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Battered Women Syndrome: A Headache for Medicine and Law

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Abstract

In many respects, the term *battered women syndrome* is an unfortunate nomenclature used in relation to a woman's prolonged and repeated exposure to domestic violence (often involves sexual humiliation). Unlike a single traumatic event, prolonged and/or repeated exposure to trauma may result in the development of a complex trauma syndrome (Zepinic, 2017). Many battered women report total physical and psychological dominance by the abuser and many being coerced into immoral and humiliating sexual practices. Most of the victims of domestic terror involve the sacrifice of children—the battered woman will report that, in relationship with the abuse, she did not care about herself but has been concerned about her children. In the courtroom, there is often evidence that the perpetrator also abused children even threatening the woman that he is going to kill them if she reports to anyone violence and torture, or if a battered woman attempts to leave the abuser. The battered woman is also a victim of a microcosm of the bias within the principles of the criminal law in general and criminal defences in particular. Domestic violence is not a new phenomenon; however, the battered woman is often in spot-lite because she managed to kill her abuser before he killed her. In addition, to induce fear, the abuser seeks to destroy the trauma victim's sense of self, identity, and autonomy. On the other hand, due to the psychological and physical dominance, domestic captivity, fear of more abusive trauma, and fear for the children's safety, the battered woman very rarely asks for any help or therapy due to developed trauma symptoms, often accompanied by physical injuries.

Keywords

Complex Trauma Syndrome, Battering, Responsiveness, Dissociation, Liability

1. Introduction

Since for the first time being introduced by a prominent psychologist (Walker,

1978), the battered women syndrome has been differently considered in the medicine and the law. In general, it was a theory of the multiple victimisations with a cycle of repeated violence and symptoms of "learned helplessness" which woman experiences by the perpetrator. Violence is a universal method of terror and it is based upon systematic and repetitive infliction of psychological trauma (often with severe physical injuries) designed to install helplessness and to destroy the victim's sense of self.

The clinicians are united that severe psychological trauma affects all structures of the self—one's image of the body; the internalised images of the others, and one's values and ideals—and leads to a sense that the self-coherence and one's goals are invaded, assaulted and systematically broken down (Zepinic, 2011). Traumatic event(s) overwhelm the ordinary human adaptations to life and generally involve threats to life or bodily integrity. The vulnerable self-structure with complex trauma is evident in the following ways (Zepinic, 2008):

1) Difficulties in self-regulation, such as self-esteem maintenance, affect tolerance, and the sense of self-continuity, or sense of one's personal agency. Such difficulties with self-regulation are the "development arrest" and can result in addictive behaviour or compulsive activity;

2) The appearance of trauma symptoms, such as frequent upsurges of anxiety, fears, depression, or irritability; and specific fears or phobias regarding the external world or one's own bodily and psychic integrity;

3) The reliance on primitive or less-developed forms of self-object relatedness with attachment figures.

Severely traumatised individuals often describe fragmentations of the self in different ways: feelings they are falling apart, losing their bearings, or treating water in the middle of the ocean with nothing to hang on; they may feel lost in space; or even they feel their body has become "strange" or "foreign" to them (Zepinic, 2011). Traumatic memories related to the trauma experience cause discomfort, avoidance, difficulties in daily functioning, and shame. Relationships with others are disturbed or broken down, and the outer world is usually seen as a dangerous place.

The traumatised self is prone to shame, and patients' ability to live comfortably among others is diminished. Patients use a wide range of words to describe their personal experience and feelings after the trauma ranging from the mildest twinge of embarrassment to severe emotional pain, whilst some keep their emotions hidden from others (usually something of an intimate and personal nature; i.e., battered or sexually abused woman, child abuse).

The fragile and precarious sense of self is deeply personal, making the patient constantly in a state of inadequacy. Painful secrets, which patients are unable to report, but which cannot be ignored, are often caused by an embarrassing or humiliating, and in a person's degrading manner. Deeper experience of emotional pain is usually handled by anger or fears, which is accompanied by guilt. It is necessary to be attentive in understanding the patient's "deep secrets" in an

attempt to uncover the levels of one's traumatised self. The nature of any traumatised self is commonly an "iceberg" for therapy (Zepinic, 2017a). This yields a great deal of information about the psychological range of emotional experience; i.e., what is happening at depleted levels of one's functioning.

To understand damages associated with the trauma, it is necessary to know the various types of patient's suffering (psychic pain); to learn how fragmentation, dissociation, dissolution, fracturing, and diffusion of the self, identity, and ego processes occur and reconfigure following allostatic changes within the psychic equilibrium. Trauma impacts the psychic core of the soul of the trauma survivor and generates a search for meanings as to why the event(s) had to happen.

The trauma may lead to de-centering of the self, a loss of groundedness and a sense of sameness, continuity and ego-fragility, leaving scars on one's inner agency of the psyche. Fragmentation of ego-identity has consequences for the patient's psychological stability, well-being, and psychic integration, resulting in proneness to dissociation. In many cases, the fragmentation of ego-identity is a fracture of the soul and spirit of the person, like a broken connection in the patient's existential sense of meaning and existence.

Many clinicians (Allen, 2004; Herman, 1992; Meares, 2000; Silverstein, 2007; Wilson & Drozdek, 2004; Zepinic, 2017) use different terms to describe processes of one's alteration in identity, consciousness, broken spirit beyond repair, and the self-structure. This is because the self is the process and centre of mental activity for organizing the meanings of the experience. Any serious disturbance or interference in its ability to function constitutes distress. The patient's sense of self, or experience of the self, is critical to a person's organizing activity. Thus, any occurrences taking an unconscious meaning, which seriously challenge or undermine this sense, and might be experienced as a traumatic shattering of the self.

2. Is Battered Women Syndrome a Complex Trauma Syndrome?

Complex trauma is a catastrophic experience of prolonged and/or repeated trauma event(s) and includes profound disturbances in intra and interpersonal relationships, estrangement from others, pervasive mistrust, hostility and suspiciousness, feeling of emptiness, and altered sense of meaning and purpose of life (Zepinic, 2019a). Severely traumatised individuals are overwhelmed by terror and helplessness; their whole mechanisms for concerted, coordinated, and purposeful activities are smashed.

