

## **Intersectionalities: Intimate Partner Domestic Violence and Mental Health Within the European Context**

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### **Abstract**

The article highlights the traumatic impact of intimate partner domestic violence (IPDV) on women, the complexity of their responses to it, its impact on their identities, and their resulting social position in Europe. An exploration of the intersectionalities between IPDV and mental distress within the context of negative social attitudes toward IPDV victims follows, highlighting the psychosocial significance of experiencing IPDV for the internalized social exclusion of victims of this type of violence. In this context it is further attempted to understand the seemingly contradictory behaviour of women experiencing IPDV in disclosing their experience and in living with, and leaving, the perpetrator. Prevalence statistics indicate the high rate of mental distress among IPDV women victims, as well as the types such distress takes. The relevance of these intersectionalities for mental health providers and workers in domestic violence services is further explored, including their distancing stance toward women experiencing both IPDV and mental distress. A case is put forward for applying the new meaning of recovery in mental health to women experiencing IPDV. That approach has the potential to provide a positive contribution, enabling them to move from being victims to becoming survivors, while taking into account several related intersectional connections.

*Keywords:* intimate partner domestic violence, women experiencing IPDV, intersectionalities, European context, social exclusion and social inclusion

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Intersectionality is defined here as the connections, interactions, and feedback between the phenomenon investigated and key factors in the psycho-social-economic-political environment in which it takes place (Hanikvsky, 2012). The application of an intersectional analysis to gender issues has been initially developed by black feminists who explored the intersections between gender, race and class (Crenshaw, 1989; Davis & Lockhart, 2010) and taken further to the analysis of gender, nationalism, and belonging by Yuval Davis (2011). The issue of belonging is of particular relevance in this paper because it directly touches on identity formation and on social inclusion and exclusion as well as on culture, all of which are also connected to social power. In applying an intersectional analysis it is also crucial to pay attention to the specific context in which the phenomenon studied is located. While the decision as to the specific factors to focus upon in this paper is mine, it is led by the existing literature on women and intimate partner domestic violence

(IPDV), my lessons from empirical research, and my emotional understanding of what increases the social exclusion experienced by women in these circumstances. Thus my own context as a researcher comes into play, as a white woman who has not experienced IPDV herself but who has come across it in my family circle and beyond; who is a researcher committed to qualitative participatory action research and the inclusion of people who use health and social services as co-researchers and trainers. A selection of the most central intersecting issues had to be made, because the number of potential intersectionalities is too large for an article to cover. The intersecting issues I will look at in this text include IPDV in relation to the European context, self-image of women experiencing IPDV, social exclusion and inclusion, class, gender, media representation, mental distress, migration, ethnicity, racialization, culture, power, and service providers.

I will be arguing that the experience of IPDV is one in which women become socially excluded by their own definition, feeling excluded from other women and from men and children. This may be the case even if they continue to live in their family home, with the partner who violated them, pretending that their world has not been shattered. Re-inclusion is possible, albeit on different terms. The process of re-inclusion begins when and if they join mutual support groups and discover the existence of other women with similar experiences, and/or when they are able to “come out” in the sense of acknowledging to themselves and others that they have been “battered,” “abused,” or “victimized” (Dayan & Ben Ari, 2008). Hence re-inclusion implies also a re-formed personal and social identity in which the experience of IPDV remains an important, yet only one, facet of the person’s multi-faceted identity.

### **The Key Experience**

IPDV is likely to be experienced as a trauma and a betrayal for the person at the receiving end (Hague, 2000; Keeling & van Wormer, 2012). This is due to the high level of personal commitment an intimate relationship often entails, its impact on one’s personal and social identity, and the violation of the high level of trust invested in the relationship and of the shared bond that might have developed (Cavanagh, 2003).

The ensuing difficulties resulting from this trauma make for a daunting list. These may include physical injury; psychological stress, which may develop into identified mental distress; the need to leave one’s home and to relocate oneself and one’s children to an unknown environment; reduced standard of living and disposable income; loss of social status; loss of social support network; loss in self-confidence; difficulties in the relationship with one’s children due to the stress experienced in the family; difficulties in relationships with one’s in-laws and members of one’s own family (Radford & Hester, 2006)

The blame (Morgaine, 2011), shame, and guilt (Cavanagh, 2003) associated with this experience need to be better understood within a background in which victims of violence are usually an object of sympathy, pity, and social support. However, this is less so in the case in IPDV. Women report that they know

intuitively that an IPDV incident should not be disclosed to anyone; children report that they, too, know that incidents of IPDV they have witnessed should not be disclosed to their friends, teachers, or extended family members. Why is this the case?

Living in European societies, we are all socialized to believe in the positive value of intimate relationships and in the need to protect such relationships from external pressure. Women are often persuaded, and at times literally forced, by their own families to return to their abusive partner, as the stigma associated with being either a perpetrator or a victim of DV, is perceived to be a stain on the reputation of the whole family (Vandello & Cohen, 2003). Both men and women invest in their intimate relationships and are socially judged on their degree of success in managing them. However, it is also assumed that women should ensure that these relationships work, rather than that both partners should be involved in undertaking this responsibility (Hochschild, 1983). This stance relates to the assumption that women are better at expressing emotions and in nurturing relationships, embedded in our universal concept of motherhood. Moreover, in the majority of cases it is the woman (i.e., mother)—attacked by her male partner (who is often the father of her children)—who is perceived as having the sole responsibility for the care of the children in IPDV situations (Hester, 2011).

A repeated experience in perpetrators' groups is that of blaming the victim, arguing that "she deserved it" or "she made me do it." Health and social care workers talk about "nagging" women who bring it upon themselves, as though nagging is a good enough reason for turning to violence, thus disregarding explicit laws against violent behaviour. Hester's (2011) concept of women as "culpable victims," in the sense that they do too little to prevent becoming a victim and staying one, as well as in the sense of being defined the main problem when there are issues of child protection, encapsulates well the prevailing social attitudes in Europe.

