies

Some governments policies preserve and reproduce gender-based violence (Abraham and Tastsoglou, 2016) because they offer insufficient support to DV survivors (Bosch, Beltran, Erice and Saramanch, 2019). The universal framing used to protect every woman's rights in Europe may meet governments' agendas at national and international levels on how seriously they intend to solve DV. However, battered women from different backgrounds and ethnicities other than the white majority are not embraced in their policies. These measures make differences between European women and 'other women'. They emphasise cultural forms of violence existing in other cultures (e.g. forced marriages, honour killings, female genital mutilation), as if those women are responsible for bringing DV into Europe and are to be blamed for it (Montoya and Rolandsen-Agustín, 2013). The reality is that European women are as much affected by DV as other immigrants or refugees living in Europe, who are victimised in many more areas of their lives than just being victims of violent relationships at home. Women who do not belong to the white cultural majority experience institutionalised discrimination, racism, heterosexism, xenophobia, and difficulties entering the labour market. They are disproportionally unemployed due to discriminatory employment and housing practices making the situation more precarious when they are dependent on their violent partners, having no resources to escape (Montoya and Rolandsen-Agustín, 2013).

4.1 Domestic violence against women in Europe

European member states are very diverse in many aspects; they have different languages, economies, social and political environments that differ from country to country. However, they all have in common: A high prevalence of domestic violence, its acceptability, and to a certain extent, its invisibility.

This section presents and analyses various topics of European reality concerning DV:

1) The Council of Europe and the Istambul Convention.
2) Ratification of the *Istambul Convention*.
3) Women Wave.
4) Violence dimension in Europe
5) DV invisibility..

For the *European Union* with presently 27 member states (after Brexit), with its diverse cultures, different income levels, own domestic policies against domestic violence, and different political interests and ideologies, it is not an easy task to coordinate efforts to make improvements in the situation of all women in the Union.

Besides implementing practical support services, the EU aims to support violence victims further to avoid their re-victimisation. To reach that purpose includes making citizens aware (educate people) that the victim is not the one to blame for what has happened to her; the only accountable for those acts of violence is the actual perpetrator (Kelly and Chair, 2018).

To gather information on critical societal issues (e.g. DV / IPV against women, victim-blaming) from representative samples of general populations is essential because that data can be used to plan prevention strategies. Today, social perceptions and public attitudes of tolerance or justification of violence in homes and victim-blaming are a reality in many European citizens' mentality (Gracia, 2014).

The *European Commission's Directorate-General for Justice, Freedom and Security* requested a *Eurobarometer Survey* in 2010 to analyse public opinion on DV against women in all 27 EU Member States, and 26,800 EU individuals participated (European Commission, 2010). This survey followed a previous one held in 1999 measuring the evolution of European public opinion on DV against women. When asked whether "*The provocative behaviour of women causes DV*," 52% agreed with the statement (European Commission, 2010).

In the *Eurobarometer Survey* (2010), all the twenty-seven members of the EU participated. Those EU countries are different concerning their levels of income, gender equality, and policies against DV. New EU countries have lower levels of income and gender equality compared to Western countries. Participants of 'new' countries in the survey either tolerated or blamed the victims. For example, Estonia accepted DV with 84%, Latvia with 79%, and Lithuania with 86%.

1) *The Council of Europe* and the *Istambul Convention*

The Council of Europe was found in the year 1949. Originally it had only ten members aiming at unity among European countries, reaching equality between the sexes, promoting human rights and democracy to protect European citizens, and devising incentives for political, legal, and administrative reforms. Presently it has forty-seven member countries (Council of Europe, 2007).

In May 2005, the *Council of Europe* and heads of state and governments committed to an *Action Plan* to eradicate all types of violence against women, including DV (Villanueva Sainz-Pardo, 2014). With that purpose, a Task Force was implemented. Aiming at improving legal and policy measures; give support and protection to the victims; enhance the collection of data, and raise awareness on the necessity to investigate and punish any kind of violence against women, including DV, and to safeguard the human rights of all citizens (Council of Europe, 2008).

The Istanbul Convention (IC) is a comprehensive international treaty adopted by the *Council of Europe* in April 2011. The IC proposes policy initiatives that are legally binding to prevent gender-based violence (women are significantly affected by this kind

of violence). Gender-based violence (GBV) includes rape, stalking, sexual assault or abuse to adults and children, honour-based violence, forced marriage, female genital mutilation/cutting, sexual harassment and exploitation, and trafficking. Governments are committed to combating such violence; to ensure safety, security and human dignity; and providing a coordinated response to GBV by offering quality services (free of charge) managed by skilled staff. Effective implementation is ensured by allocating a sufficient budget and proper data collection (Council of Europe, 2007).

The *Council of Europe* (2011) stipulates in:

Article 22 *that "specialist support services should be arranged for all women victims of violence and their children*."

Article 23 *that "appropriate, easily accessible shelters in sufficient numbers should be provided to ensure safe accommodation for women and their children."*

Article 24 *that* "*the implementation of free 24/7 telephone hotlines to provide advice, anonymity and confidentiality to callers for all forms of violence should be available*."

Article 25 *that "governments must take measures to support the victims of sexual violence by setting appropriate, easily accessible rape crisis or sexual violence referral centres for victims, in sufficient numbers to provide for medical and forensic examination, trauma support and counselling for victims"* (Council of Europe, 2011).

They entered into force in August 2014, and the EU signed it in June 2017. Although forty-seven countries signed the Istanbul Convention, it was only ratified by thirty-four. (McQuigg, 2017). Eleven countries have signed the Convention but have not yet confirmed it (Council of Europe, 2020).

2) The ratification of the *Istanbul Convention*.

With the ratification of the *Istanbul Convention*, the *Council of Europe* took one crucial step to tackle gender-based violence in Europe, which is extensive and represents a wide-ranging abuse of fundamental rights. The survey of the *EU Agency for Fundamental Rights* (FRA, 2014) found that one in three women 15 years of age or older in the EU claims to have been the victim of physical and/or sexual violence by a

current or ex-partner in the course of their lifetime (FRA, 2014). Nevertheless, it is estimated that many cases of violence are not reported to the police or any victim support organisation. Therefore, the criminal justice data does not reflect the actual number of affected individuals.

The FRA recommends a more prominent role for well-trained healthcare professionals to recognise and report violence; this measure might avoid under-reporting and facilitate policy responses (Kerbacher et al., 2019).

2) Women *WAVE*

Women Against Violence Europe (WAVE) vigorously represents women organisations in several international fora like the *United Nations* or the *Council of Europe*.

According to the *Wave Country Report* (2017), many European countries are making progress concerning women's protection. However, structural gender inequality continues to be manifested through an unequal power relationship between women and men that undermines women's rights. Many of the convened measures mentioned in Articles 22 to 25 stated at the *Istanbul Convention*, such as specialist services for victims of sexual violence, safe shelters, free 24/7 women's helplines, and women centres, are insufficiently executed. From the forty-seven countries of the *Council of Europe*, only thirty-five have national women's helplines. Only twenty-five meet the standards of the *Istanbul Convention* (helplines ought to be free of charge and operate 24/7). The 28 EU member states (now 27 after Brexit on 1st of February 2020) have a total of 21 women's helplines; 20 of those are free of charge; and 16 meet the IC standards (WAVE, 2019).

Wave (2019) also remarks that there is a lack of education plans concerning early interventions for women and girls, men and boys suffering from the violence (Hanson Frieze, Newhill, and Fusco, 2020) that includes vulnerable discriminated groups such as the LGBT+ communities, and undocumented migrant women and children. These issues need to be addressed and resolved (Wave, 2019).

Although the EU member states have a total population of 512,379,225 million (including the UK population before Brexit), only 1,914 shelters are accessible for

women. There is a shortage of beds of approximately 26,276 (51%) beds in those available shelters. Only three countries meet the IC standard (Wave, 2019).

In twenty-seven EU member states now (plus the UK before Brexit), there are a total of 2,594 women's centres, but the number needed is 5,237; thus, there are a shortage of almost 2,650 (50%) centres (Wave, 2019). These women's centres are necessary because they offer advice and support, counselling, advocacy, legal options, employment, housing, representation at court, police, and social services.

4) Violence dimension in Europe

The Nordic Council of Ministers (2016) states that women and men and boys and girls must have the same rights and opportunities in all areas of life. This concept is of fundamental value in the Nordic countries, making them the most gender-equal worldwide. However, despite gender equality measures, Scandinavian countries have paradoxically elevated physical and sexual intimate partner violence against females, amid the highest in Europe. The average prevalence of IPV in the EU was 22%, while the lowest was around 13%. Denmark had the highest IPV prevalence in the EU with 32%, Finland 30%, and Sweden 28%, notably above average (FRA, 2014).

Sweden, Finland and Denmark have the highest *Gender-Equality Index*, based on six domains: Health, knowledge, money, power, time, and work (EIGE, 2012). Nevertheless, high-income countries with well-developed economies and gender equality policies showed surprisingly high tolerance of violence and victims blaming as well: Denmark (71%); Finland (74%); Sweden (59%), Spain (33%), the UK and Northern Ireland (63%) (Eurobarometer survey, 2010).

These attitudes in any society, from both poor and rich countries, imply that the victim 'deserves' to be abused and make it permissible to perpetuate the circle of violence and injustice. When individuals condone DV, perpetrators are being reinforced in their actions; victims might feel discouraged from reporting violence to the police or health authorities or seeking help from family or friends in that community since everyone is equally tolerant to violence (Gracia, 2014). Reducing tolerance to violence or blaming the victims for what is occurring to them is not a desirable option and should be

combated through education or by implementing scientific knowledge to inform policymaking on preventive strategies (Gracia, 2014).

5) Domestic violence invisibility

DV in Europe is extensive, and in extreme cases, can result in the death of women. We know already that femicide is mainly committed by the current or former partner of the victim. Although there is increasing attention to femicide in governments' agendas, the risk of such violence seems to count less than other forms of violence, such as deaths from terrorism (Fitz-Gibbon et al., 2018).

For example, after the 9/11th attack, the global deaths caused by terrorism were approximately 25,673 persons by 2016.

Deaths caused by terrorism were accorded the status of number one security issue (Buzan and Weber, 2009; Ericson, 2006).

In comparison, 87,000 women were victims of homicide in 2017. Intimate partners or family members killed 50,000. A current or former intimate partner killed 30,000 (UNODC, 2018). Concerning Western Countries, femicide represents a significant threat to life (Walklate et al., 2019).

Researchers warn about DV victims' invisibility in the present counting of crime because there is no systematic global counting of women's killing by their intimate partners. They propose improvements in collecting data on gendered violence, especially in women's gendered killing (Walklate, Fitz-Gibbon, Culloch, and Maher, 2020).

Most European countries do not recognise femicide as a separate form of violence (Wave, 2019). According to Walklate, Fitz-Gibbon, Culloch, and Maher (2020), a gendering of homicide statistics should become a routine part of official statistics on crime, including gendered motivation (e.g. deaths link to honour killing). Walklate et al. (2020) claim that it is imperative to be aware of the actual violence dimension against women and make it visible to the public, policymakers, and politicians to commit governments to changes. These changes should reach many domains: Social

(e.g. justice). Cultural (to discourage the acceptance of DV in societies). Economic (e.g. to value women labour). Legal (e.g. gender equality) and political commitment as are stated in the *UN Sustainable Development Agenda* (SDA) for 2030. The *SDA* was adopted in 2015 to reduce gender-based violence and prevent femicide as a top priority (Walklate, Fitz-Gibbon, Culloch, and Maher, 2020).

4.2 Domestic violence against men in Europe

Male victims of domestic violence/intimate partner violence have received more attention and acknowledgement from research in recent years, making it possible to reduce the existing literature gap to violence against women.

Although males perpetrate the vast majority of cases of DV against their female partners or children, Norway has led to the investigation of DV against men from Norwegian and foreign nationalities to fill the gap in the lacking knowledge of male victimhood (gay and hetero) in the Nordic countries (Corbally, 2015). In Norway, family protection services work specifically with violence against men, but it is uncommon to have battered men's services. There are forty crisis centres for women, but since the 1970s, they have also been open to men due to new legislation of gender neutrality and equal basis. Since crisis centres are also accessible to men, there has been an increase in men using those centres (Lien and Lorentzen, 2019).

Psychological violence against men

According to the study by Lien and Lorentzen (2019), intimate partner violence also affects men. Psychological violence is the predominant form affecting men (e.g. harassment, systematic degradation, being ridiculed by the partner, experiencing sabotage by the partner around the contact with the children, anger, aggression and controlling behaviour). In some cases, due to psychopathology, partners can be overly aggressive and unstable. Men might develop strategies to avoid conflict or ways to please their partners. Still, even so, they cannot stop the frequent bursting of violence

and rage (e.g. biting, punching, kicking, scratching, menacing with a knife) that can cause serious physical harm. Many of the victims and perpetrators were themselves victims of violence during childhood. When comparing the occurrence of minor physical violence, data shows that gender disparity is small, and psychological violence occurs at equal levels for men and women with adverse health consequences for both (Lien and Lorentzen, 2019).

In the Norwegian report "*Men at crisis centres*" by Grovdal and Jonassen (2015), it was stated that "*men exposed to systematic violence from partners have many of the same needs as women with similar experiences"* (Lien and Lorentzen, 2019*)*. In cases where psychological terror and severe physical maltreatment happens, men stay in a relationship because they do not want to lose contact with their children. It would be desirable to consider implementing safe places for men in more countries in the near future. Due to the shame males feel about reporting severe violence, many men trapped in a vicious circle of violence might consider searching for safe places like crisis centres if those were readily available.

4.3 Male victims of domestic violence

"*She has been arrested two times before, and I asked that she not be arrested this time (after she broke both of my eardrums), but she gave the cops a hard time, so they took her anyway. My daughter told the police 'Daddy never hits; Mommy hits on Daddy*."

Cited by Hines, Brown and Dunning (2007).

For decades males were considered to be almost exclusively DV perpetrators but not victims. However, organisations and governments are progressively starting to recognise men victimhood. For instance, the *World Health Organisation* (WHO) initially highlighted DV against females as a significant worldwide issue for societies concerning female victims' social and health matters. Presently, the WHO states that

men in heterosexual and same-sex relationships are also subjected to domestic and sexual violence (WHO, 2013). Although legislation in some countries starts considering men's situation as victims, there is a necessity to issue policies that offer all victims of violence support and protection irrespective of gender.

In this section, there are many topics to be analysed

1) Mainstream believes in victims and perpetrators
2) Gender-neutral legislations
3) Research on male victimhood

1) Mainstream believes in victims and perpetrators

Mainstream public and media idea of DV was for a long time constructed as being a gendered, heterosexual phenomenon, where the physical component was decisive: Men are generally physically stronger than women. Thus men were more likely to be seen as the abusers, and heterosexual women their harmless victims (Josolyne, 2011). Bates (2019) maintains that stereotypical gender roles perpetuate concepts of female violence against men as being irrelevant. Notions of gendered violence create systems that disqualify male victims as needing services or interventions, leaving men without help or support (Bates, 2019).

2) Gender-neutral legislations in Europe

In 2015 the *United Kingdom's Home Office* proposed to make all legislation gender-neutral and, by so doing, recognising that males can also be victims of violence. To create support services for this affected group, the *Home Office* has launched the "*Male Victims of Domestic and Sexual Violence Funds*" to increase awareness of male victimhood's subject (Home Office, 2011).

The *UK Office for National Statistics* (2017) announced that approximately 1.9 million adults aged 16-59 were domestic abuse victims. Of those adults, 1.2 million were female victims and 713,000 male victims. The prevalence rate of physical DV victimisation is 1 in 4 women (24,8%) and 1 in 5 men (19.3%).

In Norway, gender-neutral hotlines and laws were introduced for any individuals suffering from violence. Of the 51 women's shelters, 22 were reserved for men. However, two years later, 10 of those shelters were not used because there was no demand (Halperin-Kaddari and Freeman, 2016).

Denmark, UK, Germany and other European countries use presently gender-neutral vocabulary in their laws to address different types of crimes such as domestic and sexual violence, stalking, trafficking, honour-based violence and others. This indistinction does not do justice to the number of female victims. Suddenly, there is a blur between who is the perpetrator and who is the victim.

Martin (2016) asserts that it is time to set aside comparative debates about the frequency and severity of harms caused to male or female victims to obtain financial investments and resources to tackle the problem and create needed solutions. The reality is that men also experience violence. Although those situations might not occur as often as for females victims, societies cannot continue the marginalisation of the male victims across heterosexual, gay, bisexual and transgender groups by denying that the problem exists.

3) Research on male victimhood

Research on violence towards men by their female partners is sometimes conducted as qualitative research employing in-depth interviews and narratives of men involved in abusive relationships (Allen-Collinson, 2009). Frequently the abuse by females against their male partners begins as a psychological (verbal) abuse, using language which seeks to humiliate, denigrate or cause emotional pain to control or demean the partner (Tilbrook, Allan and Dear, 2010), and progressively escalate to physical injuries (Allen-Collinson, 2009). In a case study conducted by Allen-Collinson (2009), a male victim explained that he rationalised his wife's violence, and she down-played her actions, for instance, referring to her scratching as "playful tickling'. Both abused husbands and female victims develop strategies and tactics to normalise and accept unusual behaviour as if they were normal couples' interactions (Migliaccio, 2002). Women can show aggression when they are emotionally dysregulated or lose control

(Goldenson et al., 2007). Other motives for female DV perpetration are related to mutual violence, interpersonal dependency, substance misuse, unstable mood and attachment issues that influence violence (Steward, Gabora, Allegri, and Slavin-Stewart, 2014).

Laskey (2016) researched systematically female DV perpetration and their treatments. She found similarities between male and female perpetrators and also crucial divergencies. Among the females she studied, there was a high preponderance of traumas derived from current and past maltreatment (Laskey, 2016). An important finding in Laskey's (2016) systematic review is that many female offenders were victims of present or past partners and had traumas derived from current or past abuse. Laskey (2016) also found that there is insufficient research on female perpetrators to offer them a treatment that matches their needs. The treatments mandated by the *Criminal Justice System* to female offenders of IPV were designed initially for men offenders (Carney et al., 2007).

There is one single study by Hines and Douglas (2016) that investigated female sexual perpetration. In their sample of 611 male participants, the researchers found that more than half of the participants had experienced sexual aggression in their relationships. By twenty-eight per cent, it was said to be severe sexual aggression (e.g. men were forced to engage in vaginal, oral or anal sex without consent). DV against men tends to be unrecorded in crime statistics because men do not readily report incidents for fears of ridicule (e.g. disbelief by the police) or simply because there are no services for them (Barber, 2008). DV's physical and psychological mental effects are as detrimental for women as for male victims (Merrill and Wolfe, 2000).

Psychopathology is also a motive to perpetrate violence against a partner. A sample of 103 women arrested for violence against their partners was referred to a violence intervention programme; submitted to psychological testing. The results indicated that they suffered from high rates of mental issues. Among the disorders they suffered, it can be mentioned: PTSD, substance abuse; depression; anxiety; panic; borderline personality disorders, and antisocial personalities (Stuart, Moore, Coop Gordon, Ramsey and Kahler, 2006).

Due to pronounced differences between males and female's behaviour, the interventions should be different, targeting women's works. For example, some effective measures are learning coping skills, relaxation techniques, and self-control techniques (Walker, 2013). Empathy and open-ended questions from therapists seem to benefit females clients (Woodin et al., 2012). To avoid female DV recidivism is essential to know whether the treatments used are helpful because a therapy that is effective for men does not guarantee effectiveness in female offenders.

Men who have suffered from DV do not generally report incidents of violence committed by their female partners (Cho and Wike, 2010). Nevertheless, Hines, Douglas, and Berger's study in 2015, describing the experiences of violence of 129 male callers to the *Domestic Abuse Helpline for Men* (DAHM), gives a different perspective on male victimhood.

The *DAHM* is the only helpline in the US that assists male victims of intimate partner violence (Simmons, 2015) by providing a free of charge crisis line, court advocacy support and offer help with referral to other services. Since its inauguration, the rates of calls by male victims of violence, their family and friends have increased steadily.

This helpline aims to make the public, law enforcement, and social services agencies aware of the need for a redefinition of DV that recognises and allocates resources to all IPV victims independent of gender (Hines, Brown and Dunning, 2007).

Among male callers: (n=158) Men reported the following physical aggressions:

Sixty-nine (43.7%) were slapped/hit.
Sixty-six (41.8%) pushed.
Sixty-two (39.2%) kicked.
Forty-nine (31.0%) grabbed.
Thirty-nine (24.7%) punched.
Thirty-five (22.2%) chocked.
Fifteen (9.5%) spit on.
Three (1.9%) stabbed.
Two (1.3%) scratched.
(Hines, Brown and Dunning, 2007).

Among the male callers: (n=155) The following controlling behaviour was reported:

One-hundred-and-fourteen	(77.6%) coercion or threats.
One-hundred- and- nine	(74.1%) emotional abuse.
Ninety-three	(63.3%) intimidation.
Eighty-eight	(59.9%) blaming, minimising, and denying.
Seventy-four	(50.3%) manipulating the system.
Sixty-one	(41.5%) isolation.
Fifty-six	(38.1%) economic abuse.
Sixty-nine	(64.5%) controlled through the children

(Hines, Brown and Dunning, 2007).

Men callers were often employed in stereotypical male occupations: 13.7% were police officers, military and firefighters; 4.2% worked in construction, and 11.6% were manual labourers. 8.4% lawyers, doctors or professors; 3.2% architects and engineers. Among the callers were also high profile occupations, unemployed (9.5%) and disabled (17.9%) males (Hines, Brown and Dunning, 2007).

Hines et al. (2010) conducted a research project involving 302 men. Participants in the survey were aged 18-59 years; they lived in the USA and had an intimate relationship (lasting at least one month in the previous year) with a woman before searching for assistance (Hoff, 2012). Participants were recruited from the *Domestic Abuse Helpline for Men and Women* (DAHMW) and other means, such as electronic mailing lists specialising in treating DV, father's rights issues, and other means. In their sample, men suffered psychologically from their partner aggression (Cook, 2009; Hines, 2007). Despite being physically stronger than women, economically independent, and had a higher income than their female partner, men were concerned about losing their children's custody if they left home. Men also worry about leaving their children with their violent partners. The other problem men are confronted with is that they cannot count on social services as women do; the police sometimes does not take their complaints seriously because of the deep-rooted idea that only women are victims of abuse.

Hines and Douglas (2010) showed that the prevalence of female partners' aggression was: Pushing and shoving; throwing objects at him; punching with an object which can

hurt; kicking; beating him up; menacing with a gun or knife; being choked. The injuries resulting from the aggression ranged from minor cuts, sprains or bruises. The more severe injuries required men sometimes to visit a doctor (e.g. broken bones). Seventy-one of the three-hundred men had been diagnosed with a mental illness such as depression, ADHD, PTSD; substance abuse (e.g. alcoholism); anxiety disorders (Hines and Douglas, 2010). There is disagreement among scientists about the level of violence used by women and men in relationships, whether violence is gendered or universal without gender distinction. The worldwide data obtained on a large scale by the World Health Organisation is indisputably and should be considered. Women are the most affected by DV, and the injuries caused by male partners are usually severe. Nevertheless, societies cannot dismiss male victims' suffering as rare and not worthy of considering countermeasures.

Conclusion and recommendations

Males suffering from violence from their intimate partners should be protected and offered all the services necessary to stay safe. Governments, policymakers and law enforcement are challenged by new perspectives and new situations in society, with multicultural traditions and different family compositions than in the past. These changes represent a significant challenge that requires a shift in mentality and flexibility to recognise new forms of violence and act upon them.

Research can help to enhance the understanding of male victimhood and female perpetration. It can also contribute to developing effective psychological and behavioural interventions or therapies tailored for female perpetrators of DV to stop the circle of home violence.

Studies exploring factors that increase female perpetration of DV, and the characteristics of (female) perpetrators, can increase existing knowledge. It can also help those females who batter their intimate partners or children by creating guidelines for Batterer Intervention Programmes (BIPs) and implementing effective treatments to stop violence in homes.

Chapter 5 Domestic violence in The Netherlands

In European countries, there are considerable differences regarding the prevalence of DV. According to the *EU FRA Survey* data, where 42,000 women across 28 European countries were interviewed, violence against females aged 15 and older in the Netherlands occurs at a high level. Around 45% of Dutch women said in the *FRA Survey* "to have experienced physical or sexual violence at some time in their lives" (FRA, 2014). In other countries in Europe, the average level was 33% and varied in violence levels, whether violence was structural or once only incident by intimate (ex)partners, family members, or unknown perpetrators (Römkens, De Jonge, and Harthoorn, 2014).

This section analysed the following issues.

1) DV against Dutch women
2) DV against immigrant women living in the Netherlands
3) Suspicion of child abuse in the Netherlands
4) Child protection services
5) Registered DV crimes by the police

1) Domestic violence against Dutch women

In a Dutch study with 214 women participants (aged 18 or older) attending GP consultations in fifteen general practices of the Rotterdam area, were asked about their IPV experiences. Researchers were interested to know if there is a connection between IPV and depression in the Netherlands (Prosman, Jansen, Lo Fo Wong, and Lagro-Janssen, 2011). Other international studies found that abuse women suffer from depression (Pineless, Mineka, and Simbarg, 2008).

Abusive relationships are detrimental for the victim. However, many abused women, despite often utilising the healthcare system (Lo Fo Wong, Wester, Mol, Römkens, and Lagro-Jansen, 2007), do not disclose abuse towards their doctors. These women present unexplained symptoms, have more than average mental health problems and

injuries (Hegarty, Gunn, Chondros, and Taft, 2008). Doctors find it challenging to recognise the abuse (Lo Fo Wong, Wester, Mol et al., 2008) because there are no specific symptoms. This study, which was the first to collect data in general practices in the Netherlands, had a response rate of 63%, from whom 41% of participants were migrants, showed a significant association between IPV and depression (Prosman, Jansen, Lo Fo Wong, and Lagro-Janssen, 2011).

As a result of violence in homes, people's lives are affected. When women are psychologically humiliated and belittled by their partners or experience physical or sexual violence, they are vulnerable to that negative influence and lose confidence in themselves (Radford and Hester, 2006). Distress also affect their quality of parenting because experiencing any type of physical or emotional abuse undermines parenting. Mothers are then unable to be warm to their children, which is linked to deleterious social competencies (Altschuld, Lee, and Gershoff, 2016). Anxious mothers cannot support their children to reduce their aggressive behaviour (Lansford et al., 2014), or they may start using harsh discipline, affecting children's development and well-being (Grogan-Kaylor, Galano, Stein, Clark, and Graham-Bermann, 2020).

The prevalence of physical or sexual violence in the Netherlands perpetrated by partners, ex-partners, remote family members, relatives, or close family friends in 2019 was approximately 747,000 affected individuals aged 18 or older. Of whom, 6.2% were women, and 4.7% were men (Boon and Wittebrood, 2019). In 34% of the cases were single (once only) incidents. Repeated violent incidents occurred in 41% of the cases, from which 20% were structural, happening on a daily, weekly or monthly basis (Boon and Wittebrood, 2019). The number of female victims was 97,000, and 27,000 were male victims (Van Eiken et al., 2018).

As we shall see in the tables below, domestic violence occurs mainly between partners or ex-partners, followed by violence against children and other categories of family members. The victimisation of other types of victims has experienced a decrease in 2016 compared to 2015. The data used correspond to a report by Peter Van der Heijden, Maarten Cruyff, Ger Van Gils, and Jacco Snippe (2019).

Estimated number of suspects by type of victim Data 2015 and 2016 (Van der Heijden, Cruyff, Van Gils, and Snippe, 2019).

	YEAR 2015	Per Cent	YEAR 2016	Per Cent
(Ex)partner	55,777	78	50,622	81
Children	10,592	15	7,205	12
Parents	754	1	633	1
Other family members	1,077	2	957	2
Family's friend	272	0	161	0
Elderly	1,628	2	1,399	2
Other	1,034	1	1,226	2
TOTAL	71,134	100	62,203	100

Estimated number of victims by type of violence (Van der Heijden, Cruyff, Van Gils, and Snippe, 2019).

	YEAR 2015	Per Cent	YEAR 2016	Per Cent
Bodily	80,661	68	78,207	70
Threats	15,429	13	14,539	13
Sexual	9,657	8	6,176	5
Psychological	5,792	5	6,871	6
Other types of violence	3,118	3	2,593	2
Harassment	3,262	3	4,068	4
TOTAL	117,919	100	111,963	100

Registered (suspected) perpetrators of DV by type of violence year 2015-2016

(Van der Heijden, Cruyff, Van Gils, and Snippe, 2019)

Type of Violence	**YEAR 2015**	**YEAR 2016**
Bodily	8,907	8,156
Sexual	509	323
Harassment	702	650
Threats	2,655	2,191
Psychological	1,503	1,272
Other types of violence	295	303
TOTAL	14,571	12,895

Registered victims of DV by type of violence year 2015-2016

(Van der Heijden, Cruyff, Van Gils, and Snippe, 2019)

Type of Violence	**YEAR 2015**	**YEAR 2016**
Bodily	9,362	9,905
Sexual	834	722
Harassment	968	1,113
Threats	3,097	3,212
Psychological	1,501	1,633
Other types of violence	296	384
TOTAL	16,058	16,969

Registered (suspected) DV perpetrator by types of victims (Van der Heijden, Cruyff, Van Gils, and Snippe, 2019)

Type of Victims	**YEAR 2015**	**YEAR 2016**
(Ex)partner	12,514	11,242
Children	1,480	1,171
Parents	58	46
Other family members	72	65
Family's friend	18	12
Elderly	105	98
Other	324	261
TOTAL	14,571	12,895

Registered DV victims by types of victims

(Van der Heijden, Cruyff, Van Gils, and Snippe, 2019)

Type of Violence	YEAR 2015	YEAR 2016
(Ex)partner	13,476	14,403
Children	2,066	1,990
Parents	42	44
Other family members	68	77
Family's friend	21	16
Elderly	159	200
Other	226	239
TOTAL	16,058	16,969

2) Domestic violence against immigrant women living in the Netherlands

DV incidents occur to Dutch women and to females of other ethnic backgrounds as well. The heterogeneous population of immigrant women has different reasons for leaving their country, and they differ in their levels of education. Some have a traditional gender role attitude and are without resources, depending on their husbands. If they become victims of abuse, the degree of DV severity can vary according to its nature and prevalence but certainly impact their health, quality of life, and parenting functioning (Hungerfort et al., 2012). DV's prevalence rates depend on sociodemographic variables such as cultural background and socioeconomic position (Alhabib, 2010).

In violent homes, families tend to isolate socially and maintain a culture of silence about what is happening to them. Immigrant mothers from non-Western backgrounds who belong to ethnic minorities experience victimisation via financial control (Sharp-Jeffs, 2015). Many women are victimised at home by their intimate partners, experience social disadvantage, and often feel discriminated against in the host country, making them vulnerable to mental health problems (Vinkers, Van der Vorst, Hoek and Van Os, 2021). Ethnic minorities children and adolescents with social disadvantage externalised more often problematic behaviour in comparison to Dutch youth (Adriaanse, Veling, Doreleijers, and Van Domburg, 2014), are more at risk of psychotic disorders (Veiling, Susser, Van Os, Mackenbach, and Hoek, 2011), and depressive symptoms due to perceived discrimination (Van Dijk, Agyemang, De Wit, and Hosper, 2011). Considering that in the year 2020, 2,392,060 immigrants of non-Western origins reside in the Netherlands (CBS, 2021), the problems (disadvantage) migrants face are considerable and need to be addressed.

Native Dutch mothers know how to reach social support services and get help for themselves and their children while other ethnic groups do not (Van den Broek et al., 2010).

3) Suspicion of child abuse in the Netherlands

There is much evidence that dysfunction in the family correlates with various types of abuse (Taillieu, Brownridge, Sareen, and Afifi, 2016), leading to severe child (physical) maltreatment, (emotional) neglect, and other forms of abuse (e.g. sexual) that produce harmful consequences. Harsh punishments such as slapping, hitting, pushing, and grabbing (Afifi, Mota, Sareen, and MacMillan, 2017) can induce children to develop mental health problems and increase the odds to become perpetrators of violence in adulthood (Renner and Slack, 2006).

Because child maltreatment affects us all as a society, the Netherlands has since 2012 a reporting code for domestic violence and child maltreatment to be applied in hospitals' first aid consultation, General Practitioners, and youth services (Health Inspection, 2012). In 2016 there was an evaluation of the reporting code. The results were as follows: 71.6% of healthcare personal used the reporting code; 27.7% did not; 4.7% did not answer. The healthcare sector that used the lowest reporting code was oral care, missing a chance to detect maltreatment in children and the elderly. The implementation of the code is not yet adequate, according to the Healthcare authorities.

Professionals should be well prepared to recognise abuse and neglect, take suitable measures to protect children, and report the cases to official agencies concerned with child abuse cases. However, this is not an easy task. Professionals may lack training or communication skills to recognise abuse and are, therefore, not keen on reporting to C*hild Protective Services* for fears of negative consequences for children or parents by false positive or false negative assumptions (Gubbels, Assink, Prinzie, and Van der Put, 2021).

According to research in the Netherlands, in studies where children's self-reported abuse, around 12% said they were abused (Schellingerbout and Ramakers, 2016). Nevertheless, only three per cent of abused children are detected by professionals (Alink, Prevoo, Van Berkel, Linting, et al., 2018).

4) *Child Protection Services* (CPS)

Many families in the Netherlands are known to social and child protection services because children are seriously distressed due to violence between their parents at home. They could suffer abusive (emotional) neglect (Tierolf, Geurts, Steketee, 2020). Sometimes, parents are negligent, their parenting is inadequate, and although there are no visible broken bones or bruises, children can show signs of neglect. For instance, dental caries is a sign of child abuse and neglect, supported by the literature (Gilbert, Breiding, Merrick, et al., 2015; Sillevis Smith, De Leeuw, and De Vries, 2017; De Jong-Lenters, Duisjter, Bruist, Thijseen, et al., 2014). In such cases, healthcare professionals can refer the family to social services to receive support and prevent future mistreatment. Healthcare personnel working with children should be well informed to recognise early symptoms of abuse (Sellevis Smitt, Mitjes, Hovens, De Leeuw, and De Vries, 2018).

The prevalence of children's maltreatment in the Netherlands is very high. It must be addressed to avoid (fatal) injuries resulting from severe abuse by implementing better procedures to detect abuse at an early stage. Despite CPS significant reorganisations and changes within the organisation, it aims to execute all principles of the *Convention on the Rights of the Child*, defend children's interests, safeguard their safety, and prevent child maltreatment (López López, Bouma, Knorth, and Grietens, 2018).

The Dutch authorities find that prevention is crucial and considers that individuals working with children must identify and intervene by signs of abuse. Each year, 1.2% of Dutch children are exposed to DV between their parents. Each year, approximately 200,000 adults and 119,000 children are victims of DV (Rijksoverheid, 2020).

To prevent violence, the Netherlands implemented a code of conduct for teachers, healthcare personnel, day-care employees, social support services, youth protection assistance, and the justice system, which can be applied whenever suspected violence against a child is present. This code system is mandatory so that help can be organised and security for the children guaranteed (Rijksoverheid, 2020).