Persons subjected to extreme, prolonged, and repeated trauma (like battered women) develop insidious, progressive forms of complex trauma that invades and erodes the whole personality. The victims of complex trauma may feel that their self is changed irrevocably, or lose the sense that they have any self at all. It is not surprising that complex trauma causes continually hypervigilant, anxious,

and agitated states. What is even more traumatic is that, in the case of battered woman, the trauma experience exists here-and-now unlike other complex trauma syndromes (i.e., war experiences, terrorism attacks, hostages, rape, or sexual abuse) which has its past (there-and-then).

There is always present chronic apprehension of imminent doom, of something terrible is happening, and any symbolic or actual sign of potential danger results in increased activity, agitation, pacing, screaming, or crying. As an aftermath of a continual trauma in battered women, the nightmares are universal, with themes of violence and danger, and seriously traumatised woman always remains vigilant, unable to relax or fall asleep.

Complex trauma causes battered women not to have any baseline state of physical calm or comfort and, over time, they perceive their bodies as having turned against them. It is common that complex trauma causes complaints of numerous types of somatic symptoms such as tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain. It is also very common to complain of severe tremors, chocking sensations, or rapid heartbeat. Some complex trauma syndrome patients may conceptualise their symptoms primarily in somatic terms or they are so accustomed to the condition that they no longer recognise the connection between bodily distress symptoms and the nature of terror and abuse in which these symptoms were formed.

In battered women syndrome it needs to be emphasised that trauma, to the victim's self, comprises a spectrum of complex and multifaceted conditions with different levels of interference and different meanings to the individual. However, following diagnostic features in the DSM-5 (APA, 2013) or ICD-11 (WHO, 2018), the battered women syndrome is not an independent diagnostic entity, nor even being mentioned. This absurdity has been a subject of considerable debate and numerous clinicians have questioned most of the core assumptions underlying diagnosis of the PTSD: re-experiencing, numbing and avoidance, and arousal symptoms.

Consistent with the diagnostic features of the PTSD, the battered women syndrome, if not fulfil criteria as an independent entity, fulfils the diagnostic criteria for the PTSD due to its variety of well-developed disturbances, including dissociative reactions, sexual dysfunctions, severe depression, intrusive thoughts and images of the abuse, flashbacks, anger, severe sleep disturbances, etc. The key issue in diagnosing the battered women syndrome as the PTSD is Criterion B in the DSM-5: "Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), **beginning after the traumatic event(s) occurred**[1]:

1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

2) Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

[1]In bold by the author of this article.

While diagnosing the PTSD, it is essential existence of the trauma event(s) which occurred in the past and caused presently recurrent symptoms. However, in battered women syndrome, torture and abuse are current, ongoing process with no intermission of the occurrence. The woman is directly experiencing traumatic event as a "daily dose" of torture, humiliation, physical and/or psychological abuse in repeated forms. Also, her dissociative reactions (i.e., flashbacks) are not "in which the individual feels or acts as if the traumatic event(s) were recurring" (Criterion B(3) of the DSM-5) (APA, 2013).

In battered women syndrome, alongside the classic PTSD core symptoms (hyperarousal, avoidance, and re-experiencing), the battered woman may also suffer the disturbances in self-organisation: 1) problems in affect regulation (i.e., heightened or lowered emotional reactivity; feelings of neediness, dejection, hopeless); 2) altered self-concept (i.e., feelings like failure or worthlessness; incompetent, inadequate; self-conscious; trapped); and 3) impaired interpersonal relations (i.e., difficulties in establishing and/or sustaining interpersonal connections, or avoidance of relationships; isolated; dejected or rejected)—condition which endorses definition of the complex-PTSD in the ICD-11 (Zepinic, 2021).

Affect regulation is multidimensional construct involving: 1) awareness, understanding, and acceptance of the emotions; 2) ability to control impulsive and self-harm behaviours when experiencing negative emotions; 3) flexible use of situationally proper strategies to modulate and control the intensity and duration of emotional responses; and 4) volition to experience negative emotions in the pursuit of meaningful activities (Zepinic, 2019a). Thus, battering condition is a life-threatening traumatic event that impacts the psychic core of the battered woman's soul and generates her to a search for meaning as to why the events (repeated battering) had to happen.

The act of battering is reinforcing; once an abuser has beaten the woman, he is likely to do so again as he tends to be immature, superior, non-assertive, and strong feelings of dominance and independency. The abuser's aggressive behaviour is designed to humiliate woman and to build her low self-esteem, dependency, and feelings of nihilation. In any situation that the abuser feels frustrated he will find "relief" in battering woman, or dynamics for battering may include identification with an aggressor (i.e., boss at work), or simple distorted desire to express strong manhood, and dehumanisation of the woman. By the abuser's logic, the aggression is deemed permissible; a woman is perceived as husband's property.

As an aftermath of continual and repeated trauma, the victim of battering may develop specific survival syndrome (i.e., "freezing") as the response to the traumatic event(s). Also, the vulnerable battered woman's self-structure may develop into:

1) Difficulties in self-regulation, such as self-esteem maintenance, affect tolerance, and the sense of self-continuity, or sense of personal agency. Such woman's difficulties with self-regulation can result in addictive behaviour (alco-

hol or illicit drugs use), or compulsive activities;

2) The appearance of specific symptoms, such as frequent upsurges of anxiety (fears), depression, or irritability; and specific fears of phobias regarding the external world (which is hopeless and/or helpless), or woman's own bodily integrity;

3) Reliance on less-developed forms of self-object relatedness with the attachment figures.

Due to the repeated and continual torture, the battered women usually report symptoms that could be summarised in four main groups: 1) psychosomatic (pain in different body areas, headaches, tremor, body weakness, shortness of breath, gastrointestinal and dermatological problems, excessive sweating); 2) affective (intrusive memories of the abuse, depression, nightmares, phobias, fears, panic attacks, sadness, and sensory delusions); 3) behavioural (irritability, self-destruction, sexual dysfunction, social withdrawal, anger, guilt, detachment, the self-abandonment); and 4) cognitive (poor concentration and inability to remember (a short-term memory impairment), confusion, disorientation). However, not only because of the children safety, in many cultures the women may be unwilling to report their experience of domestic abuse and humiliation due to cultural issues. For example, in India, the battered woman does not have a legal status *per see*, because there is no specific law dealing with such issue.

Being repeatedly abused physically, sexually, and psychologically, the battered women may suffer long-term trauma symptomatology, such as unwanted pregnancy, death of the victim's infant who has no further source of nourishment, infertility, an altered self-image, trustworthiness, cultural and social rejection. Data from general medical practice has identified pregnancy as a high-risk period of battering: 15 to 25 percent of pregnant women are physically abused while pregnant, and the abuse often results in birth defects (Sadock & Sadock, 2003).