In her analysis of data from two Scottish studies, Cavanagh (2003) has highlighted the complexity of the woman-victim's experience. This is mediated by the mixture of the wish to restore the relationships, the impact of the interactive relations with the perpetrator, fear, and humiliation. Women's responses are therefore often ambivalent in nature, avoiding the situation rather than tackling it head on, trying to pacify the aggressor, moving to more confrontational strategies of persuading the perpetrator to confront his violence, leaving, returning, and leaving again.

Women who feel unable to unburden themselves and ask for help are not only more trapped than those who are able to break the silence, but they are also more likely to stay in the abusive situation, thus demonstrating to the perpetrator that he can get away with the violence. These women also demonstrate to their children that there is no way out of the helplessness, anger, and sadness they feel.

The experience of IPDV is one that leaves the woman socially excluded, not by a specific act or by ceremonies of exclusion, but by her own understanding of being set apart from other people. In mutual support groups, the revelation for these women that there are other women experiencing IPDV becomes, therefore, the first

act of becoming socially included again, but only with the minority sharing this experience.

However, the high prevalence of mental distress and of suicide attempts among both women and children caught in IPDV (Humphreys & Thiara 2003; Lapierre, 2010; Rose et al., 2011) indicates that the helplessness thus experienced may be also expressed in self-harm. These situations sap the woman's energy (Dobash & Dobash, 1992) and often come after a long period in which her authority as a mother has been undermined by the perpetrator (Lapierre, 2010), hence reducing her ability to function as a mother. This in turn harms both the child and the woman, even if indirectly so.

Mothering challenges range from becoming abusive toward one's children to trying hard to compensate the child, yet most of them manage to be as good a mother as any woman who has not been a victim of IPDV (Lapierre, 2010). This finding by Lapierre indicates a considerable achievement in the context of experiencing the impact of domestic violence, highlighting the wish and ability of these women to move from being a victim to becoming a survivor. The impact of IPDV does not stop at home, as children experiencing it at home become disruptive at school, impacting further on their teachers and classmates (Humphreys & Stanley, 2006). The above analysis highlights the intersections of gender, intimate relationships management, responsibility for preventing domestic violence in the relationships, and the key responsibility of women in their mothering role. All of these social locations are mediated by social norms and expectations.

Although there are similarities among European societies, there are also differences derived from their different cultural traditions of how to respond to DV within and outside the nuclear family. Below I will be referring to data collected during a European Union (EU)-funded research project on domestic violence and mental health (titled Empower Women and Providers: Domestic Violence and Mental Health; see Ramon, 2013) carried out in five European countries, and to a small-scale, United Kingdom (U.K.)-only study on media representation of domestic violence (Lloyd & Ramon, 2015). The first study followed a participatory action research paradigm aimed at empowering the women participants to increase their control over their reality, enabling providers to change attitudes and acquire relevant skills for the work with this group, and providing skills for co-facilitation of support groups to some of the women. The second study utilized a comparative analysis of content and style in items covering aspects of IPDV in two U.K. newspapers during 2001 and 2011.

### **Migration, Ethnicity, and Racialization are Intersecting as Markers of Minority Othering**

Ethnicity is a key factor intersecting with class in the context of DV and hence also in the context of IPDV. Ethnicity is often used as marker of negative othering, in which several stereotypes are put together to indicate the assumed inferiority of members of an ethnic minority group. Members of the group may respond either by repudiating the stereotypical claims and/or by enhancing group solidarity and

accentuating the positive qualities of the group. Racialization includes the attachment of negative stereotyping to a specific group because of an assumed inferiority based on racial grouping. However, this provides an insufficient explanation for the othering of non-visible ethnic minority groups, which is presently prevalent in Europe (see the interesting analysis of Phillips, 2010). European societies have both visible and non-visible ethnic minorities, and IPDV takes place across this divide. Negative assumptions about the inferiority of non-visible minority groups tend to appear when such groups are relatively newly arrived migrants; when they seem to threaten the economic power position of the majority and hence its class position; and when elements of their lifestyle do not cohere with that of the majority. The othering in this case relates to assumptions about cultural differences, where culture is defined as

a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioural conventions that are shared by a group of people, and that influence (but do not determine) each member's behaviour and his/her interpretation of the meaning of other people's behaviour. (Spencer-Oatey, 2008, p. 3)

In the five participant countries in the study mentioned above, the ratio of visible to non-visible ethnic minorities varies, with Poland officially having insignificant numbers of either grouping, while the U.K. and Italy have significant numbers of both, with Greece and Slovenia having mainly non-visible minorities. Currently, in some high-migration countries, the number of EU internal migrants (most of whom come from non-visible ethnic groups) equals the number of those coming from outside of the EU (who are more likely to be from visible ethnic minority groups; see Eurostat Statistics Explained, 2015).

The experience of migration is known to have the potential to upset past power relations in families, as it calls for flexibility and readiness to change (Pedraza, 1991). Resorting to violence may then become a means to ensure the previous power balance and a way of expressing frustration. This relates both to partners' relationships and to parent-child relationships.

Both ethnicity and migration are impacted not only by race but also by class and gender (Anthias & Yuval Davis, 1992; Crenshaw, 1989; Sivanandan, 1977; Sokoloff & Dupart, 2005). Migrants of visible ethnic minorities are to be found among the working class and the precariat (Standing, 2011), namely at the lower socio-economic strata.

The *precariat*, a term coined by Standing (2011), refers to the increasing number of people who live on the margins of society across the globe. In Europe, people in this group are likely to be unemployed due to a myriad of reasons and would live on benefits and in poverty as "denizens" rather than fully fledged citizens (Standing, 2014).