5.1 Registered domestic violence crimes in the Netherlands

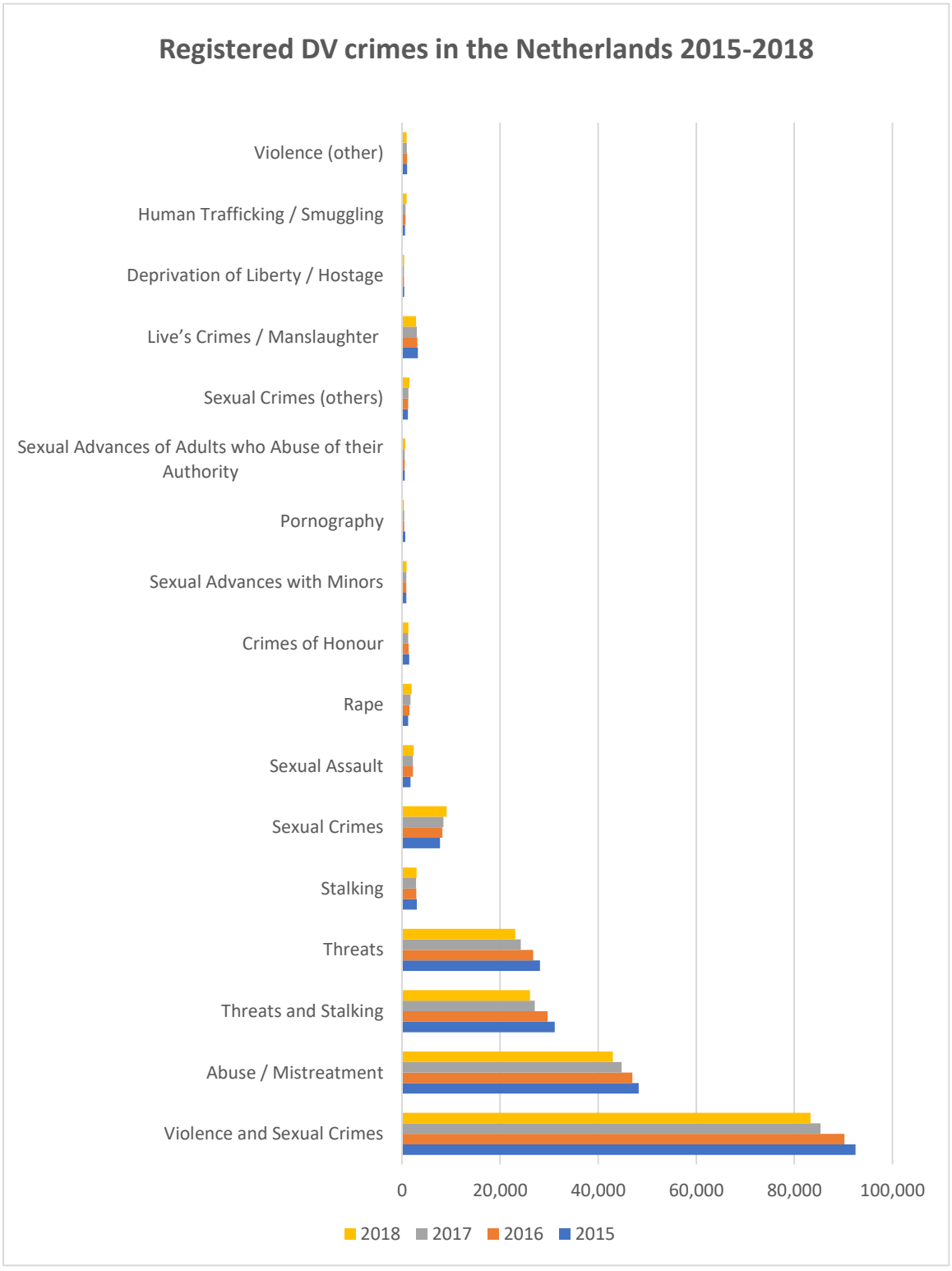
According to the Dutch police, a child and an adult died every month due to violence at home. Every year there are approximately 84,000 or more reported incidents of DV (See Table 1 below). However, the numbers are probably much higher since not all incidents are reported for reasons of shame, fear, or economic dependency (Politie, 2020).

Table 1 Total number of registered DV crimes in the Netherlands in 2015-2018.

Registered DV crimes in the Netherlands	**2015**	**2016**	**2017**	**2018**
Violence and Sexual Crimes	92,475	90,200	85,335	83,320
Abuse / Mistreatment	48,280	46,990	44,760	43,025
Threats and Stalking	31,120	29,690	27,040	26,080
Threats	28,115	26,760	24,220	23,105
Stalking	3,005	2,930	2,880	2,975
Sexual Crimes	7,730	8,235	8,425	9,100
Sexual Assault	1,720	2,220	2,210	2,385
Rape	1,265	1,535	1,760	1,935
Crimes of Honour	1,445	1,380	1,275	1,300
Sexual Advances with Minors	875	860	875	920
Pornography	660	445	425	385
Sexual Advances of Adults who Abuse their Authority	565	530	550	680
Sexual Crimes (others)	1,195	1,265	1,325	1,500
Live's Crimes / Manslaughter	3,255	3,120	3,010	2,870
Deprivation of Liberty / Hostage	440	420	400	425
Human Trafficking / Smuggling	625	730	725	940
Violence (other)	1,035	1,020	975	940

Data retrieved from the Dutch Central Bureau for Statistics (CBS).

Data obtained by the Dutch Office for Statistics (CBS, 2020)



The first Dutch national survey on the prevalence and consequences of DV and marital rape was published in 1989. The survey brought to light the nature, dynamics, and social background of the women affected. At the time, the size of migrant communities in the Netherlands was too small to be representative; thus, it was not included in a population survey. Results showed that 21% of all Dutch women had experienced violence from their male partners (Shahidullah and Derby, 2009). Half of those women were also raped. Approximately 5% of the women said that she and her partner used mutual violence, and 3% had been raped without additional physical abuse (Römkens and Lahlah, 2011)

In the Netherlands, as in other democracies globally, policy measures are being discussed in parliaments. Governments make proposals of reforms, and they form coalitions to arrive at a majority. Policies change according to the political ideas of the parliament's majority at that moment.

Around 1974, groups of feminists social workers started to be politically active and mobilised against women abuse; they opened the first shelter in Amsterdam. Time later, many more shelters opened their doors with a common name in the whole Netherlands: "*Blijf van mijn lijf*" (that in English can be translated as "*Do not touch my body*") (Roggeband, 2002). From 1976 onwards, shelters received fundings from the government. Treatments for perpetrators of violence against women became a policy goal (Roggeband, 2002). In 1991, the penal code's reformation made it possible to consider rape within the marriage as a crime (Roggeband, 2002).

The Dutch government consulted women organisations' views to establish effective policies to protect women from violence; the feminist activists highlighted that DV is rooted in gender inequality and, consequently, disparities are being sustained. As a result of women's organisations' participation, it was possible to create progressive and dynamic policies around 1984. The Dutch government's first policy plan regarding DV was '*Combating sexual violence against women and girls*.' Unfortunately, consecutive decennia policy developments were less effective in the cause of women's equality (Roggeband, 2012).

5.2 Dutch Policies

Gender-neutral policies

Since the year 2002, DV has been high on the Dutch governments' political agenda. That priority only came after copious research on DV that demonstrated how high the numbers of violent incidents were still occurring in the Netherlands. This realisation accelerated the introduction of protective measures (Van der Veen and Bogaerts, 2010). Since 2015, the *Research and Documentation Centre* (WODC) has conducted many studies on DV concerning violence against females and males by their partners or ex-partners and child abuse (Ten Boom, Wittebrood, Alink, Cruyff, et al., 2019).

The Netherlands ratified the Istambul Convention, recognising that violence against women occurs at a grand scale (Council of Europe, 2015). However, governmental policies changed from concentrating on intimate partner violence against females to a broader domain that contained any kind of violence perpetrated by present or former partners irrespective of whether the abuser is male or female (Althoff, Slotboom, and Janssen, 2019). The gender-neutral perspective of the Dutch government was criticised by the *UN Committee on the Elimination of Discrimination Against Women* (CEDAW) (2007) and by the *Special UN Rapporteur on Violence Against Women* (Ertürk, 2007) on the basis that 85% of DV victims are females. More recently, the Wave (2020) report, written by working group members with expertise on women's issues in different European countries, warns about gender neutrality policies and practices. According to Wave (2020), gender-neutral policies represent a danger for dismantling structural economic resources that facilitate access to women's only safe spaces and other types of help.

Neoliberal governments in Europe (and globally), with their profit mentality, a fixation on economic growth and increased competition, facilitate even further excluding marginalised women (e.g. minorities, disabled, migrants). The introduction of cuts in services, public expenditure, and welfare benefits affects socioeconomically disadvantaged individuals and make inequalities more visible. By making gender-

neutral policies, neoliberals negate the disproportional violence against women and women's rights to protection.

Domestic violence and police response

The police expose the magnitude of DV social problem in their report. Every month a child or an adult dies as a result of DV. Yearly there are approximately 84,000 reported incidents of DV. However, the numbers are probably much higher since not all incidents are reported for reasons of shame, fear, or economic dependency (Politie, 2020).

Despite the high number of employees (65,000) working for the Dutch National Police Force (ten regional units), of whom 51,000 are police officers, and 14,000 employees who support those units (Politie, 2020), DV interventions require high human resources and efforts to deal with threatening situations. Besides, DV is, of course, not the only work of the police.

On many occasions, children (and pets) are the victims of violence in homes, which have deleterious consequences for all members of the family: Mother's health and well-being, children's performance at school (children affected by violence isolate themselves while others react violently towards their peers), and DV often co-occurs with animal abuse (Politie NL, 2017).

The official number of reported incidents of violence committed by a partner in 2018 in the Netherlands was 74,700. One in twenty adults (5.5%) is said to have been confronted with physical or sexual violence at least once in a period of five years by an actual or former intimate partner. The reporting individuals were 18 or older (Van Eijkem, Downes, and Veenstra, 2018).

Dutch government policies on domestic violence

Since 2015, the Ministry of Security and Justice (and two other ministries) have used the data obtained every semester by *The Dutch Statistical Office* (CBS) to monitor the situation referring to Safe Shelters, Advice and Reporting Point Child Maltreatment;

and Support Centre Domestic Violence. A protocol was designed to establish what kind of information should be gathered, as shown below (CBS, 2017):

- Reasons the person has to make a report to Safe Shelter.
- Type of violence or abuse.
- The capacity of the person who makes the report.
- Date of the report.
- Date of the triage decision.
- Continuation of the report/ triage decision
- Research number.
- The nature of the third party to whom the transfer/referral has taken place.
- Information about the person to whom the report relates.

Interventions are implemented to improve the collaboration between the police and different organisations dealing with DV and combat the problems related to it. Among the measures taken are: Making the problem visible, clearly stating that DV shall not be tolerated; improving the conditions for battered women by offering help and assistance; by implementing guidelines for professionals, and also by providing interventions for offenders to increase awareness of their behaviour, and to reduce the numbers of violent incidents (Van der Veen and Bogaerts, 2010).

A study by Anderson and Van Ee (2018) reviewed the structure of tested programmes documented in the literature in fifteen different countries and wanted to find out whether those programmes make positive contributions for mothers and children exposed to DV, as well as for other categories of victims, for instance, men. The authors of the article noticed that the percentage of DV varies among countries, ranging from fifteen per cent in Japan to as high as seventy-three per cent in Ethiopia (Garcia-Moreno et al., 2006). They also noticed that even though men are victimised as well, the lower numbers of victims may be due to under-reporting, cultural bias, gender and stereotypical behaviour (Anderson and Van Ee, 2018).

5.3 The Dutch Entrustment ACT (TBS Measure)

In the Netherlands, judges have a judicial instrument of the Criminal Code (Art. 37a) that they can apply to people who, due to their developmental deficiencies and pathological mental disorders, are considered as having diminished responsibility for crimes they commit. This measure is called TBS (in Dutch Terbeschikkingstelling), and it is applied to defendants who have committed serious crimes.

Individuals are considered to have diminished responsibility when they cannot be held totally accountable for their actions, but neither can be regarded as free of guilt (Van Marle, 2002). TBS is a discretion that the State of the Netherlands has to hold individuals at the disposal of the Ministry of Justice and Security when the crimes were perpetrated under abnormal psychiatric circumstances. The Ministry can place mentally disordered offenders in psychiatric forensic hospitals for treatment. Those patients can be confined for an undetermined time, away from society, where they are not a danger or threat to others (Van Marle, 2002). The main aim of the TBS system is to treat perpetrators instead of punishing them. Also, to prepare them for reintegration into society, reducing the risk of recidivism.

Judges can impose TBS when a perpetrator commits an offence for which four or more years of prison applies (Vorstenbosch, Bouman, Braun and Bulten, 2014). Also, in cases where there is a significant risk of re-offending, the public prosecution or the judge can ask the Dutch Institute for Forensic Psychiatry to evaluate the suspect's mental health.

TBS works in combination with a prison sentence, and the measure is applied after the defendant has served a prison sentence corresponding to at least one third to half of the mandated sentence. TBS duration is decided upon regulations from the *Ministry of Justice and Security* and considerations of the treatment staff. If needed, TBS can be prolonged for decades, especially if the person is still considered a danger to society. Sometimes perpetrators stay for life in forensic settings. Recently, attention has been drawn to the length of stays in forensic psychiatric care. In the Netherlands,

the average stay (from 1990 to 2009) was between 5.6 to 9.8 years (Nagtegaal, Horst and Schönberger, 2011).

Observation centre for suspects of severe crimes – The Peter Baan Centre (PBC)

The Dutch Ministry of Justice and Security counts with an observation Centre called the Pieter Baan Centre (a forensic psychiatric observation clinic), where qualified professionals assess suspects of serious crimes. Since the year two-thousand-and-seven, the clinic is part of the *Netherlands Institute for Forensic Psychiatry and Psychology* (NIFP). The Minister of Justice and Security is responsible for funding TBS maximum security hospitals and regulates the placement and the parole release policies. Nevertheless, only the court decides whether the TBS measures are to be lifted or prolonged by a period of one or two years (Van Marle, 2002).

In the Netherlands, there is a unique collaboration between criminal law and psychiatry. Judges regularly call on psychiatrists/psychologists before they reach a decision. This collaboration is vital to do justice to both the suspects of crime and their victims and keep society safe (Meynen, 2019).

The Pieter Baan Centre (PBC) informs judges about the defendants' mental health and gives treatment advice. During seven weeks, suspects are observed by a multidisciplinary team of experts (e.g. psychologists, psychiatrists, forensic social workers, ward staff members, and a legal expert who supervises the assessment process). During the defendants stay at the PBC, the ward staff members observe and describe the defendant's activities and behaviour during their stay. The forensic social worker investigates the defendant's life history and social background (e.g. gained by interviews with family members, former employers and teachers). As a result of those observations, the degree of responsibility of defendants will be determined – whether they are fully accountable for their actions or not - (Spaans, 2016).

Refusal of assessment by detainees

Some defendants do not wish to collaborate on their mental health assessment. These psychological checks are ambulant and taken in the house of detention or in the forensic observation centre PBC. These assessments are vital sources of information for the criminal court and the judge to determine the sentence.

A study by Nachtegaal et al. (2018) found that the number of defendants who refused to participate in the assessments in an ambulatory setting in the period 2002-2016 was about 11% (range 7%-15%) - only an approximation of the number of those who did not participate since registrations are incomplete.

At the PBC, the assessment refusal in the period 2002-2017 was on average 39%; 12% partially refused. The increase in the rejection of assessments was 23% in 2002 to 43% in 2017 (Nachtegaal et al., 2018).

Some perpetrators prefer to have a regular prison sentence imposed because only then will they know when they will be released. With the TBS set, it is uncertain when the person will not be considered a danger to society.

5.4 Characteristics of female perpetrators of domestic violence in the Netherlands

Nineteen cases of female offenders in the Netherlands were obtained from the data of the Dutch Criminal Courts corresponding to the years 2015-2018.

The cases of DV treated in Dutch criminal courts are reported incidents where severe violence had been applied. Researchers or interested members of the public can obtain open data of anonymised cases about DV that give an impression of the types of cases and their seriousness occurring in the country. Many of the defendants have psychological disorders and substances abuse.

Here are the main characteristics of female perpetrators in this sample:

These females age range was between 24 and 50 years.

Twelve had the Dutch nationality (63.2%), and the rest were born elsewhere: In Antilles (5.3%); Somalia (5.3%); Soviet Union (5.3%); Turkey (5.3%); and the nationality of one defendant was missing, the only remark was “Foreign Citizen” (5.3%).

Their victims were, in nine cases, their current partners (47.4%), in three instances, their ex-partners (15.8%), and the rest were “Other.”

The place of crime was in eleven cases where victims and perpetrators lived together (57.9%). In five cases, the crime occurred at the victim’s house (26.3%), and the other crimes happened on a public road (5.3%), a recreation place (5.3%), and on the street (5.3%).

All female perpetrators had a diagnosis of severe mental/personality disorders. There were two exceptions. There was no psychopathology in one of the females despite the violent nature of the crime, and the other refused to be psychologically assessed.

Among the combinations of disorders the defendants suffered were:

- Antisocial / Borderline
- Borderline / Narcistic and Dependant Traits
- Borderline / Psychotic / Paranoia

- Mild intellectual disability / PTSD / NOD with a dependant and evasive trait
- PTSD (her step-father abused her) / Borderline / Dissociative Disorder
- Schizophrenia / Borderline

Individuals with a combination of severe personality disorders share some characteristics in their personality by disregarding others, lack of remorse and empathy, manipulative, narcissistic, and aggressive (APD; PPD). Changeable mood, anger, impulsiveness (BPD)., and unpredictable, among other deficits.

Their aggressive personality reflects on the type of head injuries they inflicted on their victims, as we shall see in some examples below:

- A knife wound in the left ear
- Children were scratched in their face
- Hit husband's head with a wooden bat
- Punches in the head/face
- She threw a mobile phone against her husband's head
- Squeeze the throat/neck tightly
- Stab wounds in the neck
- With the fingernails scratch the face of her sister-in-law

Description of Torso Injuries

- Broken hip joint
- Broken ribs
- Children were regularly abused by their mother
- Hits
- Stab wound in the stomach
- Stabbing with a meat-knife to the chest
- Wound of 5 cm under his left shoulder blade

Limbs Injuries

- Broken left wrist and upper arm
- Insulin induction while the husband slept
- Kicks in the arms and legs
- Stab her brother in the arm
- Stab wounds in the arms
- Stab wound in the shoulder

Other types of injuries

- Blindfolding
- Beaten-up and kick against children's body
- Bites, scratches and punches
- Deadly threats, "I will kill you."
- Due to an incident, the victim got a psychological trauma
- During an argument, the defendant threw scalding water over her partner
- Lung injury
- Multiple fractures in the body
- Packed and buried the victim's body in the woods
- Penetrated the vagina of another woman with a bottle
- Punches and kicks the belly of a pregnant woman (her future sister-in-law
- Regularly pinched the children
- Rubbed the vagina of the victim with a stem of a flowering plant
- Set a fire in the bedroom using turpentine
- Set the children under a cold shower
- Stab wound in the leg
- The mother punched and slapped the children with a belt

5.4.1 Real Criminal Cases of Female Perpetrators in the Netherlands

The cases of DV treated in Dutch criminal courts are reported incidents where severe violence had been applied. Researchers or interested members of the public can obtain open data of anonymised cases about DV that give an impression of the types of cases and their seriousness occurring in the country. Many of the defendants have psychological disorders and substances abuse; the majority of defendants are male.

It is essential to mention that the Dutch criminal system and other international jurisdictions differentiate in their sentencing when the offender records severe mental disorder.

This section selected some real cases, summarised in length, from the Dutch Court's dossiers (anonymised open data) concerning DV perpetrated by females in 2015-2018. From the study of 253 severe DV cases treated by the criminal court, there were 19 female perpetrators.

YEAR 2015

Case 5027

The defendant has three children from an ex-partner. She was seventeen years in a relationship with another man, with whom a daughter was born. The new partner did not recognise this child as his; consequently, there was no legal family relationship between him and the 12 years old girl.

The couple separated due to prevailing long-standing relationship problems and because he physically and mentally abused the defendant. Despite her attempts, she could not end the relationship definitively partly because of her personality disorder. Although the victim moved out of the house, he was allowed to continue visiting the children regularly.

On the day of the crime, the twelve-year-old daughter was taken by her father without permission; the girl did not want to leave home where she lived with her siblings and her mother but was forcibly taken away in her father's car.

The girl was very afraid and tried to phone her mother, who was not at home; she needed help to prevent her father from taking her out of the country - he had mentioned they were going to Belgium.

Her mother called emergency number 112 to report the kidnapping before driving home. On the way home, the defendant had to stop at a red traffic light. At that moment, she noticed her ex-partner's car with her daughter sitting beside him, driving in the opposite direction.

She stopped near the victim's car. The victim got out of his vehicle and ran towards her, threatening that she would lose her daughter forever. The woman also feared for her own life.

The defendant gave gas and drove her car in the direction of the victim. According to two witnesses, the front of the defendant's car came in contact with the man's legs, causing him to fall backwards and hit the ground on his back. Then the defendant drove with the right front wheel and the right rear wheel over his legs and then over his chest.

Medical examinations showed that the victim had suffered severe injuries. Namely broken ribs; fractures in the back, the left shoulder blade, multiple fractures on the

pelvis, a fracture in the left hip joint, numerous fractures in the hip and displacement of fragments of the bones from the left upper arm, and injury to a tendon of the left little finger. Several operations were necessary to save his life.

The physician estimated that the rehabilitation would take many months. It could not be predicted whether the victim would ever reach the same level of functioning as before.

The defendant stated to the police, the judge commissioner, and at the hearing that she did not intend to kill her ex-partner, only to break his legs. The woman stated she was in a state of panic before and during the incident because she feared never again seeing her daughter.

In response to the charges, a psychologist investigated the mental capacity of the accused. He reported that the defendant had a morbid personality disorder classified as Not Otherwise Defined (NOD) with both dependent and evasive traits, influencing her choices and behaviour.

The psychologist advised the court to consider the defendant as not being fully accountable for her actions.

The court accepted the behavioural expert's opinion and conclusion that the proven evidence could only be attributed to the defendant to a reduced extent.

Moreover, since the circumstances had not allowed a plausible reduction of the accused's criminality, the court considered the defendant liable for Aggravated Assault. The court sentenced her to a prison of 24 months, of which eight months were probational.

During probation, the woman behaved according to the regulations and instructions of Probation Netherlands, even if that meant participation in outpatient treatment. Probation supervision should assist the accused during this period.

On appeal, the court accepted the defence argument of psychological force majeure.

The defendant’s actions were disproportionate, but she acted out of fears and worries about her ex-partner's violent temper and his unlawful kidnapping of her daughter. She also feared that there was a risk of a sexual assault of the girl. The defendant was acquitted of all criminal charges.

Year 2015

Case 1696

The defendant and the victim have a son together. When the couple separated, their child stayed with his mother. The parents continued in contact with each other for the sake of the child.

On the night of 15th December, the defendant drove to the victim's house. They argued; the victim was angry and told the defendant to leave his home.

One hour later, around 4 am, the defendant decided to go back to the victim's house. This time she took a knife with her to defend herself in case it was necessary. Again, this second visit ended up in a quarrel around issues concerning the child. The child's father asked questions (about the child), but the defendant did not answer any of them. For the third time, without any response, he attempted to grab her. They were in the kitchen in front of each other, separated only by a table. According to the defendant, her ex-partner became very aggressive, and when he approached her, she took the knife that she had hidden inside of her jacket and stabbed the victim's chest, he collapsed.

After the police intervention, the victim was taken to the hospital. A pneumothorax was discovered caused by a two-centimetre knife wound to the left side of his chest, between the ribs and four-centimetre to the left of his Sternum.

It could be established without a doubt that the defendant was the one who injured the victim with a knife. The court considered that stabbing a person in the chest with a knife near the heart, where vital organs are located, represents a significant risk of causing a person's death.

By carrying out the offence, the courts asserted that the defendant had accepted the possibility of taking the victim's life but had not completed the intended crime. The court, the prosecutor and the defence agreed that it could not be proved that the defendant's act was premeditated.

In deciding the sentence to be imposed, the court considered the nature and seriousness of the acts and the crime's circumstances. The defendant had no previous convictions, and she was repentant of her actions. Besides, she was responsible for the care of her child.

The court found the defendant guilty of Attempted Manslaughter and sentenced her to prison for 24 months, of which six months were probationary. The defendant had to follow the treatment recommendations advised by probation during the probationary period, allowing supervision, home visits, and measures to deter further offences.

YEAR 2016

Case 8209

The Limburg Court sentenced a thirty-eight-year-old woman to eight years of prison for her husband's attempted murder (premeditated intent). The woman was accused of injecting her husband (very early in the morning) with insulin while he was sleeping in the house where they lived together. At around 09:00 hours, she left the house to go shopping at the supermarket. She returned home to find that the police had arrived but did not mention the insulin because she was afraid of prison.

The victim could call the police for help; they found him on the floor near his bed, unconscious, with low blood values and suffering from hypothermia (33.6 degrees Celsius). The ambulance transported the victim to the hospital. He spent several days (from 9 to 14 March) due to persistent hypoglycaemia (a low glucose concentration in the blood) caused by exogen insulin.

About the offence: For the Court to rule 'Criminal Attempt' in a case, it is necessary to answer the question as to whether or not the means used by the defendant to take the victim's life would have been effective or not. The answer is yes, according to the opinion of experts and forensic doctors.

This case referred to a woman who injected insulin into her husband, who is not a diabetes patient. The court concluded that insulin could take a person's life and, therefore, a criminal attempt could be ruled. The fact that the victim consumed a fair amount of alcohol and that the insulin's dose injected could not be determined with precision does not diminish the defendant's responsibility. The defendant's motivation to commit such an act was to free herself from her husband to start a new life in a new relationship. She also hoped that by injecting insulin, the crime would not be discovered.

The victim has suffered psychological consequences because the person he lived with for many years has tried to kill him. The victim's immediate environment also was affected by the crime.

The defendant had no previous criminal convictions. Despite the prosecutor's advice to implement a longer prison sentence, the court considered eight years imprisonment an adequate punishment.

The accused refused to collaborate with the researchers at the Peter Baan Centre in their objective of issuing a report on her state of mind or possible psychopathology to determine whether or not the defendant was fully accountable for her actions.

Year 2016

Case 800

A 42 years old woman was convicted of attempted manslaughter and not murder because the crime was not premeditated. The victim, her brother-in-law's new girlfriend, was sleeping on the beach of a recreational lake when the defendant approached her without warning. The defendant kicked the victim forcibly in the abdomen and then stabbed her with two knives, one in each hand, in her chest, arm, shoulder and neck.

Previous to this incident, according to the victim, the defendant had threatened her via Facebook: "If you come to the Netherlands by plane, you will go back to Thailand in a coffin." The court did not find any evidence that threats were made via social media and, therefore, acquitted the defendant for threats.

According to the forensic psychologist, the defendant had developed an adjustment disorder due to an accumulation of painful emotions and multiple stress factors (her child's death). The psychologist concluded that the defendant was under tremendous emotional pressure during the crime and lost control of her behaviour. He advised that she should be considered impaired.

The court accepted the expert's conclusions that the defendant was in a state of diminished responsibility at the time of the crime and sentenced the defendant to 3

years in prison, from which one year was probationary. The defendant was committed to long ambulant treatment in a forensic clinic due to her psychological mental state to avoid recidivism.

YEAR 2017

Case 4101

The suspect had tried to take her husband's life by burning him with turpentine while he was sleeping in the bedroom.

The sequence of the defendant's actions on the night of 11th July showed a planned approach. Firstly, the suspect took a bottle of turpentine from the kitchen and threw a laundry pile on the bed where her husband was sleeping, creating extra fire material. She did not throw the turpentine directly over the victim's body but deliberately poured it around him to prevent him from waking up. Because it was dark, the defendant could not see where the liquid was poured. She emptied the bottle almost entirely and then locked the bedroom's door. Next, she lit a handkerchief, opened the door and threw the burning handkerchief onto the bed (which was covered with turpentine), closed the door and locked it intending to prevent the victim from escaping.
During those preparations, the defendant had plenty of time to think about the consequences of her actions and had time to abandon her murderous criminal plan.

The police forensic investigation team examined the victim's bedroom a few hours after the incident was reported. This team said that the smell of turpentine in the bedroom was very strong. There was turpentine on the bed, the floor and the wall. On the bedside, a partially burned handkerchief was found and showed visible signs of fire.

When the Police checked the suspect's smartphone, they found, among other things, her search history on the Internet. They found the following: Turpentine evaporation; cause of bedroom burnt-out; fire produced by turpentine; man sets sleeping homeless people on fire.
Concerning the results of the smartphone investigation, the defendant stated at the hearing that it was her and nobody else who sought and read about those specific

terms. Nevertheless, she stated having made those searches in a different context, namely investigating what her husband could do to her. The court considered this argument illogical and unlikely and overrode the statement in this section.

Furthermore, the court considered no plausible contraindications which could stand in the way of a charge of premeditation.

It is essential to mention that the day in question – even according to the defendant – had been quiet in the house, without any significant quarrels. At the time, everyone in the house, except the suspect, was sleeping peacefully.

The defendant stated in this regard that she could not sleep that night and that she was motivated by a quarrelling couple she saw walking past on the street, where the man had a loud, angry voice and the woman was crying, in which she recognized the characteristics of her unhappy marriage.

The court could not reasonably see that the alleged observations - if true - had such an impact on the defendant's state of mind that it has led her to act in the way she did. The court considered that the defendant acted with premeditation.

The report dated 18 October by Probation Netherlands included the following:

Before the offence, there was a long-standing, problematic relationship between the defendant and her husband. She suffered, namely from DV perpetrated by her husband.

According to the defendant, she attempted to end the relationship, but ultimately she was not decisive enough to turn her intentions into actions. Feelings of tension, frustration, and powerlessness had, as a result, increased over the years.

Probation Netherlands estimated both the risk of re-offending and withdrawal from the court's conditions to be low/average. The defendant had a personality disorder Not Otherwise Specified (NOS), with evasive, dependent, narcissistic and borderline traits.

The defendant and her husband were not in contact with each other at the time. However, they still had to go through divorce proceedings, where the possibility of tension and frustration surrounding the financial settlement and dealing with the children could be present.

The defendant was cooperative and open to assistance and had no previous record of violent behaviour.

The probation service advised the court to impose a (partly) suspended prison sentence with mandatory probation contact and participation in outpatient treatment at a forensic clinic.

Also, a psychologist [name expert] compiled a report on the suspect. The information included the following:

The likelihood of a recurrence of the crime as charged was considered moderate. Based on the suspect's personality disorder, she is inclined to avoid conflicts or act in a dependent or avoidant manner. Nevertheless, due to the same condition, she is easily hurt and lacks the skills to deal with difficult situations. The disorder can reinforce each problem in a negative sense.

She has little regard for the interests and needs of the other. Those factors combined increase the risk of re-offending. The suspect also had a limited network which could also increase the risk of re-offending.

Based on the psychologist's assessment, it was recommended that the suspect's personality problems be treated through Schema Therapy. It was advised to report the suspect to [name of the setting] and supervised by the probation service, whereby the treatment could be absorbed through Schema Therapy as an exceptional condition in the case of a (partly) suspended sentence for detention.

The court concluded that the defendant acted with premeditation and objected to the defence's argument that it was a motivated psychological act. The court sentenced the defendant to Attempted Murder and Arson and imposed prison for four years. One year was subjected to the special condition that the defendant undertook treatment.

Year 2017

Case 4543

For the abuse/mistreatment committed against her nine-year-old son, the mother was sentenced to 40 hours of community service.

The defendant had a history of problems with her ex-partner, the father of her children. These sometimes violent interactions between the parents provoked tensions in the whole family. The defendant and her ex-partner were used to involving the children in their problems and mutual quarrels.

On 2 April 2017, the situation went too out of hand when the defendant, full of anger, grabbed and held her son by the throat, resulting in red welts on the child's throat/neck.

By acting in this way, the suspect created a very unsafe situation for her son. It is known that children affected by DV can acquire a dysfunctional emotional development due to what they experienced or witnessed in their homes.

In this case, the Probation Office recommended to the court that a psychological assessment of the defendant is made to facilitate the most appropriate treatment for her. There would be positive results for the family if the defendant learned that her conduct has consequences. The creation of a safe environment for her children is fundamental for their well-being. By building a supportive social network, she could improve the situation in the family.

The court accepted the advice given by Probation and imposed a partially suspended sentence on the defendant.

Year 2017

Case 925

The defendant went to the bedroom, found a wooden object and went to the living room where the victim (her husband) was sitting in front of a laptop. She hit him repeatedly on the head and the arms. She then put her blood-stained clothes in the washing machine and left the house while her unconscious, bleeding husband laid in a pool of blood.

The police intervened, and the victim was brought to a hospital where he was treated for fractures to his skull base, jaw, eye socket and two ribs. The victim also had lacerations to the head and slight bleeding in the brain that could have been fatal.

According to the public prosecutor, the defendant intentionally and premeditatedly carried out the alleged offence, intending to kill him.

Unlike the prosecutor, the court considered that it could not be established that the defendant acted with a preconceived plan and, therefore, acquitted her of premeditation. The mere fact that the weapon used by the suspect was taken from the bedroom to the nearby living room was certainly not sufficient for the conclusion of premeditation. It could not be established when the defendant had decided to batter the victim. In the court's opinion, it could not be ruled out that the defendant acted in a sudden violent drift.

The psychiatrist and the health psychologist concluded that the woman's actions could be explained by accumulated anger towards her husband caused by years of mental abuse and emotional displacement. During the morning of the incident, the victim denigrated his wife, provoking a forceful angry discharge during a severe emotional outbreak. During and after the crime, the defendant's actions can be explained as a dissociation defence mechanism.

In her thinking, feeling and acting, the suspect became detached from herself and her surroundings and made a strange and inappropriate choice of action.

The court accepted the behavioural experts' advice and concluded that the defendant's criminal acts did not demonstrate premeditation.

In the verdict, the court considered that the defendant had no previous convictions and her home situation. In the file, it was noticed that the victim had always been a difficult man and that he was morbidly jealous and abusive towards his wife. He had belittled and humiliated her for years. The defendant's role in homes was that of a carer. She was barely allowed to contact the outside world (including her children and grandchildren).

Although these facts did not justify the accused's criminal actions, they were taken into account in favour of the accused in determining the verdict.

Nevertheless, the court argued that there was a conditional intent on the death of the victim. As a result, the defendant was charged with Attempted Manslaughter (instead of attempted murder as proposed by the prosecution) and served a prison sentence of 18 months.

The defence attorney requested an entitlement for the defendant for a psychological force majeure (the person is freed of liability when an extraordinary circumstance or

event is beyond the control of a party) and, therefore, dismissing all legal charges. The defendant's personality disorder (dissociation), according to the counsel, could not resist the pressure of been mentally abused and humiliated by her disabled husband from whom she was dependent and to whom she was loyal at the same time.

The prosecutor and the court refused the argument of psychological force majeure. The court was guided in her verdict on the seriousness of the evidence and the circumstances under which the crime was committed.

YEAR 2018

Case 5761

The couple was at home, the defendant was on the couch, and her husband was sitting at the table. Suddenly, he saw something flying in his direction; it hit the corner of his eye, and he felt a hard blow to his right cheek. He saw that the telephone fell apart on the floor. His wife got up from the couch, stood next to him and punched him on the nose. His right cheek was bruised.

The victim went to the police station to report the incident, where the officers were witnesses to the injuries inflicted on his face.

The court believed that the defendant created an unsafe situation for her son, who was present in the home and caused pain and injury to her husband, and ruled that there were no plausible circumstances that could exclude the acts' criminality, which meant that the actions were punishable. The prosecutor requested a sentence of six weeks in prison.

The defendant pleaded guilty to DV against her husband. She admitted punching him and throwing a telephone at his head.

DV infringes on the physical integrity and health of the victims, affecting society as a whole. From the police file, it came to light that the police knew the family for causing a nuisance in the neighbourhood on several occasions.

The defendant had a previous record of assaulting her husband three times before. Although she has been offered help several times, she was not willing or motivated to

accept it. All police and other social services attempts have not been successful in substantially improving the family situation.

The court sentenced the defendant to fifty hours of community services and imposed a two-year probation period. If the defendant does not comply with the duties to be performed or does not undertake her tasks properly, her community services will be substituted for a prison sentence of 33 days.

Year 2018

Case 3839

On 20 February 2018, the police was called to Utrecht. When officers arrived at the address in question, they saw a woman in the house and an injured man bleeding heavily - he said: “she stabbed me.”

The officers saw that the man had a stab wound of around 4-5 cm in his shoulder; he was examined by the ambulance personnel and was taken to hospital.

The defendant pleaded guilty to assaulting her ex-partner by stabbing him with a knife. Also, the defendant was guilty of insulting the police officers who arrived at the scene. The couple had a long history of DV; they were both addicted to drugs.

A psychiatrist reported the defendant's personality and concluded that the defendant suffered from a morbid disorder of emotion regulation and had cognitive deficits. Besides, she lived in a vulnerable environment and was a drug addict (GHB, cannabis, cocaine), had a borderline personality disorder, and a non-specified schizophrenia spectrum disorder. The expert recommended that the defendant should be considered as having a diminished responsibility for her acts.

In their report, the Probation Office recommended supervision with special conditions, including long-term treatment. The defendant has no previous criminal record.

The court imposed a lower sentence than the prosecutor requested, namely one-month imprisonment, treatment in a forensic clinic, and the imposition of a restraining order prohibiting her from living at the same address as her friend to avoid future altercations or drug relapse. She was also committed to a probationary period of two years, monitored by the Probation Office.

5.4.2 Presentation of the Dutch Courts' data concerning female perpetrators.

Characteristics of Female Offenders in the Netherlands regarding severe DV cases in the period 2015-2018.