Trauma exposure to the domestic violence may lead to woman's significant mood changes; severe depression with suicidal thoughts or attempts; eating and sleeping patterns changes, with some women going days without being able to rest or eat appropriately. Fear of an everyday trauma experience with uncertain outcomes leads to the event of social isolation, provoking feelings of claustrophobia, and self-injurious coping behaviour. Also, battering is often so brutal and severe involving severe physical injuries (i.e., broken limbs, broken ribs, internal bleeding, and brain damage). If the battered woman tries to leave the abuser, he often became doubly intimidating and aggressive to shaw her "who is the boss" and threatens to "get" her. In the case of having small children, the abuser could be so cruel waging a conscious campaign to isolate children from her as she is "worthless, useless, helpless".

(Dutton & Painter, 1993) found that the battered women experience three aspects of the battered women syndrome: high rates of trauma symptoms, the lowered self-esteem, and heightened "paradoxical attachment" to the batterer. These effects are usually closely intercorrelated making a complex trauma syn-

drome exist even long-time after the trauma experience is over. Furthermore, these effects are significantly related to the intermittency of a positive-negative psychological treatment, to power differentials in the former relationships, and to the extremity of the battering.

As a result of the continual trauma, the battered woman's self-structure is attacked, the image of the own self and body, the intermittent images of others, and the values and ideal what leads to a sense that the self-coherence is broken. These aftermaths of the trauma (domestic violence) are outside the normal range of human comprehension and threaten basic assumptions about one's self and one's place in the world. These assumptions include personal safety, integrity, self-worth, and invulnerability, and a view about the outer world as meaningless and dangerous place.

Woman exposed to a constant and repeated domestic violence, threat and torture, is powerless and helpless, developing a sense of the futility, surrender, and languishment. One of our patients who was referred for treatment following her suicidal attempt reported:

"The anger towards myself took a lot of my self-confidence, esteem, energy, and identity. It is breaking my heart to look back and see how much was taken from me by my violent partner…I am asking myself all the time why God gave him such personality to destroy me and our children…I often asked Hell: have you had enough? And the answer is: is there more?"

The trauma-victim's self-continuity and self-cohesion pose a continual distraction, depletion in the sphere of the self-consciousness with a dissociative status leading to a disruptive sense of self-identity. Because of timeless torture and abuse, and unintegrated nature of traumatic memories, the victim of brutal and repeated domestic violence remains embedded in the trauma as one contemporary experience, instead of being able to repair a broken sense of the self. Unlike other trauma victims whose trauma memories belong to there-and-then (past) circumstances, in battered woman the trauma exists here-and-now deepening all broken self-structures more and more every day.

The meaning of domestic violence and torture evolve over time and include feelings of irretrievable loss, anger, betrayal, and helplessness. Often any triggering factor interferes with healing and homeostasis, and can activate stored traumatic memories of the battering and remind woman of forthcoming torture and abuse. A woman who has been exposed to the battering for a while has developed intrusive and distressing feelings and may, after exposure to any distress, feels as if battering occurs right now. In case of any distress which is totally unrelated to the domestic torture and abuse, the woman may react like defending herself and her children from the batterer.

An approach to the battered women syndrome often lacks in its scientific values if not considered what happened every day to a battered woman. Regardless of an absence of the reexperiencing as one of the well-known PTSD cluster symptoms, the battered women syndrome is a stress-related disorder which may

cause catastrophic consequences upon the victim's personality. It is worthy to say that triad of the PTSD clusters (re-experiencing, numbing/avoidance, arousal symptoms) are determined by clinical observations rather than by empirical research.

Another diagnostic obstacle for battered women syndrome is that the DSM and the ICD manuals defined independent single entity, but not syndromal condition. In clinical practice, it is evident that PTSD three clusters hung together even the symptoms in each cluster did not exactly overlap with the symptoms in the cluster of the DSM or the ICD. For example, (Foa & Rothbaum, 1998) observed that in the DSM-IV the avoidance symptoms (i.e., efforts to avoid thoughts about the trauma) and the numbing symptoms (i.e., a restricted range of the affect, feeling of detachment or estrangement from others) are lumped together into one cluster.

It is common in clinical practice observation that the numbing symptoms and the avoidance symptoms in stress-related disorder may belong to the different factors, or causes. The numbing and avoidance symptoms may represent a separate trauma caused phenomenon and also may relate differently to the other post-trauma or trauma-after-trauma symptoms. Many severely traumatised individuals, who did not meet full criteria for PTSD, endorse symptoms of intrusion, arousal, and avoidance.

The DSM-5 (APA, 2013) defined that an essential feature of PTSD is the development of characteristic symptoms following exposure to one or more traumatic events. In history of suffered battered women syndrome, the victim reports multifactorial exposure to the trauma which caused chronicity of fears, helplessness, horror, anhedonic or dysphoric mood states, negative cognitions and depleted or completely lost sense of self-identity. It is the experience which daily threatens actual physical assault on the victim, sexual violence and humiliation, and deep human degradation.

In battered women syndrome, unlike in other severely traumatised individuals, the avoidance is more desire than possibility to do that. Although battered woman avoids to express herself regarding domestic torture and abuse, in essence the avoidance (as it is defined in the DSM-5) is not possible as torture and abuse are always here and inescapable—in thoughts, memories, and feelings. The battered women cannot avoid situations of torture, nor the aggressor, and often escape is a search either for suicide or homicide.

Although suicidal behaviour is not diagnostic criterion for PTSD, there is general consensus among clinicians about a strong association between psychological trauma and suicidality. Studies (Harned et al., 2010; Panagioty et al., 2009; Zepinic, 2019) have examined factors which confirmed that those diagnosed with complex PTSD are under severe suicidal risk. These studies demonstrate that suicidal risk is significantly and positively associated with one's re-experiencing symptoms cluster, hyperarousal, and negatively or insignificantly associated with the avoidance and numbing symptom cluster.

However, the existing literature examining associations between stress-related disorders and suicidal behaviour did not provide enough evidence to elucidation the mechanism by which a suicidal behaviour develops from the stress-related disorders (including in battered women syndrome). One possibility for this clinical puzzle is that particular symptoms of the stress-related disorders lead to depression, which then leads to the patient's suicidal behaviour (Panagioty et al., 2009; Zepinic, 2015). Further, one's comorbid depression may lead to suicidal behaviour because it exacerbates the effects of the trauma symptoms.