### Learning from European Background Data

An analysis by the Council of Europe (2002) of ten DV prevalence studies found that 1 in 4 women experience IPDV during their lifetime, and 6–10% of women are the victims of it in a given year. Women Against Violence Europe (WAVE; 2011, p. 4) quotes a figure of 2 million women victims of IPDV per day, and 100 million women are affected over their lifetime. Furthermore, in response to specific questions asked in the special Eurobarometer 344 (TNS Opinion & Social, 2010, p. 30), most respondents stated that they have come across domestic violence. More women than men knew of victims of this type of violence, but stated that such cases were rare among those they are closely familiar with. Given the high rate of acknowledging this type of violence, the statement pertaining to its rare occurrence in one's circle of friends and family, immediate neighbours, and work colleagues seems somewhat contradictory.

More recently, on 6 September, 2013, the BBC and Sky News covered in most of their daily news editions that 16% of U.K. women are raped, but 78% of them do not report this abuse to the police. It is unknown how many of these rapes count also as IPDV.

Indeed, most researchers agree that the published figures of IPDV represent an underestimate of the real prevalence, due to the shame attached to an admission of being a victim of IPDV, coupled with the fear of reprisal. The hidden nature of this experience, and hence the predominant reliance on victim self-reporting, reduce the likelihood of having accurate mapping of its prevalence. For example, U.K. women experience on average 35 violent incidents before contacting the police (Starmer, 2011), all of which do not appear in the existing statistics. Similar findings come from Poland and Greece. For example, 97% of Poles surveyed have heard of IPDV, and 80% consider it unacceptable, according to their NGO helpline report (Durda, 2012). This helpline has received as many as 11,000 calls per year since its inception. The Polish police also issue a Blue Card providing IPDV victims with information, with the number of police interventions related to IPDV going up from 72,000 in 1999 to 96,773 in 2005. Yet only 26% of victims have asked for help, and of those only 14% have had a response from the police (Durda, 2012). In Greece the General Secretariat for Gender Inequality (2005) reports that 80% of women reported IPDV, 65% of whom continue to live with the perpetrator. Greek women who participated in our study reported that 87.5% of them continued to live with the perpetrator, as compared with 50% Polish women, 50% Slovene women, 40% Italian women, and 33.7% of the English women (Ramon, 2013). This high rate of the Greek women reflects the power of social norms pertaining to couple and family life, even in the case of violent relationships.

Racialized and migrant women of non-visible ethnic groups are more likely to delay disclosure even further than other women, due to strong community codes of not disclosing negative experiences to the majority, and/or fears of being deported if the police will be approached (Siddiqui, 2013; WAVE, 2011)

Recent prevalence data from Greece, Italy, Poland, Slovenia, and the U.K. illustrate not only the difficulty of obtaining data, but also of the variations between

countries and type of violence. Thus in Poland 39% of adult women report experiencing DV (Public Opinion Research Centre, 2007), compared with 25% in the U.K. (Home Office, 2010), 14.3% in Italy (Istat, 2007), and 20% in Slovenia (Leskošek, Urek, & Zaviršek, 2010). The one, and as yet the only, survey of IPDV in Greece was carried out in 2002–2003. Of the 1,200 women sampled, 65% reported psychological abuse; 3.6%, physical abuse; and 3.5%, sexual abuse. When reporting on abuse by a previous husband, 39.7% declared that they had experienced IPDV (WAVE, 2011, p. 100). This discrepancy in the figures is perceived to be the outcome of Greek women not treating psychological abuse as IPDV. Furthermore, a recent Greek study aimed at identifying emotional and physical abuse in postpartum found that 35.6% of new mothers screened reported intimate partner violence (Vivilaki et al., 2010).

Midwives report that pregnancy is a period of increased rate of IPDV (Women's Aid, 2005). This finding contradicts the social recognition of women's vulnerability in that state, and the professed wish in most societies to treat the expectant mother well. The increased rate is explained as a reflection of the threat the baby to be born poses to the central place the partner had in the intimate relationship. The intersection between gender, pregnancy, and IPDV highlights the potential connection between the experience of vulnerability in the intimate relationships and opting to respond to it by violence—denoting anger and frustration—toward the more vulnerable partner.

Pertaining to types of IPDV, emotional abuse tops the list across Europe, followed by physical violence. In comparison to physical violence, emotional abuse is usually invisible and not easy to define, which goes some way to explain why spending on responding to physical violence outstrips by a huge margin the response to mental health difficulties in the aftermath of IPDV. For example, the annual financial cost of domestic violence to the U.K.'s National Health Service has been estimated at £1.2 billion in relation to the cost of treating it, while the cost to mental health services is estimated at only £176 million (Walby & Allen, 2004). It would seem that an inverse relationship prevails between the recognition that emotional abuse is outstripping physical abuse vs. the investment in tackling it. IPDV can occur at any social strata, including health and social care professionals (Ben Ari & Dayan, 2008), and any ethnic group. However, reporting rates are higher among people living in poverty (Sokoloff & Dupart, 2005, p. 48), due to the culmination of a number of aspects of one's life experienced as being beyond control, with the woman partner being an easy target to be scapegoated.

We have conflicting evidence as to whether the rate among different ethnic groups in a given society does vary or not, with Roma communities being cited often as the example of a high rate of DV, and Jewish men as not exercising IPDV (they do in Israel, but less so in the diaspora). In addition, racialized groups vary in their difficulty of disclosing DV incidents. In some racialized groups the shame of such a disclosure is felt more keenly than in others, and may lead to reprisals from the woman's community in addition to potential reprisal from the perpetrator (Palmer & Ramsay, 2002)). Consequently some racialized ethnic minority women are more reluctant to disclose than women from the majority socio-cultural group. Reluctance

to disclose per se is a feature in any society, reflecting the sense of shame, guilt, and hope against hope felt by the woman outlined above.

### **The Impact of Intimate Partner Domestic Violence on Women's Mental Health**

While there are shining examples of women surviving these experiences, this is not the case for many others (for a range of true stories, see Domestic Violence Resource Centre Victoria, n.d.).