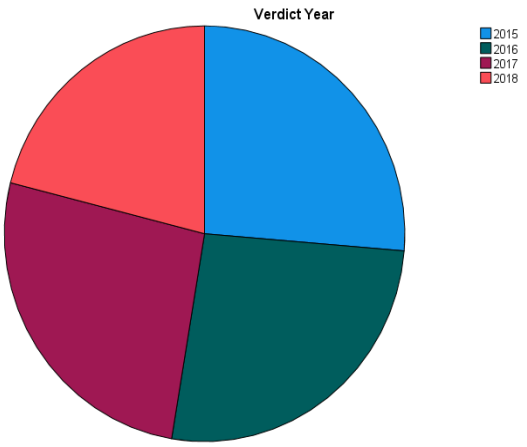
Sex Culprit

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Female	19	100.0	100.0	100.0

From 2015 to 2017, there were five severe DV cases (26.3% each year); and four cases (21.1%) in 2018.

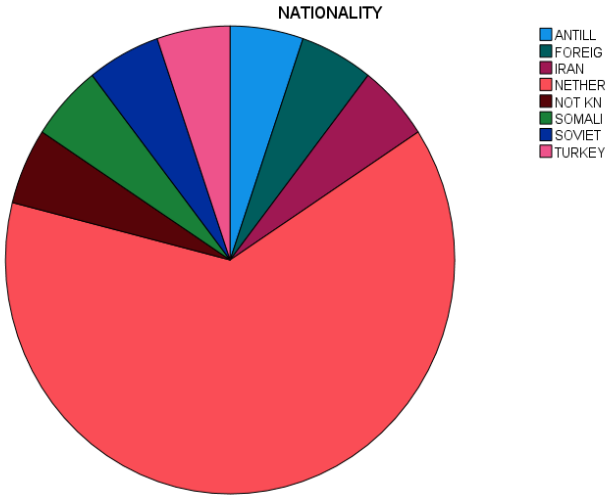
Verdict Year

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	2015	5	26.3	26.3	26.3
	2016	5	26.3	26.3	52.6
	2017	5	26.3	26.3	78.9
	2018	4	21.1	21.1	100.0
	Total	19	100.0	100.0	



Country of Birth of the defendant

Of the 19 female offenders of severe violence in the Netherlands, twelve (63.2%) were Dutch. The others were one from the Antilles (5.3%); one from Iran (5.3%); one from Somalia (5.3%); one from the Soviet Union (5.3%); one from Turkey (5.3%); in one case, it was written that the offender was a foreign citizen not specifying from which country.

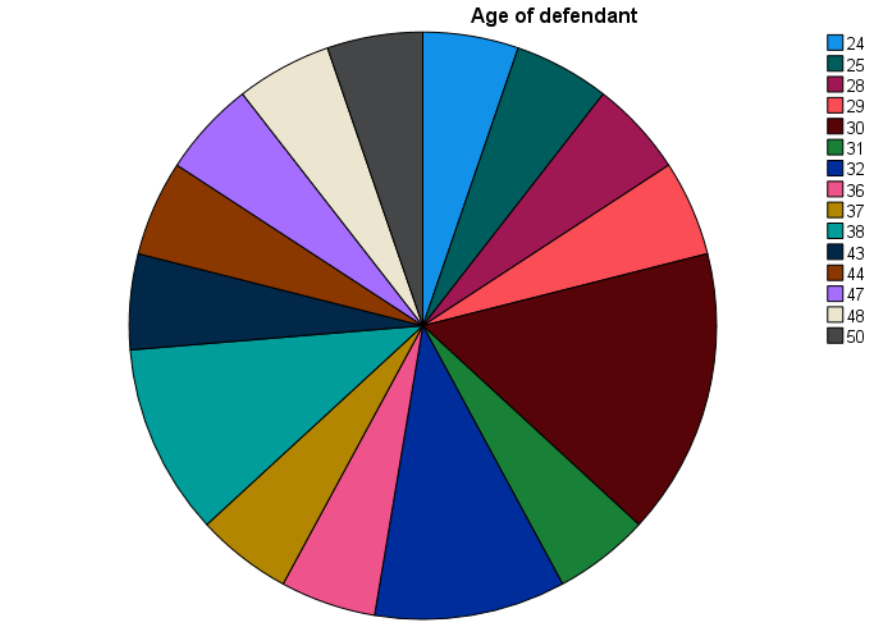


THE NATIONALITY OF FEMALE OFFENDERS

		Frequency	Per cent	Valid Per cent	Cumulative Per cent
Valid	ANTILL	1	5.3	5.3	5.3
	FOREIG	1	5.3	5.3	10.5
	IRAN	1	5.3	5.3	15.8
	NETHER	12	63.2	63.2	78.9
	NOT KN	1	5.3	5.3	84.2
	SOMALI	1	5.3	5.3	89.5
	SOVIET	1	5.3	5.3	94.7
	TURKEY	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Age of the defendant

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	24	1	5.3	5.3	5.3
	25	1	5.3	5.3	10.5
	28	1	5.3	5.3	15.8
	29	1	5.3	5.3	21.1
	30	3	15.8	15.8	36.8
	31	1	5.3	5.3	42.1
	32	2	10.5	10.5	52.6
	36	1	5.3	5.3	57.9
	37	1	5.3	5.3	63.2
	38	2	10.5	10.5	73.7
	43	1	5.3	5.3	78.9
	44	1	5.3	5.3	84.2
	47	1	5.3	5.3	89.5
	48	1	5.3	5.3	94.7
	50	1	5.3	5.3	100.0
	Total	19	100.0	100.0	



Age of the defendants

The defendant's ages range from twenty-four years to fifty.
Three females (15.8) were thirty years when they committed the crime.
Two females were thirty-two years old (10.5%).
Two were thirty-eight years old (10.5%).
Ages 24; 25; 28; 29; 31; 36, 37; 43, 44,47; 48 and 50 years (5.3% each).

Months in which the crime was committed

The highest number of crimes were committed in April, four cases (21.1%).

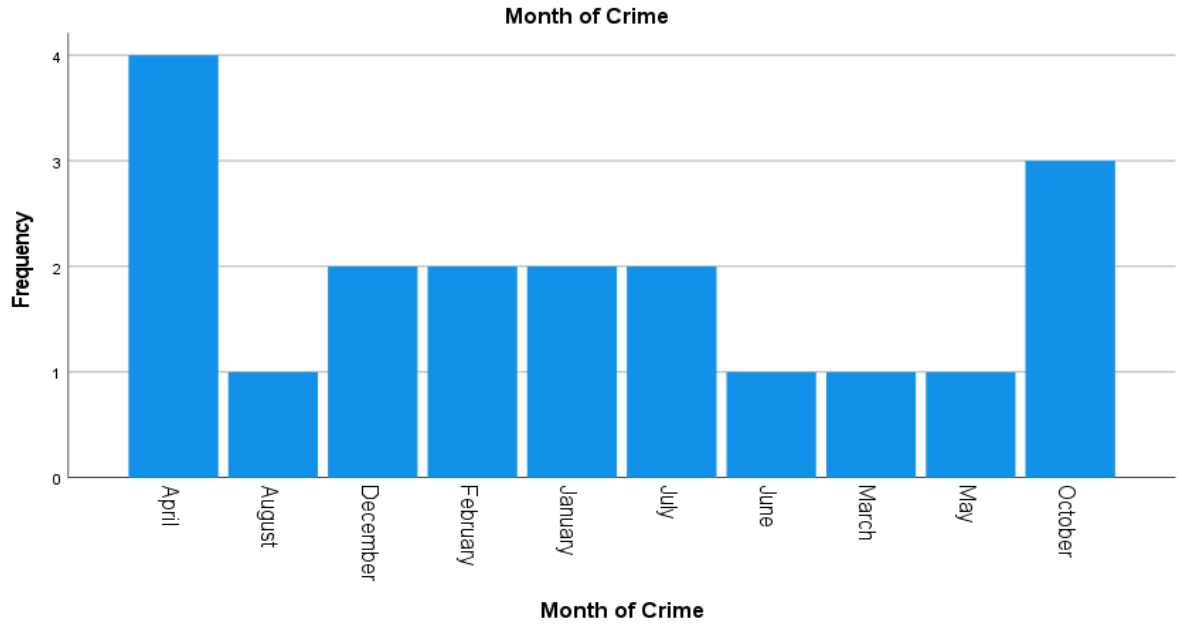
Followed by October, three cases (15.8%).

January, February, July, two cases in each month (10.5% each)

In March, May, June, August, one case in each month (5.3% each)

Month of Crime

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	April	4	21.1	21.1	21.1
	August	1	5.3	5.3	26.3
	December	2	10.5	10.5	36.8
	February	2	10.5	10.5	47.4
	January	2	10.5	10.5	57.9
	July	2	10.5	10.5	68.4
	June	1	5.3	5.3	73.7
	March	1	5.3	5.3	78.9
	May	1	5.3	5.3	84.2
	October	3	15.8	15.8	100.0
	Total	19	100.0	100.0	



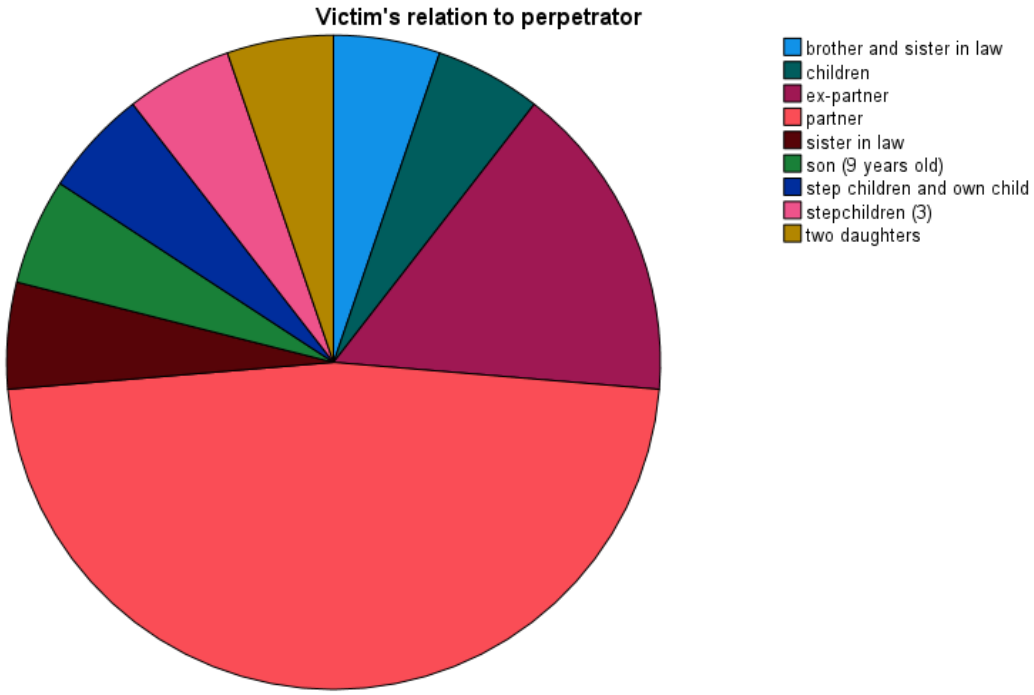
Victim's relationship to the perpetrator

Nine out of nineteen victims were the partners of the perpetrator (47.4%); three were ex-partners (15.8%).

Other relationships were brother and sister in law (5.3%); Children (5.3%); sister in law (5.3%); son of the defendant (5.3%); stepchildren and own child (5.3); two daughters (5.3%)

Victim's relation to the perpetrator

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	brother and sister in law	1	5.3	5.3	5.3
	children	1	5.3	5.3	10.5
	ex-partner	3	15.8	15.8	26.3
	partner	9	47.4	47.4	73.7
	sister in law	1	5.3	5.3	78.9
	son (9 years old)	1	5.3	5.3	84.2
	stepchildren and own child	1	5.3	5.3	89.5
	stepchildren (3)	1	5.3	5.3	94.7
	two daughters	1	5.3	5.3	100.0
	Total	19	100.0	100.0	



Place of crime

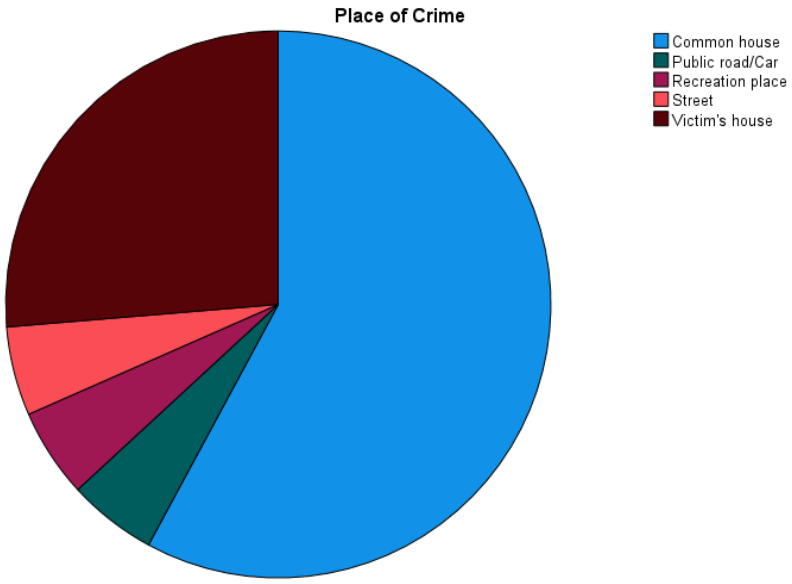
Eleven Times (57.9%) crimes were committed in a shared house of the perpetrator and the victim.

Five times, the crime was committed in the victim's house (26.3%).

The other three crimes were committed in a car parked at a public road (5.3%), in a recreation place (5.3%), and on the street (5.3%).

Place of Crime

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Common house	11	57.9	57.9	57.9
	Public road/Car	1	5.3	5.3	63.2
	Recreation place	1	5.3	5.3	68.4
	Street	1	5.3	5.3	73.7
	Victim's house	5	26.3	26.3	100.0
	Total	19	100.0	100.0	
	Total	19	100.0	100.0	



Description types of head injuries

Children were scratched in their face
Hit husband's head with a wooden bat
Squeeze the throat/neck tightly
Stab wounds in the neck
With the fingernails scratch the face of her sister-in-law
Threw a mobile phone against the victim's head
Punches in the head/face
A knife wound in the left ear

HEAD INJURIES

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	0	7	36.8	36.8	36.8
	1	12	63.2	63.2	100.0
	Total	19	100.0	100.0	

Description of torso injuries

Broken ribs
Broken hip joint
Wound of 5 cm under his left shoulder blade
Stabbing with a meat-knife to the chest
Stab wound in the stomach
Children were regularly abused by their mother
Hits

INJURIES TORSO

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		10	52.6	52.6	52.6
	Children were regularly abused by their mother	1	5.3	5.3	57.9
	Hits in the torso	1	5.3	5.3	63.2
	Knife wounds in the torso	1	5.3	5.3	68.4
	Knife wounds to the chest	1	5.3	5.3	73.7
	One stab wound in the stomach	1	5.3	5.3	78.9
	Stab wounds in the torso	1	5.3	5.3	84.2
	Stabbed with a meat-knife in victim's torso	1	5.3	5.3	89.5
	Two broken ribs/hip joint	1	5.3	5.3	94.7
	Wound of 5 cm under his left shoulder blade	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Limbs injuries

Broken left wrist and upper arm
Stab wounds in the arms
Stab wound in the shoulder
Insulin induction while the husband slept
Stab her brother in the arm
Kicks in the arms and legs

LIMBS INJURIES

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		13	68.4	68.4	68.4
	Broken left wrist/upper arm	1	5.3	5.3	73.7
	Insulin induction while the husband is asleep	1	5.3	5.3	78.9
	Kicks in the arms and legs	1	5.3	5.3	84.2
	Stab her brother in the arm	1	5.3	5.3	89.5
	Stab wound in the shoulder	1	5.3	5.3	94.7
	Stab wounds in the arms	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Other types of injuries

Multiple fractures in the body
Long injury
The mother punched and slapped the children with a belt
Regularly pinched the children
Set the children under a cold shower
Punches and kicks the belly of a pregnant woman (her future sister-in-law
Packed and buried the victim's body in the woods
Penetrated the vagina of another woman with a bottle
Rubbed the vagina with a stem of a flowering plant
Set a fire in the bedroom using turpentine
During an argument, the defendant threw scalding water over her partner
Bites, scratches and punches
Stab wound in the leg
Due to an incident, the victim has a psychological trauma
Blindfolded
Beaten-up and kick against children's body
Deadly threats, "I will kill you."

JAIL IN DAYS

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	0	2	10.5	10.5	10.5
	30	1	5.3	5.3	15.8
	33	1	5.3	5.3	21.1
	90	1	5.3	5.3	26.3
	137	1	5.3	5.3	31.6
	168	1	5.3	5.3	36.8
	226	1	5.3	5.3	42.1
	240	1	5.3	5.3	47.4
	270	1	5.3	5.3	52.6
	365	1	5.3	5.3	57.9
	450	1	5.3	5.3	63.2
	730	2	10.5	10.5	73.7
	1095	1	5.3	5.3	78.9
	1460	1	5.3	5.3	84.2
	2920	2	10.5	10.5	94.7
	4015	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

The highest number of days in jail corresponded to a female perpetrating manslaughter. The defendant killed her ex-partner and buried the body in the woods with the help of a male companion. The defendant did not have a history of DV perpetration. She refused to be psychologically assessed and was considered to be fully accountable for her acts. She had to pay the victims family compensation of €6,103.

TBS

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		17	89.5	89.5	89.5
	TBS Mandated	1	5.3	5.3	94.7
	TBS with Conditions	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Community work in hours

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	30	1	5.3	16.7	16.7
	40	1	5.3	16.7	33.3
	50	1	5.3	16.7	50.0
	120	1	5.3	16.7	66.7
	150	1	5.3	16.7	83.3
	200	1	5.3	16.7	100.0
	Total	6	31.6	100.0	
Missing	System	13	68.4		
Total		19	100.0		

Probation in years

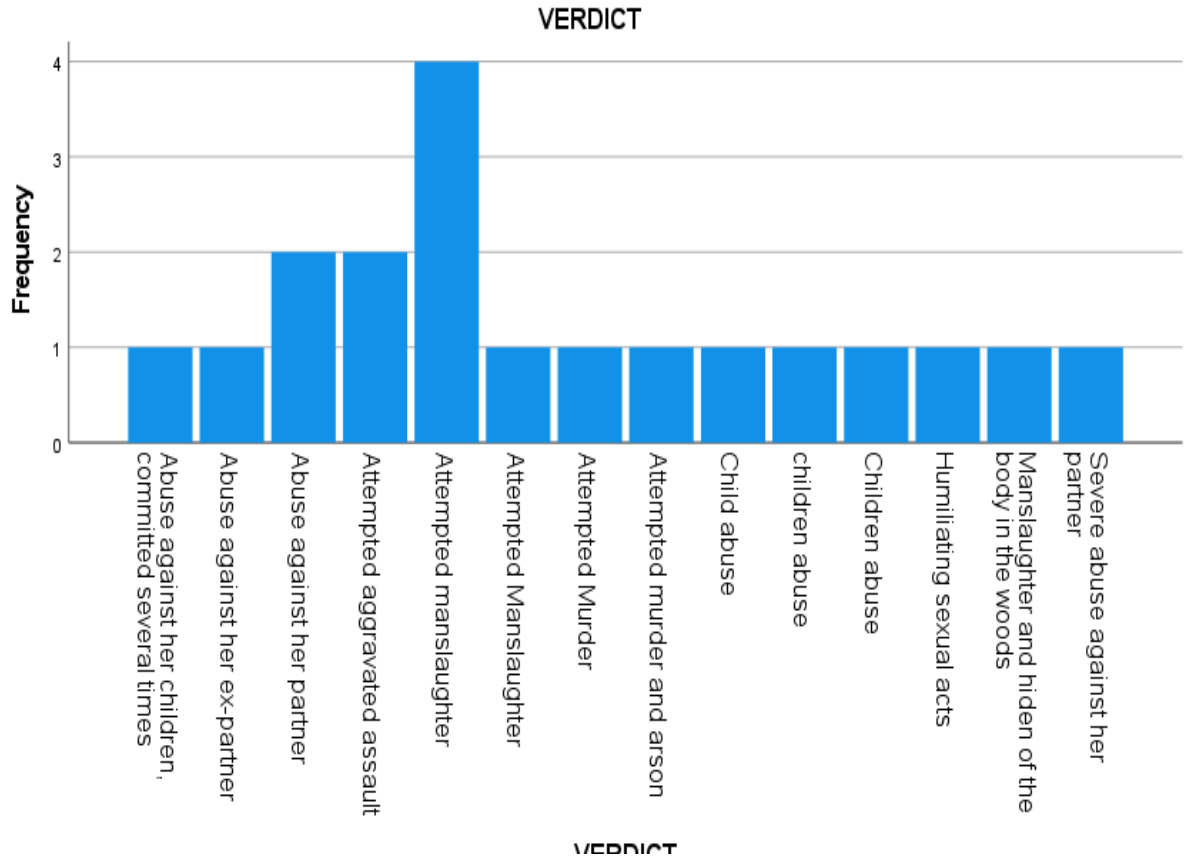
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	2	8	42.1	61.5	61.5
	3	5	26.3	38.5	100.0
	Total	13	68.4	100.0	
Missing	System	6	31.6		
Total		19	100.0		

Previous Crimes

Of the nineteen defendants, sixteen had no previous convictions for domestic violence (84.2%). One defendant had only one prior conviction for DV (5.3%). Two defendants had three previous DV convictions (5.3%).

Previous Crimes

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	no	16	84.2	84.2	84.2
	yes	1	5.3	5.3	89.5
	yes, three times DV	1	5.3	5.3	94.7
	yes, three times DV	1	5.3	5.3	100.0
	Total	19	100.0	100.0	



Diagnosis of Personality Disorders

NOD with dependant and evasive traits
PTSD (her step-father abused her) / Borderline/Dissociative Disorder
Borderline / Psychotic / Paranoia
No psychopathology found
Defendant refuses to be psychologically assessed
Antisocial / Borderline
Borderline / Narcistic and Dependant Traits
Mild intellectual disability/PTSD
Schizophrenia / Borderline

From six defendants (31.6%), it is not known whether they have any type of psychopathy or not.

Two defendants refused to be psychologically assessed.
In one of the defendants, was found no psychopathology.
Most female offenders in the sample were diagnosed with some form of psychopathology. Many of them had a combination of various severe mental disorders.
Two defendants were diagnosed with PTSD, thus having experienced traumas in their past. One of the defendants had PTSD in combination with a Mild Intellectual Disability.
The other was having PTSD. She was abused by her step-father and had Borderline Personality Disorder and Dissociation Disorder.

Diagnosis/Personality Disorders

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		2	10.5	10.5	10.5
	Antisocial/Borderline	1	5.3	5.3	15.8
	Borderline	1	5.3	5.3	21.1
	Borderline/Narcistic and Dependent traits	1	5.3	5.3	26.3
	Borderline/Psychotic/Paranoia	1	5.3	5.3	31.6
	Defendant refuses to be psychologically assessed	1	5.3	5.3	36.8
	Mild intellectual disability/PTSD	1	5.3	5.3	42.1
	No psychopathology found	1	5.3	5.3	47.4
	NOD with dependent and evasive traits	1	5.3	5.3	52.6
	Not known	6	31.6	31.6	84.2
	PTSD (she was abused by her step-father/Borderline/Dissociative disorder	1	5.3	5.3	89.5
	Refused to be psychologically assessed	1	5.3	5.3	94.7
	Schizophrenia/Borderline	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Addictions

Eleven of the defendant (57.9%) had an addiction, either alcohol or drugs, or a combination of the two.

Only three of the defendants had no addictions. In one case, it was not known.

Addictions

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		11	57.9	57.9	57.9
	Alcohol addiction	1	5.3	5.3	63.2
	Alcohol and drugs addiction	1	5.3	5.3	68.4
	Alcohol and durgs addiction (cannabis)	1	5.3	5.3	73.7
	Drugs addiction	1	5.3	5.3	78.9
	no	3	15.8	15.8	94.7
	Not known	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Items used to commit the crime

There were various items used to commit the crimes:

Six of the females used physical violence against their partners (31.8%).

In five cases, the defendants used a knife (26.3%). In another case, she used a knife and kicks.

One case of arson; insulin injection to a partner who was no diabetes patient; child abuse; drove the car over the body of her ex-husband; sexual abuse while the female partner was unconscious; physical abuse to the three defendant's step-children

Item used to commit the crime

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Arson	1	5.3	5.3	5.3
	bat and knife	1	5.3	5.3	10.5
	Car	1	5.3	5.3	15.8

	Child abuse	1	5.3	5.3	21.1
	Insuline injection	1	5.3	5.3	26.3
	Knife	5	26.3	26.3	52.6
	Knife and kicks	1	5.3	5.3	57.9
	Physical abuse of the three stepchildren	1	5.3	5.3	63.2
	Physical violence	6	31.6	31.6	94.7
	Sexual acts while the victim was unconscious	1	5.3	5.3	100.0
	Total	19	100.0	100.0	

Female Perpetrators Other Details

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		1	5.3	5.3	5.3
	Defendant continues to commit DV	1	5.3	5.3	10.5
	Defendant has out of herself took the initiative to search for psychological help	1	5.3	5.3	15.8
	The defendant is considered fully accountable for her acts	1	5.3	5.3	21.1
	The defendant is considered to be in a state of diminished responsibility	2	10.5	10.5	31.6
	Defendant is now homeless	1	5.3	5.3	36.8
	The defendant put something in the drink of the victim from which the victim lost consciousness	1	5.3	5.3	42.1
	The defendant was herself a victim of domestic violence.	1	5.3	5.3	47.4
	The defendant was physical and psychological abused by the victim for many years	1	5.3	5.3	52.6
	Defendant's recidivism risk is calculated to be medium to high without therapy	1	5.3	5.3	57.9
	Restraining order for 2 years	1	5.3	5.3	63.2
	Supervision by Probation	1	5.3	5.3	68.4
	The children were out-placed	1	5.3	5.3	73.7
	The defendant has a new-born baby	1	5.3	5.3	78.9

	The risk of recidivism is very high; therefore, TBS with conditions	1	5.3	5.3	84.2
	The victim has a history of DV perpetration	1	5.3	5.3	89.5
	The victim stayed many days at the hospital	1	5.3	5.3	94.7

Seven of the 19 female offenders were ordered to pay compensation to the victim(s)

Compensation to the Victim(s) in Euro

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	500	1	5.3	14.3	14.3
	1500	1	5.3	14.3	28.6
	1730	1	5.3	14.3	42.9
	2302	1	5.3	14.3	57.1
	2767	1	5.3	14.3	71.4
	6103	1	5.3	14.3	85.7
	7860	1	5.3	14.3	100.0
	Total	7	36.8	100.0	
Missing	System	12	63.2		
Total		19	100.0		

5.5 Characteristics of male perpetrators of domestic violence in the Netherlands

From two-hundred fifty-three cases of severe domestic violence obtained from the Dutch Criminal Courts in the Netherlands, two hundred thirty-four were male, and nineteen were females.

The salient characteristics of these male offenders will be mentioned in this section. The complete data is shown in section 5.5.1

One-hundred sixty-four perpetrators (69.8%) had Dutch citizenship. The other 30.2% a foreign nationality. In four cases, the age was unknown.

The youngest perpetrator was eighteen and the oldest seventy-three years old.

The highest occurrence of DV crimes

- 17 cases - were men aged thirty-two (7.2%).
- 11 cases for every age category: 26 (4.7%); 33 (4.7%); 34 (4.7%); and 45 (4.7%).
- 10 cases for every age category: 27 (4.3%); 38 (4.3%); and 43 (4.3%).
- 9 cases for every age category: 35 (3.8%).
- 8 cases for every age category: 29 (3.4%);
- 7 cases for every age category: 37 (3.0%); 40 (3.0%), 42 (3.0%); 44 (3.0%); and
  - 50(£.)%).
- 6 cases for every age category: 39 (2.6%).
- 5 cases for every age category:: 22 (2.1%); 24 (2.1%); 25 (2.1%); 49 (2.1%);
  - 51 (2.1%).
- 4 cases for every age category: 28 (1.7%); 36 (1.7%); 41 (1.7%); 47 (1.7%);
  - 48 (1.7%); and 54 (1.7%).
- 3 cases for every age category: 18 (1.3%); 23 (1.3%); 30 (1.3%); 46 (1.3%);
  - and 52 (1.3%);
- 2 cases for every age category: 55 (0.9%); 57 (0.9%); and 59 (0.9%)
- 1 case for every age category: 20 (0.4%); 60 (0.4%); 65 (0.4%); 69 (0.4%);
  - and 73 (0.4%).

Places of crime: In one hundred and nine cases, the crimes occurred at the shared house of the couple (37.9%).

In fourteen cases, in the house of the perpetrator.

Other locations were: Camping, car, hospital parking, hotel, public park, hotel, street, house or work of the victim, caravan, football club, and at the place of a third person.

Months and number of committed crimes

January	26
February	20
March	15
April	21
May	24
June	26
July	16
August	15
September	18
Octubre	22
November	22
December	9

Types of head injuries inflicted against their partners		
Squeeze the throat/neck tightly	Beaten-ups	Intent of strangulation
Hit the victim with a sock filled with stones	Headbutts	Struck on the head with an iron bar
Injure the victim with a knife	Pull her hair with force	He threw a cast iron bonfire to her head
Fractures on the face/head	Concussions	Cuts on left check of ca. 8-10 cm.
Punches	Stab wounds in the face	Hit her head with a hammer

Types of torso injuries inflicted against their partners		
Hits in the back	Blows torso with a metal pipe	3rd-degree fire wounds in the chest
Broken ribs	Stabs in the abdomen	Knife wound of 21 cm deep

Beaten several times in the abdomen	Stab wounds in the back and breast	Bites in the breast
Blows in the back with the elbow	Strokes with a shoe and fist	Dorsal spine fracture
Kicks in the hip	He kicks in the belly of his pregnant wife	Bruises

Types of limbs injuries inflicted against their partners		
Tide her limbs with a rope	Stabs wounds in the upper arm	Multiple stabs in the limbs
Hits her arms with a metal object	Kicks in the legs	Turn her arm around
Broke her arm	Cuts on the foot	He hit the fingers with a hammer
Produced various fractures	Bites on the arms	Stab her with a fork in the arm
Perforation of heart, lung and other vital organs with a knife	He took her by the shoulder and shook her.	Punches on the left shoulder

Fifty-one out of two hundred thirty-four perpetrators had a previous DV related conviction, in some cases, multiple convictions.

In hundred sixty-three cases out of 234, perpetrators were diagnosed with a combination of severe mental or personality disorder.

Fifty-six were diagnosed with antisocial personality disorder (APD) combined with other conditions such as borderline, narcissistic, PTSD, obsessive-compulsive, mild intellectual disability, psychotic, ADHD and other ailments.

Twenty perpetrators refused to be psychologically assessed.

Despite the seriousness of the injuries or nature of the crime, the psychiatrist found no psychopathology in four cases.

5.5.1 Real Criminal Cases (Males)

Here is a selection of few real cases of severe domestic violence committed between 2015-2018 by male offenders in the Netherlands. These cases are from the Dutch Criminal Courts.

Year 2015

Case 762

The defendant was convicted of assault, theft, trespassing and attempted aggravated assault against his partner.

The suspect entered his ex-girlfriend's house through a window he had smashed, hit her several times with an iron bar on her head/face and body, kicked, punched and pulled her hair. He also continued hitting the victim while lying on the ground and at one of the children's presence. The victim's multiple injuries caused her great pain, and she had to be treated at the hospital.

The court considered that the defendant infringed the victim physical integrity. Since the abuse took place at his ex-girlfriend's home, he also affected severely her sense of security, for which the court charged the suspect heavily.

In determining the sentence, the court scrutinised the nature and seriousness of the offence, the accused's personality report, judicial documentation, and the public prosecutor and counsel claims.

A report from the judicial documentation showed that the defendant was convicted five times before for violent crimes, including domestic violence.

The Probation Netherlands report showed that the defendant is homeless, has various health and mental problems, and is addicted to alcohol.

Probation recommended the suspect to be sentenced to a partially suspended sentence under the condition that he is treated in an outpatient forensic clinic; that a restriction order within a radius of six kilometres from the victim's home address is issued and supported employing an electronic device. Besides, probation also recommended his admission into an institution of assisted living or social daycare.

The court dictated imprisonment of twelve months against the defendant, four of which conditionally.

Year 2015

Case 4480

On 25 February 2015, at around 19:05 hours, the police were notified to go to [address]. Police arrived at the scene shortly after the assault. A woman opened the door; she kept a wet cloth by her face. Police officers saw that the victim had stuffed cheekbones, red spots on her face and neck. They also noticed that she had blood on her face's left side and saw hair strains on the floor, a table in the hallway, and the room. The victim reported to the police that her ex-partner broke into her house by smashing a window, punched her, pulled her hair forcibly, stole her mobile phone, and attacked her with an iron bar.

Health authorities also issued a report that noted that the victim had bruises on the right side of the face, shoulder, stomach, and other body parts inflicted by an iron bar.

The information in the file could not determine whether the defendant had a so-called 'full' intent to inflict grievous bodily harm on the victim. Therefore, the court had to assess the suspect intentions. In this particular case, conditional intent would mean that the defendant had knowingly accepted the significant likelihood of inflicting grievous bodily harm on the victim.

Based on the evidence, the court considered that the defendant deliberately struck the victim with an iron bar on several occasions, including at least once in the head. Furthermore, at the time of the blows, the victim must have been lying on the ground. The statement of [witness] supports the victim's information on this matter.

The court had no reason to doubt the reliability of [name of witness] testimony. In the court's opinion, it could be inferred from the evidence, in particular from the injury report, that the defendant struck (at least) once the victim's head with a hollow iron bar. However, other details could not be determined (e.g. force used; whether the victim laid already on the ground when attacked, or if her head was kicked). Therefore,

the court considered there was no significant and convincing evidence that there was a likelihood that the victim would die due to the violence carried out by the defendant.

According to previous examples of this type of injury, striking with force with an iron bar raises the significant chance of the victim suffering severe bodily harm, especially if the victim is lying on the ground. The defendant must have been aware of this. Facts or circumstances from which the opposite might be inferred have neither been established nor proven. It follows that the defendant had conditional intent on inflicting grievous bodily harm on the victim.

The court sentenced the defendant to prison for twelve months, from which four months conditionally. The defendant was charged with abuse against his ex-partner, stealing a mobile phone, and attempted aggravated assault. The defendant was subjected to particular conditions: He must be supervised by Probation Netherlands, undertake ambulant treatment for his drugs and alcohol addictions and has a prohibition to contact the victim, which is to be monitored by an electronic device.

Year 2016

Case 4821

The Hague court imposed a 38 year-old-man a prison sentence of 300 days plus mandated TBS due to domestic violence during three consecutive years against his partner and two young children. The probability of reoffending was considered high due to the defendant's intellectual disability and severe personality disorders.

The defendant had used frequent violence against the family members, among other things, by hitting them against the jaw, head and body, not shying away from the use of a chair's leg and a hammer. The man had exercised absolute terror over his partner and children.

The experts who assessed the defendant's mental state pointed out factors such as limited problem awareness, lack of empathetic abilities, and impulsive behaviour. Besides, he had alcohol and substance abuse problems, intellectual disability and severe personality disorders contributing to high reoffence risk. The man, therefore, needs long-term, intensive clinical treatment.

The court took the experts' conclusions that the man has an intellectual disability and severe personality disorders. The court also believed that the imposition of TBS (by which the government nurses the defendant) is the correct action to take. The main reason for this decision was that a lighter measure, such as TBS with conditions, might not be appropriate for the defendant. The measure could be stranded due to his lack of cooperation. He has limited awareness of the problem and always sees himself as a victim, not as a perpetrator.

The defendant is accused of mistreatment of his two children and wife.

Victim 1: A child over whom the defendant exercised authority, a child he cared for and brought up as belonging to his family. He deliberately assaulted the child several times by beating with the fist on the head or back of the neck, hit the body, let the child sleep on the ground in an unheated shed without bed linen or blankets; hit him with force with or without an object on the right arm. As a result, the victim had suffered pain and injuries and felt severe discomfort.