Regardless of the causal factors, suicidal risk in battered women represents serious public health problems and should be prioritised in prevention and treatment. Familiarity with risk factors for battered woman's suicidal behaviour, help the clinician to register the import of the data from the clinical interview and/or psychometric assessment, and make a more cogent appraisal of the patient's thoughts from an idea that the death would be welcome to the immediate intent/attempt to commit suicide.

Thus, the suicidal behaviour remains the most dreaded outcomes of the battered women syndrome and commonly represents silent issues of the patient's problems. Suicidality in the battered women syndrome exists as a spectrum from nonspecific suicidal ideation, such as thoughts of death, to thoughts of one's own death, and finally to suicidal thoughts with a plan and intent to commit suicide as a way out of misery. The vast majority of battered women report that they did not commit suicide only because of the fear that their children must stay and live with the abuser after mother's suicide.

One of our patients stated: "On many occasions I wanted to kill myself or my husband when he tortures me. I could not do that leaving my children to his torture and abuse. On the other hand, if I killed him, my children will grow up without both parents. So, I sacrifice for my children not even tell anyone about my trauma". Her symptomatology revealed how the battering consequently impacts all aspects of the self-structure and one's image of the body; the internalised images of others; and one's values and ideals—and leads to a sense that self-coherence and self's goals are invaded, assaulted and systematically broken down.

Chronic trauma causes identity diffusion, fragility and feelings of self-discontinuity with severely disrupted or shattered trauma victim's self-cohesion, intra and interpersonal relationships, and the existence as human being (Panagioty et al., 2009; Herman, 1992; Walker, 1978). Repeated and continual trauma, such as domestic violence, overwhelms an ordinary human adaptation to life and generally involves threat to life, or bodily integrity. A close and constant personal encounter with severe violence, confronts battered woman with the extremities of hopelessness, disconnection, terror, disempowerment, and evokes the response of inescapable catastrophe.

The vulnerable and disordered self-structure of the battered woman could be evidenced in difficulties in self-regulation, affect tolerance, sense of self-cohesion and continuity, or the sense of personal agency. Furthermore, there is constant

appearance of the stress syndrome in form of frequent, but unprovoked, urges of fears and anxiety, depression, or irritability. The battered woman is an individual who relays on less-developed forms of self-object relatedness with attachment figures. (Douglas, 1987) stated that battered women syndrome is a collection of specific features and effects of abuse on the battered woman.

We can subdivide the battered women syndrome into three major categories: the traumatic effects of victimisation by violence, learned helplessness deficits resulting from the violence and others reactions to it, and self-destructive coping responses to the violence. (Douglas, 1987) argued that effects of victimisation in battered women are similar or identical to those for posttraumatic stress disorder: learned helplessness, re-experiencing of the trauma, intrusive recollection, generalised anxiety, and social withdrawal. Finally, two apparently opposite emotional responses she described as common: psychic numbing, or reduced responsiveness to the outer world, and general hyperarousal (such as exaggerated startle response). We emphases that exaggerated startle responses are a result of cumulative and on ongoing exposure to the torture by the abuser.

Further, the feeling of inescapable torture may cause an idealisation of the abuser, denial of danger, and suppression of the victim's own anger—similar sequelae found in the prisoners of war (Levy, 2010; van der Kolk et al., 1996; Zepinic, 2019a). In our clinical experience working with battered women who had been brutally and repeatedly exposed to violent trauma, their clinical presentation does not satisfy in full the diagnostic criteria for a diagnosis of PTSD; however, the presence of numbing symptoms, loss of the self-values and a sense of the identity, sleep disturbances (nightmares and/or insomnia), and the loss of trust, the best identify their trauma syndrome. It is our opinion, however, that the clinicians should focus attention on the presented symptomatology (in particular to sexual abuse) of the battered women than matching reported condition to the diagnostic criteria for diagnosis.

There are numerous studies which revealed that survivors of prolonged and repeated trauma (such as in battered women syndrome) suffer complex trauma syndrome. Their general levels of severe distress are higher than those with a simple trauma and they usually score higher than other trauma survivors on the standardised measures of somatisation, dissociation, depression, phobias and fears, interpersonal sensitivity, and depleted sense of self. They experience own self as a self-at-worst state compromised without a safety net or an access to emotional resources. In terms of practical reality and given the complexities in the ways that constant torture and abuse unfolds over time, we assume that the perceived life-threat aspects of the trauma are often of the strongest predictors for the battered woman's suicide.

There are numerous studies about domestic violence upon trauma victim's mental health and prevalence of developed stress-related disorders. Most studies used a retrospective methodology to assess the prevalence of developing stress-related disorders (PTSD, battered women syndrome, dissociative disorders, re-

active attachment disorder, depression) after trauma event(s) is over to assess the presence and duration of the stress-related symptoms. However, there are limited studies which revealed symptomatology of the trauma victims whose trauma is ongoing and it is a continual process (such as in battered women).

Further, it is worthy to note that 6 - 8 out of 10 battered women did not report domestic violence for some reasons: cultural and social stigma, lack of trust by those who deal with a crime of violence, media embarrassment, but the most reason not to report the violence is to avoid re-traumatisation during legal proceedings. In case that domestic violence (battering) takes a legal action, the trauma victim should be interviewed by her defence, prosecutor, police, the court, …altogether, she should usually 5 - 8 times report details about trauma experience to those who are not health professionals; in essence, during the legal proceeding the battered woman is exposed to severe re-traumatisation.

Numerous studies (Foa, Herman, Kilpatrick, Resnick, Rothbaum, Taylor, Young) about raped or sexually abused women report a remarkable similar (60% - 65%) prevalence of stress-related disorders among the trauma victims. Among them, 40% - 45% met criteria for PTSD one year after the trauma event(s) occurred. In our clinical practice, we observed that most female trauma victims reported severe trauma symptoms when time passed for while after the trauma event(s) than in the first month. It is possible that, due to social stigma, raped or battered women tried to withdraw any memory or reminder of the trauma experience. However, as time passed on, the memories of the trauma experience became more present than it was during or short after the trauma is over. It is also common that trauma victims seek medical help due to increased intrusive memories over the time.

The memories of the trauma are recorded and stored in a hierarchal way; those trauma events which do not cause severe disorganisation are recorded in memory system and they are not evident early in life. However, extreme traumatic events will cause memory system to become inactive. Due to the trauma experience, the trauma victim's memory system is organised as a complex of cognitions, emotions, and tendencies to respond (Zepinic, 2008). It is further elaborated that a series of events such as being bullied, ridiculed, humiliated, the victim's experience is stored in memory system which is usually not an ordinary consciousness.