Although the physical scars are likely to heal in many cases, the emotional and social ones may take longer to heal or may not heal at all. For example, the known effect on children of witnessing IPDV may be long-term and may impede their intellectual, psychological, and social development (Humphreys & Stanley, 2006). It may also impact their mothers, who often indicate their sense of guilt of being unable to protect their children from witnessing violence, and hence think of themselves as failing to be good enough mothers (Humphreys & Thiara, 2010). However, the long-term impact on the psychosocial well-being of women has not been researched.

The evidence pertaining to the impact of IPDV on women's mental health from a meta-analysis of 18 studies highlights that 64 % of these women experience post-traumatic stress disorder, 48 % suffer depression and 18 % attempt suicide (Itzin, 2006).

High levels of depression, anxiety, eating disorders, suicidal thoughts, and, at times, suicide attempts, poor self-esteem, and difficulties in concentrating have been identified, while the more frequent clinical diagnoses attributed to this population are depression and personality disorder (Itzin, 2006). While depression is easily understood as a reaction to the betrayal and the sometimes hopeless mess the women find themselves in as a result of domestic violence, the diagnosis of personality disorder is less easy to understand. Personality disorder implies difficulties in sustaining relationships and in meeting responsibilities most adults are expected to meet. Most studies on personality disorder reveal a high rate of childhood abuse—around 80%—as a key experience in the life of those who subsequently have been identified as having a personality disorder. Yet the formal diagnostic manuals used in Europe and the United States do not recognize the trauma of child abuse as an etiological factor in this diagnosis (Castillo, 2003). The denial of the trauma in these cases reveals the wish to treat the person as having an illness rooted in biological causes, despite the lack of evidence for such an assertion, as well as the wish not to consider the impact of the abuse as a betrayal of the child by a person they trusted. Personality disorder is assumed to be a reflection of being anti-social, callous, and dangerous, thus marginalizing these women even further. Furthermore, the denial of the impact of the trauma signifies that the cause of the illness is in the woman, rather than in her life events.

The intersection between a history of child abuse, its impact on the mental health of the person experiencing abuse, and becoming a victim of IPDV in adulthood requires critical attention, as the underlying assumption is that the person has internalized an identity of being a victim of domestic violence as an inevitable,



permanent component of their lives. The mentality of being a victim may include a deep sense of injustice, and/or the sense of deserving to be a victim due to assumed wrongdoing as a child, reconfirmed by acting outside socially acceptable norms in adulthood. Being unable to trust people is common among people who have been abused as children, and is indeed most common among those to whom the diagnosis of personality disorder has been attributed (Castillo, Ramon, & Morant, 2013).

Compared to the general population, women experiencing mental distress are more likely to be victims of violence (Coid, Petrukevitch, & Chung, 2003). There is no clear-cut explanation of this phenomenon, apart from their vulnerability due to the initial trauma, as well as the irritability and discomfort felt by those in close contact with them when they are in a crisis. These women are also less likely to function well when in a mental health crisis, which becomes, in turn, another source of frustration for their partners. Contrary to the myth that people experiencing mental distress are often engaged in harming others, it is the rate of self-harm which is much more frequent than media coverage would suggest (Pilgrim & Rogers, 2006; Taylor & Gunn, 1999). This would imply that women experiencing mental distress are more likely to become victims of IPDV, but does not negate the opposite inference, namely that this experience may lead to mental distress in its own right.

Viewing IPDV as a *symptom* of a woman's mental state rather than as an underlying *cause* can contribute toward absolving the abuser of responsibility for the effects of his actions, and has implications for the services offered to the woman. Labelling a woman as having mental health problems has been shown to have ramifications for her contact with her children (Williams et al., 2001). While she may be unable temporarily to look after them, once the children are removed it is difficult for the mother to get them back (Humphreys & Thiara, 2003). Child protection workers might begin from the assumption that experiencing mental distress almost automatically disqualifies women from being good enough mothers. The removal of the children has usually negative repercussions in terms of reducing further the woman's self-confidence in her key role of being a mother, and of labelling her incapable of looking after her children for a long time to come (Keeling & van Wormer, 2012; Morgaine, 2011).

Furthermore, the complex needs of women experiencing both IPDV and mental distress can make for circuitous referral pathways. When the underlying causes of their difficulties go unrecognized, a mismatch between their needs and the services on offer often ensues. Humphreys and Thiara's (2003) U.K. research revealed that survivors of IPDV came into contact with up to ten agencies before their needs were identified and appropriately addressed. Eight years later, Rose et al. (2011), also researching in the U.K., highlighted the high prevalence of women who use mental health services and who have also experienced domestic violence. Based on their qualitative study in a socially disadvantaged area of South London, this group of researchers concluded that the medical model of mental illness itself is a key barrier to understanding these women and to enhancing the disclosure of domestic violence by them, because of its focus on symptoms rather than on the underlying social problems.

At this stage of our knowledge of mental distress and of domestic violence we can only conclude that while feedback relationships between these two phenomena can be assumed, experiencing mental distress per se is unlikely to cause IPDV most of the time. However, the higher likelihood of such an experience in successive generations of the same family, and that of child abuse, often found in life histories of people attributed with the diagnosis of personality disorder in particular (as highlighted by Castillo, 2003), may indicate a psychosocial vulnerability of the victim matched by the perpetrator's life experiences and qualities that lead to the manifestation of such violence (Buchbinder & Birnbaum, 2010). The many testimonies and the few systematic studies in existence shed light on the subjective experience of IPDV and mental distress, indicating how far-reaching is its negative impact, as already stated above (Cavanagh, 2003; Lapierre, 2010).

Of particular interest in this context is research that investigated how women working as mental health professionals have experienced domestic violence and how they dealt with the impact of such an experience, because it reflects on the intersections between class and IPDV, as well as between a professional understanding of distressing intimate relationships and a direct personal experience of IPDV. Ben Ari and Dayan (2008) have conducted in-depth interviews with nine such women in Israel, self-selected for this purpose. Israel is a society in which professional women usually enjoy a high status and have equal career opportunities to male colleagues. All of them have felt that IPDV had a profoundly negative effect on their self-image and their key relationships. Furthermore, it temporarily affected their ability to work with other women with similar experiences, in that during the acute stage of IPDV and for a time to come they were reluctant to bracket themselves as "battered women" and were unsure of their ability to listen and take in the similar experience women clients had. However, only one of the nine interviewees has decided to discontinue her work in the mental health field.