Victim 2: The defendant beat many times the child with his fist on the head, jaw, stomach, arms, placed the girl on a chair and taped her mouth; held a lighter to her fingers, let her sleep on the floor in an unheated shed without bed linen or blankets; hit her with a hammer against her head and fingers, kicked her nose and cut her hair against her will. As a result, the victim has suffered pain and injury. She had namely several hematomas, felt pain and discomfort in her body for six months.

The court states that the children's statements are sufficiently reliable, contrary to what the defence argued. To this end, the court considered that those statements on multiple and insured components are independent of each other. There is no reason to assume that the mistreated children have not told the truth about the abuse. Their statements are supported by other means of evidence in the file, such as the Child Care and Protection Board, their mother's declaration [Victim 3] to a magistrate. The defendant had committed acts of domestic violence.

Victim 3: Stated about the children's mistreatment, she heard her partner yelling at victim 2, who came home from a party. The following day she saw blood near the girl's nose and blood drops on the floor. In the kitchen, there was a towel with blood. Victim

2 told her mother that daddy kicked her nose. She also stated that her husband regularly gave small taps on the head and punched the girl, who often had bruises on her arm, sometimes strains of hair were in the trash. Once, the suspect burned her fingers with a lighter. The mother confirmed that the children had to sleep in the barn without heating and blankets; children were always terrified and cried.

The defendant's partner did report him to the police for domestic violence against herself and the children. She said he had beaten her with a chair on her back. Consequently, she fell to the ground, where he kicked her ribs her against and threw a wooden table on her. She felt much pain. He also attacked her with a table foot against her legs and punched against her jaw.

The suspect denied the beatings against his children, but he recognised the kick in the nose of victim 2, arguing that it happened during the kickbox lessons he gave the children. He said he had worked hard for years to make the children harder and teach them to defend themselves in society. In retrospect, he recognised he had cross borders. However, neither the suspect partner nor the children stated about defence lessons or similar actions during a game situation. They always talk about punishment by hitting them with fists, kicking, and punches in the face. The children were in a state to differentiate between hitting for fun or for real.

The court considers that the statements of the defendant must be discarded as untruthful and unbelievable.

The court decision was based on the seriousness of the offence, the accused's personal circumstances, as demonstrated during the hearing investigation. In particular, the court weight the severity of DV inflicted on his victims. The image that surge from the files is that of a father exercising terror over his partner and children. DV had infringed on the victims' physical integrity and health and caused discomfort and complaints due to feelings of shame, fear, and insecurity. Home should be a place where the family feels secure, especially children. The court observed from many judicial documents that the defendant had used extreme violence. He had been accused of using force against his family, but that did not stop him from continuing those offences.

The suspect has been proven guilty of DV. He used frequent violence against his partner and two young children by punching them against the jaw, head and body. The image

Judicial documentation

The court has taken heed of the judicial extract relating to the defendant and other documentations. These showed that there is a pattern of violence and use of force against his family. There was a reoffending within two running trials periods. They did not seem to have stopped the suspect from committing criminal acts.

The behavioural reports

The court considered the Probation Advice Summary of Probation Netherlands, a behavioural expert's advice, and a Netherlands Institute of Forensic Psychology's (NIFP) report.

The defendant did not want to collaborate with assessing his psychological state of mind at the Peter Baan Centre. Nevertheless, through observations, the teams could make a diagnostic of his personality.

Psychologist [name of psychologist] considered that the suspect's personality development is strongly influenced by long-term substances use (alcohol and drugs) and weakness. There is a clear skew of personality, which leads to problems in different areas of his life and can be diagnosed as a personality disorder. The suspect reacts primarily impulsively to his environment. He lacks conscious and empathetic capability, and some characteristics point to psychopathy. The suspect meets a B-cluster personality disorder, mood swings, impulsiveness, fear of abandonment, and addiction sensitivity.

The court took over health professionals' advice and considered that mandated TBS is the right measure for the defendant, who must submit to a long-term, intensive clinical treatment. The defendant must pay compensation of € 1,000 to each of the victims.

Year 2016

Case 2502

A male, twenty-five year-old-man was sentenced to eight months in prison and TBS with Conditions. The defendant abused his girlfriend, causing severe injuries in the abdominal area, against her back and in different parts of her body. He punched, kicked, hit, headbutted and grabbed her throat and quizzing it tightly. Systematically, he intimidated his partner and forced her to make false statements. He had to pay a compensation of €2,598.58 to the victim.

The defendant attempted to inflict grievous bodily harm on the victim and unlawfully deprived her of her liberty for three days. He forced her to confess in a film, made with his telephone, to having sex with other men. He filmed the abuse he was inflicting, threatening to send the videos, under the name ‘slut’, to her parents and all other contacts on her telephone. He also threatened to hurt her family, neighbours and dog if she left him for good.

To dictate a sentence, the court requested that behavioural specialists advise to reduce the risk of recidivism.

The court noticed that the defendant had previous convictions related to domestic violence. According to a report made by a psychologist [name of psychologist] and a psychiatrist [name psychiatrist], the defendant has a narcissistic personality disorder; and is intellectually impaired. The psychiatrist stated that there were clear indications of mixed personality disorders. The experts advised treatment in a forensic psychiatric clinic or a psychiatric institution due to the intellectual disability of the suspect and, given previous unsuccessful treatments and withdrawals. The expert recommended offering this treatment as a special condition in the event of a conditional sentence and placing the defendant under the supervision of Probation Netherlands.

The court followed the experts' advice to consider the suspect in a state of diminished responsibility and applied clinical treatment as a special condition specified by Probation Netherland.

Year 2017

Case 614

The defendant was charged for Attempted Manslaughter and the continued act of assault committed against his wife, for which he was sentenced to imprisonment for 32 months. The defendant was acquitted of the alleged Assassination Attempt. The injured party received compensation of € 5,161.62.

Preface

The suspect and his wife, the victim, had been married for 4.5 years at the time of the charges. They had together a son of a few months. The suspect had discovered that his wife had a relationship with another man, which caused him much stress and suffering. On the night of June 14th, the suspect hit his wife's head several times with a hammer while she was sleeping. When the victim awoke, she noticed that the suspect held her by the throat, and he tried to strangle her.

According to the Public Prosecutor's Service, the act could be considered a 'premeditated' act, given the fact that the victim had been asleep when it occurred.

The victim struggled and resisted the attack; once she freed herself, the defendant put both hands around her neck and tried to strangle her again. She noticed that she had blood in her head. She felt dizzy and asked her husband to call emergency number 112. He did. Subsequently, she went outside and asked the neighbours for help; but the suspect followed and beat her with an umbrella, which broke, but did not stop him from beating her with it.

He repeatedly stabbed his wife in the neck, arms, back and shoulder blades with the broken umbrella, demonstrating intent on death. With that broken (down part) of an umbrella, it was possible to pierce the skin. The maximum depth of the stab wounds that could be reached with the object was at least 9.3 cm. Substantial bleeding can quickly be fatal.

Based on those facts and circumstances, the court considered, in particular, that administering stitches to the neck or other vital parts such as the carotid artery could have caused the death of the victim.

The court considered that legally and convincingly could be proven that the defendant had committed the offence deliberately and premeditatedly to take his wife's life. He intended at least to inflict grievous bodily harm on her. He acted with intention and calm deliberation when he squeezed his wife's throat and put her in a chokehold. However, the execution of that intended crime had not been completed.

Arguments of the defence

The defendant's counsel took the view at the hearing– following his plea notes – that the attempts of hammering and strangling had been voluntary, but that he stopped on time, then called 911, grabbed a towel for the victim, and took care of the child. He could have continued to complete the offence since he had the opportunity to do so, but he did not. In the defence's view, the defendant should be acquitted of all legal charges of attempted manslaughter.

The court determination

The court determined the sentence based on the facts' seriousness and other circumstances under which they were committed. Also, based on the accused circumstances, as demonstrated by the investigation at the hearing. In particular, the court considered the following: The defendant abused his ex-wife and attempted to take her life, causing severe injuries to the victim. These are grave facts.

The defendant's actions constituted an unacceptable breach of the victim's physical and personal integrity. The offences have been committed in a domestic sphere, a place where the victim should have felt safe. At the hearing, the victim stated she still suffered from that crime's psychological and physical consequences.

The court concluded that only a custodial sentence of significant duration constitutes an appropriate response given the facts' seriousness. The court took into consideration that the defendant had not previously been convicted for any offence.

In determining the penalty, the court considered Attempted Manslaughter an appropriate and necessary response and sentenced the defendant to prison for 36 months.

Year 2017

Case 2759

The defendant has been charged with:

Primarily: He, on 17 January 2017 in Arnhem, had inflicted to [name of the victim] intentionally grievous bodily harm, namely a brain contusion, bruises on the (left) jaw, a fractured eye socket, laceration and bruisings in the face; bruises on the body and head; burn (blister) on the right arm and neck, while the victim was in bed.

The defendant punched (with clenched fists) and kicked several times the victim's head and body. Subsequently, hit her at least once with a belt and its buckle against the head and body. He stabbed and cut into the victim's left cheek with a knife (or another sharp pointed object). He also put inflammable liquid in contact with open fire and pressed a burning cigarette against her neck while executing that intended offence has not been completed.

Considerations relating to the evidence

Based on the evidence, it could be established that the victim and the defendant had an affective relationship at the time of the crime.

On the afternoon of 17 January 2017, the defendant and the victim argued. Part of that argument was recorded by the suspect on his phone's video camera. The videos show that [the victim] has injuries to her neck inflicted by the defendant.

On 23 January 2017, a forensic doctor [name of doctor] identified various injuries, including bruises in the face, a fresh scar on the left cheek, and a right eye socket fracture. The doctor also found a discolouration around both eyes, in the right eye, on the left nose side and the outer side of the eye socket of the left eye, swelling in the right lower jaw and discolourations under the chin, on both arms and legs, back and chest, all caused by blunt force. Furthermore, the victim had a vertical running wound of 1.5 to 2 centimetres on the left cheek; and had an irregularly shaped injury to the left of the neck with a yellow crust appropriate for a scrape or burn.

The prosecutor could only prove that the defendant was guilty of punching the head and body of the victim. There was no convincing legal proof for a subsidiary charge,

Attempted Aggravated Assault against his partner. According to the prosecutor, the injuries suffered by the victim, particularly the fracture of the eye socket and the other injuries in vulnerable areas of the face, indicate the use of significant force, and the defendant should have known that his actions could have resulted in grievous bodily harm.

The defence's position

The defence argued for acquittal for both the primary and other subsidiary charges. According to the defence, the victim was not reliable. She had injured herself several times in the past due to her borderline problem (which she acknowledged), characterised, among other things, by self-harm.

According to the defence, the video shows the defendant being upset and a suspect very calm, reinforcing the defence's belief that the victim inflicted the injuries on herself. Furthermore, it can be inferred from the suspect's mobile phone data, including the Whatsapp messages and the metadata, that the suspect left after the filming.

The defence advocated acquittal for the primary and subsidiary charges. Furthermore, there was insufficient knowledge of the force with which it would have been struck, making it difficult to speak of an Attempt to Aggravated Assault.

Assessment by the court established that on 23 January 2017, the victim suffered the injuries as described under the facts. The most important question facing the court was whether the defendant was the one who inflicted those injuries or not. The court considered this as follows. The victim explains that on 17 January 2017, she was sleeping in her bed; at about 20:00 hours, she woke up with a hard punch to her face.

The victim saw the suspect standing in front of her bed. The suspect then punched her many times; he then took his belt and hit her neck and legs with the buckle's side of his belt. The suspect hit her across her body, kicked and punched her.

According to the forensic doctor [name], the injuries were caused by blunt force inflicted by punches or blows with a hard object. The laceration on the left cheek may have been caused by a sharp object, such as a knife, pen, scissors or nail. Given the

medical declaration about the injuries and the victim's statements, the court considered lawfully and convincingly proven that the defendant repeatedly punched and hit the victim in the head and body with a clenched fist, that he repeatedly kicked and punched against her body with the buckle of his belt. The court's conviction was reinforced by the victim's fear of the defendant as she showed on January 23, 2017, and described by witnesses [witness 1] and [witness 2].

In the victim's statement, the court read that she did not flee from the accused until three days after the violence was inflicted because she feared the possible bursting of violence of the suspect. However, the court does not consider that the defendant kicked the victim in the head. The victim did not specify this. Furthermore, the court was not convinced that the defendant stabbed the victim in the cheek with a knife, sprayed a flammable substance on the victim's arm and then put the liquid in contact with fire and pressed a lit cigarette into the victim's neck. Therefore, the court acquits the accused of these acts. Although according to the expert, it is not plausible that the victim inflicted these injuries on herself, the court considered that possibility to be present.

Cuts and burns caused by such actions may be appropriate for auto-mutilation. The victim has stated that she sometimes injures herself. The forensic report indicated that he does not consider any injuries likely to have been self-inflicted, except for the wound on the left cheek. Technically, many injuries can be self-inflicted. In practice, this often involves injuries in which a sharp object is used to cut or scratch. Self-inflicted blunt force trauma is less common and, therefore, less likely.

Concerning the injuries on the back, the upper right arm and upper left arm, the forensic doctor stated that it does not appear to him that the victim inflicted this injury herself. Furthermore, the court considers that the defendant's statement was not plausible because he did not seek medical attention or approached the counsel upon seeing the victim's injuries.

The court did not agree with the defence because the videos from the defendant's phone and, as shown in court, show no sign of the victim as unreliable, aggressive and unstable. The court sees in the videos a woman who repeatedly tells the defendant to

leave and stop filming. The court explains the victim's conduct out of her impotence towards the defendant. Finally, the presence of a third person has not seemed plausible.

Qualification

The court considered legally and convincingly proven that the defendant had used force against the victim; the question then arises about how to qualify the violence.

Together with the prosecutor and the defence, the court considered that it could not be proven that the defendant has committed the primarily aggravated assault charge. The court found evidence that the defendant was guilty of Attempted Aggravated Assault. The suspect punched the defendant several times in the head. From the injury of the victim and the eye socket fracture, it can be inferred that the defendant applied force. He knowingly accepted the significant likelihood that he would cause grievous bodily harm to the victim. It is a fact of general awareness that hitting a person's head multiple times can lead to fractures and brain injury.

Year 2017

Case 1834

The Overijssel court sentenced a 44-year-old man to be placed in a psychiatric hospital for Attempted Manslaughter to his wife.

On January 13, in a delusion, the defendant repeatedly hit his wife in an uncontrolled manner in her head, face, and arms with clenched fists. He threw her to the floor and kicked her several times against the head with a steel-nose lump, producing severe injuries. By so acting, the court argued, the chance of death of the victim was considerable.

The court received a Pro Justice Report about the defendant's mental state, dated March 24, 2017. The report was written by (name of the psychiatrist), who found that the suspect has various personality disorders: Psychoticism and bipolar disorder, maniac, delusional and schizoaffective disorders. The defendant was addicted to alcohol and had a personality variant of Cluster A and B traits.

At the time of the crime, his control was absent due to a psychotic episode. During a psychotic episode, the person has a disturbed reality assessment and limited impulse control. The suspect also suffered from possible jealousy delusions, financial problems, an extreme workload in his company, sleep deprivation, mainly since he stopped taking his antipsychotic medicaments.

.Another report dated 7 March 2017, by [name of psychologist], showed that the suspect had a delusional disorder of the type delusional and possibly jealousy and infidelity. Differential diagnostics can be considered for a schizoaffective condition of the bipolar type. Presumably, from 2015, after the phase-out of antipsychotic medication, the suspect slowly slipped again. He suffered from psychosocial stress and the care of his father, combined with other stressors. It is likely that led to a distortion in the realism in which he developed delusions of greatness and relationship jealousy delusion.

This disorder seemed to have developed gradually due to poor coping skills and lack of assertiveness and was fueled by multiple mutually reinforcing factors. It is likely that the suspect has difficulty dealing with stress and tension and therefore has problems in the reality check.

Combined with increasing psychosocial (financial, business), relational stress and sleep deprivation, this could have led to delusional experiences. To what extent the defendant's statement about the cause of the alleged abuse in which a strange man informed him of the extramarital sexual contact with his wife is not to be established by the researcher. It could be argued that there were jealousy delusions.

The criminality of the accused and this particular situation could fit well into the accused's delusional experiences. However, now that there seems to be evidence of his wife's actual extramarital relationship, it is complicated to establish whether his conviction is congruent with reality. It is unclear to the researcher how long these delusions have been present and their origins with his (daily excessive) alcohol consumption, but there is sufficient evidence that this psychiatric disorder was also present at the time of the charge.

The defendant was manically and psychotically decompensated before and during the crime. This psychiatric disorder influenced the suspects' behaviour due to his delusions and (manic)psychotic disruption; his awareness of reality was absent. The psychiatrist advised to consider the suspect to be completely insane.

The court takes over the psychologist and psychiatrist's recommendations that the defendant is considered insane and freed him from all legal procedures. The defendant has to compensate the victim with € 2,500.

Year 2018

Case 2909

The accused, a 65 years-old man, was charged with the following: He on 9 March 2018 in [name of the place] had intentionally intended to take the life of [Name of Victim], his wife, forcefully beaten her with a wooden stick on the back of her head. The execution of that crime has not been completed; nevertheless, the defendant has deliberately inflicted severe physical injuries on the victim.

The victim reported that her husband was at home when he suddenly stood behind her and hit the back of her head with a hard object. The victim felt a terrible blow and fell to the ground. When she turned around, she saw the suspect standing with a wooden stick in his hand.

In a report, it was established that the injuries observed match the description given by the victim. The suspect denied hitting his wife. He said that his wife fell because the dog took her down. In the court's opinion, the injury report's and her declaration is convincing legal evidence that the defendant hit his wife.

The victim called emergency number 112, and she said, ‘I am terrified, my husband hit my head’. When the ambulance arrived, she told the ambulance’s personnel that her husband had hit her with a wooden stick on the back of her head.

In the court’s opinion, the statement made shortly after the incident was reliable; her husband and not the dog made her fallen down. The court also considered that the victim reported previous incidents, namely a fall from the staircase in January 2018;

on that occasion, her husband had given her a higher dose of her medicine. The defendant explained that he was walking the stairs behind the victim and accidentally kicked her legs because his slippers were wet, and he slipped. About the high dosage of the medicine, he said he had misread the quantity.

Altogether, the incidents, as outlined by the victim, were in the core confirmed. The court believed that the declaration of the victim was accurate.

The same applies to the perpetrator's financial problems appointed by the victim but denied by the suspect during the police questioning. After the investigation, those problems appeared to be true. The defendant's statement denying those problems deems the court unbelievable, given the many unopened emails in the defendant's office and the fact that he indicates that he was the one who managed the finances. Those problems and the probability of discovering the situation by the victim formed the motive for the crime.

The court considered legally and convincingly proven that the defendant hit his wife with a wooden stick on the back of her head. Subsequently, the court assessed how this should be legally interpreted.

In the court's opinion, it could not be proven that the suspect intended to take his wife's life due to too little available information. This court's opinion also applies for intent in a conditional sense because specific information to assess whether a blow with the object used presented a significant risk of death was missing.

The court believed that it could be proved that the defendant had intent on causing severe physical injury to the victim. He came from behind her and hit her. The victim could not defend herself and fall to the ground. Given the injury, he must have hit her with force.

The court found that the fact alleged has been proven and dictated a prison sentence of twelve months. Besides, the defendant must pay a compensation of €1,500 to the victim.

Year 2018

Case 361

A 34 year-old-man was sentenced to a partly conditional prison sentence and community service work for having committed domestic violence against his partner.

On 23 April in Ulft, the defendant mistreated his partner by forcibly squeezing her throat and violently grabbing her right upper arm.

The prosecutor stated that the charges against the defendant could be proven lawfully and convincingly.

The defence advocated for acquittal due to a lack of legal or convincing evidence.

The court's judgement

The suspect is the partner of the victim. The victim stated the following: On 23 April, she was together with the suspect in her home at [address]. They argued, she saw that the suspect was getting very angry. She was sitting on the sofa when he approached her, sat over her, and took her throat. The defendant released the victims as a result of her scratches, kicks and hits. Once she could get free, she started to shout and called for help. The neighbour [witness 1] came for help. He later told the police that around 18:40 hours, he was at home and heard his neighbour screaming. After five minutes he went to the neighbours' house. The victim opened the door; she was very emotional. The witness saw that the victim's partner was in the kitchen puffed up.

The victim reported the incident the following day to the police. The police officer saw she had an injury to her neck and bruises on her right upper arm.

The court considered proven that the defendant had committed a severe assault against his partner in her house, where the victim should have felt safe.

To determine the penalty to be imposed, the court considered the nature and gravity of the acts, the defendant's circumstances, various reports made by Probation Netherlands, and a Pro Justitia Report (psychological assessment).

The defendant was considered guilty of domestic violence. The victim had suffered injuries and pain due to her partner's actions, violating the victim's physical integrity.

The court also noticed that the defendant had a previous DV conviction and showed no remorse for his actions.

The Pro Justitia Report stated that the defendant has ADHD and a personality disorder with avoidant, dependent and compulsive traits. According to the psychologist, these disorders were present when he committed the abuse, influencing his behaviour, and he should be considered in a state of diminished responsibility.

The court did not agree or adopt this conclusion for the following reason: The defendant indicated to the psychologist making the report that his substance abuse was regular, although he told Probation Netherlands that he was addicted since his 16 years to 'anything available.'

The court considered that the defendant had not fully disclosed all the facts to the psychologist and dismissed her advice.

The court sentenced the defendant to fifty-night days of prison and 80 hours of community service. Besides, he must be under probation of Probation Netherlands as long as necessary to monitor his clinical treatment and detoxication of substance abuse by regularly controlling urine and blood.

5.6. Presentation data of male perpetrators

Country of birth of perpetrators: In 164 cases, the offender had the Dutch nationality. In seven cases, ethnicity was not mentioned on the records of the court.

All others were males were from different countries/continents.

Country of birth of the accused

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Afghanistan	4	1.7	1.7	1.7
	Algeria	1	.4	.4	2.1
	Antilles	5	2.1	2.1	4.3
	Aruba	1	.4	.4	4.7
	Country of birth (accused)	1	.4	.4	5.1
	Cuba	1	.4	.4	5.5
	Foreign citizen	24	10.2	10.2	15.7
	Hungary	3	1.3	1.3	17.0
	India	1	.4	.4	17.4
	Indonesia	1	.4	.4	17.9
	Iran	2	.9	.9	18.7
	Iraq	2	.9	.9	19.6
	Libya	1	.4	.4	20.0
	Morocco	2	.9	.9	20.9
	Netherlands	164	69.8	69.8	90.6
	Not known	7	3.0	3.0	93.6
	Poland	1	.4	.4	94.0
	Polen	1	.4	.4	94.5
	Portugal	1	.4	.4	94.9
	Romania	1	.4	.4	95.3
	Sint Maarten	2	.9	.9	96.2
	Suriname	3	1.3	1.3	97.4
	Syria	2	.9	.9	98.3
	Turkey	2	.9	.9	99.1
	Uganda	2	.9	.9	100.0
	Total	235	100.0	100.0	

Age of male perpetrators

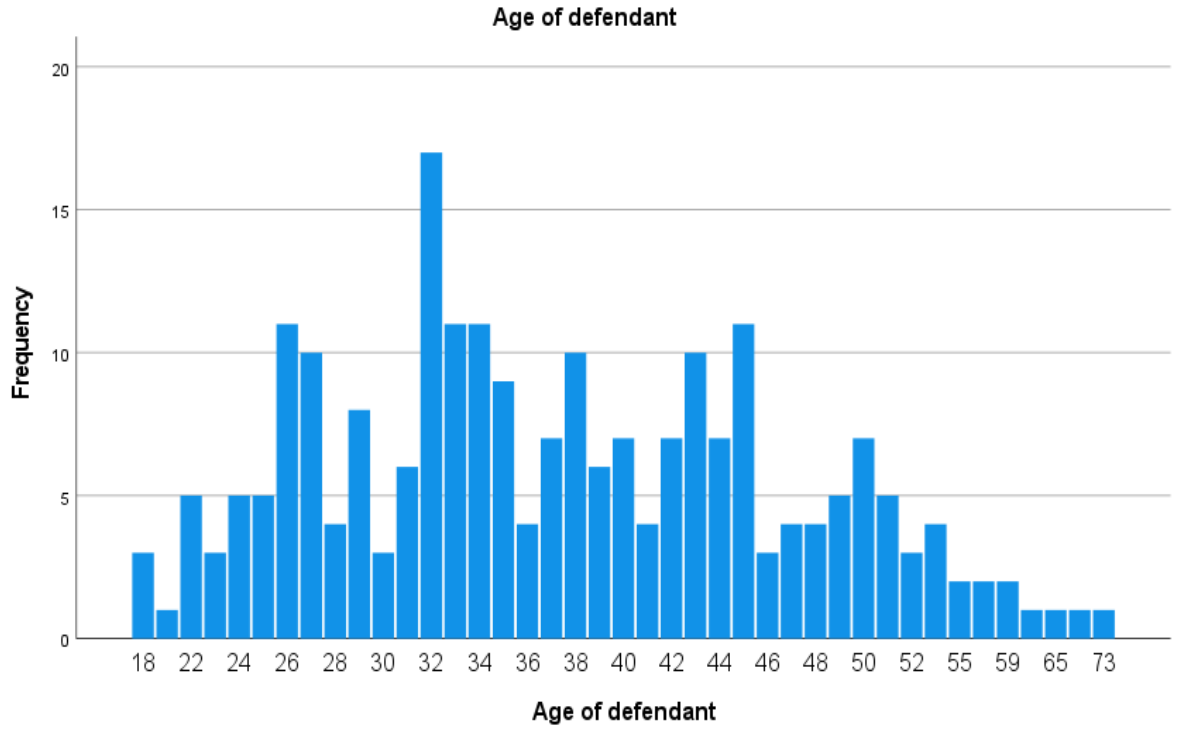
The youngest three defendants were aged eighteen; the oldest one was aged seventy-three. From four defendants, the age was unknown (1.7%).
Most frequent age of perpetrators was thirty-two (7.2%); followed by eleven defendant of twenty-six (4.7%); eleven defendants aged thirty-three (4.7%); eleven aged thirty-four (4.7%); ten defendants aged twenty-seven (4.3%); nine aged thirty-five (3.8%). For the small rest percentages, please see the table below.

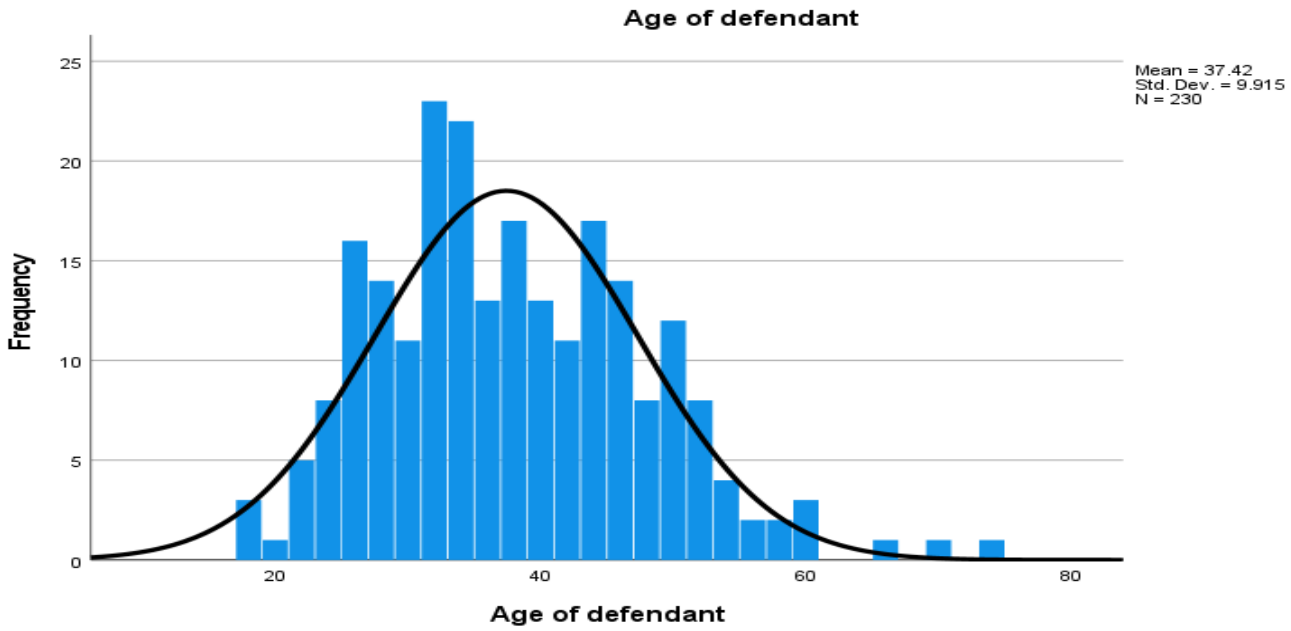
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	18	3	1.3	1.3	1.3
	20	1	.4	.4	1.7
	22	5	2.1	2.1	3.8
	23	3	1.3	1.3	5.1
	24	5	2.1	2.1	7.2
	25	5	2.1	2.1	9.4
	26	11	4.7	4.7	14.0
	27	10	4.3	4.3	18.3
	28	4	1.7	1.7	20.0
	29	8	3.4	3.4	23.4
	30	3	1.3	1.3	24.7
	31	6	2.6	2.6	27.2
	32	17	7.2	7.2	34.5
	33	11	4.7	4.7	39.1
	34	11	4.7	4.7	43.8
	35	9	3.8	3.8	47.7
	36	4	1.7	1.7	49.4
	37	7	3.0	3.0	52.3
	38	10	4.3	4.3	56.6
	39	6	2.6	2.6	59.1
	40	7	3.0	3.0	62.1
	41	4	1.7	1.7	63.8
	42	7	3.0	3.0	66.8
	43	10	4.3	4.3	71.1
	44	7	3.0	3.0	74.0
	45	11	4.7	4.7	78.7
	46	3	1.3	1.3	80.0

	47	4	1.7	1.7	81.7
	48	4	1.7	1.7	83.4
	49	5	2.1	2.1	85.5
	50	7	3.0	3.0	88.5
	51	5	2.1	2.1	90.6
	52	3	1.3	1.3	91.9
	54	4	1.7	1.7	93.6
	55	2	.9	.9	94.5
	57	2	.9	.9	95.3
	59	2	.9	.9	96.2
	60	1	.4	.4	96.6
	65	1	.4	.4	97.0
	69	1	.4	.4	97.4
	73	1	.4	.4	97.9
	Age of defendant	1	.4	.4	98.3
	Not known	4	1.7	1.7	100.0
	Total	235	100.0	100.0	

Age of male perpetrators

The age range of the perpetrators was from 18 – 73. Within the span of ages, most perpetrators were aged 32.





Place of Crime

The most frequent place of crime was at the victim's house (45.4%), followed by the shared home of the couples (37.9%) and the culprit's house (5.8%).
Other places were camping, car, caravan, football club, hospital parking, hotel, street, prison, and victim's house or work.

Place of Crime

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid		6	2.5	2.5	2.5
	Camping	1	.4	.4	2.9
	Car	2	.8	.8	3.8
	Caravan	1	.4	.4	4.2
	Common house	91	37.9	37.9	42.1
	Culprit sister's house	1	.4	.4	42.5
	Culprit's house	14	5.8	5.8	48.3
	Football Club	1	.4	.4	48.8
	Home	1	.4	.4	49.2
	Hospital parking	1	.4	.4	49.6
	Hotel	1	.4	.4	50.0
	Parent's house	1	.4	.4	50.4

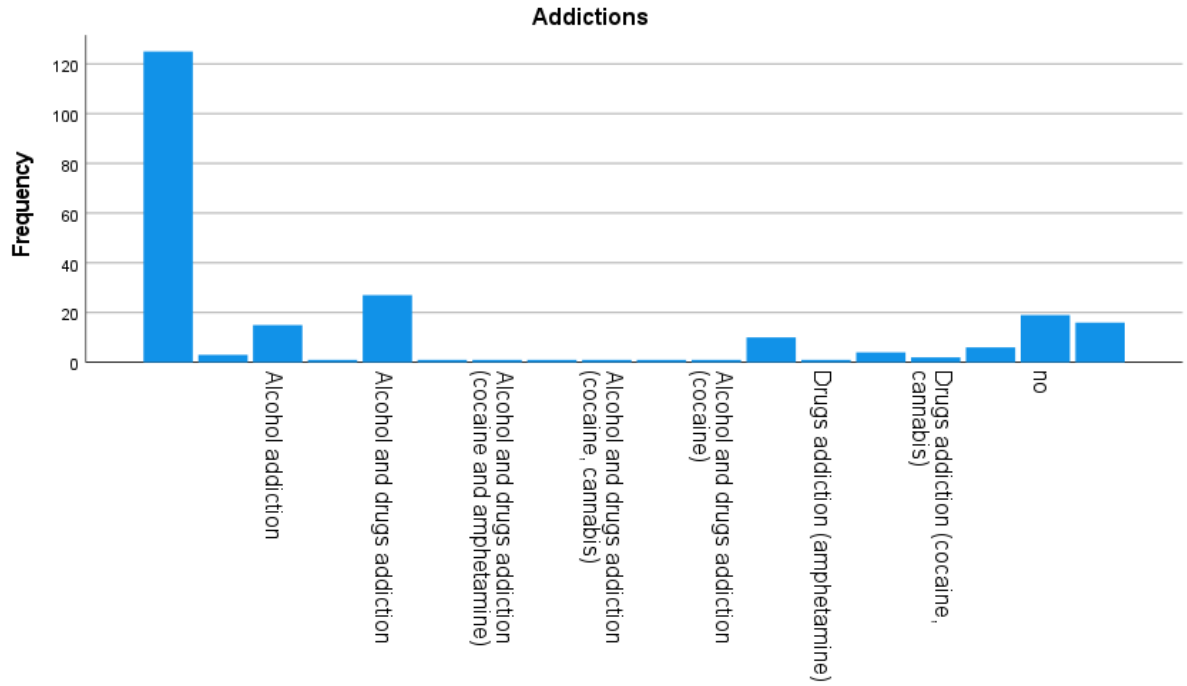
	Penitentiary	1	.4	.4	50.8
	Public park	1	.4	.4	51.2
	Street	4	1.7	1.7	52.9
	Victim's house	109	45.4	45.4	98.3
	Victim's house and work place	1	.4	.4	98.8
	Victim's house/work	1	.4	.4	99.2
	Victims' house	2	.8	.8	100.0
	Total	240	100.0	100.0	

Head injuries

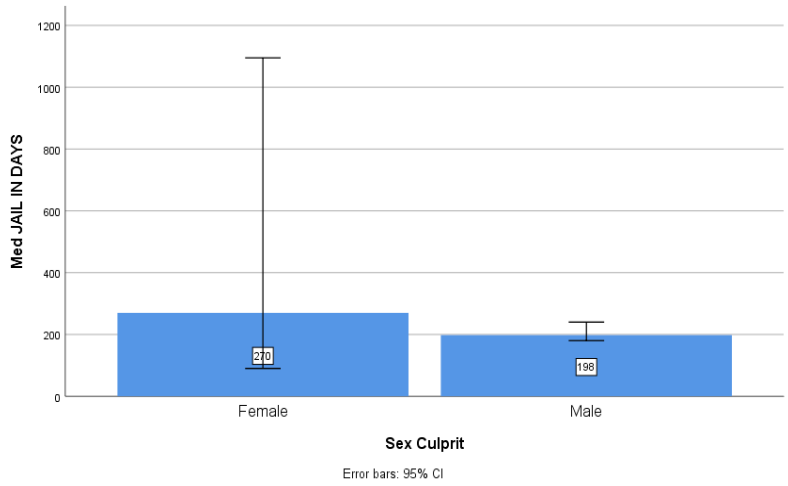
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	0	37	15.7	15.9	15.9
	1	196	83.4	84.1	100.0
	Total	233	99.1	100.0	
Missing	System	2	.9		
Total		235	100.0		

Statistics

		Age of defendant	Place of Crime	Head injuries
N	Valid	230	235	233
	Missing	5	0	2
Mean		37.42		.84
Std. Error of Mean		.654		.024
Median		36.00		1.00
Std. Deviation		9.915		.366
Kurtosis		.216		1.545
Std. Error of Kurtosis		.320		.318
Minimum		18		0
Maximum		73		1
Percentiles	25	30.00		1.00
	50	36.00		1.00
	75	44.00		1.00



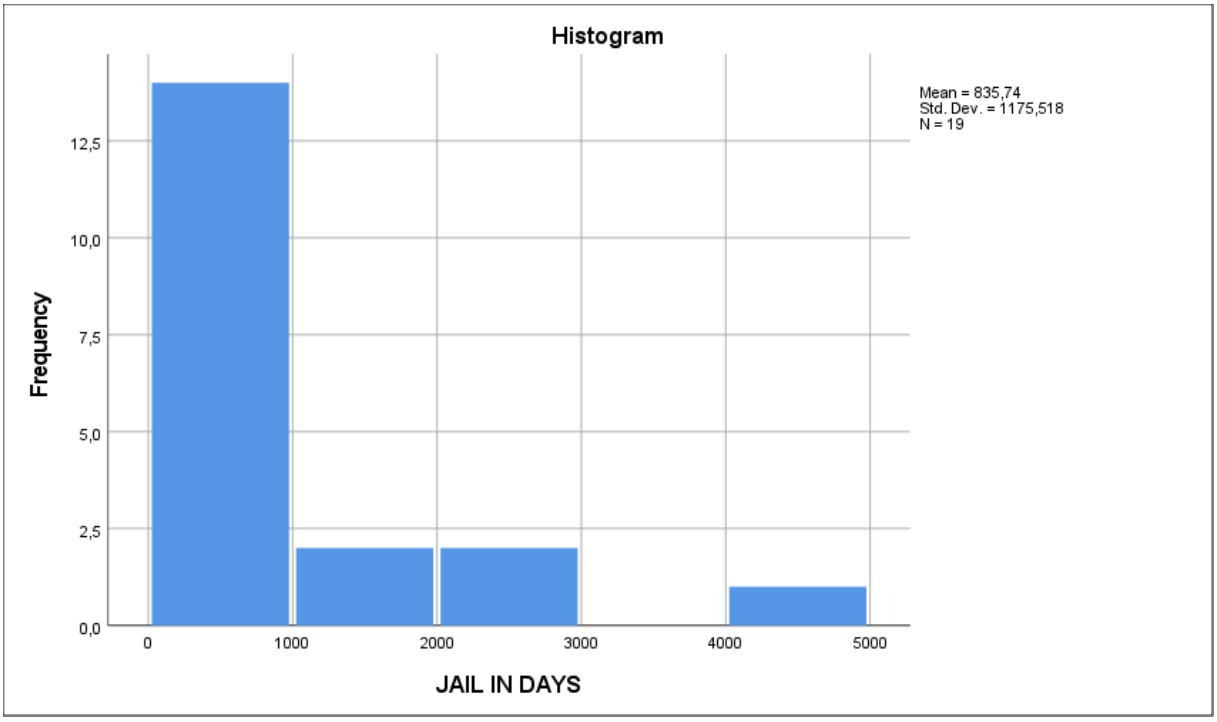
Here, we analysed differences in the days people spend in prison, depending on gender. The results show no differences in the days' people spend in jail depending on gender (U x 1883.5, p x 0.292).