The intrusive memories of trauma event(s) are very common and can be interpreted in a negative way (for example that battered or raped woman is going mad (psychotic), or severe suicidal). Such negative interpretations are important in explaining the maintenance of intrusive memories. It is of particular interest to evaluate the trauma victim's maladaptive control strategies, efforts to supress intrusion, rumination, and dissociation (Zepinic, 2017a). It is common that, in severely traumatised victims of sexual violence, dissociation implies some kind of divided or parallel access to awareness in which two or more mental processes are not associated or integrated—the awareness of the one's emotions (anger, havoc, irritation, rage, hate), or thoughts are diminished and avoided, and one

altered state of the fragmented consciousness exists.

When a battered woman feels threatened by the aggressor, she experiences a significant narrowing of the consciousness, and remains focused on central perceptual details. This narrowing of consciousness sometime seems to evolve into complete amnesia for the traumatic event(s). The word dissociation in trauma victim is utilised to refer to three distinct but related mental phenomenon. Primary dissociation is the fragmented nature of the traumatic memories initially experienced as fragments of the secondary components of the event(s)—as visual images; olfactory, auditory, or kinaesthetic sensations; or intense waves of feelings that a trauma victim usually reports as representations of the element of original trauma. (Zepinic, 2017a) reported that the trauma experience initially came into the consciousness in the form of somatosensory flashbacks experience.

Secondary or peritraumatic dissociation is between observing and experiencing the own self. Many battered or sexually abused women experience depersonalisation, "out-of-body" experience, confusion, disorientation, and altered pain perception, tunnel vision, altered body image, and immediate dissociative experiences. Although the use of "out-of-body" experience and the other peritraumatic dissociative responses at the time of trauma my defend against even more catastrophic state of helplessness and terror, dissociation at the time of trauma is one of the most important risk factors for the one's subsequent development of chronic trauma syndrome (Courtois & Ford, 2009; van der Hart et al., 2006; Zepinic, 2018, 2019a).

Tertiary dissociation is seen as development of dissociative disorder. It has been observed that once trauma victims have learned to dissociate in response to the trauma, they tend to continue to do so in the face of subsequent stress—development of the "survival skills" (Zepinic, 2015). This prevents them from exploring any alternative ways of coping and interferes with a general adaptation. The traumatised victim feels lost, powerless, overwhelmed, and has difficulties with active problem-solving strategies, and consolidates the helpless and a passive social stance (van der Hart et al., 2006). Dissociation allows traumatised victims to maintain their existing schemata and is often seen as a defence against feelings, which may be overwhelming, and engendered by catastrophe (Meares, 2000).

The problem about this view of tertiary dissociation is that the patients who dissociate are more vulnerable to further stress than those who do not dissociate. The episodes of dissociation include fugue states that cause the disturbances of memory and changes in attention span, which (Janet, 1925) called "contraction of the field of consciousness". Janet proposed that intense arousal (vehement emotions) seems to interfere with a proper information processing and the storage of the information into narrative (explicit) memory. Repeated and continual psychological trauma, such as battering or sexual violence, causes an intensity of the emotions up to a point at which the self loses its effectiveness, which (Horowitz, 2001) described as "acute catastrophic stress reaction" characterised

by the panic, a cognitive disorganisation, disorientation, and dissociation.

Due to the repeated ongoing traumatisation, the battered woman may develop deeply unconscious memorised a specific event of beating. When the dissociation as such, then battered woman has the real and firm beliefs of the existence of a fact which is wholly unconscious and out of woman's control run by the inner conflicts. The unconscious drives deliver an intense force if she does act violently towards her abuser, it would be justifiable because it was done out of her control (unconscious).

The victim of repeated traumatisation is then unaware of the inner conflict drives, and not responsible for an act which occurred under, by her, uncontrolled inner impulses. The battered women typically do not suffer from the sort of severe mental disorders, as it is classified under diagnostic manuals—the DSM and the ICD—and in legal proceedings against the battered woman due to the murder or grievous bodily harm, the judiciary requires to sustain defence due to "the defect of reason" caused by disease of the accused's mind.

Most expert's testimony about a battered woman is to evaluate the reasonableness of the person who perceived a danger having a reasonable perception of imminent threat (Zepinic, 2018a). Sometimes the testimony is offered just to explain a typical way of the battered person's perceived danger rather than the specifics of particular accused's state of mind. Before the law, the accused who has been a victim of battering should be evaluated in regards to thinking, feelings, and acting in the context of endangered life as well as the ways of an abuse (violence) and psychological stress which specifically impacted on a person's psychic equilibrium. Subsequent to the level of abuse, the testimony should evaluate reality or reasonableness of an imminent and/or inescapable danger experienced by the trauma victim.

However, despite the expert's testimony it is common that court rejects accused's defence of experience and perception as the battered woman "cannot provide real and convincing evidence of imminently existed danger". Thus, some courts reject evidence submitted that the battered woman fights back taking a risk of being further and more seriously abused, or trying to defend herself or her children from the abuser. Most important is the understanding that the most batterers stalk and killed battered woman when she tried to leave the abusive partner. Women face risks when they leave an abusive partner: they have a 75 percent greater chance of being killed by their batterers than women who stay (Sadock & Sadock, 2003). In case of court proceedings, the expert's testimony requires to explain the battered woman's state of mind at the time of an incident, and it usually reveals that she responded to the repeated abuse and horror in a manner similar to the others who had been repeatedly exposed to different kinds of severe trauma.

One of the most reported difficulties that the battered women report are cognitive disturbances including repetitive intrusive memories with or without the exposure to stimuli that serve reminders, difficulty concentrating, and loss of memory which appears in denial, minimisation, and repression of the battering

incidents. Cognitive confusion, attention deficits and lack of concentration are also reported. Battered women who had experienced the multiple forms of abuse are especially likely to confuse about previous abusive incidents and, when placed in another frightening situation, the woman often experiences the flashback episodes which cause her to re-experience fragments of previous abusive incidents.

These flashback episodes increase battered woman's perceptions of an imminent and inescapable danger (Zepinic, 2021). In such circumstances, the only option is to fight against the source of danger. Due to the perception of inescapable danger, the battered woman is augmented by neurochemical and physical changes becoming extremely hypervigilant to the clues of an imminent danger which she cannot escape, nor delay. It is common that a panic attack and phobic responses are also evident with an inability to control the inner conflict drives (Courtois & Ford, 2009; Dutton & Painter, 1993; Herman, 1992; Panagioty et al., 2009; Zepinic, 2017, 2019a). An obsessive rumination and intrusive thinking along with compulsive behaviour may also be observed in particular when the trauma victim is alone face-to-face with a batterer.