The others described a long period of experiencing coexisting contradictory identities and the difficulty of accepting for themselves the identity of a battered woman. Yet a tremendous relief was felt by them once they were ready to accept that identification and to disclose the experience to colleagues, family members, and friends. The interviewees described the considerable support received following the disclosure, and how this had helped them in reintegrating their professional and new personal identities together. Some of them have gone for counselling, which they also cite as a source of help in moving from having contradictory identities to a merging, reintegrated one

### **Explanations of IPDV and Related Mental Distress**

Explanations for IPDV are wide-ranging and variously located on a continuum of viewpoints. One of the dominant perspectives concerns blaming the victim, whereby a woman's performance as a sexual partner, housewife, and mother is viewed as an antecedent of IPDV. Pathologizing women in this way contributes to absolving the abuser of culpability. In a similar vein, moralist perspectives pinpoint family breakdown and divorce or separation as mitigating circumstances in cases of IPDV. Further explanations for IPDV include the discourse of sanctioning privatized

violence, experiencing violence during childhood, the valorization of male aggression, male power and male powerlessness, and a crisis of masculinity. Alcohol consumption, religious affiliation, and male sporting activities are also cited as triggers of domestic violence. Greek research (General Secretariat for Gender Equality, 2005) has highlighted that before the abuse many of the perpetrators (42%) are under the influence of drugs (15%), anti-psychotic medication (10%), and alcohol (30%). Yet a Slovenian survey has found no evidence for consumption of alcohol leading to increased domestic violence incidents (Leskošek et al., 2010). In Scotland, football matches between Glasgow's two rival Catholic and Protestant teams consistently led to significant increase in domestic violence incidents, as though the aggression on the pitch, enhanced by beer drinking, was replayed at home (Jack, 2011). However, caution should be exercised when examining the origins of IPDV; some of the explanations discussed here focus on contributory rather than causal factors of domestic violence.

Poverty is likewise viewed as a social marker concerning the distribution of risk though it is not perceived as having a causal effect on domestic violence (Messing, Mohr, & Durfee, 2012). While wider structural inequalities need to be taken into account when analyzing the emergence of IPDV, this is not to suggest ignoring personal responsibility, or psychological factors at play. Conversely, risk factors—such as poverty and childhood experiences of violence—can have a bearing on people's inclination to apply domestic violence as a solution to their intimate relationship problems, or on how they respond to IPDV (Buchbinder & Birnbaum, 2010; Messing, Mohr, & Durfee, 2012). Yet it is important to guard against overly deterministic explanations of IPDV, given that just as biology is not destiny, nor is nurture. Individuals who possess all known prevalence characteristics do not homogeneously follow the trajectory to domestic violence.

Although IPDV toward women in heterosexual relationships transcends social class, education, religion, ethnicity, and cultural background differences, its historical, cross-national common denominator appears to lie in the power differential between men and women. In a recent convention on preventing and combating violence against women and domestic violence the Council of Europe (2011) recognizes the deep roots of gender inequality:

Violence against women is a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women. (Council of Europe, 2011, p. 2)

Efforts by the Council of Europe to eliminate violence against women and IPDV highlight the need to develop substantive gender equality “including by empowering women” (Council of Europe, 2011, p. 3).

The deep-rooted nature of gender inequality is of central importance to feminist explanations of domestic violence, which view power within patriarchal societies as concentrated in male hands. Women's historical and global limited access to power within the public spheres of education, employment, politics, judiciary, religion, and health and their corresponding lack of power within the private sphere of the family

are seen as mutually reinforcing each other. Thus the gendered power dynamics of domestic violence interact with those of wider society. The long-standing feminist articulation of “the personal is political” (Millett, 1970) has continuing resonance with international domestic violence patterns today.

Visible minority ethnic groups may differ from the majority in terms of gender inequality, and consequently in reactions to domestic violence. Where women are perceived as in need of being segregated and of being controlled by their father, brother, or husband, IPDV tends to be more socially accepted and women are expected to live with it in silence. Examples include Roma women across Europe (Palmer & Ramasay, 2002, country reports on Albania and on Bosnia and Herzegovina), the quest for specialist refuge for black ethnic minority women (Gill & Banga, 2008), and the rare but shocking cases of honour killing among Moslem families in the U.K. (Ashencaen-Crabtree, Husain, & Spalek, 2008). It would seem that the explanations are rooted primarily in attitudes toward use of violence in intimate relationships, rather than in structural or generic psychosocial factors, though these, too, play a part worth investigating.

### **Barriers to Adequate Support**

#### **Difficulties Experienced in Disclosure and Help-Seeking**

The rate of awareness of IPDV in EU countries is high, as indicated in Eurobarometer 344 (TNS Opinion & Social, 2010), in which 98% of the general population have heard about DV and consider it unacceptable behaviour. However, the gap between this awareness, requesting help, and being responded to adequately, continues to be considerable. As outlined above in the section on background data, in England, Greece, and Poland the majority of the women reporting experiencing IPDV either opt not to ask for help or do so only after many incidents. These findings illustrate how difficult women experiencing IPDV find it across Europe to disclose their situation and to seek help. As already mentioned, most European countries do not have legislation enabling the removal of the perpetrator in the case of IPDV without a lengthy legal process; countries where such a removal is enabled include Germany and Austria.

Rose et al. (2011) looked at the barriers preventing women who use mental health services from disclosing that they had experienced IPDV. These include the fears that the disclosure would not be believed or that it could lead to further violence, fear of repercussions related to immigration status in the case of migrant women, and the feelings of shame and blame, inclusive of self-blame. Women were more ready to disclose to professionals with whom they felt they had good relationships.