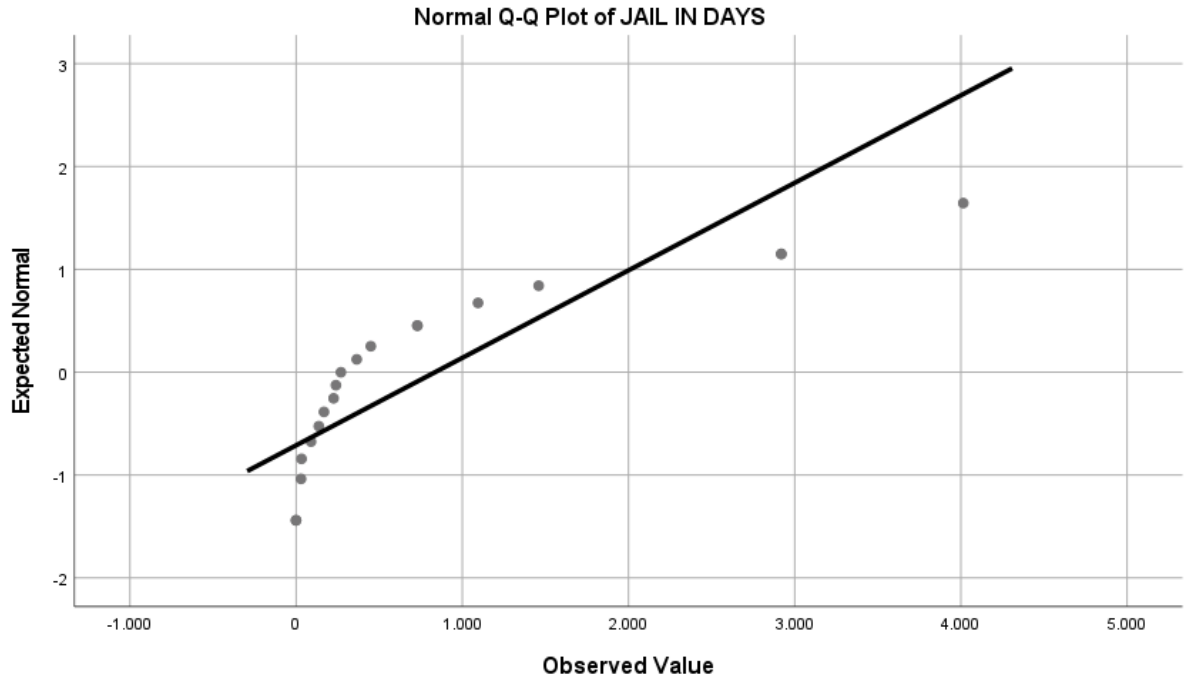


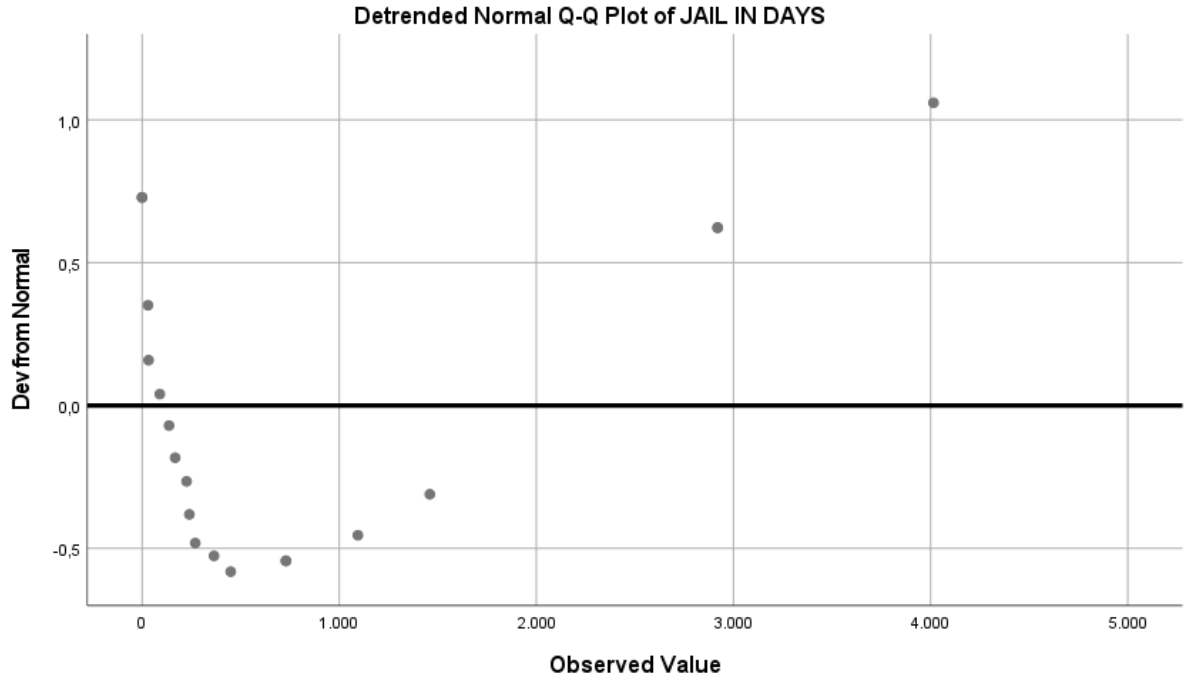
Test of Homogeneity of Variance[a]

		Levene Statistic	df1	df2	Sig.
JAIL IN DAYS	Based on Mean	2,321	1	249	,129
	Based on Median	1,278	1	249	,259
	Based on Median and with adjusted df	1,278	1	245,887	,259
	Based on trimmed mean	2,199	1	249	,139

a. There are no valid cases for JAIL IN DAYS when Sex Culprit = .000. Statistics cannot be computed for this level.




Normal Q-Q Plot of JAIL IN DAYS
Expected Normal
3
2
1
0
-1
-2
-1.000
0
1.000
2.000
3.000
4.000
5.000
Observed Value


Detrended Normal Q-Q Plot of JAIL IN DAYS
Dev from Normal
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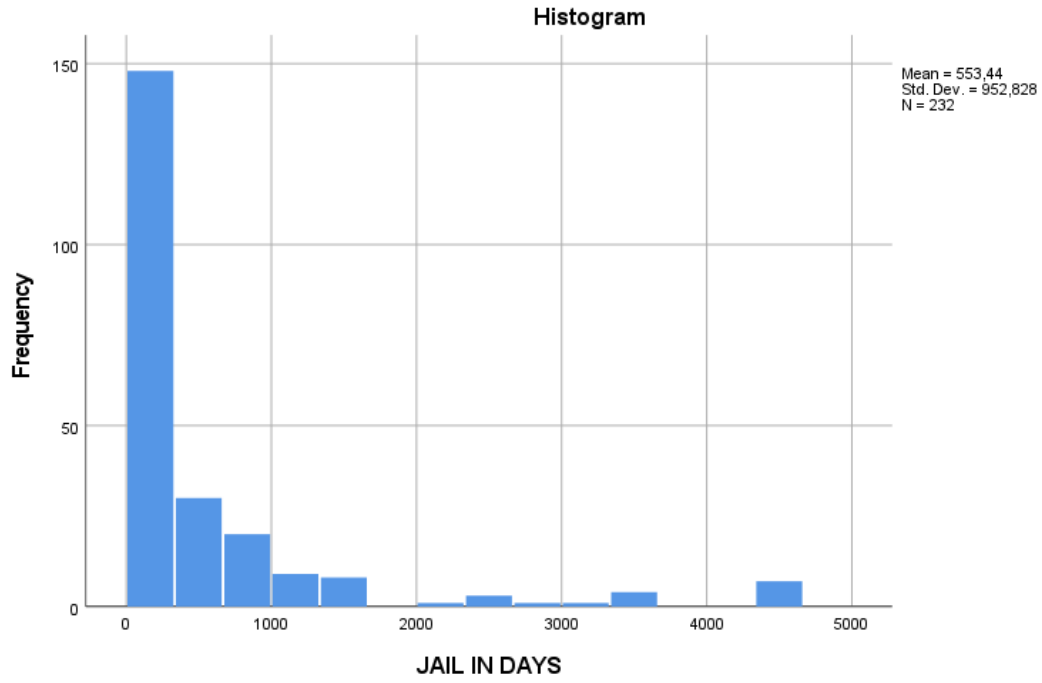
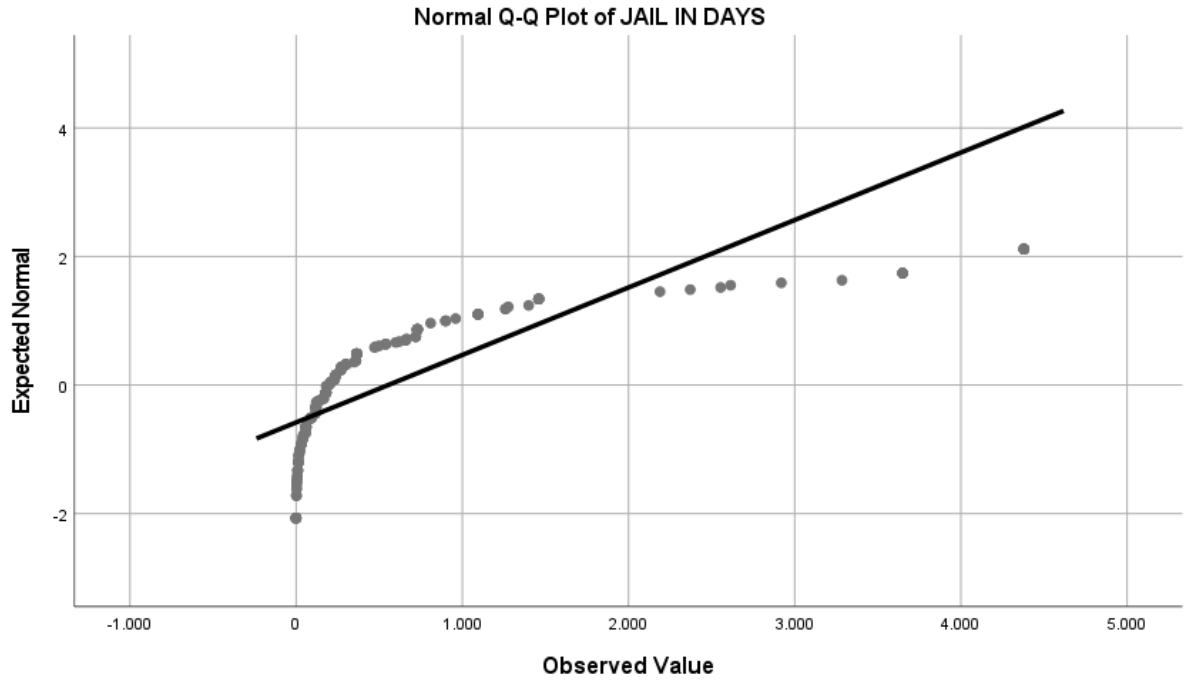
0,5
0,0
-0,5
0
1.000
2.000
3.000
4.000
5.000
Observed Value


Histogram
Mean = 553,44
Std. Dev. = 952,828
N = 232
Frequency
150
100
50
0
0
1000
2000
3000
4000
5000
JAIL IN DAYS


Normal Q-Q Plot of JAIL IN DAYS
Expected Normal
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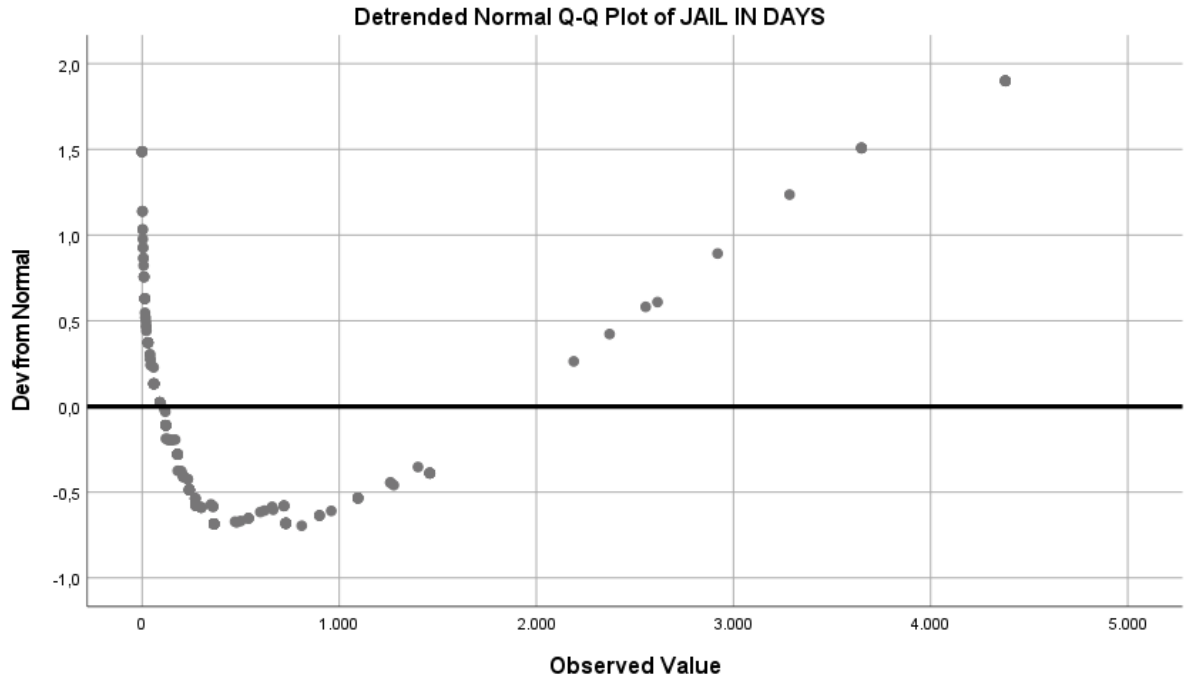
2
0
-2
-1.000
0
1.000
2.000
3.000
4.000
5.000
Observed Value


Detrended Normal Q-Q Plot of JAIL IN DAYS
Dev from Normal
2,0
1,5
1,0
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-0,5
-1,0
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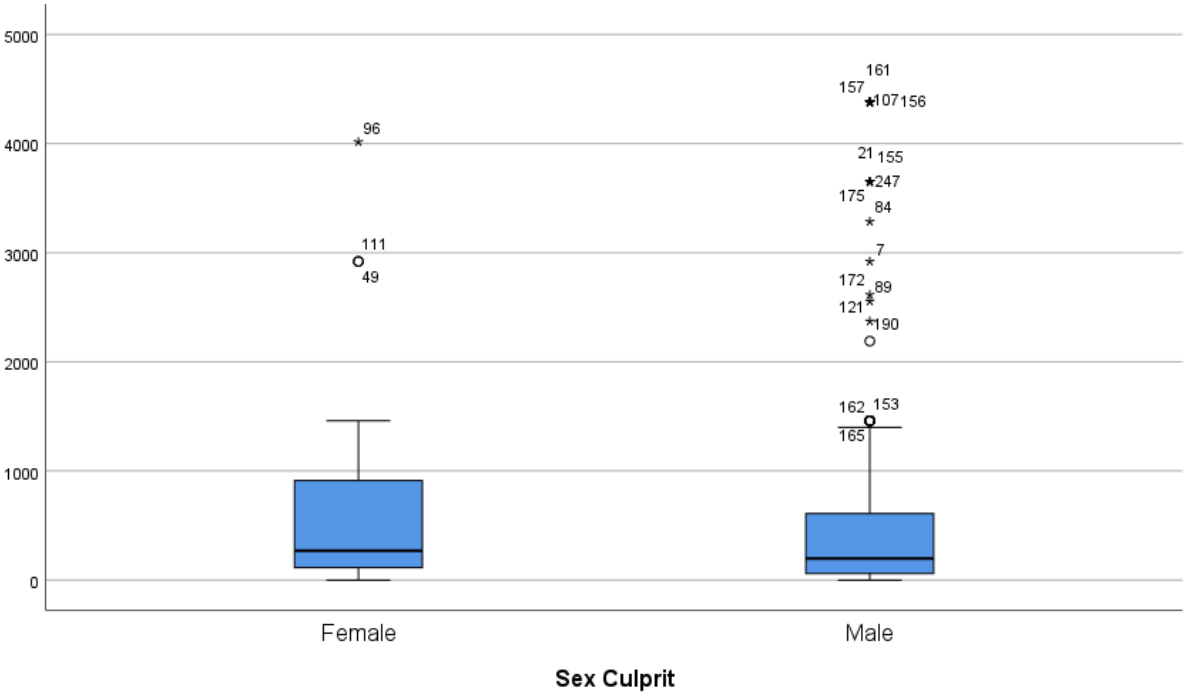
1.000
2.000
3.000
4.000
5.000
Observed Value


5000
4000
3000
2000
1000
0
96
111
49
161
157
107
156
21
155
247
175
84
7
172
89
121
190
162
153
165
Female
Male
Sex Culprit

5.7 A comparison between male and female perpetrators in the Netherlands.

Sex Culprit

Case Processing Summary

		Cases					
		Valid		Missing		Total	
	Sex Culprit	N	Per cent	N	Per cent	N	Per cent
JAIL IN DAYS	Female	19	100,0%	0	0,0%	19	100,0%
	Male	232	99,1%	2	0,9%	234	100,0%

Tests of Normality

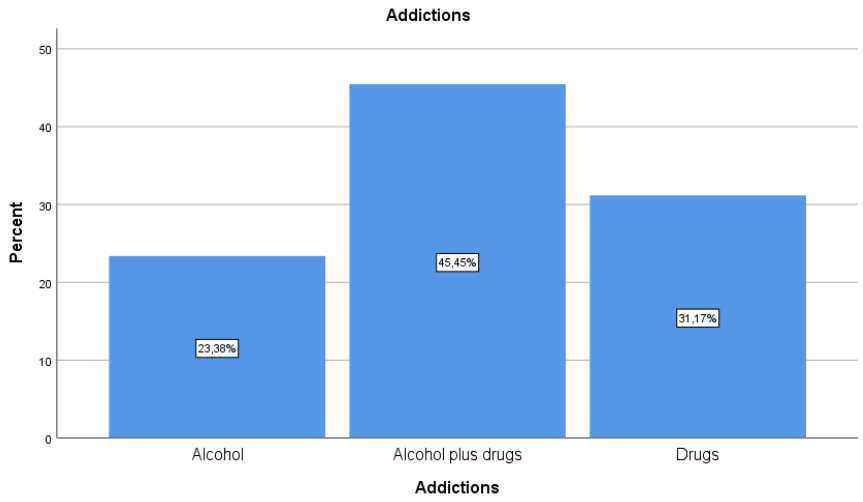
		Kolmogorov-Smirnov[b]			Shapiro-Wilk		
	Sex Culprit	Statistic	df	Sig.	Statistic	df	Sig.
JAIL IN DAYS	Female	,273	19	,001	,715	19	,000
	Male	,298	232	,000	,574	232	,000

a. There are no valid cases for JAIL IN DAYS when Sex Culprit = .000. Statistics cannot be computed for this level.

b. Lilliefors Significance Correction

Addictions

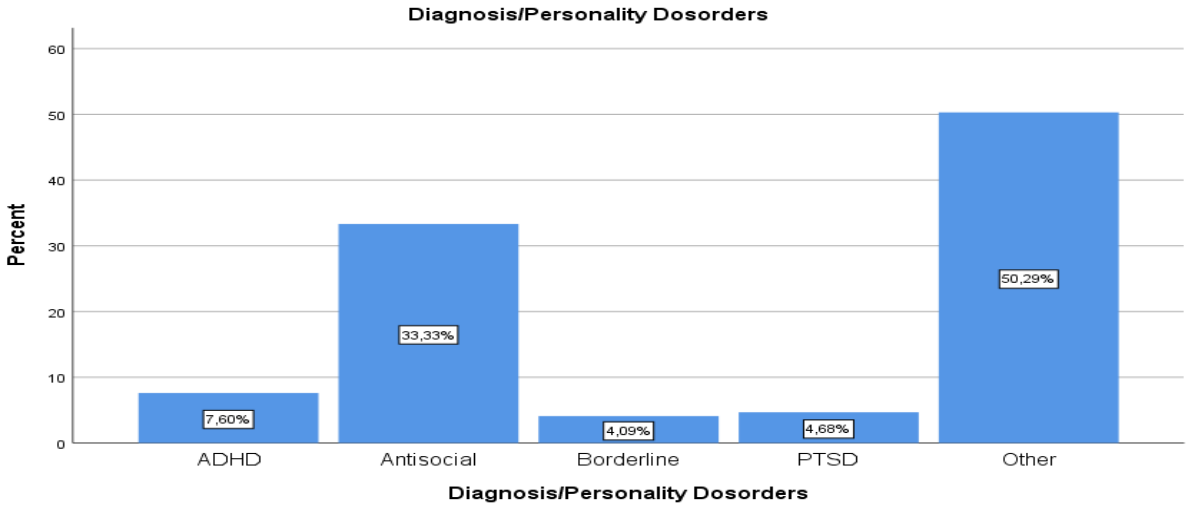
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Alcohol	18	7,1	23,4	23,4
	Alcohol plus drugs	35	13,8	45,5	68,8
	Drugs	24	9,5	31,2	100,0
	Total	77	30,4	100,0	
Missing	System	176	69,6		
Total		253	100,0		



23.38% of people have an Alcohol addiction, 45.45% have Alcohol plus drugs addiction and 31.17% have a drug addiction.

Diagnosis/Personality Disorders

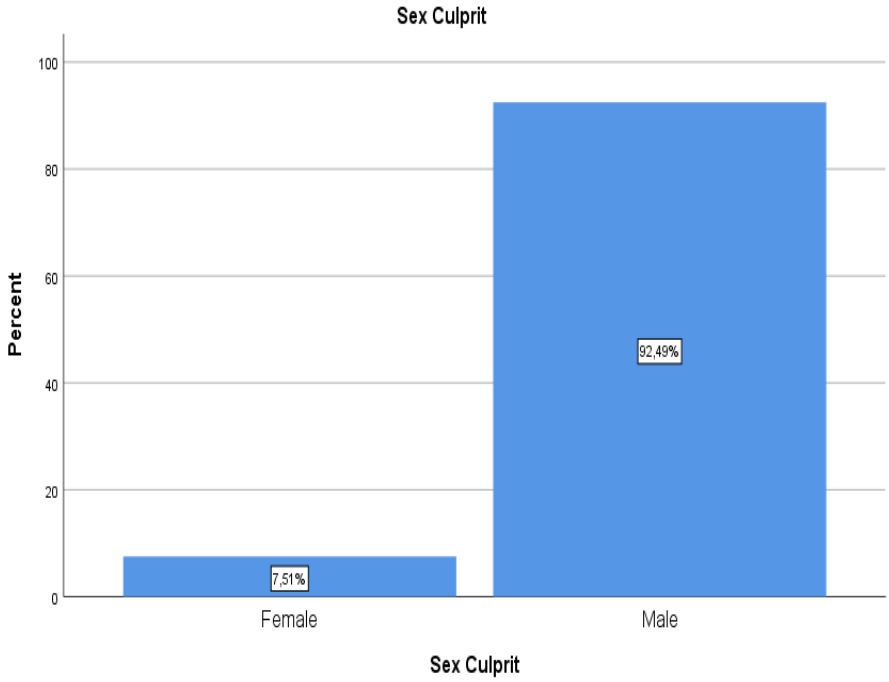
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	ADHD	13	5,1	7,6	7,6
	Antisocial	57	22,5	33,3	40,9
	Borderline	7	2,8	4,1	45,0
	PTSD	8	3,2	4,7	49,7
	Other	86	34,0	50,3	100,0
	Total	171	67,6	100,0	
Missing	System	82	32,4		
Total		253	100,0		



7.6% of perpetrators have an ADHD personality disorder, 33.33% have an Antisocial personality disorder, 4.09% a Borderline personality disorder, 4.68% have PTSD disorder, and 50.29% have other conditions.

Sex Culprit

		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Female	19	7,5	7,5	7,5
	Male	234	92,5	92,5	100,0
	Total	253	100,0	100,0	



7.51% of people are women, and 92.49% are men.

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Addictions * Diagnosis/Personality Disorders Crosstabulation

Count

		Diagnosis/Personality Disorders				
		ADHD	Antisocial	PTSD	Other	Total
Addictions	Alcohol	1	5	1	7	14
	Alcohol plus drugs	4	16	1	9	30
	Drugs	6	5	0	8	19
Total		11	26	2	24	63

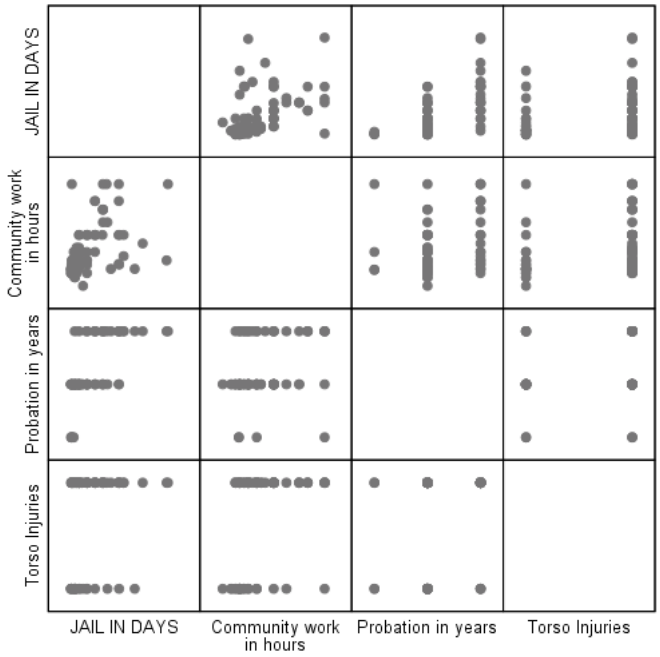
Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	7,925[a]	6	,244	,243		
Likelihood Ratio	8,254	6	,220	,279		
Fisher's Exact Test	7,566			,222		
Linear-by-Linear Association	1,301[b]	1	,254	,267	,136	,016
N of Valid Cases	63					

a. 5 cells (41,7%) have expected count less than 5. The minimum expected count is 44.

b. The standardized statistic is -1,141.

A test has been done to check for a relationship between the type of addiction and the type of personality disorder in men. The results indicate no connection between the two variables (Fisher's exact test of 7,566; p x 0.222).



Correlations

			JAIL IN DAYS	Community work in hours	Probation years
Spearman's rho	JAIL IN DAYS	Correlation Coefficient	1,000	,573**	,
		Sig. (2-tailed)	.	,000	
		N	251	76	
	Community work in hours	Correlation Coefficient	,573**	1,000	
		Sig. (2-tailed)	,000	.	
		N	76	77	
	Probation in years	Correlation Coefficient	,413**	,273*	1
		Sig. (2-tailed)	,000	,018	
		N	190	75	
	Torso Injuries	Correlation Coefficient	,095	,347**	
		Sig. (2-tailed)	,135	,002	
		N	249	77	

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Correlation analysis of Sperman was performed, which suggests some correlation between the Jail in Days, Community work in hours, Probation in years, and Torso Injuries variables. All correlations are positive.

Addictions * Diagnosis/Personality Disorders Crosstabulation

Count

		Diagnosis/Personality Disorders			
		Antisocial	Borderline	PTSD	Total
Addictions	Alcohol	0	0	1	1
	Alcohol plus drugs	1	1	0	2
	Drugs	0	1	0	1
Total		1	2	1	4

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	5,000[a]	4	,287	,833		
Likelihood Ratio	5,545	4	,236	1,000		
Fisher's Exact Test	4,550			1,000		
Linear-by-Linear Association	1,263[b]	1	,261	,500	,250	,167
N of Valid Cases	4					

a. 9 cells (100,0%) have an expected count of less than 5. The minimum expected count is 25.

b. The standardized statistic is -1,124.

A test has been done to check for the relationship between the type of addiction and the type of personality disorder in women.

The results indicate no relationship between the two variables (Fisher's exact test of 4.55; p x 1).

Descriptives

	Sex Culprit			Statistic	Std. Error
JAIL IN DAYS	Female	Mean		835,74	269,682
		95% Confidence Interval for Mean	Lower Bound	269,16	
			Upper Bound	1402,32	
		5% Trimmed Mean		705,54	
		Median		270,00	
		Variance		1381842,649	
		Std. Deviation		1175,518	
		Minimum		0	
		Maximum		4015	
		Range		4015	
		Interquartile Range		1005	
		Skewness		1,776	,524
		Kurtosis		2,241	1,014
	Male	Mean		553,44	62,556
		95% Confidence Interval for Mean	Lower Bound	430,19	
			Upper Bound	676,70	
		5% Trimmed Mean		388,70	
		Median		198,00	
		Variance		907881,902	
		Std. Deviation		952,828	
		Minimum		0	
		Maximum		4380	
		Range		4380	
		Interquartile Range		556	
		Skewness		2,855	,160
		Kurtosis		7,857	,318

a. There are no valid cases for JAIL IN DAYS when Sex Culprit = .000. Statistics cannot be computed for this level.

Chapter 6 Domestic violence in Spain

6.1 Introduction

The tolerance towards domestic violence and child abuse in some societies are related to the cultural construction of gender roles and whether the victim or perpetrator has witnessed violence or has learned to solve problems using physical force. All these elements are risk factors to further victimisation and victim-blaming attitudes. Fortunately, the public awareness of DV in Spain is increasing, and equality policies are issued to combat social and health issues.

This chapter will analyse the following topics:

6.1.1 Tolerance to violence.

There is globally a persistent and widespread problem related to violence against females by their intimate partners (WHO, 2013). In some societies, there is support to acts of violence, which encourages its perpetration, contributing to further violence. Those attitudes of tolerance towards violence are increasingly recognized as critical risks for social and public health issues. Some women are more at risk of DV than others due to their socio-economic status because of gender inequality in education, health, employment, immigrants status or other stigmas based on cultures and traditions. The Spanish Government proclaims that one out of three young women does not consider controlling behaviour as a form of abuse (Ministerio de Sanidad, Asuntos Sociales e Igualdad / Ministry of Health, Social Services, and Equality, 2013).

In Spain, the tolerance to violence is higher among males, the elderly, and less educated people. Regarding the subject of victim's blaming and exonerating

perpetrators, there are differences between the attitudes of males and females, which are affected by factors such as age, level of education, and whether individuals condone intimate partner violence or not (Sanchez-Prada, Delgado-Alvarez, Bosch-Fiol, Ferreiro-Basurto, and Ferrer-Perez, 2020).

This DV persistence may be related to cultural constructions of masculinity. In patriarchal societies, men are the head of the family, the primary breadwinners and usually decide and dominate over many issues and intimate relationships (Tun and Ostergren, 2020).

A (high) level of education could be a protective factor against domestic violence, tolerance and sexism. However, in a study among university students in which 1,322 individuals from three Spanish universities participated (Psychology, Nursing, and Medicine); the researchers found the following:

	Psychology students	Nursing students	Medicine students
DV tolerance	75.0%	57.0%	60.3%
Sexism	80.8%	62.2%	62.7%

Data from García-Díaz, Fernández-Feito, Bringas-Molleda, Rodríguez-Díaz, and Lana (2020)

From the three universities, psychology' students had the highest level of domestic violence tolerance and sexism. However, DV tolerance in advanced students in the mentioned disciplines (psychology, nursing, and medicine) was lower in females than in males psychology students. But there was less support of sexism in males, but not in females (García-Díaz, Fernández-Feito, Bringas-Molleda, Rodríguez-Díaz, and Lana (2020).

Another way to understand why DV occurs in so many societies would be to apply concepts obtained from the *Social Learning Theory*, which is still a leading theory of crime and deviance (Akers and Jensen, 2006). It explains how violence is learned via observing others and passes it down to succeeding generations. Children witnessing violence in their family of origin, or being maltreated by their parents, internalise behavioural scripts for violence and accept them as 'natural' (Bandura, 1977). As

adults, those individuals may adopt attitudes that condone partner violence and become perpetrators (Bartholomew, Schmitt, Yan, and Regan, 2013). Nevertheless, not all children exposed to violence will use it in adulthood (Smith, Ireland, Park, Elwyn, and Thronberry, 2011). It will depend on whether the behaviour is being reinforced or not, whether the child has suffered corporal punishment, or whether the person adopts attitudes that support violence. Some individuals with antisocial tendencies use violence to settle conflicts in intimate relationships (Eckhard, 2011). Besides, the approval of male-to-female spousal violence influences the use of violence among married couples.

Early experiences with a partner also contribute to learning processes (e.g. a partner who perpetrate violence, is controlling, and is unfaithful). That experience will be taken to the new relationship; thus, it continues beyond what was learned at the family of origin (Herrero-Arias, Ortiz-Barreda et al. 2019). Previous experiences might mould the attitudes concerning the acceptability of violence.

6.1.2 Beliefs regarding the use of violence

A number of 928 adolescents who participated in the Toledo Adolescent Relationship Study (TARS) supplied detailed data about the family's background of those young people, the respondents' sociodemographic characteristics (e.g. age, gender, race, ethnicity; education-level, positioning and beliefs regarding the use of violence. Copp, Giordano, Longmore and Manning (2017) investigated what other factors apart from being exposed to interparental violence in homes are associated with attitudes of acceptance towards domestic violence. The researchers wanted to empirically demonstrate the role of other social norms such as gender, sociodemographic characteristics, current life status (e.g. neighbourhood poverty, minority status, education, relationship status), and public attitudes based on cultural values influence DV acceptance.

The study results indicated that females rather than males were more accepting of violence against an intimate partner, maybe due to previous experiences of controlling behaviour from a partner or (the lack of) education shaped their point of view about DV (Copp, Giordano, Longmore and Manning, 2017).

This knowledge is vital to implement evidence-based programmes and treatments to change social norms that sustain gender inequality and violence, considering the differences between men and women when designing programmes (Jewkes, Flood and Lang, 2015).