One major action system is defensive in nature and involves a variety of efforts to survive or fight against imminent threat to the integration of one's body and life. Thus, the battered woman's defensive action is associated towards escaping from, and avoidance of physical and psychological impacts. This response could be either in the fight, flight, freeze, or total submission to the aggressor (batterer)—the woman is frightened with her apprehended danger. It is a trauma experience which could divide one's self in two or more dissociative subsystems or parts (Courtois & Ford, 2009; van der Hart et al., 2006; Zepinic, 2017, 2019a).

We emphasised that the traumatic memories are dissociated from the consciousness, and stored as sensory perceptions, obsessional ruminations, or behavioural re-enactments. Thus, the repeated trauma experiences, such as battering or sexual abuse, cause long-term consequences to the trauma victim's personality of which victim is not aware due to the unconscious traumatic memories. These memories include overwhelming anxiety related to intrapsychic events and their elaboration then exceed the trauma victim's ability to cope and to defend.

Studies (Dutton & Painter, 1993; Herman, 1992; Foa & Rothbaum, 1998) reveal that the women who had been sexually abused or repeatedly battered, compared with those who do not report such experience, had been found more depressed and anxious, have lover levels of self-esteem, have higher levels of dissociation, and display more trauma symptoms on global health measures (elevated levels of the obsessive-compulsive symptoms, heightened interpersonal sensitivity, elevated signs of hostility, and paranoid ideation). Such traumatic experience also causes significant difficulties in relationship problems, self-perceptions, and problems with sexuality.

Being exposed to repeated trauma, disrespect and humiliation, the battered

women develop an inability to trust and to love, a broken emotional and/or physical intimacy, fear of being abused, rejected, betrayed, or abandoned, feelings of being misunderstood and overly dependent. Some study findings (Avina & O'Donohue, 2002; Steele et al., 2005) indicate that, compared with the controls, the trauma victim individuals diagnosed with trauma-induced personality disorders reported higher levels of dissociation than those diagnosed with the personality disorders but who had not been exposed to the stress. Traumatic event(s) and memories cause disruption of the self-concept and support prediction of suffering personality disorder seen as consequences of an arrest in a sphere of the self.

One of our patients with suffered battered women syndrome (who had repeatedly been sexually abused) described her feelings as follow:

"I deserve no love nor attention by my family (depleted self-valuation)…I am not able to share intimacy with my abuser and I feel a total failure (self-dislike, failure, loss of sexual desire)…It is hard for me to get interested in anything (loss of interest)…I have totally different kind of feelings and I feel utterly worthless (worthlessness)…I hate myself, and I blame myself for everything bad happened to me (self-criticalness)…I feel tired, depressed, and isolated…I cry over every little thing (fatigue, loss of energy, loss of pleasure)."

It is worthy to note that in ongoing trauma, the traumatic memories are active and distractive upon trauma victim's emotional life, intra and interpersonal functioning. The battered women are filled with emptiness, severe anger, alienation, and they are suffering disturbances in the sense of self and identity. Pervasive sense of emotional emptiness has painful intensity and the trauma victim often takes desperate attempts to "fulfil" emptiness with some "positive stimulus" such as substance abuse, alcoholism, gambling, or even prostitution in order "to punish her abuser". Such women are overwhelmed by fears and anxiety; they experience a sense of alienation, the sense of unreality about surroundings, and their estrangement causes disruption in the sense of well-being, and a loss of warmth and intimacy.

3. Battered Women Syndrome in the Courtroom

It has always been some controversy in using "psychiatric damages" in the courtroom—the chief law objection is that it is entirely inappropriate (in particular in criminal law) to describe the harm for which relief may be had. Even more, some judges have gone so far as to stigmatise the use of such terminology as "misleading and inaccurate" on the proviso that it is understood to refer to the psychiatric illness (or mental health disorders) that result from emotional stress and not the emotional stress itself (Zepinic, 2015a). The first step to developing a modern approach of coherent principle governing the law in this area is to adopt findings which are consistent with modern medical practice and accurately reflects the psychological injury which one's seeks to redress.

The modern law rests on the principle that the person suffers legally recog-

nisable harm—a recognised psychiatric illness (or mental health disorder) resulting from infliction or suffering of distress, outrage and the like. Today is well-known medical fact that severe emotional distress can be the starting point of a lasting disorder of mind. It should be noted that physical symptoms also resulting from severe distress, such as strokes, miscarriages, peptic ulcerations or increased blood pressure, which fall outside the category of recognisable psychiatric illness, and it is conceptually distinct from damage to the mind.

Public awareness of the battered women syndrome is highlighted mostly due to its presence in the courtroom because of charges against the battered woman for a murder or attempted murder of her abuser. The criminal act is usually committed against abusive partner whose behaviour was intolerable or due to an inescapable horror before possible the victim of battering being killed by the abuser. The vast majority of such committed crime is a result of the trauma victim's attempt to protect herself or someone else (usually children). The domestic violence nor spousal killing are not new phenomenon in any society. However, the most records and statistical analysis show that many men killed wives and, also, but less often, it is the wife who killed her husband. Thus, we can only speculate on which of the women who are in jail are there only because she managed to kill abuser before he killed her (Bartal, 1995).

Although it is a trauma-related condition, the battered women syndrome is often used as a legal defence that rests on the justification of the act committed. In essence, killing her abuser for the battered woman was either her own death or goals and, if we believe in the concept of volition, we may say she has chosen the lesser of the available evils. However, if we review the nature of spousal abuse and the abused spouse who committed murder, it is worthy to note that until 2 - 3 decades ago (but it still exists in some society) the battered or abused women have been denied an existence in that she has been hidden from view. In most court proceedings there was no evidence whether the accused women had been a subject of domestic violence, sexual abuse, humiliation, and degradation.

While reading some court files we can found some evidence that, even she repeatedly was beaten and abused, for some judges it was irrelevant and therefore inadmissible to the question of whether the accused had acted voluntarily (instinctively) or intentionally and without lawful excuse. In the courtroom, the battered women syndrome is often called the battered woman self-defence—the defence to demonstrate that those who are living in domestic violence has such major impact upon a woman's psychological condition (state of mind—*mens rea*) that could make an act of homicide or grievous bodily harm. The battered woman could make a violent act which is justifiable—the act when the first look at the facts which do not appear to be traditionally confrontational self-defence.