#### **Approaches to IPDV by Mental Health Service Providers**

The contrast between women victims’ awareness of being violated and their taking necessary action is echoed to an extent by the professional response to working with them in the field of mental health. In any mental health intervention, the approach by the professional provider is of key importance, because of the

sensitivity of the issues at stake and due to the often low self-confidence of the service user at the referral stage. In the context of IPDV this is also justified by the likely and understandable fragility of the woman's state of mind at the post-traumatic phase. A non-judgmental yet emphatic attitude by professionals and a grounded understanding of what women stand to lose by leaving an abusive relationships, coupled with good assessment and trust building skills, are indispensable for a woman at a low ebb of self-esteem, in fear of her life, ashamed, and feeling guilty of finding herself in this position. However, unless coupled by an approach that gives women tacit permission to discuss the IPDV on their own terms, the above will not suffice. In addition, women coming from a Black or minority ethnic (BME) background are likely to have experienced racist attitudes from providers, which would make them reluctant to seek help from a service they expect may respond in this way to them.

The rather meagre existing evidence of this aspect illustrates the discomfort mental health professionals experience when it comes to working with this client group. As part of the EMILIA project (an EU Framework 6 project on mental health and social inclusion (see Ramon et al., 2010; Ryan, Ramon, & Greacen, 2012), a survey was carried out among the staff of the eight demonstration sites involved in the project. The survey asked participants to identify areas of high relevance for their practice yet about which they would want to increase their knowledge. Domestic violence topped the agenda. In response, a small-scale pilot project of training on this topic took place, including the professionals in the Greek site (Athens, EPAPSY) and the Polish site (Warsaw, Institute of Neurology and Psychiatry). The interactive training program<sup>1</sup> included several case studies designed to increase awareness of the complexity of the issues this work entails, and of the range of issues and emotions this presents to the staff, in addition to information about prevalence, explanations, and intervention methods. The training program was evaluated before and after its delivery. This exercise highlighted that staff members had many reservations as to their ability to appropriately support these women and tended to refer them to other services as a way out of this dilemma. However, this strategy did not help, as the women were re-referred to mental health services because their difficulties in this area did not disappear; and furthermore, the message transmitted to them in this referral and re-referral process has been that IPDV is not an issue the mental health provider welcomes. In the study by Rose et al. (2011) mentioned above, professionals were unclear and unsure about role boundaries and about their competence as well as confidence in working with this client group. To this list they have added the need to navigate between competing demands on their time, the presence of the abusive partner in the conversation, and doubts about their competence to do so.

A specific stumbling block that has not been researched is the observation that many professionals seem to indicate that they do not understand why women who have been abused in this way do not leave the perpetrator. This lack of understanding

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<sup>1</sup> A copy of the training program can be obtained from Dr. Mojca Urek at [mojca.urek@fsd.uni-lj.si](mailto:mojca.urek@fsd.uni-lj.si)

is tinged with blaming the woman for further abuse, by not taking the necessary safety measures (Morgaine, 2011). Yet the reasons outlined above for the tension in professionals' response to IPDV highlight the very real difficulties these women face in making the decision to stay or not to stay with their intimate partner. Furthermore, the lingering hope that the perpetrator wants to, and can be, reformed and the wish not to lose one's home and social position lurk in the background together with the possibility of blaming oneself for bringing about the violence.

Slovenian research (Leskošek et al., 2010) highlights that women diagnosed with mental health difficulties are not accepted in their local domestic violence refuge services. The reasons given include:

- We are not trained to deal with women having mental health difficulties.
- We are afraid how other women will accept women with mental health difficulties.
- We do not know enough about mental illness, so we do not know how to react.

While these are valid reasons, they raise the question as to why suitable training focused on mental health issues is only rarely provided. Thus it would appear that this subgroup is likely to be doubly shunned by both mental health service and domestic violence service providers, reinforcing their social exclusion. Furthermore, the providers seem to concur with the dominant lay attitude to this experience in Europe, where the discomfort felt about domestic violence of any type is insufficient to lead to positive action, or to attitudinal change by service providers (Keeling & van Wormer, 2012).

Perhaps the need to treat this group of women as “others”—i.e., the people the providers assume they will never become—may stem out of the fear that IPDV can happen to everyone, including to mental health professionals. Yet the rare example of research about women professionals experiencing IPDV (Ben Ari & Dayan, 2008) mentioned above highlights that the response of colleagues to the disclosure of IPDV has been supportive and made a real positive difference to the ability of the battered woman professional to become a survivor of domestic abuse.

### **Existing Range of Services for Women**

Social services, hospital accident and emergency departments, family-focused services, mental health services, and educational institutions are likely to be the settings in Europe where the impact of IPDV might be detected and, at times, disclosed if trusting relationships are in place. If IPDV incidents are known, the service providers would usually respond by referring the women to a specialized service. Such a service is more likely to be in the not-for-profit voluntary sector, and may also include advocacy (Coy & Kelly, 2011) and re-housing (Jones, Bretherton, & Croucher, 2010). In a number of European countries few such services exist. As highlighted above, attitudes within mental health services and within the specialized domestic violence agencies toward women with the dual experience of IPDV and mental health issues militate against the social inclusion of these women. Some

European countries have made an effort to co-ordinate their DV multi-agency range across the criminal justice, health, and social care services. Yet fragmentation and contradictions in practice continue (Hester, 2011). A greater focus on women at high risk prevails, which has its positive and less positive aspects in paying insufficient attention to the prevention of IPDV.