Women affected by their partner's violence have to endure a long process to heal their physical injuries and psychological health even after deciding to leave the abuser (Keeling, Smith and Fischer, 2016).

6.1.3 Risk factors for domestic violence against pregnant women

DV in pregnancy is, sadly, globally pervasive, impacting the mother and the unborn child. Spain is not an exception; therefore, the Spanish government issued in 2004 the *Organic Act on Integrated Protection Measures* (Law 1/2004) to combat gender violence. This law includes coercion and threats, occasional or structural abuse as punishable crimes and mandates harsh penalties for offenders.

A study by Martin de las Heras et al. (2019) took place in 15 public hospitals offering obstetric services in Andalusia, Spain. It aimed to evaluate the adverse outcomes of physical and psychological intimate partner violence (IPV). Their sample consisted of 779 mothers receiving antenatal care. Data about those women's socio-demographics, kin support (of the lack of it), maternal outcomes and hospitalisation was collected by experienced midwives using the "Index of Spouse Abuse" (in Spanish).

Their results showed that 153 women (21.3%) were affected by IPV, of which 26 (3.6%) said to have experienced physical IPV and 151 women (21%) were victims of psychological abuse. Twenty-four women (3.3%) had experienced both types of violence during pregnancy. The researchers concluded that women who suffered from IPV during pregnancy had health problems and worries about their unborn babies. The researchers recommended an early detection method and screening to improve the physical and mental health of victims of IPV (De las Heras et al., 2019).

Spain prioritises now prevention and intervention programmes (Loewenberg, 2005).

Gender inequality and economic dependency play a role in the prevalence of DV/IPV. A women's income and financial independence are favourable factors; the less economic security, the higher is the risk for DV victimisation in women (Sandes, 2015; Gilroy, Symes and MacFarlane, 2015; Okuda, 2015).

6.1.4 LGBT+ Migrants

The migration of LGBT+ people to Europe is in most countries not well registered (Zardiashvili and Kasianczuk, 2020). People migrate for multiple reasons. There is an assumption that the reasons for LGBT+ migration are security (e.g. avoiding persecution in their country of origin) and the search for a more open society where they will not be stigmatised, discriminated or harassed. Although the trend of LGBT+ migration is increasing, Europe has not solid guidance concerning the protection of LGBT+ asylum-seekers. Even at the borders, they are treated discriminatorily by border officials, and once in the new country, they are doubly stigmatised: because of being LGBT+ and foreigners. These stressful situations have a toll on their health and well-being (Zardiashvili and Kasianczuk, 2020).

Although Article 3 of the *Treaty on the European Union* (TEU) proclaims that equal treatment to all persons, socially, culturally, and economically, is fundamental, LGBT+ people are discriminated against in various fields. Firstly, when requiring protection in Europe based on sexual orientation and gender identity (SOGI), LGBT+ must give 'evidence' that their persecution in the country of origin was due to SOGI. Many of the asylum's requests are denied due to stereotypical conceptions of what an LGBT+ individual should be like. Some of them are considered by the official deciding about their status either 'not gay enough' or 'too gay.' (Nossem, 2021). At immigration detention centres, LGBT+ individuals waiting for a decision on their status are bullied, victimised and intimidated (Zadeh, 2019).

The credibility of asylum seekers plays a role in the decision of employees who decide whether to give a resident permit. Lesbians are asked, for instance, "*How much of a lesbian are you*"? (Singer, 2021).

Since 2009, a (gay-friendly) policy in Spain recognises the sexual orientation's right to asylum. However, asylum applications based on sexual orientation are presently not applicable due to increased requests and the lack of resources to detect violent situations produced by increasing LGBT+ phobias in reception centres (ACNUR, 2017).

In Spain, the Ministry of Health, Social Services and Equality (MSSSI) coordinates the programmes to achieve equitable health centres across the country. However, the conservative government's budget to prevent HIV was dramatically reduced (75% up to 90%) in 2012. Healthcare for transgender people in Spain is omitted in some regions (Pérez Rodríguez, González Rojo, Marrero Jaén, and Rebollo Norberto, 2015).

6.1.5 COVID-19 in Spain

The Covid pandemic has affected the whole world. Still, In Spain, the mortality due to the virus was highest in Europe, producing traumas in health personnel or families losing their loved ones.

Women living alone were more affected than men due to their higher stress levels by social isolation (Gebhard et al., 2020; Spagnolo et al., 2020). However, experiencing DV during the pandemic increased female's depressive symptoms resulting in a deterioration of their emotional well-being (García-Fernández, Romero-Ferreiro, Padilla, et al., 2020); less animosity to seek any available service offering assistance and protection and worries for job loss or income reduction. Besides, during a lockdown, victims have lesser opportunities to report incidents or to leave the abuser since shelters and other places offering help are not functioning (Cluver et al., 2020)

In the first ten days of the Covid-19 confinement, there was an increase of 18% of calls to the toll-free emergency number 016 on gendered violence; 597 more calls were done than in the same period 2019. Regarding mail consultations, there was an increase of 269% (Pitarch, 2020).

Only days after the confinement on March 14^{th,} the first assassination case was reported to the Spanish Police in Castellón. The victim was a 35 years old woman

killed by her husband in the presence of their two minors sons (aged 11 and 7) (Pitarch, 2020).

Conclusion and recommendations

We saw that some societies are more tolerant than others concerning DV and child abuse. Cultural constructions of gender roles can influence whether a person condones violence against intimate partners or children; young Spanish women do not consider controlling behaviour as a form of abuse.

DV tolerance in Spain is prominent among males, older adults, and less educated people. However, in a research study among university students of three disciplines (psychology, nursing and medicine), students scored high in IPV tolerance and sexism.

People may condone DV because of their history of violence at home and due to the influence of their sociodemographic characteristics (e.g. age, gender, race, ethnicity, education level). Learning from wrong modelling makes the acceptance of aggressive behaviour and intimate partner violence acceptable.

Gender inequality and economic dependency are risk factors for physical and emotional DV against (pregnant) women.

Concerning LGBT+ migrants in Spain and other countries in Europe, despite issued legislation, LGBT+ people are not correctly registered. Their protection is not safeguarded by governments or by individuals dealing with the issue of residence in the host country. Transgender people receive adequate and specialised medical healthcare only in some regions.

The Covid-19 pandemic has affected many individuals in Spain who have lost their loved ones and still live uncertain about their future. The lockdown made clear that societies must rethink their policies to answer any breakdown in the future.

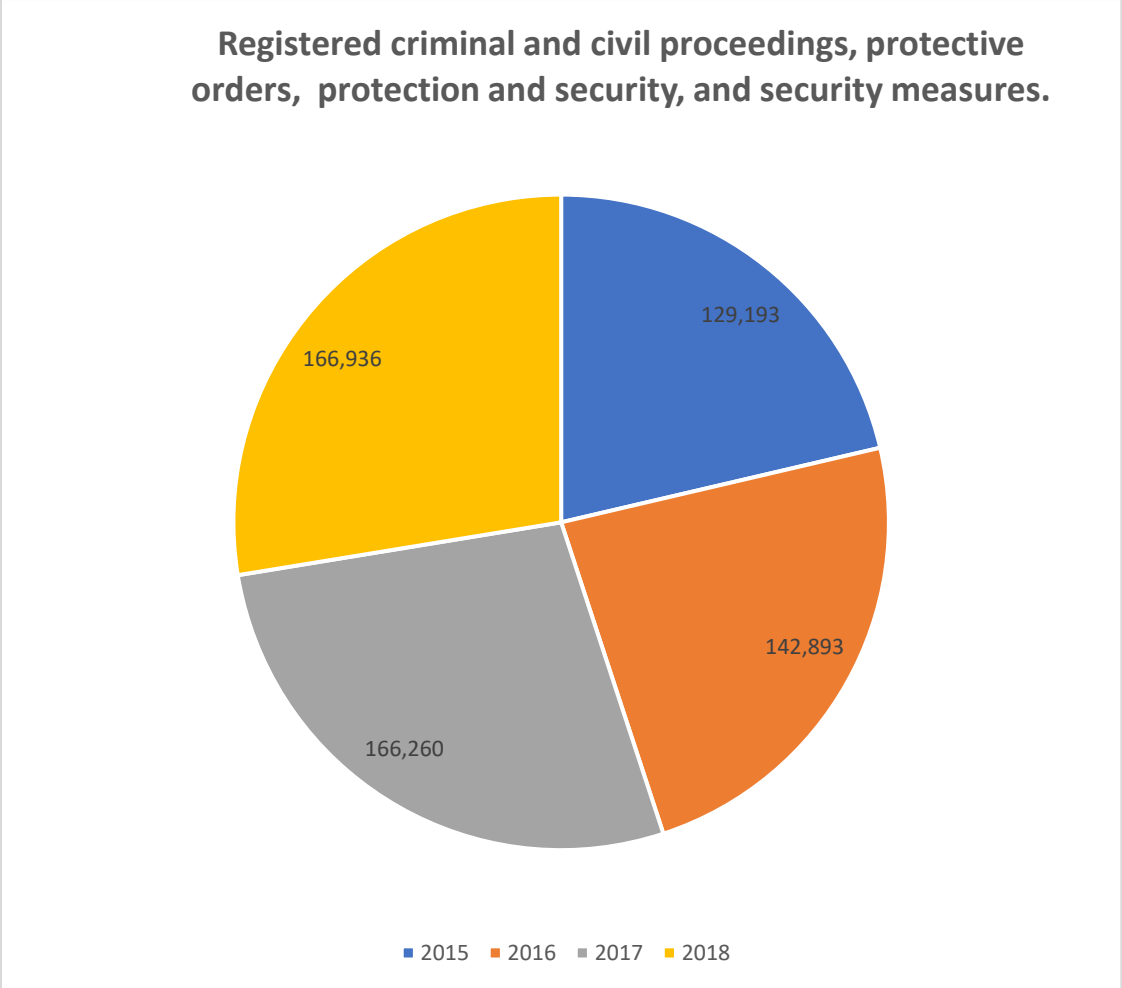
6.2 Presentation of the Spanish Data

General Counsel of the Judiciary

Spanish data on complaints, registered criminal and civil proceedings, protective orders and protection and security measures requested in the courts of violence against women and judgements handed down by the courts in this area in 2015-2018.

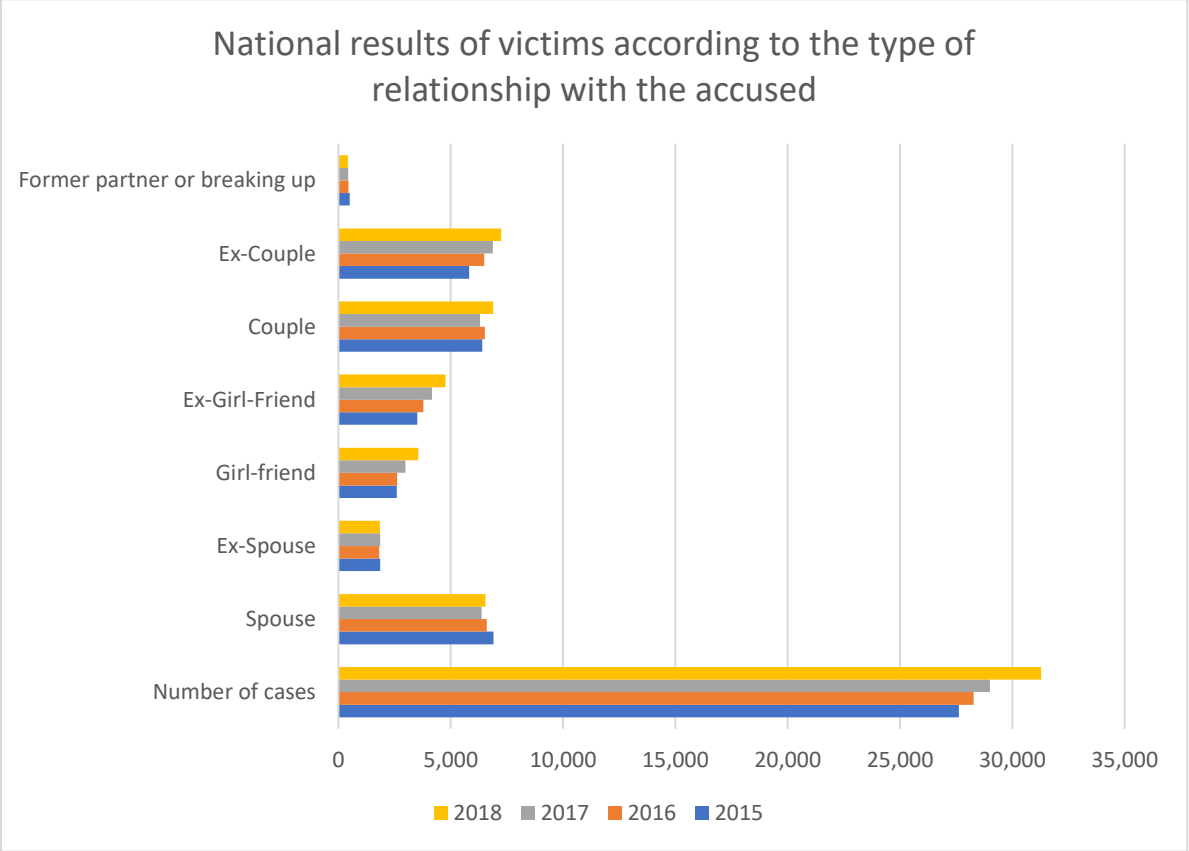
2015	2016	2017	2018
129,193	142,893	166,260	166,936

Data from INE / Spanish Statistical Office



National results of victims (with a protective order and preventive measures) according to the type of relationship with the accused

YEAR	Number of cases	Spouse	Ex-Spouse	Girl-friend	Ex-Girl-Friend	Couple	Ex-Couple	Former partner or breaking up
2015	27,624	6,909	1,866	2,594	3,513	6,411	5,824	507
2016	28,281	6,601	1,817	2,614	3,786	6,520	6,488	455
2017	29,008	6,384	1,859	2,990	4,165	6,302	6,871	437
2018	31,286	6,552	1,846	3,557	4,766	6,888	7,251	426



YEAR 2015

Data of complaints, registered criminal and civil proceedings, protection orders and protection and security measures requested in the court of violence against women and sentences handed down by the judicial bodies in this matter in 2015.

	Total Complaints	129,193	%
	Presented directly by the victim to the court	5,238	4.05
	Presented directly by relatives	1,323	1.02
Cases denounced by the police	With the victim's complaint	83,848	64.90
	With family report	1,595	1.23
	By direct police intervention	20,131	15.58
	Reporting of injuries directly to the court	14,575	11.28
	Third-party support services in general	2,483	1.92

Data from INE / Spanish National Institute of Statistics

Types of crimes being investigated in 2015

Crimes		**Per cent**
Injuries and ill-treatment Art. 153 PC	83,641	62.4
Injuries and ill-treatment Art. 173 PC	15,400	11.5
Against freedom	10,911	8.1
Injuries and ill-treatment Art. 148	5,305	4.0
Breach of Measures	5,005	3.7
Against moral integrity	3,026	2.3
Breaking Sentence	3,728	2.8
Against family rights and duties	448	0.3
Against sexual freedom and indemnity	922	0.7
Homicide	76	0.1
Abortion	2	0.0
Injuries to the foetus	0	0.0
Others	5,606	4.2
Total	**134,070**	

Persons prosecuted in the courts for violence against women

Persons prosecuted in the courts for violence against women		Convicted persons		Acquitted persons	
		Spanish citizens	Foreigners	Spanish citizens	Foreigners
Men	18,965	10,863	3,666	3,768	668
Women	**136**	**65**	**21**	**45**	**5**
Total	19,101	10,928	3,687	3,813	673

The nationality of women victims of gender-based violence was:
Criminal Matters For Types of Processes on Violence Against Women in Spain:
152,115

Total Registered Cases in 2015 at the Criminal Court on Violence Against Women in Spain: 26,584.

YEAR 2016

Total of Protective Orders from Courthouses (Duty Courts/Juzgados de Guardia) in Spain according to sex and nationality: 5,465

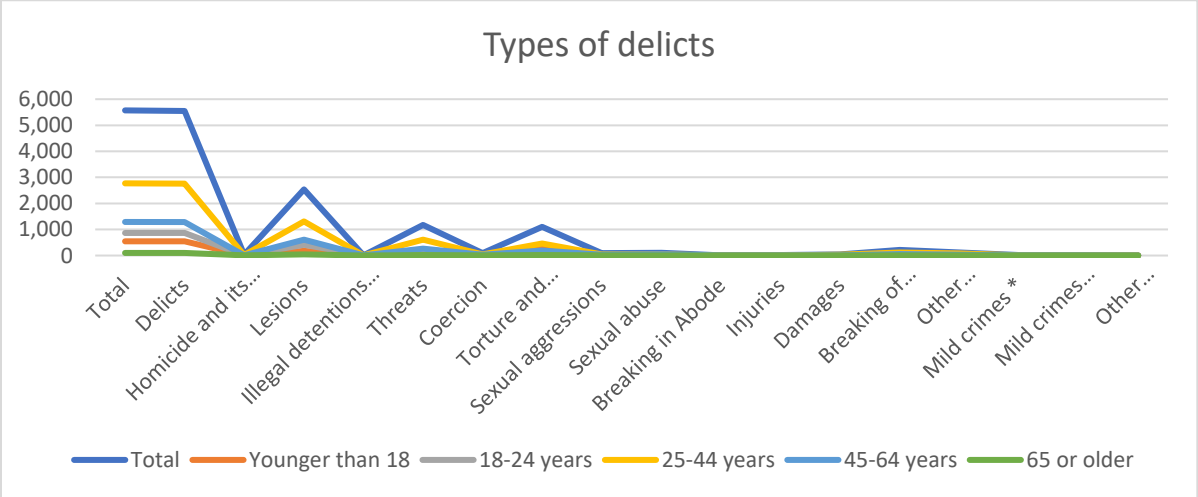
Victim: Adult Spanish Women	Victim: Minor Spanish Women	Victim: Adult Foreign Women	Victim: Minor Spanish Women	Denounced Spanish Men	Denounced Foreign Men
3,952	62	1,422	29	4,028	1,437

Domestic Violence Statistics.

Domestic Violence (initiated cases of DV). National Results.
Criminal offences charged to the reported person according to the type of infringement and age group.

	Total	Younger than 18	18-24 years	25-44 years	45-64 years	65 or older
Total	5,570	545	866	2,770	1,289	100
Delicts	5,549	545	861	2,761	1,282	100
Homicide and its forms	32	1	2	19	9	1
Lesions	2,541	175	412	1,303	603	48
Illegal detentions and kidnappings	11	0	2	3	6	0
Threats	1,169	71	213	605	266	14
Coercion	91	7	10	45	28	1
Torture and moral integrity	1,106	283	154	461	190	18
Sexual aggressions	89	1	9	40	32	7
Sexual abuse	106	2	5	45	46	8
Breaking in Abode	9	0	2	4	3	0
Injuries	18	1	4	11	2	0
Damages	41	1	6	28	6	0
Breaking of conviction	214	0	32	121	59	2
Other unspecified crimes	122	3	10	76	32	1
Mild crimes *	21	0	5	9	7	0
Mild crimes against people	21	0	5	9	7	0
Other unspecified mild crimes	0	0	0	0	0	0

- In July 2015, a Criminal Code reform came into force that suppressed the terminology 'faults', replacing it with 'mild crimes.'



YEAR 2016

Statistics of Domestic Violence and Gender Violence. National Results

	Victims Total	Victims: Male	Victims: Female
Victims Total	**6,863**	**2,574**	**4,289**
Age Range			
Younger than 18	1,585	637	948
From 18 to 19	228	62	166
From 20 to 24	345	118	227
From 25 to 29	265	113	152
From 30 to 34	275	114	161
From 35 to 39	413	168	245
From 40 to 44	547	204	343
From 45 to 49	537	195	342
From 50 to 54	563	197	366
From 55 to 59	511	209	302
From 60 to 64	380	151	229
From 65 to 69	363	129	234
From 70 to 74	303	111	192
From 75 and older	548	166	382

Data INE (Spanish Statistical Office)

From the total number of victims, both male and female in Spain's whole territory, 6,154 were born in a European country, from which 5,780 in Spain.

Two hundred forty-five victims were born in Africa, 424 in the Americas, and 40 in Asia.

Of the total male victims, 2,329 were born in a European country, from which 2,195 in Spain. Ninety-three male victims were born in Africa, 132 in the Americas, and 20 in Asia.

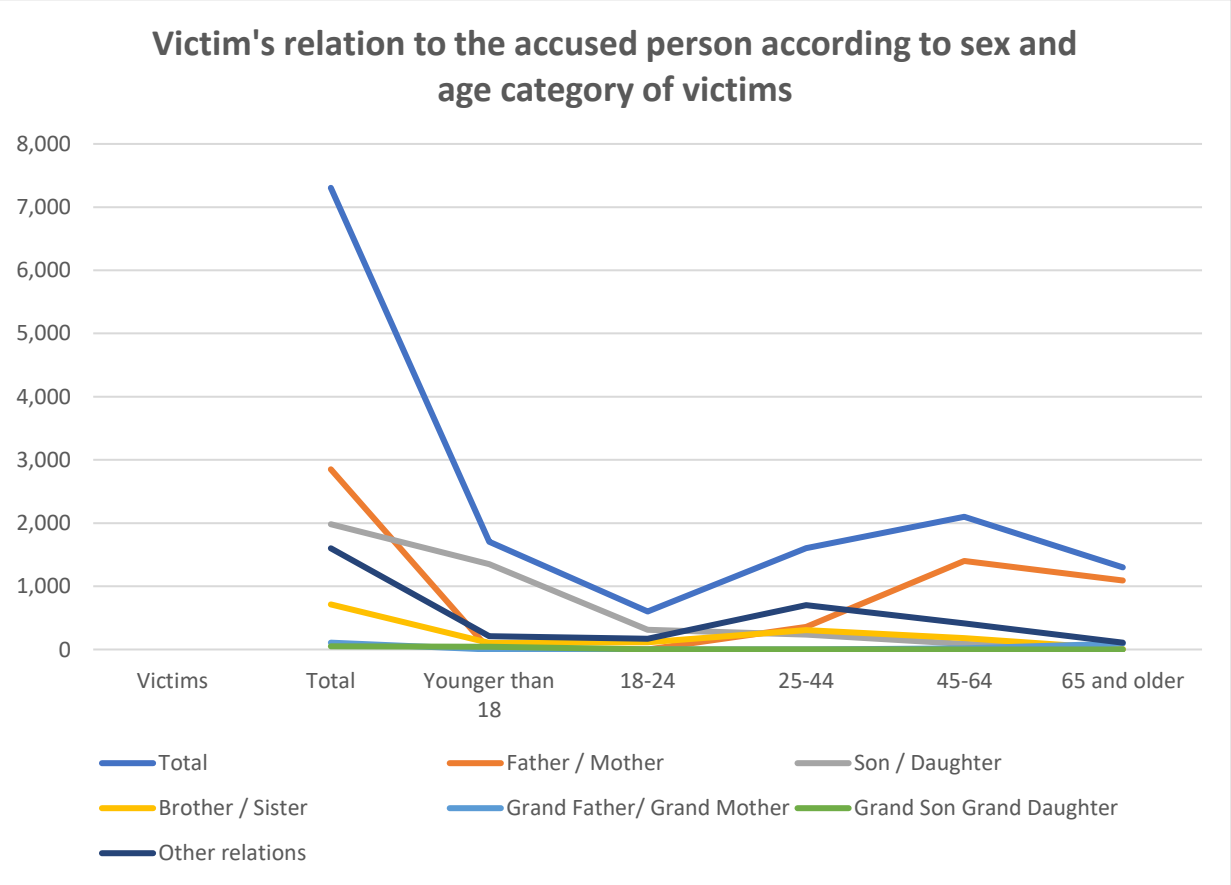
Of the total number of female victims, 3,825 were born in a European country.

3,585 in Spain, 152 in Africa; 292 in the Americas; and 20 in Asia.

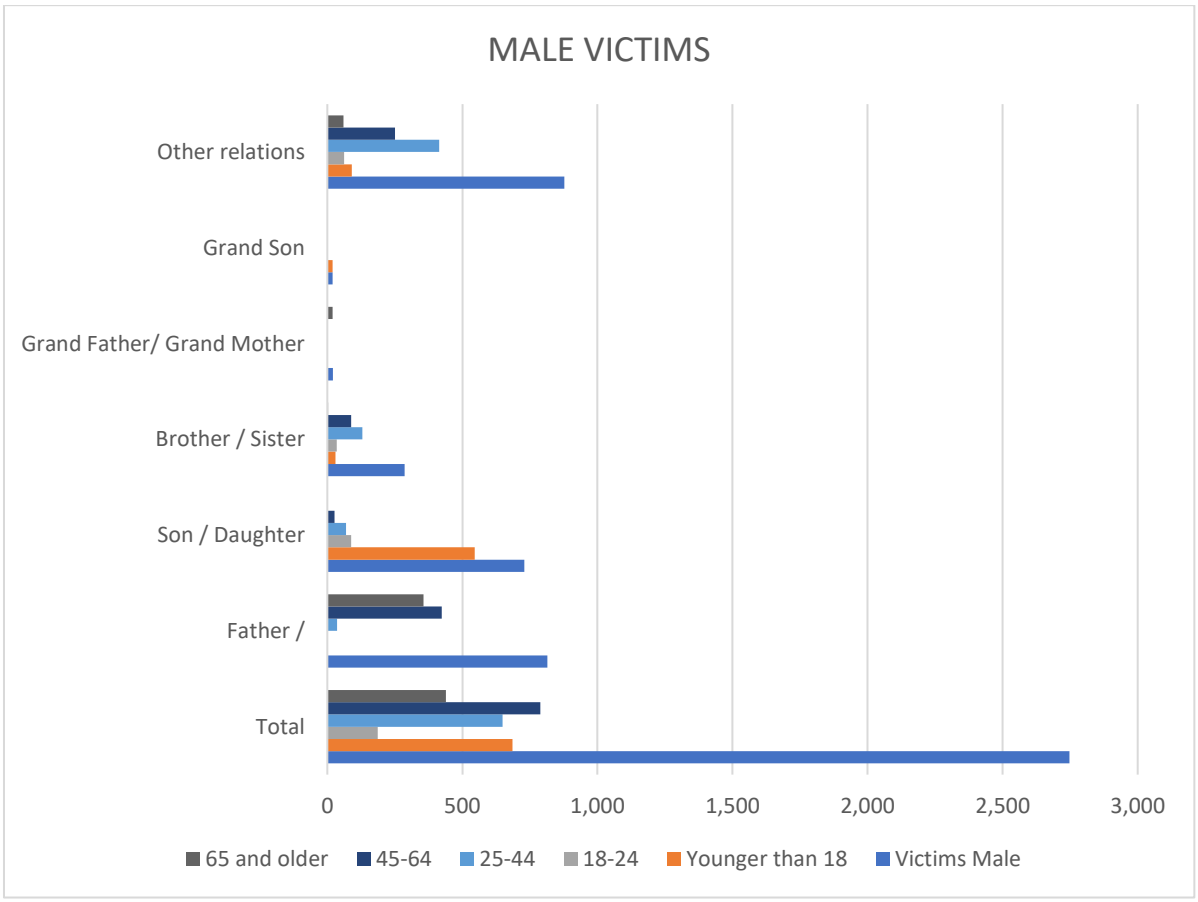
Year 2016

Victims' relations to the accused persons according to sex and age category of victims

	Total	Father / Mother	Son / Daughter	Brother / Sister	Grand Father/ Grand Mother	Grand Son Grand Daughter	Other relations
Victims Total	**7,305**	**2,851**	**1,982**	**713**	**108**	**50**	**1,601**
Younger than 18	1,706	0	1,350	102	0	42	212
18-24	601	0	310	116	0	4	171
25-44	1,602	358	235	306	0	4	699
45-64	2,099	1,403	87	182	16	0	411
65 and older	1,297	1,090	0	7	92	0	108

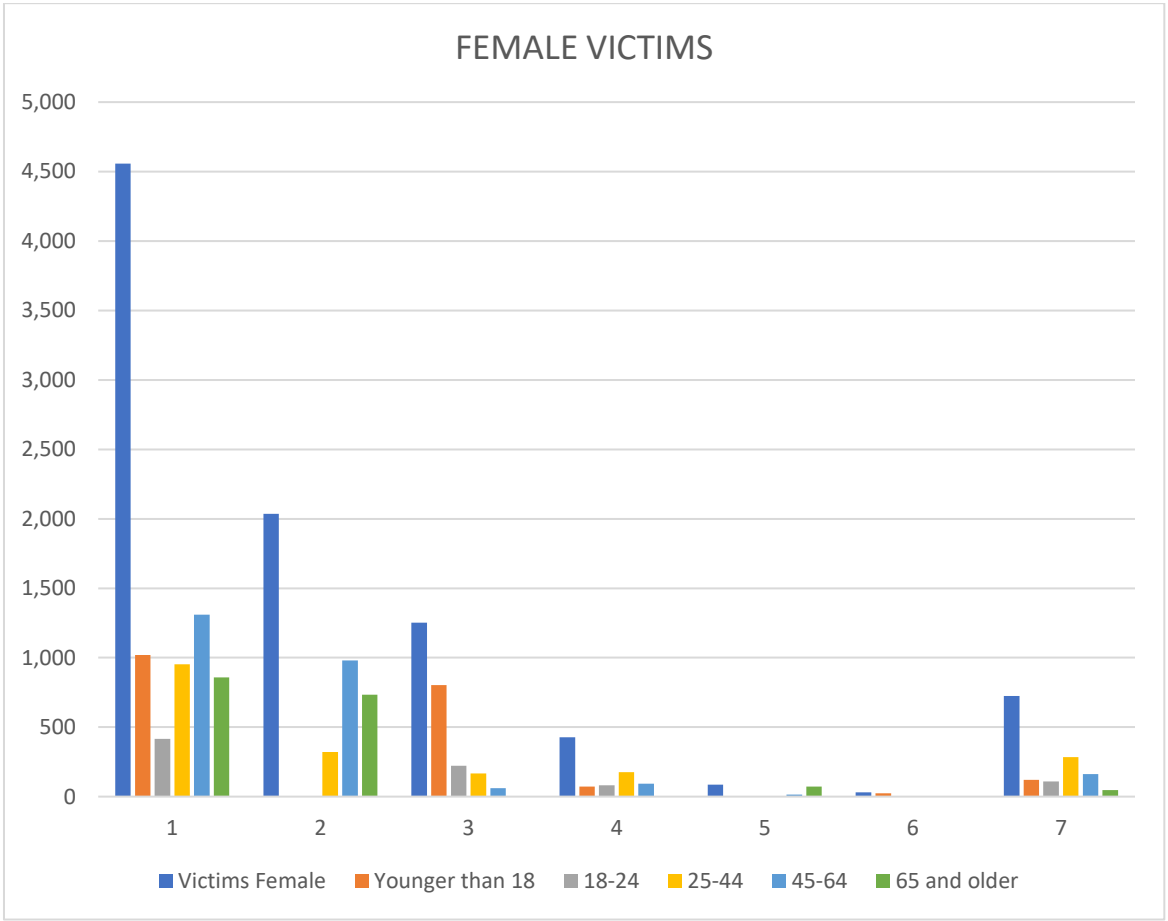


	Total	Father / Mother	Son / Daughter	Brother / Sister	Grand Father/ Grand Mother	Grand Son Grand Daughter	Other relations
Victims Male	**2,748**	**815**	**729**	**286**	**21**	**20**	**877**
Younger than 18	686	0	546	30	0	19	91
18-24	186	0	88	35	0	1	62
25-44	649	36	69	130	0	0	414
45-64	788	423	26	88	1	0	250
65 and older	439	356	0	3	20	0	60



Victims Female	**4,557**	**2,036**	**1,253**	**427**	**87**	**30**	**724**
Younger than 18	1,020	0	804	72	0	23	121
18-24	415	0	222	81	0	3	109
25-44	953	322	166	176	0	4	285
45-64	1,311	980	61	94	15	0	161
65 and older	858	734	0	4	72	0	48

Data INE (Spanish Statistical Office)



Year 2017

Women's Violence Courts by TSJ

Number of women who appear as victims in the complaints filed and their evolution.

Women Victims of Gender-violence in Spain	Spanish Victims	Foreign Victims
158,214	110,104	48,110

Statistics on domestic violence and gender violence

Year 2017

The number of victims of gender violence holding protective orders or interim measures recorded in *Register1* was 29,008 women.

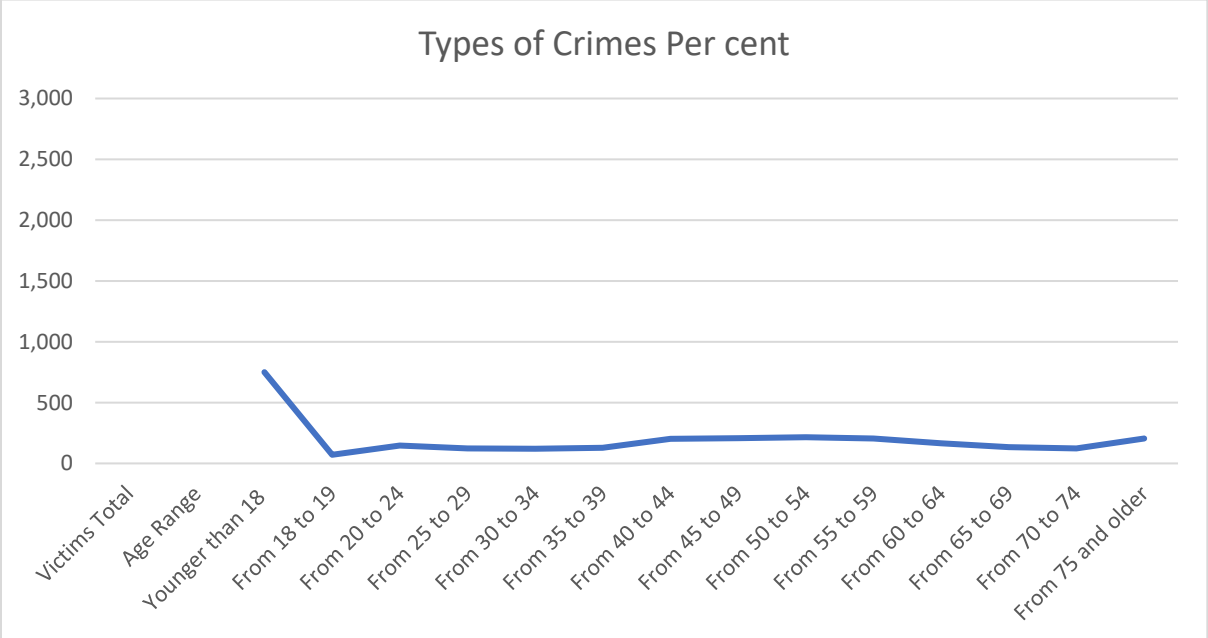
There was an increase in domestic violence and gender violence of 2.6% compared to the year 2016.

The total number of victims of domestic violence was 6,909. The rate of victims of gender violence was 1.4 per 1,000 women aged 14 years and older, an increase of 0.7% compared to the year 2016.