The most reason why battered women syndrome we consider as the complex trauma syndrome is the circumstances under which the murder or attempted murder occurred considering the accused's mental state at the time when delict was committed. It is a defence which usually requires from the court that the

accused's mental state be examined by an expert in mental health, in particular in area of stress disorders (psychiatrist or clinical psychologist), to provide a medico-legal report in which the expert should deliver whether the accused suffer or not some type of mental health disorder (i.e., dissociative identity disorder, dissociative amnesia, complex trauma syndrome) due to repeated domestic violence, beating, abuse, humiliation, or bullying.

Prior to the introduction of the battered women syndrome in the criminal law (although not being recognised as an independent disorder in the diagnostic manuals) the accused had proceeded on an old defence system (insanity defence). Under stereotypical male behaviour in the courts, the classic situation of wrong behaviour is the scenario of a husband finding his wife of wrong doing; the scenario which very rare will involve an abused (battered) woman who killed husband on defence, unlike she is being found insane.

Most women who committed or attempted murder have been told by their attorney that the act resulting in the partner's death had no defence and were encouraged to plead guilty of the murder. In a small number of cases when the battered woman was given any defence at all, it was usually some form of an insanity defence. However, from the clinical point of view, the battered women syndrome is an unfortunate category used in relation to the woman who has been subjected to prolonged and repetitive abuse by her partner, causing significant impact upon her personality, affects, and cognition.

Any criticism of this condition, as the suffered complex trauma syndrome, cannot be related to simple identification of the problem as a trauma syndrome itself. In some respect, it might be argued that the problem seen in battered women is a microcosm of the wider problems of bias within the principles of the criminal law in general, and criminal defence in particular. For example, in the UK there are 50% more women killed by the violent partners than men killed by the women. The reasons for the sentencing women leave an open dilemma what the law, in general, should do with an abused woman (sexually, physically, psychologically) who killed her abusive partner.

The killing is a response not only to prolonged and ongoing domestic violence but a fearful attempt to avoid future violence. It is to assume that one way of sentencing would be to allow woman's trauma experience to be taken into account when applying the relevant principles. The term battered women syndrome itself may enforce a gender stereotype of seeing abused women as passive victims and is, thus, not without its disadvantages. The point is, however, that such women who killed her batterer did so through her fear whereas provocation to do so requires, in the courts, to provide the evidence of loss of self-control and anger (Loveless, 2012).

Ironically, due to the stereotypical approach allowing the abuser who killed woman a plea of provocation and a lesser sentence, the reality of the battered women's situation is not a matter of the common, or the same, understanding for the courts (juries). In Australian case (*My Chhay* [1994] 72 A.Crim R.1),

Chief Justice Gleeson while discussing the situation that a loss of control can develop as a result a long time after the trauma, he then observed that: "this is an area in which psychiatric evidence may assist juries to develop their understanding beyond the commonplace and the familiar under the law".

Thus, as an immediate resolution of the puzzle is introduction of the expert testimony referring to the battered women syndrome. However, as this syndrome is not a medical diagnosis, the expert report is usually heavily criticised by prosecution as an incomplete report if not saying clear category and diagnosis of the disorder. On the other hand, the court (*R v Emery* [1992] 14 Cr App R 394) accepted that the absence of mental disorder does not mean that someone's mental state at the time of act was normal as repeated abuse (battering) caused a condition of dependent helplessness.

The battered women syndrome itself can be described in various ways but common to them all is the pattern of woman's abusive relationship and the subjection of the woman to abuse or horror which has a psychological impact on her; which cannot be diagnosed in accordance with current diagnostic manuals of mental disorders (DSM-5 and ICD-11). The prosecutor usually relies that the battered woman equipped herself to kill her partner, or although she had not firmly resolved her mind to do so but had prepared herself to do so in the event of continued mistreatment (abuse). Also, one of the problems with the use of battered women syndrome in defence is that the expert's report focuses on a woman's mental health rather than looking at the circumstances surrounding her *automatism* to do an act.

The first English court case to admit evidence of the battered women syndrome was case (*R v Ahluwahlia*, [1992] 4 All E.R. 889 AC), and decision in this case is also important for its implied changes to the "immediacy" requirement of provocation. The court accepted that as delayed, opposed to an immediate loss of self-control, would not necessarily preclude the use of abuser's provocation, albeit, the longer delay, the more likely that provocation would be rejected as a defence of the accused. Further, the court decision in this case was significant to the defence of the battered women syndrome because of its impact upon the *reasonableness* requirement following loss of self-control. Judge Taylor stated:

"The phrase 'sudden and temporary loss of self-control' encapsulates an essential ingredient of the defence of provocation in a clear and readily understandable phrase. It serves to underline that the defence is concerned with the actions of an individual who is not at the moment when he or she acts violently, master of his or her own mind…"

The court in Ahluwahlia case held that the psychological characteristics of the battered women in the form of the expert testimony about the syndrome, is useful for the jury considering the accused's requirements of self-defence and provocation. Thus, to the court it was given the opportunity to consider effects of long-term abuse as it applied to the reasonable person standard. The court decision in Ahluwahlia case admitted that the accused's defences based on the

self-defence and provocation could be used instead of *diminished responsibility* (partial insanity), which were previously not employed owing to the difficulty in conforming to the requirements of the former old defence. Provocation mitigates moral culpability to the extent that a person acted in a less-than-fully-controlled manner in circumstances in which there was reasonable justification for accused to feel aggrieved at the conduct of another (Ormerod, 2011).

Partial insanity (monomania) means one's mental impairment which is not so complete (and could be short and temporary) as to render its victim responsible for the criminal act. The abnormality of mind (which not be a brain disease) must substantially impair mental responsibility of the accused for the act (i.e., reduced powers of control, judgment, or reasoning to a condition that would be considered abnormal by the ordinary person—(*R v Byrne* [1960] 2 QB 396). In Ahluwahlia case, the court recognised (although there is no formal legal defence properly referred to as battered women syndrome) that battered woman suffered a psychological syndrome as a result of prolonged and extreme physical and emotional abuse by her partner.