At present most European countries have telephone help lines available for women to contact as a first port of call, as well as police emergency numbers. They can also approach their primary health care service. While more women use the internet as a source of information and support, many women in Europe do not know of the existence of help lines, underscoring the intersections of class and accessibility to technological innovation. The anonymity of telephone help lines is perceived as facilitating disclosure, but it might be an inhibiting factor for some callers. Likewise, disclosing to one's family doctor can be relatively easy if relationships of trust exist, but not otherwise. Calling the police is usually a drastic step because of its connotation of crime and punishment and its reputation as a bureaucratic, largely unsympathetic organization that considers domestic violence to be of less importance than other offences. Across Europe, many women withdraw their initial complaint to the police under pressure from the perpetrator and their extended family, rendering the police unable to proceed in such a case. One outcome of such withdrawals is the reluctance of the police to respond urgently to calls for assistance made by women fearful of an impending attack by their partner or ex-partner. This intersection between women's and the police's responses ends all too often in the killing of the woman (see recent governmental demand for improving police response to IPDV calls in the U.K., e.g., Grice [2013]). Furthermore, the known higher ratio of racialized men in custody is likely to act as a barrier for racialized women to be seen colluding with the police, known to be a structurally racist institution.

If disclosing, women might be referred to a support group where they would meet women experiencing similar IPDV situations and would learn from the group facilitators and from the other participants of the options they have for handling their own situation, and of existing services. This will enable them to begin to be socially re-included. A minority of women go into counselling and psychotherapy, and an even smaller group bring their partner to the therapy.

Refuge services exist in most European countries, albeit not in the numbers or level of provision required. While a refuge is a lifeline for women in need, it comes with a considerable cost of being uprooted from one's own (and one's children) environment. Being in a refuge signifies an ambiguous position in terms of social inclusion. In most European countries it is usually the victim who is forced to leave her home, as existing legislation makes it complicated to remove the perpetrator against his will, even when convicted. Perpetrators rarely disclose and rarely seek treatment; when found guilty they are likely to be forced to participate in group work within the local criminal justice system. Jones et al. (2010) highlighted the issues entailed in enabling women experiencing IPDV to remain in their homes. Thus our respective societies condone the expulsion of the victim, often with her children, from her legitimate home in the name of the human rights of the perpetrator. This

highlights the degree of hypocrisy displayed in many European societies and the degree of contradiction between the values they espouse and their actual behaviour.

It would seem that only few of the existing services are designed to overcome the barriers listed above. Furthermore, while these services can be seen as having in principle a secondary or tertiary preventive function, none of them tries to tackle primary prevention. In addition, the existing provisions are focused on supporting women to survive the more immediate risks, rather than concentrating on how to ensure they move from being victims to becoming a survivor of the experience of IPDV. Working with women toward leading a life beyond this experience, which includes having dreams, ambitions, and use of their potential strengths, as well as contributing toward a good life for others, remains a missing focus in many services.

### **The Value of Models of Practice**

The text has thus far highlighted the traumatic impact of IPDV on women, the complexity of their responses, the connections between these two factors and social attitudes toward IPDV in Europe, and the implications for the social exclusion and inclusion of women with this experience. These are elements that have to be taken into account when considering the type of services needed to support victims of IPDV. Furthermore, the gap between the barriers to accessing and utilizing existing services raises the issue of what are the reasons for the gap, and what should be the measures that will bridge it in Europe.

The development of an innovative strategy that would attempt to provide a better response can benefit from considering the relevance to this client group of the current move in mental health services, focused on the new meaning of recovery. The new meaning, constructed initially by service users in the United States, defines recovery as the ability to live better with the distress and living beyond it (Davidson, 2003). This implies that while symptoms and negative experiences may not disappear, they can become better managed by the person, and the engagement in activities beyond focusing on the distress supports their social inclusion and ability to lead a more personally fulfilling and socially valued life. The longitudinal research on recovery, most of which was carried out in Europe (Davidson, Harding, & Spanoil, 2005), and the many recovery-oriented projects established since (Ryan et al., 2012) have amply demonstrated that this is possible. This approach is rooted in the strengths model and the evidence related to its implementation (Rapp & Goscha, 2012). The model promotes the idea that people with a long-term disability have strengths and not only deficits and weaknesses, even if they had negative experiences in their lives. Through activating their strengths, people can better confront the difficult issues they may be facing. The examples of women experiencing IPDV who became survivors, moving out of victimhood, illustrates the likely value of this approach to this area of human experience.

It is argued here that it would be useful to apply a similar approach in working with women who have experienced IPDV and mental health difficulties. Like other people experiencing mental distress following a trauma, they, too, deserve to be supported to improve their ability to be in control of their lives, regain self-



confidence, and use their strengths as mothers, partners, friends, learners, or workers. This objective is best met within a recovery-oriented health promotion approach, which tackles in parallel the external stigma toward victims of IPDV and the stigma that each victim has internalized about herself (see research on internalized stigma by West et al., 2011). Given the complex set of intersecting issues operating in IPDV, a dual-pronged orientation should be supported by structural measures, such as improved EU legislation pertaining to the removal of perpetrators, as well as public campaigns and in-depth early education to increase awareness about IPDV and reduce the stigma attached to those who have experienced it.

The work of WAVE highlights the potential of such an approach regarding IPDV. WAVE (2011), an EU-funded voluntary organization, carried out a European survey, highlighted good practice models and policies in the making, and designed a training program related to IPDV in the context of EU ethnic minorities. The good practice models cover all three levels of intervention, such as public awareness, state action, prevention in the health services, multi-agency collaboration, and programs for perpetrators. Unfortunately, none of the examples focuses on IPDV and mental health. The WAVE evaluation of the different intervention projects showed the wide range of activities already undertaken in this field, many with the active support of the EU, what such activities can offer but also what they are not good at. It would seem that it is difficult to assess the effectiveness of public awareness projects, while the more focused projects on intervention with either victims/survivors or perpetrators are often limited in their scope and in the small size of their sample.

The increase in self-confidence and ability to control one's life is best encapsulated in the WRAP (Wellness Recovery Action Plan) program developed by Ellen Copeland (a service user and a qualified psychologist from the U.S.; Copeland, 1997), which is also practised successfully in Australia and the U.K. (Evans & Sault, 2012). The core of this program is the activation of existing personal abilities and external support from family, friends, and service providers in pursuing the specific objectives a person may have for wellness and recovery. Within the context of IPDV it is of particular importance to ensure that personalized plans are not focused only on relationships with children, but also include other areas of women's lives, such as training, employment, and having a supportive social network.