Year 2018

Offences prior to the accusation made and the pronouncement made by the sentence

Crimes		**Per cent**
Injuries and ill-treatment Art. 153 PC	92,951	53.9
Injuries and ill-treatment Art. 173 PC	20,043	11.6
Against freedom	10,868	6.3
Injuries and ill-treatment Art. 148	5,960	3.5
Breach of measures	18.265	10.6
Against the Moral Integrity	3,288	1.9
Against Intimacy and the Right to One's Own Image	769	0.4
Against the Honour	941	0.5
Breaking Sentence	11,691	6.8
Against Rights and Family Duties	606	0.4
Against Freedom and Sexual Indemnity	1,522	0.9
Murder	74	0.0
Abortion	1	0.0
Foetus Injuries	1	0.0
Others	5,531	3.2
Total	**172,511**	



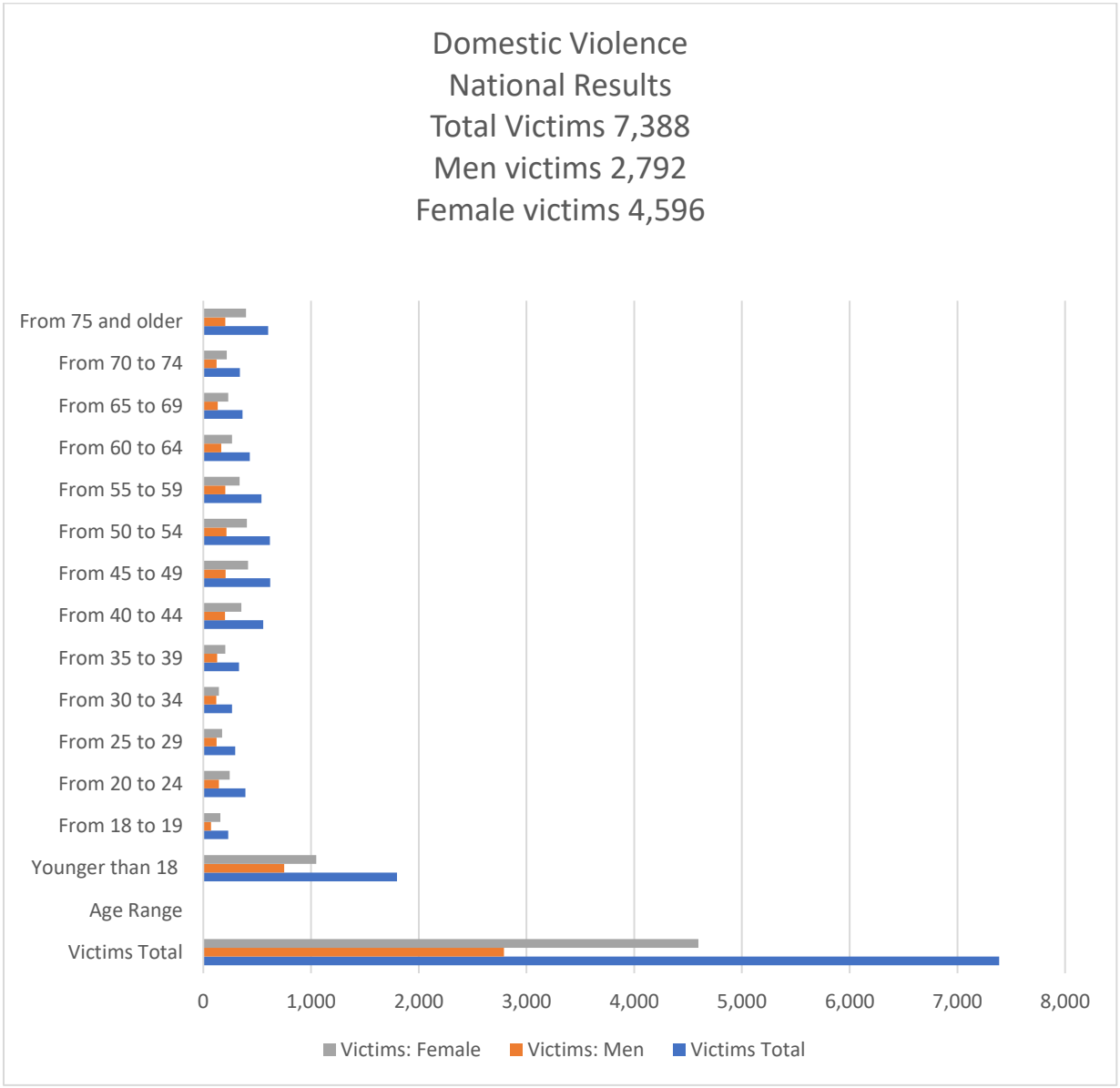
Year 2018

Domestic violence (started cases). National Results.

Gender and age of the victims with a protective order or precautionary measures.

	Victims Total	Victims: Men	Victims: Female
Victims Total	**7,388**	**2,792**	**4,596**
Age Range			
Younger than 18	1,798	750	1,048
From 18 to 19	230	71	159
From 20 to 24	392	146	246
From 25 to 29	297	123	174
From 30 to 34	266	120	146
From 35 to 39	331	128	203
From 40 to 44	555	202	353
From 45 to 49	622	208	414
From 50 to 54	619	215	404
From 55 to 59	541	205	336
From 60 to 64	431	165	266
From 65 to 69	365	133	232
From 70 to 74	340	122	218
From 75 and older	601	204	397

Data INE (Spanish Statistical Office)


Domestic Violence
National Results
Total Victims 7,388
Men victims 2,792
Female victims 4,596
From 75 and older
From 70 to 74
From 65 to 69
From 60 to 64
From 55 to 59
From 50 to 54
From 45 to 49
From 40 to 44
From 35 to 39
From 30 to 34
From 25 to 29
From 20 to 24
From 18 to 19
Younger than 18
Age Range
Victims Total
0
1,000
2,000
3,000
4,000
5,000
6,000
7,000
8,000
Victims: Female
Victims: Men
Victims Total

Chapter 7 Data comparison between the Netherlands and Spain

7.1 Data comparison between the Netherlands and Spain (obtained from the FRA Survey, 2014)

The comparison is related to violence against women in the EU from the FRA survey, showing the main results for the Netherlands and Spain:

Women who experienced physical and or sexual violence by a current and or previous partner or by any other person since the age of 15, by EU Member State (%)

EU Member State	Current Partner	Previous Partner	Any Partner (current or previous)	Non-partner	Any partner or non-partner
Netherlands	9	27	25	35	45
Spain	4	18	13	16	22

Women who experienced physical and or sexual violence in the 12 months before the interview, by type of perpetrator and EU Member States (%)

EU Member State	Current Partner	Previous Partner	Any Partner (current or previous)	Non-partner	Any partner or non-partner
Netherlands	4	(3)	5	7	11
Spain	(1)	(1)	(2)	2	4

Women who indicated that the most severe incident of violence came to the attention of the police by type of perpetrator (%)

EU Member State	Partner Violence	Non-partner Violence
Netherlands	18	21
Spain	24	17

Women who experienced psychological violence during the relationship, by type of perpetrator and EU Member State (%)

EU Member State	Current Partner	Previous Partner	Any Partner (current or previous)
Netherlands	27	51	50
Spain	17	37	33

Data FRA-Survey – Prevalence of stalking since the age of 15 and in the 12 months before the interview, by EU Member State (%)

EU Member State	Since the age of 15	In the past 12 months
Netherlands	26	6
Spain	11	3

Most severe cases of stalking since the age of 15 that came to the attention of the police, by EU Member State (%)

EU Member State	Police aware of the most severe cases of stalking
Netherlands	28
Spain	26

Prevalence of sexual harassment since the age of 15, based on full and short sets of items measuring sexual harassment, by EU Member State (%)

EU Member State	Sexual harassment full set of items	Sexual harassment short set of items
Netherlands	73	66
Spain	50	39

Prevalence of sexual harassment in the 12 months before the interview based on full and short sets of items measuring sexual harassment, by EU Member State (%)

EU Member State	Sexual harassment full set of items	Sexual harassment short set of items
Netherlands	32	22
Spain	18	11

Data FRA-Survey – Prevalence of unwelcome touching, hugging or kissing since the age of 15, by EU Member State

EU Member State	Unwelcome touching, hugging or kissing
Netherlands	51
Spain	16

Cyber-harassment since the age of 15, by EU Member States (%)

EU Member State	Cyber-harassment
Netherlands	17
Spain	10

Sexual harassment since the age of 15 based on a full set of items measuring sexual harassment for all women and for women with tertiary education by EU Member State.

EU Member State	Sexual harassment since the age of 15 (all women)	Sexual harassment since the age of 15 (women with tertiary education
Netherlands	73	79
Spain	50	62

Childhood experience of any violence before the age of 15, by adult perpetrators (%)

EU Member State	Physical violence	Sexual violence	Any physical or sexual violence	Psychological violence by a family member	Any physical or psychological violence
Netherlands	16	20	30	14	35
Spain	21	11	28	6	30

Childhood experience of any violence before the age of 15 (%)

EU Member State	Childhood experience of any violence before the age of 15 (%)
Netherlands	16
Spain	21

Data FRA-Survey – Childhood experience of any sexual violence before the age of 15 (%)

EU Member State	Childhood experience of any sexual violence before the age of 15 (%)
Public situations or places	20
Public situations or places	11

Overall worry about violence and risk avoidance behaviour by EU Member State.

EU Member State	Worry about being physically or sexually assaulted by type of perpetrator		Avoidance of public and private situations or places for fear of being physically or sexually assaulted	
	Unknown person	Known person	Public situations or places	Private situations or places
Netherlands	13	11	40	26
Spain	7	7	41	31

Knowledge of domestic violence cases in the circle of friends or family or the work environment by EU Member State (%).

EU Member State	DV cases in the circle of friends or family	DV in the work environment
Netherlands	43	30
Spain	35	16

Awareness of institutions or services that offer services to victims of violence against women by EU Member State (%).

EU Member State	Not aware of any of the three organisations	Aware of one organisation	Aware of two organisations	Aware of all three organisations
Netherlands	4	18	62	16
Spain	15	38	18	29

7.2 Different Forms of Violence Against Women – Prevalence Data UN Women (2016)

The percentage of ever partnered females aged 18-74 experiencing IPV and or sexual violence

Physical and/or sexual IPV	Lifetime Prevalence	In the last 12 months
Netherlands	25%	5%
Spain	13%	2%

Gender Equality Indexes

Data *UN Women* (2016)

	Gender Inequality Index Rank	Global Gender Gap Index Rank
Netherlands	3	16
Spain	15	29

"*Violence against women is the greatest human rights scandal of our time. From birth to death, in times of peace and war, women face discrimination and violence at the hands of the state, the community and the family. Violence against women is not confined to any particular political or economic system, but it is prevalent in every society in the world and cuts across boundaries of wealth, race and culture*."

Ingrid Vledder

Chapter 8 Measures taken to combat DV in the Netherlands

Everyone should feel safe at home, adults and children; ideally, there should not be a place for violence in any home. However, physical and emotional violence is a daily reality in many families. The Dutch government aims to prevent violence by launching campaigns to make people aware of DV problems. Victims can be alerted where to get help, and outsiders can report their concerns if they suspect maltreatment against adults or children by calling '*Veilig Thuis*' (*Safe at Home*) toll-free number for advice and help.

When victims feel threatened at home, they can call an emergency number, line 112. According to the seriousness of the case, individuals in danger are advised to leave and search for a safe place with family or friends. During Covid-19, when victims could not make a call because of the perpetrator's presence at home, they could chat with *Safe at Home* or use a code at pharmacies to announce they were in danger (Code Mask 19).

Another target for the government is to reduce DV by offering a reliable, safe network to help victims and perpetrators to break the circle of violence that is passed down from one generation to the next (National Government, 2020).

National programmes target thus prevention of violence and support for victims. Two ministries and the association of Dutch municipalities participate, and they meet three times a year to evaluate the programme.

Not only ministries and municipalities are involved in the project. More than one million professionals are active in social services and security by local organisations and governments.

Well-trained professionals (e.g. health personnel, general practitioners, teachers, paediatricians, police officers, lawyers, and judges) are crucial in fighting against DV. These professionals can support the victims and help them exit the violent relationship by, for instance, guiding the survivors to networks that can help them (Monacelli and Mori, 2020).

Professionals working with vulnerable groups are warned to be alert to home situations to detect early signs of violence. Many times when DV occurs, other sorts of violence are also present. Examples are child abuse, violence against pregnant women, elder abuse, shaking syndrome in children, female genital mutilation, forced marriage, stalking, parents involved in complicated (fight) divorces, accusing each other of abuse against children, among others (National Government, 2020).

The programmes are monitored for quality and their impact and effect on people's lives. Programmes are put in practice by multi-disciplinary teams that can learn from the experience of others group members and share information on how to improve their actions plans. Teams meet for a learning circle six times a year, supervised by three regional advisers (National Government, 2020).

8.1 Measures taken to protect women and their children

In the Netherlands, approximately 200,000 adults and 119,000 children are yearly victims of domestic violence (National Government, 2020).

Most families where violence occurs are vulnerable due to caregivers' mental health problems, substance abuse, poverty, and other complex needs requiring interventions from specialised services (Riding, Thevenon, Adema, and Dirwan, 2021; Organisation for Economic Cooperation and Development, 2015).

Professionals working in health, education, youth, and justice areas receive training and supervision on how to act in suspected cases of acute or structural insecure situations related to domestic violence/intimate partner violence or child abuse and neglect. However, social services targeting the individual aspect of a problem is not adequate. Instead, coordination of services avoids duplication in support services and is more effective (Riding, Thevenon, Adema, and Dirwan, 2021).

Since the 1st of January 2019, a Reporting Code to *Safe Home* has become a professional norm and is mandatory (Rijksoverheid / National Government, 2020).

The steps professionals must follow are:

1 Mapping the signals.

2 Consult a colleague and eventually *Safe Home* about the case.

3 Talk with the affected person, parents or children about the situation at home.

Based on these three steps, the professionals can evaluate whether there is a risk of DV or child abuse and suspicions of acute structural unsafe situations.

4 Ask questions about possible DV or child maltreatment.

5 The professional can decide to report the case or organise practical help if the affected person wishes to collaborate. The primary purpose is sustainable security for the victim.

This code is meant to combine information from different notifications to assess the urgency of the signals to ensure the victim's safety. Professionals do not transfer their assistance; they work together with *Safe Home* to protect the victims (Rijksoverheid / National Government, 2020).

8.1.2 Campaigns to protect children from maltreatment/abuse

Child maltreatment and sexual abuse are severe problems with harmful consequences for children (e.g. depression, post-traumatic stress disorder) and society. Research evidence shows that sexually abused children are at high risk of being re-victimised later in their lives, a phenomenon called "*Sexual Revictimisation*" (Walker, Freud, Ellis, Fraine, and Wilson, 2017).

Campaigns to recognise children abuse and neglect encourage the general public to take action and report abuse incidents. The Dutch government made a list of signals that may point to unsafe homes. Some signs indicate children abuse and neglect, and recognising them is paramount. However, it is not always easy for a layperson to conclude that abuse occurs. Visible wounds, hematomas or scars are easier to detect; emotional abuse is not.

Among bodily signals are the untidy appearance of the child (dirty hair and clothes, bad teeth); the child is often ill.

Behaviourally, abused children may be absent, have reservations in contacting others, are afraid of places or people, live in their own world, and friends are not permitted at home. Other signals are loneliness, often absent from school or arriving too late, doing things that do not concur with their age, such as playing violent sexual situations or using alcohol and drugs.

Parents actions against their children may also point to abuse. For instance, the parent does not respond adequately to comfort the child when crying. Alternatively, shouts, shove, hit or kick the child or leave children alone without supervision for extended periods.

8.1.3 Assessment tools

Professionals have tools available to assess whether child maltreatment occurs at home or there is an elevated risk of abuse for the child in the future. The most used risk assessment in the Netherlands is called "*ARIJ*" (the translation in English would be: Actuarial Risk Assessment Instrument Youth Protection) (Van der Put, Assink and Stams, 2016). ARIJ was designed by the *University of Amsterdam* and the *Child Welfare Agency*. This instrument replaced the previous one (LIRIK) due to its lack of predictive value (Vial, 2021).

Child Protection Agencies and other Community Outreach Services use this validity instrument, which comprises 30 items. Some risk factors that are key to predict child maltreatment are: "History of DV." "Caregiver was maltreated as a child." "Caregiver is emotionally absent." (Vial, 2021).

An effective tool can help to choose the right decision to protect children from imminent danger at home.

8.1.4 Evidence-based policymaking

The Dutch government strives to prevent violence by coordinating health services with other systems/organisations to create evidence-based policymaking and practices to support effective programmes against domestic violence. Health professionals treat the effects of domestic violence (e.g. hospitalisation because of injuries, mental health problems, substance abuse) and can detect and report DV cases to be handled by social support services (Vives-Cases, La Parra, Goicolea, et al., 2014).
A further target is to promote quality assessments to identify best practices for professionals, identify populations at risk, address language and cultural barriers for migrants and other ethnic minorities suffering from domestic violence to access without discrimination the resources offered to native women (Vives-Cases, La Parra, Goicolea, et al., 2014).
The development, implementation and evaluation of tools could be employed in prevention measures and early interventions (Riding, Thevenon, Adema, and Dirwan, 2021).

Conclusion and recommendations
We saw that the Dutch government targets evidence-based measures to assure effective programmes to prevent DV. The Netherlands already has a mandatory code on proceeding with (suspected) abuse against adults and children and offering help to victims of violence. However, the emphasis lies on (healthcare) services, practitioners, or the public noticing who is at risk. Nevertheless, these measures are cosmetic. They are not going to destroy the pillars that sustain DV:

Poverty: Around 17% of the total Dutch population (ca. 17 million) of the sixth-largest economy in the EU is at risk of poverty or social exclusion. Of which 2.6% have severe financial constraints, and 9.5% live in households with low work intensity (European Scale, 2019). Affected individuals are mainly single parents, older adults, non-Western families, and people living on social assistance (The Borgen Project, 2021). The global economic crisis In 2008 and the Covid-19 pandemic exacerbated the differences between the have's and have-not.

Inequality: In all EU states, couples with lower socioeconomic status are at higher risk for domestic violence than couples economically independent. Poverty mainly signifies that individuals do not have a high level of education and must live in impoverished neighbourhoods to afford their rent and living expenses. Social insecurities can lead to violence, especially when there is already a history of violence outside of the relationship or addictions. Economic dependency can be a trigger for DV (Reichel, 2017).

Unfair distribution of wealth: The wealthiest 10% of the population in the Netherlands control about 24.9% of the whole country's wealth. On the other hand, the impoverished only 2.3% of the wealth (European Scale, 2019).

The Netherlands utilises 10.3% of the GDP in healthcare expenditures. In comparison, other EU countries spend on average 9.9% of their GDP on healthcare. Since 20% of DV victims suffer structural violence resulting in injuries, women require specialised healthcare that is very costly (NL Times, 2021). Therefore, governments should prioritise DV prevention, empower women and girls, invest in organisations with know-how in this matter, and make it possible for women and children to escape from an abuser and have a safe place to stay. These measures could be expensive, but the benefits of the actions outweigh the costs of inaction, saving women from traumas and pain and governments from high (healthcare) expenditures caused by DV.

The *WHO Europe* (2014) recommends good training for healthcare professionals and emphasises that understanding the vulnerability of domestic violence on migrants and ethnic minorities is vital. The *WHO Europe* also recommends sharing best practices and engaging in programme coordination with organisations that work directly with individuals experiencing domestic violence (Vives-Cases, La Parra, Goicolea, et al., 2014).

8.2 Measures taken to combat domestic violence in Spain

After Franco's dictatorial regime ended, Spain has progressed from being a very conservative country where women's roles were mainly as mothers and homemakers, and men, breadwinners (Cáritas Espaňola, 1983), to reaching milestones such as the Constitution's approval in 1978 and the *European Union*'s membership in 1986.

Since the democratisation process after Franco, Spain has developed a well-established democracy. The Constitution contains fundamental rights for all Spanish citizens, but those stated rights have special significance for women. For example, Art. 14 reaffirms that "*Spaniards are equal before the law and may not in any way be discriminated against on account of birth, race, sex, religion, opinion or any other condition or personal or social circumstance."*

However, gender inequality is deep-rooted on (ancient) beliefs of men superiority over women. A society structured on ideas of gender inequality and established gender roles cannot overnight change its mentality when entire communities are conditioned to such principles. There is, in some situations, no concordance between what the Constitution states and the daily reality of how people behave (Alfaro Castellano, 2020).

Since the 1990s, the country aims to make policy reforms concurrent with the rapid social and gender roles changes (EIGE, 2013). Also, to fulfil national and international agreements. Among those, we can mention the *Istambul Convention*, the *United Nations Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW). *CEDAW* was ratified in 1984, for which Spain is committed to periodic reviews to present the signs of progress being made towards recognising women's rights (Díaz and González, 2016). The country also follows European regulations.

Juridical changes have been made in the fight against violence at home. Nevertheless, gender-based violence continues to be a problem to society because, despite legal regulations, discrimination against women in many fields of life continues. The Organic Law (Ley Orgánica, 1/2004, from 28th December) was aimed as a comprehensive measure against gender-based violence to achieve equality between the sexes. Legally, Spanish legislation recognises that women are victimised at home primarily

by their partners or ex-partners. But also, on a grand scale, they are discriminated against in public life.

In this section, the following subjects will be explained:

8.2.1 Differences between domestic violence and gender-based violence.

8.2.2 Issues related to gender equality.

8.2.1 Differences between domestic violence and gender-based violence.

As we shall explain in this section, Spain differentiates between gender-based violence (GBV) and domestic violence (DV). The table below shows the reported cases of female victimisation of GBV are DV.

GENDER-BASED VIOLENCE	**YEAR 2015**	**YEAR 2016**	**YEAR 2017**	**YEAR 2018**
Total Victims Females	27,624	28,281	29,008	31,286
Total Denounced Persons Males	27,562	28,201	28,987	31,250
DOMESTIC VIOLENCE				
Total Victims	7,229	6,863	6,909	7,388
Females	4,552	4,284	4,313	4,546
Males	2,677	2,574	2,596	2,792
Total Denounced Persons Females	1,245	1,301	1,318	1.397
Total Denounced Persons Males	3,736	3,342	3,590	3,696
Total Denounced Persons and Victims at the same time	259	187	217	221
Females	108	68	71	87
Males	151	119	146	134

Data from INE (Spanish Statistical Office),

In line with a new social reality, penal reforms were considered necessary to protect women and other vulnerable family members from maltreatment and abuse at home and sanction the abuser - since DV perpetration is currently regarded as a crime by the law. - However, the main problem arises from the discrepancy between the rights conceded in constitutional articles that emphasise the equality of men and women and the daily reality.
Here follows the text of some relevant Constitutional Articles recognising equal rights to women and men:

Article 23.1: "*Citizens have the right to participate in public affairs, directly or through their representatives freely elected in periodic elections by universal suffrage*."

Article 32.1: "*Men and women are entitled to marry based on full legal equality*."

Article 32.2: "*The law shall regulate the forms of marriage, the age at which it may be entered into and the required capacity, therefore, the rights and duties of the spouses, the grounds for separation and dissolution, and the consequences thereof.*"

Article 35.1: "*All Spaniards have the right to employment, to free choice of profession or trade, to advancement through their work, and to sufficient remuneration for the satisfaction of their needs and those of their families; moreover under no circumstances may they be discriminated against on account of their sex*."

Article 39.1: "*The public authorities shall ensure the social, economic and legal protection of the family*."

Article 39.2: "*The public authorities likewise shall ensure full protection of children, who shall be equal before the law, irrespective of their parentage, and of mothers, whatever their marital status. The law shall provide for the investigation of paternity*."

Article 39.3: "*Parents must provide their children, whether born in or out of wedlock, with full assistance while they are still underage and in other circumstances in which the law is applicable*."

Although the Spanish Constitution clarifies that there is no place for discrimination against women or men, violence is still condoned since ancient times due to cultural traditions that perpetuate male superiority and discrimination against females. For example, in the Roman Empire, men had the right to hit their spouses or even kill them because women were considered men's property (Aldrete, 2018). This male superiority "tradition" is deeply rooted in societies despite the concessions of rights to women. Violence against women is a social phenomenon related to stereotypical concepts of patriarchy that normalise patterns of men dominance and women submission that maintains believes in male superiority (Cruz Blanca, 2009).

Fortunately, DV has gained public interest, and steadily, communities are becoming less accepting of this persistent problem: A survey commissioned by the *Spanish Ministry of Health, Social Policy and Equality* revealed that 91.2% of the participants considered DV unacceptable (cited by Morillas Fernández et al., 2014). Therefore, the Spanish legislation could not stay behind these new realities and makes a differentiation between domestic violence and gender-based violence, which will be explained below:

Domestic Violence

Maltreatment and abuse of women at the hands of their intimate partners is a severe problem in Spain (and worldwide) because it represents suffering for the affected individual, harms the health and wellbeing of other family members sharing the violent home, and is a burden for society.

The (Spanish) Penal Code of 1995 did already penalise by law repeated maltreatment causing physical injuries to women. However, modernisation processes in the country, changing social attitudes about DV, and feminist movements demanding a severe response to the structural violence against women at home and in other domains of public life, required even wider legislative attention (Morillas Cuevas, 2002).

Family in Spain is considered the pillar of social values. Governments could not let unresponded the aggression happening to women and other vulnerable family members at home, such as children or the elderly. According to Morillas Fernández,

physical maltreatment among couples has a prevalence of approximately 84.6%, and children are, potentially, often the recipients of that violence at home (Morillas Fernández, 2003). Nevertheless, in some cases, DV or intrafamilial violence may include varied combinations of violence happening at home, irrespective of the recipient of maltreatment within the family, whether it is a female, a male, a child, or the elderly. For example, parents using violence against their children or vice versa, violence among siblings or against grandparents, etc.

Former legislation included only physical violence as a crime. Thus, a new actualisation of the Penal Code had to incorporate both physical and non-physical injuries. For instance, psychological abuse, sexual violence, stalking and harassment, coercion, insults, threats or arbitrary deprivation of liberty, whether in private or public life. Protection had to expand and include other active and passive individuals experiencing violence at home (Domínguez Izquierdo, 2002).

These DV reforms extended the legal protection of the victims, including any behaviour that violates their rights to safety or moral integrity. Violence perpetrated by a current or former spouse, current or former partner or someone who had a romantic relationship with the victim in the past, even without cohabitation, could be made accountable. Legally, it includes and protects more extended family members, counting vulnerable individuals sharing the home and needing protection. Among others, ascendants, descendants, siblings of the spouse or cohabitant, minors, persons with disabilities, persons under tutelage, foster care or de facto guardianship of the spouse or partner, and individuals who are vulnerable and subject to custody (Article 173.2 of the Penal Code) (Libano Beristan, 2018; Consejo General del Poder Judicial / General Council of The Judiciary, 2016)

Besides, the reform aimed at harsher punishment for DV perpetrators. Nevertheless, as Domínguez Izquierdo notes, determining what kind of aims the new law has when referring to “peaceful coexistence and harmony within the family group.” Or what type of behaviour should be considered punishable by law is intricate because a blurred concept such as “victim’s vulnerability” is broad. Therefore, what constitutes a crime

or a misdemeanour is not straightforward and could be subjected to different interpretations (Domínguez Izquierdo, 2009).

Violence in homes is a chronic problem in many societies. By differentiating domestic violence (compounding exclusively intrafamily violence) from gender-based violence, opens up an opportunity to concentrate on further issues of violence affecting females out of the house but which are more related to inequality and discrimination in public life.

Gender-Based Violence (GBV)

Gender-based violence can be understood as violence committed against women who have an ongoing affectionate relationship with the (male) aggressor or had this in the past. There is no difference whether there was or not cohabitation. GBV does not include other types of intrafamilial violence external to the family (Alfaro Castellano, 2020). More specifically, gender-based violence is the victimisation of females at home, work, and public places and as a means to exercise power and dominance upon them (Bolea Bardon, 2007).

Gender-based violence recognises that violence against women is structural and based on social inequalities and discrimination (Laurenzo Copello, 2005). It is based on dominant ancestral cultural beliefs and stereotypical gender roles that make it possible to maintain gender inequalities and aggression emanating from historically unequal power relations between genders (Laurenzo Copello, 2005).

Violence against women has always been present in society. Its invisibility could be explained due to concealment. The murder of Ana Orantes in 1997 committed by her husband caused commotion to the Spanish community that demanded a stop to extreme violence against women. However, we must not forget that gender-based violence is still part of cultures that do not reject violence or blame the victim for what is happening to her. Instead, it gives enough room for violent men to perpetuate it by accepting male violent behaviour as "normal." (Lorente Acosta, 2009).

Violence against women aims to control and dominate females to preserve the social construction of men as superior to women, as the family protector who warrants order and security, the breadwinner. Gender inequality maintains power and control over women. Inequality serves to keep identities as they are: Women's accepted role is as a mother, children's carer, and housekeeper who gives affection and resolves conflicts at home (Lorente Acosta, 2009).

Nevertheless, Spain is committed to decreasing violence against women and has signed many international treaties. The country also follows EU regulations to achieve comprehensive protection against gender-based violence. For that purpose, issuing effective (criminal) laws is necessary to respond firmly and unequivocally that violence against any citizen, especially those who suffer aggression, is not tolerated (cited by Rodríguez Ferrández, 2020).

The Organic Law (Ley Orgánica 1/2004) was approved unanimously by the Spanish parliament on December 28, 2004. It aimed at achieving equality between men and women, eradicating gender violence and decreasing the high incidence of violence suffered by women. The law also aimed at preventing violence and at protecting victims in various domains: Social, educational, and work-related caused by, for instance, the uneven relation of power of men against women, work discrimination, sexual harassment, unequal opportunities compared to men, among others (Laurenzo Copello, 2005).

Since the Organic Law (OL 1/2004) approval, specialized courts were created to deal with crimes of gender violence. The concept of positive discrimination was introduced as a social policy to improve the quality of life of women and other disadvantaged groups. Social, ethnic, and minority groups that have suffered discrimination and social injustice throughout history could receive access to resources and services that earlier were denied to them, improving their quality of life. However, women's positive discrimination raised the claim from opponents that the OL 1/2004 was unconstitutional because it went against the concept of equality for men and women of Art. 14 of the Constitution. The law was also criticised due to a series of problems of interpretation that needed clarification. Although positive discrimination towards women provided

them with a compelling opportunity to improve their social disadvantage, the conservative opposition contested it.

To conclude, this section summarises domestic violence and gender-based violence concepts. It also highlights the necessity of well-prepared legislation to overcome violence against women and inequality issues to improve women's position and comply with national and international treaties (e.g. *Estambul Convention, CEDAW, European Union*'s regulations).

The concept of gender-based violence recognises that violence against women is structural and based on social inequalities and discrimination (Laurenzo Copello, 2005). It is based on dominant ancestral cultural beliefs and stereotypical gender roles that make it possible to maintain gender inequalities and aggression emanating from historically unequal power relations between genders (Laurenzo Copello, 2005).

As Rodríguez Ferrández (2016) mentions, it is indispensable that governments draft their proposed laws in a well-prepared and well-informed manner outlining clearly the goals the law should achieve. Since rules set standards and principles that must be followed, parliaments are expected to act consciously of their great responsibility to protect all citizens. Otherwise, the law could have unforeseen consequences for society.

8.2.2 Issues related to gender equality

Gender equality, empowerment, and effective laws to protect women, children, and other minorities against violence are high on the Spanish agenda at a national and regional level (Bustelo, 2014).

Empowerment to women and girls is a crucial factor to correct gender imbalances and make it possible that women can access relevant decision-making positions in parliaments or the labour market. Empowerment to girls is achieved when they have unrestrictive access to education, a safe place to live and protection from any kind of harm, for example, from forced prostitution, trafficking, genital mutilation, honour crimes (Gil Lafuente et al., 2019).

Although gender equality is already declared a fundamental right stated in article 23 of the *Charter of Fundamental Rights* of *the European Union* (European Union, 2000), there is a discordance between written purposes and the actions taken to achieve the proposed goals. Ten years after the Charter, the objectives presented in 2000 were not reached, making it necessary to issue a new public policy's strategy on gender equality (European Commission, 2010).

To arrive at gender equality at a global level is paramount. However, up to now, women's labour force participation is only 63% compared to 94% of men (UN Women, 2018). Women still perform 2.5 times more unpaid care and domestic work than men (International Labour Organisation, 2017). There is a wage gap of approximately 23% to men's counterparts (UN Women, 2018).

To reduced gender inequality, the *United Nations* (UN) has launched the "*2030 Agenda for Sustainable Developmental Goals"*, which contains critical targets of gender equality, specifically women and the labour market, empowerment, and reducing inequalities among countries. Glamorous long-term goals promise improvements in the future. However, the concept of gender equality will remain an illusion as long as gender-based violence and domestic violence against women remain unresolved.

At the European level, EU policies bring new opportunities to policy-making in the member states and accelerate policy transfers at the supranational European level that foster mutual learning from member states (Alonso and Forest, 2012).

Nevertheless, gender equality is not a fixed concept. The term is constructed according to the interpretation of political parties using this concept for their political discourses (Lombardo, Meier, and Verloo, 2017). Neoliberal governments tend to reduce revenues (e.g. social welfare, services for disabled children or adults). Gender equality is not their principal priority. Instead, the highest profits are. Other more socially inclined governments, on the other hand, aim for inclusion and gender equality (Lahey and De Villota, 2013). Once again, high-quality education could make citizens aware of their responsibilities and conscious of their choices since those have consequences for the whole community.

Plantenga et al. (2009) suggest implementing a European Gender-Equality Index (GEI) instead of a global GEI. Such an index would be more efficient to create evidence-based policy-making in countries in Europe that are more or less at similar levels. They assert it would be possible to book progress when comparing what one country does to solve inequalities, and other countries could learn from successful models (Plantenga, Remery, Figueiredo, and Smith, 2009).

Comparisons between countries could create incentives to improve disparities in earning models between males and females. Aiming to:

- Identify the extent of gender (in)equality at a certain point in time.
- Determine causes for inequality and suggest policies to reduce those.
- Enable monitoring of the impacts of policies over time.

The model of gender equality proposed by Frazer (1997) is very appealing because it nominates straightforward measures that could help any individual.

Below, there is a table showing two timeless models to create egalitarian societies. Inequality is not just inappropriate but exacerbates situations of violence. DV is mainly committed against women without resources, who have no place to escape from their abuser and cannot live from their (primarily part-time earned) salary.

Simple but effective measures are to be preferred over complicated, expensive plans having uncertain results.

Frazer (1997)		Plantenga, Remery, Figueiredo, and Smith (2009)
Anti-poverty		Greater equality in the distribution of paid and unpaid work
Anti-exploitation		The index must be feasible and reliable
Income equality		Availability of harmonised statistics
Leisure time equality		Lower the number of indicators
Equality of respect		“Outcome Indicators” (dependent variable)
Anti-marginalisation		Independent (or instrumental) indicators should not be included
Anti-androcentrism		

The Spanish Gender-Equality Index (GEI)

The Gender-Equality Index (GEI) was introduced in 2013 by the European Institute for Gender Equality (EIGE).
Spain occupied place 11th on the Global Gender Gap Index in 2006.
In 2020 it reached the eighth place with 79.5% (World Economic Forum, 2019).

The leading indicators of the GEI are:

1) Work participation in the labour market
2) A balanced quality of work and remuneration
3) Financial resources
4) Knowledge

(European Institute for Gender Equality, 2017)

Reaching the leading indicators of the *Gender Equality Index*, with equal opportunities for males and females in Europe and globally, is recommendable.
Societies that wish to contribute a step forward to progress should consider promoting development (Adina, 2014) and positively impact various fields such as politics, economics, and social changes (Agarwal, 2018).

Chapter 9 Answers to the research questions

The present study shows how diverse, far-reaching and complicated domestic violence (DV) is. As mentioned earlier in the introduction, DV's 'unbeatable' character was an enigma I hoped to uncover by performing my own research on the characteristics of perpetrators and answering the research questions. Those questions (and the answers) are presented below:

Research question 1: Why would anyone stay in a relationship that harms physically, psychologically, and financially?

Both laypeople and researchers formulate this question, maybe with entirely different purposes. The former to understand why their neighbour, friend or colleague does not leave the abuser. Researchers are more interested in developing theories to understand human behaviour and intervening with practical solutions (for example, treatments, clinical interventions, policy) for this significant global problem.

Indirectly in this question, there is an insinuation of psychopathology in abused women (for example, masochistic tendencies) to stay with their violent partners, either because they are passive or accept to be harmed due to low self-esteem. However, most cases involve blaming the victim for staying and not the perpetrator for continuing to use violence at home (Jones, 2021). Alternatively, by asking ourselves, "Why does she stay"? we are placing the responsibility (and the blame!) on the victim and not on the perpetrator or the governments and systems incapable of helping those involved in violent situations with no resources to leave. Domestic violence can happen to anyone, in poor and rich countries, to individuals of different ages, religions, or social statuses, who are engaged with a partner who seeks to maintain power and control.
Nevertheless, generally, it is poor and marginalised women who are most affected. However, this is not always the case. For example, in a 2019 *United Nations Women's Report*, researchers found that Spanish women with a high academic degree, such as Master, Doctorate or even Post-Doctorate, take (on average) longer than 13 years to report abuse (e.g. physical, sexual or psychological). Women with lower schooling –

secondary education or university studies- take 7 to 10 years to report. Those with primary education take around ten years (Gomez Plaza, 2019).

Many women gave as the prime reason for not reporting abuse their beliefs to be able to solve the problem themselves (45%), fear to the perpetrator, or shame (28%). Others do not leave the abuser due to children, economic reasons, and fear that they will not be recognised as victims (34%). Some women live in homes surrounded by luxury, money, and power and are afraid of losing all that prestige (Gomez Plaza, 2019).

Researchers try to explain the phenomenon of DV with existing theories. For instance, *Bandura's Social Learning Theory* (Bandura 1977) accentuates that children learn from the behaviour of their caregivers. If children experienced violence in childhood, they could be more tolerant towards DV in adulthood.