These strategies do not exclude clinical interventions where relevant, but they prevent the medicalization of the person and her experience, which in turn leads to the repression of the trauma and its impact, and as such would not enable the person to come to terms with it.

The necessary structural, economic, social, and psychological interventions are interdependent, as befits an intersectional approach. For example, enabling and encouraging women to re-enter employment needs to happen at the individual and support-group level. However, without affordable and adequate child care provision—a structural tool—women who are mothers to young children will not be able to work. Likewise, without support in reducing the initial high level of the psychological trauma, women will not be able to move on, to live on their own, or to engage in vocational training.

Both the underlying complex intersectionality of women's experience and the interdependency highlighted above, make it all the more complicated to implement a well-being promotion policy in practice. Likewise, the transdisciplinary nature of the input necessary in working with this group of women, given their multiple difficulties, also increases the effort entailed in enhancing good practice. The project Empower Women and Providers: Domestic Violence and Mental Health ([www.empowerw.eu](http://www.empowerw.eu)), carried out between 2011 and 2013, tested the usefulness of the line of intervention proposed above within an exploratory project funded under the EU Daphne program. The project provided women who experienced IPDV and mental distress with an interactive small group training program focused on enhancing self-confidence and control over their lives. It also enabled some of them to be engaged further in a training program to become co-facilitators for women's support groups. In parallel, mental health providers were given the opportunity to participate in a training program focused on increased awareness, assessment, and relationship-building skills in this area. A pre- and post-program evaluation was applied. The partners to the project were academic institutions and practice agencies based in England, Greece, Italy, Poland, and Slovenia. The findings have been positive for the two programs for women, in enabling them to reduce the guilt and blame, to gain in self-confidence, and to find not only hope but also dreams and ambitions. While mental health services managers accepted the need for training both the women and the providers, a number of obstacles were put in the way of enabling the programs to fulfil their objectives, highlighting the lack of belief in this way of working and in the underlying values leading it. This is in line with the finding by the large-scale U.K. Time-to-Change project on stigma and anti-stigma that mental health providers, as a group, had more negative attitudes toward people using mental health services than other population groups had (Brindle, 2013).

### **Conclusion**

This article has attempted to make sense of IPDV and mental distress in the European context, a neglected area in terms of understanding and research. To this end, the significance of experiencing IPDV and its impact for women was outlined, followed by the presentation and examination of prevalence data, the barriers to disclosure and seeking help, the range of interventions available, and the gaps remaining, teasing out key intersection issues. The text looked at the discomfort mental health providers often experience in working with this group, the likely reasons for this, and its impact on women service users of both mental health and domestic violence agencies. The interdependency of different types of intervention was highlighted, side by side with the lack of adequate legislation concerning the removal of perpetrators on the one hand and, on the other hand, concerning interventions that focus on enabling women to move beyond coping with the here and now.

The existing interventions have a valid place within a perspective on these issues that focuses on mental health promotion, it has been proposed that an approach emphasizing the application of the new meaning of recovery to women experiencing IPDV may provide a positive contribution. Such a contribution would

enable these women to move from being victims to becoming survivors. This application includes the promotion of well-being, regaining control over one's life with increased coping competencies, being encouraged and supported to develop their strengths, to have ambitions, and to embark on fulfilling them. Furthermore, fundamental attitudinal change and skill development have been identified as necessary among mental health providers who work with this group of women, for them to have a more positive contribution and for this move from victim to survivor to have a real chance to succeed.

The above concluding comments are underpinned by the intersectional analysis of the interaction between structural and attitudinal factors, such as class, ethnicity, gender, migration history, and race. In each case it is the way a factor is applied within our largely neo-liberal societies, and its impact on most other factors which triggers the intersectional effect. The intersectional effect is best exemplified in the intersection of class, gender, and race, in part through the long-term impact of poverty and the over-representation of racialized women among people living in poverty. The repeated traumatic incidents of IPDV among this group of women adds to the on-going devastating effect of living in poverty:

- a. Indirectly impacting on the woman's self image and social position.
- b. Reducing her ability to move out of victimhood to becoming a survivor.
- c. Increasing the degree of stress she experiences.
- d. Leading at times to periods of being unable to function as she would like to in her mothering role or to work outside home.

In turn this may lead to the children being taken away from her, thus to experiencing a further trauma and social devaluation of one of her key identities. This spiral can be stopped by having the right support at the right time and delivered in the right way by family members, friends, and professionals, as the example of the project Empowering Women and Providers has illustrated. It is possible for women, despite all of the odds, to move from being victims to becoming survivors, regaining their self-respect and the energy to re-enter their preferred social roles.

While all too often the impact of structural factors leads to oppressive outcomes, the attitudinal factors are more open-ended because they are more impacted also by specific encounters. In these encounters the impact of agency (Archer, 2003, 2012)—i.e., the individual—can be more potent and can sway against the oppressive impact of the structural factors.

As individuals and groups are acting in situations to defend their vested interests and to realize their projects, they reproduce or transform the structural and cultural conditions that impinge on them, but in this process they are themselves being transformed from involuntarily placed agents into social actors and individual persons. (Archer, 2012, p. 31)

The empowering options outlined above in the context of the project Empowering Women and Providers open the possibility of agency to dominate against structure, as demonstrated time and again by survivors of domestic violence

and other adverse experiences (for example, see Ahulwhalia & Gupta, 2007). Therefore, the resulting intersecting issues highlighted above need to be treated as likely possibilities, rather than simply as a given that cannot be changed.

### Limitations

The majority of IPDV victims in Europe are women (WAVE, 2011); this paper focuses only on this group. Furthermore, due to the complexity of the theme, this paper examines the key intersectionalities in the impact of Intimate Partner Domestic Violence (IPDV) on women who have experienced it within heterosexual relationships. This is not to deny the importance of a similar investigation concerning IPDV in lesbian relationship, but to defer this analysis to a separate text.

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