Other researchers explain the phenomenon of why women stay in violent relationships as a combination of a feeling of love for her partner intertwined with dynamics characterised by periods of abuse followed by apologies and promises of change from the abuser, making the decision to leave the relationship complicated (see the *Theory of Learned Helplessness* by Lenore Walker in Section 3.3., pp. 152 for a review).

Reasons to remain are not always straightforward because women might have other reasons to stay that are not motivated by passivity or psychopathology but are related to decisions about their own safety, their children's safety and fears of retaliation (Focht, 2013).

In some developing countries, a large percentage of the population live in rural areas that follow customary laws. Men pay a dowry to the father of their future wive(s), upon which he obtains absolute power over the female(s). In a study in Kenya by Ondicho (2013), where 112 battered women participated, the most salient characteristics of those women were that 87.8% were unemployed. They had a low level of education, 21.6% engaged in small businesses such as selling vegetables, and 12.3% worked in poorly paid unskilled jobs that could not cover living expenses. When women were asked why they did no leave the relationship, the most common answers were lack of

financial independence from their husbands or family member's support; they did not want to separate children from their father; fears of isolation, traditional beliefs that marriage must be preserved at all costs, and some women blame themselves for what has happened to them (Ondicho, 2013).

Although women in Western countries may have a broader net of services to lean on in domestic abuse cases, victims of violence consider similar factors to their counterparts in developing counties before leaving the relationship. A vital consideration is given to access to social support, financial and housing resources. For instance, can she, with her paid work, sustain herself and her children? Can she stay in the place where she presently lives? When resources are lacking, deciding to leave is difficult, especially when women have young infants because they fear losing custody of children associated with divorce (WHO, 2016). Abused partners might wish to stay in the relationship in order not to interrupt, for instance, her work if she has one; or her welfare benefits (the beneficiary has to have an address); neither does she want to alter the routine activities of her children or interrupt childcare accommodations or schools (Cross, 2018).

Victims also consider other important factors related to their safety and that of their children: How safe can they be after leaving? Can she avoid being stalked, attacked or even killed if she decides to leave? (Cross, 2018). When women feel unprotected or do not trust the criminal justice system, they are more reluctant to go (Joseph and Jergenson, 2020). Police response to DV plays an essential role in whether women stay or leave (Henaghan and Ballentine, 2010).

When women finally decide to sever the abusive relationship but do not have a family or a network to support them, they can suddenly become homeless - sleeping in cars, public spaces or overcrowded shelters.-

Ending an abusive relationship means a significant life transition, from having a home to being homeless. Due to their gender, females and children are exceptionally vulnerable to sexual exploitation and assault while homeless.

There is not an answer that fits all the situations of women experiencing abuse at home. Leaving the abuser has implications for the lives of women and their children.

Sometimes, women must choose whether to stay or leave, and those choices are far from being the result of psychopathology but about their security and their children's security.

In many societies, there is a persistent idea that women are responsible for what is happening to them and the only ones to be blamed for staying in a violent relationship instead of blaming the actual perpetrator. However, there are more responsible actors for these tragedies at home: Governments, inadequate justice system and lack of social resources or safe places to make leaving possible.

It is known that there are risk factors that can be avoided by providing more support to affected women and their children, for instance, by offering own affordable houses, work, education interventions and social support.

Research question 2): What kind of factors contribute to maintaining DV pervasive phenomenon?

Many factors are involved in domestic violence at the personal, societal, and governmental levels. It is already known that most DV perpetrators have themselves experienced abuse in their childhood, that multilevel factors are associated with maltreatment forming considerable risks for DV's intergenerational transmission. Among the factors most commonly found for DV prevalence and maintenance are poverty, parents substance misuse and mental illnesses. Each of these factors or a combination can count for a negative outcome in families, including child abuse and neglect.

Family stress can be caused by a weak socio-economic position and instability in the labour market. Even rich countries have this problem. For example, 17.3% of the population in wealthy Europe experiences poverty, including family poverty (The Borgen Project, 2021).

Couples with low education and employment levels with economic constraints are more often entangled in DV than economically solid relationships. The prevalence of violence during pregnancy in these unstable families is detrimental for the mother and

her unborn child. Preventive measures and especially the empowerment of women are therefore crucial (Singh et al., 2015).

There is sufficient poverty worldwide, as are enough strategies outed by prominent global and local institutions and governments to commit themselves to end poverty. For instance, one key policy in Europe was the '*Europe 2020 Strategy'*, aimed at '*lifting 20 million people (and their children) out of poverty and social exclusion by 2020*.' These goals have not been met.

The *United Nations Convention on the Rights of the Child (UNCRC*), first held in 1989, promoted universal children's rights to healthcare and lives without poverty or maltreatment. Up to now, these goals have not been met.

Achieving the aims promised by global institutions and local governments is vital since financial strains adversely affect parents and children's interactions. Berger (2005) found a significant relationship between family income and violence.

Indicators that goals have failed are, for example, the high number of household that cannot afford to heat the house in winter; is unable to buy or repair an old necessary household item when the old one is out of order; have difficulties in paying all the debts on time. Alternatively, stress shines when parents can never take children on holidays due to financial motives. Parents are more prone to conflicts with their intimate partners in such situations, leading to poor parenting or maltreatment.

Many countries, governments, and institutions may propose ambitious plans to end poverty, but poverty is still growing despite all well-intentioned efforts.

Another factor contributing to maintaining DV across generations is when children of any age have experienced violence at home or witness violence against their parents (mostly against their mothers). The literature on intergenerational violence signalises that DV perpetrators often were themselves victims of violence in their childhood. They have learned to resolve difficulties or conflicts by behaving aggressively against peers (e.g. bullying) and, later in adulthood, against intimate partners or children. The risk that violence will continue to be passed down to the succeeding generation is present when the child's living conditions are far from ideal: Deprived homes and

neighbourhoods, interparental violence, lack of positive role models, insensitive parenting leading to insecure attachments, among other factors.

Mothers play an essential role in children's lives. However, when women are physically, psychologically or sexually abused, have mental health issues or addictions, they are impaired or unable to respond adequately to their infant's needs. As a result, children may develop dysfunctional attachments that may, once again, lead to maltreatment. Every step of childhood development can be challenging and has consequences in children's future lives. Helping parents break the intergenerational circle of violence in homes could spare whole societies and future generations from the harms created by violence.

The same could be said about institutions and governments. Long-term promises are not going to make improvements to people's lives. Immediate actions are.

Prevention, protection policies and effective lines of research can make a difference in the lives of women who suffer violence from their partners and whose children are also affected. When violence against women occurs, the likelihood that children will also be maltreated is present in many cases (Guedes, Bott, Garcia-Moreno, and Colombini, 2016). It is very traumatic for children to witness violent interactions between their parents or have to flee suddenly to a shelter or see police interventions in their homes (Cater, Miller, Howell, & Graham-Bermann, 2015).

These incidents aggravate the risks for behavioural, psychological and educational problems (Vu, Jouriles, McDonald, & Rosenfield, 2016). They can result in damaging images of the self affecting their daily lives (Bancroft and Silverman, 2002). Besides, the fact that their mothers – their crucial attachment figure- are in imminent danger in such a violent relationship creates anxiety and fears in children (Jouriles, Rosenfield, McDonald, and Mueller, 2014).

Research question 3): What type of characteristics have DV perpetrators?

The Dutch data shows the following characteristics of perpetrators:
For more details, please see Section 5.4 to 5.7.

Male perpetrators

From all criminal courts in the Netherlands, a sample of 253 severe cases of DV (years 2015-2018) was gathered, from which nineteen were female perpetrators. Most of the perpetrators were males.
The defendants' files were illustrative of the type of individuals committing DV.
Fifty-one out of 234 male perpetrators (21.8%) had a previous DV related conviction - in some cases, multiple convictions.
Twenty perpetrators refused to be psychologically assessed.
In four cases, psychiatrists found no psychopathology despite the seriousness of the injuries or nature of the crime.
In 163 cases, perpetrators were diagnosed with a combination of severe mental or personality disorders. Fifty-six perpetrators were diagnosed with antisocial personality disorder (APD) combined with other conditions: Borderline (BPD), Narcissistic, Post-Traumatic Stress Disorder (PTSD), Obsessive-Compulsive, Mild Intellectual Disability, Psychoticism, Attention-Deficit/Hyperactivity Disorder (ADHD).
The ages of perpetrators ranged from 18-73 years.
In 7.2% of the cases, perpetrators were aged 32.

Female perpetrators in the Dutch sample:

From the selection of 19 females, 63.2% had Dutch nationality.
The ages ranged from 24-50 years.
In 9 cases (47.4%), the victim was a partner; in 3 cases (15.8%), an ex-partner.
Other victims were family members (e.g. own children, step-children, in-law family).
Of the 19 defendants, 16 (84.2%) had no previous convictions for domestic violence.
Two defendants had three (10.6%) prior convictions.
One defendant (5.3%) had only one previous conviction for DV.
The psychopathology found by perpetrators were:

NOD with dependent and evasive traits (1 case).

PTSD (2 cases) combined with Borderline (5 cases), Psychoticism (1 case) /Paranoia (1 case) / Dissociative Disorder (1 case)

No psychopathology found 1

Not known 8

The Spanish data shows the following characteristics of perpetrators:

For complete data's details (2015-2018), please see Section 6.2

Same as in the Netherlands, the number of DV cases in Spain is high. It varies only in small proportions across the years, as we can observe below from the national results of victims (with a protective order and preventive measures) according to the type of relationship with the accused:

YEAR	Number of Cases	Spouse	Ex-Spouse	Girl-Friend	Ex-Girl-Friend	Couple	Ex-Couple	Former Partner or Breaking up
2015	27,624	6,909 25%	1,866 6.7%	2,594 9.4%	3,513 12.7%	6,411 23.2%	5,824 21%	507 1.8%
2016	28,281	6,601 23.3%	1,817 6.4%	2,614 9.2%	3,786 13.4%	6,520 23%	6,488 22.9%	455 1.6%
2017	29,008	6,384 22%	1,859 6.4%	2,990 10.3%	4,165 14.4%	6,302 21.7%	6,871 23.6%	437 1.5%
2018	31,286	6,552 20.9%	1,846 5.9%	3,557 11.3%	4,766 15.2%	6,888 22%	7,251 23.2%	426 1.4%

In Spain, as in the rest of the world, domestic violence is harmful to women and children witnessing violence at home. Researchers are interested in mapping the characteristics of perpetrators to understand what triggers their aggression, whether psychopathologies are influencing their conduct, what kind of measures or treatments are the most efficient for that kind of population to stop the circle of violence.

In the scientific literature on DV's batterers and their characteristics, researchers have classified them into two groups: Specialists and Generalists.

Specialists are offenders who mostly have domestic violence records, such as assaults and battering (Herrero et al., 2016).

On the other hand, generalists can have varied records of crimes other than DV, for instance, robbery, public health, or economic offences. They present high levels of psychopathology, such as antisocial and borderline personality disorders, have sexist attitudes and come from dysfunctional communities (Herrero et al., 2016).

A study by Teva et al. (2020) found among a sample of 740 men convicted for domestic violence in Spain, whose ages oscillated between 18 to 71 years (M=39.74) that 305 (41.2%) participants could be classified as specialist batterers and 391 (52.8%) as generalist batterers.

The researchers noticed that specialist batterers had more often than generalists experienced violence in childhood (child abuse and maltreatment) or witnessed physical and psychological abuse towards their mother or siblings (Teva, Hidalgo-Ruzzante, Perez- Garcia and Bueso-Izquierdo, 2020).

In another study by Siria, Fernandez-Montalbo, Echauri, Arteaga, Azkarate and Martinez (2021), the researchers explored the prevalence of personality disorders of male perpetrators of DV with or without any experience of violence in their childhood among a sample of 981 men of whom 293 with childhood family violence (CFM) and 688 without childhood family violence

Siria's et al.(2021) results showed that perpetrators with childhood family violence had high rates of psychopathology (sometimes a combination), used substances (e.g. had alcohol or drugs dependency), had low scores on the scale passive-aggressive

compared to participants without CFM. Participants with CFM also had a low level of education and were often unemployed.

In large-scale research with a representative Spanish sample, 9,731 cases from the VioGen System, Gonzalez-Alvarez et al. (2021) found that the violence was bi-directional in most cases, and perpetrators had a high level of antisocial traits.

Research question 4): Why we, as a society, cannot defeat the invisible but dangerous reality affecting too many people globally, causing more deaths than terrorism?

This question was tricky because it is broad in scope and can be answered differently according to the writer's point of view. Alternatively, and most relevant are the governments' points of view. Neoliberal governments in Europe and globally highlight the responsibility of each citizen. When someone lacks financial resources is because the individual is lazy and undeserving of help. Welfare states are, in their views, to be dismantled because it is a too large post in the economy. Everyone should go to work to make their country richer and be self-sufficient. That is the philosophy. However, the same governments cannot say that individuals are victims of domestic violence due to laziness or commodity. The reality is that DV exist because the conditions are favourable for it to happen. For instance, in too many countries in the world, women and girls (also LGBT+ individuals or other minorities) do not have protection against violence. Some governments do not concede rights to women and other minorities, and abuse and maltreatment are condoned.

According to the *United Nations Office on Drugs and Crime* (UNOCD, 2018), the deaths of those women killed by intimate partners do not usually result from a random or spontaneous act but instead is a culmination of prior gender-related violence. When domestic violence committed by intimate partners or ex-partners occurs in a continuum, it can culminate in the killing of women irrespective of whether perpetrators have a misogynistic motive or not. Since not all female homicides are gender-related, academics, some governments, organisations and advocates dealing with women's

rights use the term "*femicide*" for a gender-related killing of a woman or a girl perpetrated by an intimate partner or a family member.
In heterosexual relationships, women are mostly killed by a male partner. In contrast, perpetrators of both sexes can be responsible for women's killing by family members, although these kinds of crimes are less prevalent (UNODC, 2018).
Unfortunately, up to now, not all countries use the exact legal definition when collecting data on female homicides. This fact makes the data across countries non-comparable. The *UNODC* calculates that in 2017 globally, approximately 87,000 deaths of women and girls were intentional homicides. About 50,000 of those homicides were perpetrated by a current or former intimate partner, alleging motives such as jealousy and fear of abandonment. Around 30,000 women were killed by family members such as fathers, brothers, mothers, sisters or other family members because of their role and status as women (e.g. honour killings, dowry). The highest number of femicides are committed in Asia, followed by Africa and the Americas (UNODC, 2018).

Nevertheless, this thesis is not about remote countries with dubious governments, but it refers to two well-developed European counties: The Netherlands and Spain. They differ in culture and history in their democracies representing Northern and Southern Europe. Old democracy versus new democracy. When referring to domestic violence, these countries have much in common. Both have a high incidence of DV and rising rates of femicide by intimate partners or ex-partners. In the Netherlands, there were 33 victims of femicide in 2015, of whom 22 were killed by their intimate partner and eleven by a family member (EIGE, 2021).
In Spain, there were 76 women killed in 2015; of whom 60 were killed by an intimate partner and 16 by a family member (EIGE, 2021)

In Europe, DV causes more victims than terrorism. The UK MP Seville Roberts said that DV kills 15 times more people than terrorism; and that a significant percentage of victims are women (Dowards, 2019). From 2000-2018 in the UK, there were 1,870 DV related murders, while 126 were due to terrorism. Paradoxically, the budget to fight terrorism has increased while DV funding has decreased (Dowards, 2019).

Challenging the structures permitting inequality in social, economic and political fields is the only way to stop violence against women or other vulnerable individuals. Moreover, when countries issue gender-neutral policies, they take away much needed budgetary resources destined for women and children, who are the most affected. According to the *WAVE Report*, 2017, the EU have a total population of 512,379,225 million (including the UK population pre Brexit), but only 1,914 shelters for women. There is a shortage of approximately 26,276 (51%) beds in those available shelters. There are 2,594 women's centres, but the number needed is 5,237; thus, there is a shortage of almost 2,650 (50%) centres (Wave, 2019). These women's centres are necessary because they offer advice and support, counselling, advocacy, legal options, employment, housing, representation at court, police, and social services. *Wave* (2019) also remarks on a lack of education plans concerning early interventions for women and girls, men and boys suffering from violence (Hanson Frieze, Newhill, and Fusco, 2020).

Another reason why DV continues unabated is that there is a kind of (convenient) invisibility on the problem. Femicides seem to weigh less than death from terrorism (Fitz-Gibbon et al., 2018). The 9/11th terrorist acts caused 26,673 deaths. In comparison, 87,000 women were victims of homicide in 2017 (UNODC, 2018).

Domestic violence, sexual harassment, stalking or crimes related to interpersonal or domestic spheres between spouses or former partners occur to females and other populations, such as LGBT+ communities or other minorities (e.g. undocumented migrants). They, too, are to be considered and deserve to be recognised as victims and be protected.

Many countries are committed to taking action to address violence against women and gender-related killings. Some nations adopt legal measures, early interventions and other multi-agency efforts by creating special units and offering training in the criminal justice system. In Latin America, legislation that criminalizes femicide as a specific offence in their penal codes has been implemented. However, the number of femicides have not yet decreased as expected. The emphasis should be to prevent those killings by efficient and coordinated services for women in danger. Police, criminal justice systems, and health and social services could play a vital role in implementing those

measures. In the end, the only acceptable solution is to protect all the vulnerable, irrespective of gender or life circumstances, because that is our duty, as a society, for those living in unsafe homes.

Research question 5): What kind of measure takes a Northern and a Southern European country differing in their culture, representing old versus new democracy, to solve DV issues?

The Netherlands and Spain have ratified the *Istanbul Convention* pledging to improve the situation of individuals suffering from violence (especially women and children) and protect them. Both countries have also endorsed the *United Nations Convention on the Elimination of all Forms of Discrimination Against Women* (*CEDAW*) as part of a *European Union* commitment to gender equality in all its member states.

Globally, 189 countries have ratified the *CEDAW* treaty.
The Netherlands has signed the treaty in 1980 and approved it in 1991.
Spain signed the treaty also in 1980 but ratified it earlier, in 1984.

The *CEDAW* .expect from all countries ratifying the convention to implement non-discriminatory regulations and ensure that women are not discriminated against. The prohibition of discrimination is emphasised0 in the first article of the treaty.

Article 1 of the *CEDAW* states the following:

> "*The term discrimination against women shall mean any distinction, exclusion or restriction made based on sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, based on equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."*

The treaty highlights the necessity to concede more rights for women to achieve equal rights to men in all areas of private and social life, such as in political and

public administrations, labour and income, education, health, nationality, marriage, and others.

Every four years, the *CEDAW Committee* monitors that countries comply with the *Women's Convention*. Governments are obliged to report the advances they have reached to improve women's positions and combat discrimination against them.

In the Netherlands, diverse women's rights organisations find a platform in the convention to monitor the implementation of the *UN Women's Convention's* measures. The Network coordinates the creation of the shadow report for the *CEDAW Committee* that contains information not only on compliance but also includes points of view of the civil society and is, therefore, critical of the government's report and committed to good national reporting on *CEDAW*.

Regarding the measures taken by the Netherlands on domestic violence, the country has launched campaigns to make citizens aware of the necessity to signalise signs of violence and to report them so that institutions can help the victims of abuse.

It is mandatory for professionals working with maltreated women and children to report abuse, child maltreatment or neglect.

Spain is committed to improving the protection of victims of violence. Among other measures to achieve the goals of the conventions, Spain has generated a new protocol for police risk assessment and security management, which are instruments that will undoubtedly represent a significant advance in the fight to eradicate gender violence. Besides, the country has improved the institutional coordination for the comprehensive protection of women victims of gender violence and their children (Carmona Vergara, 2016).

The entry of Spain to the *Istanbul Convention*, published in the *Official Spanish Bulleting* of June 6, 2014, undoubtedly obliges the country to adopt legislation in line with the ratified agreement and rethinking legal concepts of gender violence and violence against women. Professionals specialised in violence against women and the judicial system have united their efforts to help women break out of the circle of violence thanks to institutional support.

The Netherlands and Spain strive to achieve equal opportunities for males and females in employment and occupation in the *European Union*. These principles are paramount to reducing inequalities and are clearly shown in power structures and the lack of representation of women in high positions in companies and parliaments.
In 2018, the *EU* adopted the *Gender Equality Strategy* (Council of Europe 2018) to foster equal rights and opportunities for women and men, which comprises the following goals:

- Contest gender stereotypes and discrimination.
- Prevent violence against women.
- Assure access to justice for females.
- Foster equal participation in political and decision-making for both genders.
- Create policies and measures to achieve gender equality.

And more recently, a new goal was added:
Protect migrants and refugees women and girls seeking asylum in Europe.

Since 1957, gender equality is one of the main targets of the *European Union.*

The Netherlands	**Total %**	**Spain**	**Total %**
Total population at risk of poverty or social exclusion	16.5	Total population at risk of poverty or social exclusion	25.3
By sex Women	17.0	By sex Women	26.0
By sex Men	16.1	By sex Men	24.6
By Age Less than 18	15.5	By Age Less than 18	30.3
By Age 65 Years or older	12.6	By Age 65 Years or older	15.7
By Household composition		By Household composition	
Without Children	18.3	Without Children	22.1
With children	14.6	With children	28.6
By Activity Status		By Activity Status	
Employed	6.4	Employed	14.2
Unemployed	75.7	Unemployed	63.1

9.1 Discussion of Findings

Domestic violence exists in all countries in the world and affects mainly women of all ages and socioeconomic statuses. However, men and LGBT+ people are also affected. Still, it is essential to highlight that a vast majority of victims are women. Europe is committed to fighting against DV, issuing policies to protect individuals from violence and incorporating measures to alleviate their situation. However, it is essential not to forget that we will not win the battle against violence against women if governments do not tackle DV risk factors. Among those risks, we can mention poverty, gender inequality, lack of education, unequal opportunities for vulnerable groups, deficient mental and healthcare, and discrimination, just to name few risk factors. We mentioned how vital gender equality is. The Netherlands ranks sixth in the Gender Equality Index, and Spain ranks eighth in the EU (EIGE Publications, 2020). Both countries strive to progress combating DV by applying research-based measures, but according to the number of DV cases, the levels are stable and remain high across the years.

This thesis also considers other issues. For instance, in the DV literature, some theories try to answer the question of whether women are as violent as men and whether they perpetrate DV at the same level as their partners. There are heated debates among researchers about the asymmetry or symmetry of domestic violence: On the one hand, the *Asymmetric Perspective* adopts the view that domestic violence is perpetrated mainly by men against women (and their children) (Dobash and Dobash, 1998, 2001, 2004; Johnson, 1995, 2010; Leone, Johnson, and Cohan, 2007; Kelly and Johnson, 2008; Ferraro, 2017).

On the other hand, the *Symmetric Perspective* sustains that women are as violent as men and commit even more violence against their partners (Steinmetz, 1978; Straus, 2008, 2009; Pengpid and Peltzer, 2016).

These statements from both perspectives have implications for the arrangements and financing needed for the victims of violence and the type of policing needed.

In the end, the only acceptable solution is to protect all the vulnerable, irrespective of gender or life circumstances, because that is our duty, as a society, for those living in unsafe homes.

9.2 Limitations

This study used data from the *Dutch Criminal Court,* which treats exclusively severe DV cases. Other courts treat DV cases that are the most common incidents and do not require long sentences.

Perpetrators of minor incidents are not sent to forensic settings, and their mental states are not being assessed. Most of the defendants in the Dutch sample had some kind of psychopathology or had a combination of severe psychopathology.

The period selected for examination corresponded to recent years: 2015-2018, which is a limitation in the number of defendants.

The data retrieved from the Dutch courts sometimes omitted some information about sociodemographic information of the defendant and contained partial information on the victims.

The Spanish data obtained by the *INE (Spanish Statistical Office)* is relevant for comparison but does not contain all the information of the Dutch sample. Thus, only some information is comparable, and others, such as perpetrators' psychopathology, is missing. Even the less detailed data shows the uneven number of male and female victims. Thus, females are the most affected by violence.

Resumen en Español

En el pasado, las cuestiones de violencia doméstica (VD) estaban relacionadas con la falta de derechos femeninos. En la historia de la mayoría de las civilizaciones, los hombres no consideraban a las mujeres como ciudadanas igualitarias. Ellas eran consideradas como la propiedad privada de sus maridos y tenían un papel de subordinación, creando una "norma" social muy persistente de que el lugar de las mujeres era en la casa realizando todas las tareas hogareñas, sin recibir retribución alguna por ello.

La falta de protección legal, la desigualdad de género y las creencias culturales profundamente arraigadas en una superioridad masculina fueron algunos de los factores que facilitaron por siglos que la VD no fuera considerada un crimen. Por ejemplo, en los Estados Unidos, la violación conyugal quedó impune al menos durante 300 años porque los gobiernos no vieron entonces la urgencia de crear leyes para proteger a las mujeres, ya que la VD era considerada un asunto privado.

Cuando los movimientos feministas hicieron de la VD un tema público, y exigieron que el sistema de justicia actuara contra los agresores, los puntos de vista tradicionales de la familia en ese momento eran de dos individuos del sexo opuesto donde el marido era el abusador y su esposa la víctima. Décadas más tarde (alrededor del año 2000), se introdujo una nueva terminología: Violencia de Parejas Íntimas (VPI) para enfatizar que el abuso puede existir en cualquier relación intima independientemente de la orientación sexual. Cuantitativamente, las víctimas femeninas afectadas por VD es abrumador. Este fenómeno criminológico es una sombra que afecta la vida cotidiana de millones de mujeres en todo el mundo, tanto en los países desarrollados como en los que están en vía de desarrollo. Niños, jóvenes y adultos pueden convertirse en víctimas.

Según la Organización Mundial de la Salud (OMS) (2021), a nivel mundial, el 31% de las mujeres (alrededor de 852 millones) sufren violencia física, sexual y psicológica cometida por sus parejas íntimas a lo largo de su vida. En Europa, la prevalencia de VD es de aproximadamente 26% (OMS, 2021). Cuando la VD existe, toda la familia se ve afectada, las parejas, sus hijos, y eventualmente, otros miembros cercanos de la familia que comparten ese hogar (por ejemplo, otras personas mayores y mascotas).

Para los gobiernos, solucionar las situaciones derivadas de la VD tiene un impacto negativo en sus presupuestos debido a los enormes costes financieros (por ejemplo de atención médica especializada, pérdidas de productividad, gastos del sistemas de justicia, entre otros). Anualmente en Europa, aproximadamente 228 mil millones de euros se utilizan en servicios causados por violencia de género (Walby y Olive, 2014). Un presupuesto de esa dimensión podría invertirse en proyectos para prevenir activamente la VD en lugar de reaccionar después de que se hayan producidos los daños. El acceso a una educación de alta calidad para todos es un excelente ejemplo de prevención. En primer lugar, una buena educación podría impedir que la VD suceda, abriendo puertas para vidas más satisfactorias.

Los científicos que estudian el fenómeno de la VD dedican sus esfuerzos en trazar teorías y encontrar posibles soluciones o medidas para disminuir el problema de VD.

La VD es explicada en forma diferente de acuerdo a la teoría que se utilice. Por ejemplo, Bandura (1977, 2001) la explica como una acción que se aprende en el hogar. Los niños toman a sus padres u otras personas importantes en sus vidas como un ejemplo. Cuando los padres tienen confrontamientos y usan violencia como medio para resolver conflictos, los niños aprenden esas conductas disfuncionales y siguen usándolas con su pareja y luego con sus propios hijos, produciéndose un circulo transgeneracional de violencia.

La otra teoría que explica la violencia en el hogar es la Teoría del Apego de Bowlby (1969. 1973, 1980). Esta teoría esta relacionada con la importancia de los cuidados maternales (en ausencia de la madre por otros familiares) para aprender sobre seguridad y otras competencias sociales y emocionales. Un apego seguro satisface las necesidades emocionales del bebé y sus medios para sobrevivir y crea un vínculo poderoso entre éste y la madre u otro cuidador.

Los niños que observan violencia en el hogar son particularmente agresivos contra otros niños en la escuela, intimidan (bully) a otros niños excluyéndolos de actividades conjuntas, compartiendo fotos o videos comprometedores en las redes sociales (cyberbullying).

Muchos de los autores de violencia han sido ellos mismos víctimas de abuso. Madres que fueron maltratadas o abusadas sexualmente en el pasado no pueden responder adecuadamente a las necesidades de protección de sus hijos porque no están en condiciones de brindarles atención y cuidados. Como consecuencia, las experiencias adversas en los niños pueden resultar en violencia intergeneracional, como un comportamiento que se transmite de generación en generación.

Afortunadamente se han realizado algunos progresos. La VD ya no se considera un asunto privado, sino una negación de los derechos humanos. Organizaciones internacionales como la Organización Mundial de la Salud, UNICEF, el Banco Mundial, la Unión Europea y otras prestigiosas instituciones han alzado sus voces sobre la necesidad de unir fuerzas para detener la violencia contra las mujeres y las niñas y otras personas vulnerables (por ejemplo, personas LGBT+, refugiados, inmigrantes y minorías étnicas). En la actualidad, se considera que los niños que viven en un entorno violento sufren maltrato infantil.

En algunos países los gobiernos han incluido violencia de pareja como un delito en el código penal. En otros, la VD se tolera porque no hay leyes de protección. Alternativamente, si existen leyes, no se aplican. Las tradiciones culturales también pueden mantener prácticas nocivas (por ejemplo, el asesinato por cuestiones de honor, la mutilación genital femenina).

Este estudio tiene como objetivo revelar las diversas caras de la VD y cómo esa violencia daña profundamente las vidas de las personas, justamente donde deberían sentirse protegidas: en su hogar. También analiza cómo las (in)acciones de los gobiernos pueden tener consecuencias y mantener los círculos de violencia. Los

factores que sostienen esos círculos son: pobreza, desigualdad de género, discriminación y oportunidades desiguales hacia grupos vulnerables, sistemas deficientes o inalcanzables de salud física y mental, actitudes sociales que justifican la VD, falta de educación que resulta en niveles altos de desempleo femenino, un nivel laboral más bajo que el de los hombres o con el mismo nivel pero menos remunerado, entre otros. Si estos factores de riesgo que mantienen la VD no son superados, no se podrá ganar la batalla.

Aunque muchos países europeos ratificaron el Convenio de Estambul comprometiéndose a poner fin a la violencia contra las mujeres –para lo cual originan políticas y leyes para lograrlo– no es suficiente. Tampoco es suficiente con proponer pero no realizar metas y planes muy ambiciosos de corto, medio y largo plazo. Muchos de los planes para reducir pobreza (infantil), para bajar el porcentaje de adolescentes que dejan la escuela antes de obtener un diploma, o para mejorar el mercado laboral para ofrecer mayores tasas de empleo, no se han logrado.

La dura realidad es que el número de víctimas de VD continúa alto a lo largo de los años. ¿Por qué? Ese carácter de 'imbatibilidad' de la VD me llamó la atención y me dio incentivos para investigar las causas y para responder a las siguientes preguntas de investigación:

1) ¿Por qué alguien permanece en una relación que daña profundamente física, psicológica y financieramente?

2) ¿Qué tipo de factores contribuyen a mantener el persistente fenómeno de VD?

3) ¿Qué tipo de características tienen los perpetradores de DV?

4) ¿Por qué nosotros, como sociedad, no podemos derrotar la realidad invisible pero peligrosa de VD que afecta a millones de personas en todo el mundo, causando más muertes que el terrorismo?

5) ¿Qué tipo de medidas se adoptan en un país del Norte y uno del Sur de Europa -que difieren en su cultura y representan antigua y nueva democracia- para resolver los problemas de VD?

Las fuentes de información para escribir esta tesis, incluyendo las respuestas a las preguntas de investigación, requirieron datos. Estos fueron obtenidos de literatura científica sobre el tema y revisiones de la literatura, con excepción de la pregunta 3. Para esa pregunta llevé a cabo mi propia investigación con datos de los tribunales penales holandeses (período 2015-2018), filtrando los casos de VD que fueron tratados por la Fiscalía. El resultado fue una muestra de 253 incidentes graves.

Para los detalles ver Capítulo 5, secciones 5.4 a 5.7.

Los datos de España fueron recogidos del INE (Estadísticas Nacionales de España) , Ministerio de la Mujer y literatura de investigación.

Para los detalles ver Capitulo 6, Sección 6.2

Este estudio se divide en nueve capítulos que están interrelacionados, porque la presencia o ausencia de ciertos factores pueden encender la violencia en los hogares. El objetivo es responder los "Qué", "Cómo", "Cuándo " y "Por qué" de la VD en dos países Europeos: los Países Bajos (donde vivo) y España (donde estoy haciendo mi doctorado).

Esta tesis también abarca otras cuestiones. En la literatura sobre VD, hay debates que se centran en las diferencias de VD usada por los hombres y las mujeres. Si es que hay asimetría o simetría en violencia.

Por una parte, la Perspectiva Asimétrica adopta el punto de vista que violencia doméstica es perpetrada principalmente por los hombres contra las mujeres (y sus hijos) (Dobash y Dobash, 1998, 2001, 2004; Johnson, 1995, 2010; Leone, Johnson y Cohan, 2007; Kelly y Johnson, 2008; Ferraro, 2017).
Por otro lado, la Perspectiva Simétrica sostiene que las mujeres son tan violentas como los hombres y cometen aún más violencia contra sus parejas (Steinmetz, 1978; Straus, 2008, 2009; Pengpid y Peltzer, 2016).

Estas declaraciones de ambas perspectivas tienen consecuencias para las medidas que se implementan y la financiación necesaria para las víctimas de violencia y el tipo de medidas políticas a imponer.
De acuerdo con los datos resultantes de este estudio, tanto en Holanda como en España, el número de perpetradores masculinos sobrepasa significantemente a los casos de violencia cometidos por mujeres.
Los resultados obtenidos en esta tesis están en línea con la Perspectiva Asimétrica de violencia.

Con referencia a las medidas adoptadas para combatir la violencia en el seno del hogar, los Países Bajos han lanzado campañas de concientización para el público en general sobre la importancia de no ignorar señales de violencia y de denunciar casos de maltrato contra mujeres, niños, u otros miembros familiares. Hay también una línea telefónica para consultas y asesoramiento sobre VD.
Para profesionales de salud pública, maestros, dentistas y otras profesiones que pueden señalizar maltrato o abuso se ha establecido un código obligatorio de denuncia de (posibles) casos de violencia doméstica para facilitar que otras instancias tomen las medidas necesarias de protección de las victimas.

En España se hace a nivel judicial una diferenciación entre violencia doméstica y violencia de género.
Dentro de la terminología VD están comprendidos todos los miembros de una familia o de otras personas compartiendo ese hogar. También se incluyen a otras personas que hayan tenido una relación afectiva con la victima, aun sin cohabitar.
Mientras que los maltratos familiares son en su gran mayoría cometidos por hombres contra sus parejas, otras interacciones violentas pueden tener lugar, por ejemplo, uso de violencia entre hermanos, padres contra hijos, hijos contra sus padres, abuelos, etc.

El concepto de violencia de género es mas amplio y esta relacionado con violencia contra las mujeres u otros grupos sociales vulnerables en la sociedad (por ejemplo personas LGBT+, refugiados, inmigrantes, minorías como Roma o Sinti, entre otros). Está relacionado con actitudes discriminatorias sociales y laborales, con desigualdad de las mujeres comparado con los hombres (ej. menor remuneración por el mismo tipo de trabajo).
A pesar de que muchos países se han comprometido a alcanzar un nivel de igualdad entre los géneros, las mujeres (y los niños) tienen aún una posición mas desprotegida en las sociedades y corren mas riesgos de ser acosados sexualmente o de ser explotados.

Hemos mencionado lo importante que es la igualdad de género. Cuando las mujeres dependen económicamente de sus parejas, la prevalencia de VD aumenta.
Los Países Bajos ocupan el sexto lugar en el Índice de Igualdad de Género. España el octavo (EIGE, 2020). Ambos países han ratificado el convenio del CEDAW, de Estambul y se han comprometido a aplicar medidas de la Unión Europea en la lucha contra la VD/ VDG mediante leyes u otras medidas efectivas para lograr igualdad entre hombres y mujeres. A pesar del alto posicionamiento de los dos países en el Índice de Igualdad de Género, el número de casos de VD se mantiene alto.
Este tema requiere más atención y puede ser un tema interesante de investigación.

Para finalizar, y en mi opinión personal, la única solución aceptable es proteger a todos los grupos vulnerables, indistintamente de su género o de las circunstancias de sus vidas, porque ése es nuestro deber, como sociedad, para aquellos que viven en hogares violentos.

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