The self-defence and provocation used as the accused's defence is, in fact, taking into account the circumstances that caused act of murdering a battered woman's abuser. Taking this into account, the accused's defence should not be based on insanity defence (due to serious psychiatric disorder) but her act may be seen as rational, necessary, and reasonable, even unavoidable to the criminal act in particular if threat was addressed to the children as well (Zepinic, 2019, 2019a). The insanity defence (is not guilty by reason of insanity) is a complete defence to a criminal charge because of the accused's mental defect.

According to the rules, the accused battered woman must show that she was suffering from a defect of reason arising out of a disease of mind and the time of committing the act. The accused must also shaw that, as a result of the defect of reason, she either did not know "the nature and quality" of the act, or she did not know that her act was wrong, even if she knew its nature and quality—(*R v Windle*, [1952] 2 QB 826). If the accused is suffering some insane delusion due to her condition (i.e., dissociative disorder, complex trauma syndrome), the court treats her as though the delusion was true and will have defence which if there would normally be one on those facts that she is acting in self-defence—(*R v Falconer*, [1990] HCA 49).

However, it is much easier for the judiciary and others to focus on an eventual woman's psychiatric condition than to focus on circumstances of *causa causans* (the real, proximate, immediate or main cause). This approach allows the Madonna/whore dichotomy to be maintained which assumes that the woman is mad rather than bad. This approach does not threaten male hegemony because the problem is a woman not a society, nor a culture.

One of the leading and pioneered law cases of the buttered women syndrome was *R v Falconer* heard before the Full court of the High Court of Australia. The woman (M.S. Falconer) was convicted before the WA Supreme Court of wilful

murder of her husband. The deceased was killed when the accused fired a shotgun, the blast of which struck the deceased at close quarters. She gave evidence at the trial of the difficulties she had had with her husband during marriage. They had separated as the result of her having discovered from her adult married daughters that, in their earlier years, their father had dealt with them sexually. Just before the shooting, the deceased taunted her in a way which suggested to her that he had had some sexual dealings with their younger girl who had been in her custody.

The case revealed that not only the physical abuse (beating) was taken in the battered woman syndrome case, but also psychological stress (humiliation, betrayal, bullying) may cause significant impact upon the abused woman's personality. As a result, the victim of psychological stress (like in any other case of the stress-related disorder) may suffer a severe defect of reasons which is, by itself, enough to make an act irrational and therefore normally to exclude one's responsibility under the law.

The accused's defence relied on the evidence of two psychiatrists with a view to showing that her conduct was consistent with an act of automatism what means she is not responsible for her husband's death. One psychiatrist giving evidence which allegedly led up to the shooting stated: "I think she could have panicked and that could have been the mechanism which realised the full-blown dissociative state. Where part of her personality would be sort of segmented and not functioning as a whole and she became disrupted in her behaviour, without awareness of what she is doing. In classical major dissociative state person can be acting normally, quietly normally, or purposefully or whatever, so that if there had been witnesses, wherever it happens, they would say: This person appears normal enough to me."

Another psychiatrist reported about automatism saying: "I believe it is possible to act in an automatic fashion without any evidence of internal or external stress. For example, somebody might be sitting listening to your cross-examining and knitting at the same time and may not consciously aware of the stitches they are casting. It is unlikely, though, that they would sit and listen to you cross-examine and unconsciously pull trigger of a gun at the same time."

The psychiatrist further elaborated the accused's psychological stress was insufficient by itself to produce the state known as dissociation: there had to be psychological conflict as well: "I think she was faced with an intolerable dilemma at that moment, that on the one hand it is undeniable that he is, to use her words 'a filthy bastard and yet I love him. Possibly by extension that makes me filthy too'. She is faced with what I would call a psychological conflict. I think it is in that setting of psychological conflict that a person is capable of losing control of mind, of acting—perhaps quite briefly—in an automatic way. I think that her inability to remember what happened next is consistent with that."

In criminal court cases, two principles should be present to find the accused responsible for the act: *mens rea* (criminal mind or intent) and *actus reus* (a state of affairs prohibited by the criminal law and caused by the accused's act). In

criminal trial of the battered woman who killed her partner, the *actus reus* is not in question; otherwise, the accused should not be on trial. However, the *mens rea* is a principle on which accused will be charged or not[2]. In the above stated Australian case, both psychiatrists were of opinion that the accused, at the time when fired a shotgun, was in a state of being unable to control her mind and action. The mental awareness or an intent amounting to guilty mind is a necessary ingredient (beyond a reasonable doubt) in making out nearly all crimes (Zepinic, 2018a).

The battered women syndrome was entered as the legal realm requiring expert testimony at trials of a woman accused of killing her partner. Although the clinicians provide evidence to the courts to show that the woman has been severely traumatised due to repeated domestic violence and horror, the law may translate in the courtroom such clinical findings only as an argument of the self-defence. On the other hand, some courts assert that some women become so demoralised and degraded by the fact of being repeatedly abused and that she cannot predict, nor control, the violence bringing trauma victim into a state of psychological paralysis and being unable to take any action at all to improve or alter the situation. However, in some countries, the battered woman does not have a legal status *per se*, because there is no specific law dealing with this matter.

Hypervigilance, the mental and physical preparation for the attack, is the most disturbing trauma victim's behaviour which invades personality profoundly. The severely traumatised woman appears with a self-defensive responsiveness for acting and for her is no place to complete shed vigilance (Zepinic, 2018a). Exposed to the continuous "real threat" and an ongoing trauma, the battered woman remains mobilised for her (and her children) survival indefinitely without having any comfort. Persistence of the expectation for an unavoidable danger is for battered woman inescapable and imminent terror, without the possibility to make any other response than focusing on "now-moment", as it was during trauma experience in order to survive and defend herself. During this period of dissociative flashbacks, the battered woman is run by the inner conflict drives—the action is out of her control and consciousness.

Many legislatures define imminent as being on the brink of or about to happen inescapable. This is quite important in the expert's testimony because the hypervigilance of the impeding danger and accurately perceived the seriousness of the situation by other person who had not been repeatedly abused and consequently might not recognise danger. Thus, the battered woman may make a "pre-emptive strike" before the abuser has actually inflicted much physical damage, anticipating his next moves which she knows from previous experience. However, such psychological self-defence in regards to an abusive victim's experience and perception of a danger, it is often not, by the court, a legal defence considering that the battered woman cannot provide real and convincing evidence of the imminently existed danger.

[2]*Actus not facit reum nisi mens sit rea* (an act does not make a man guilty of a crime unless his mind also is guilty).

As the battered woman is a subject of the cycle of violence and of the learned helplessness, some critics argue that the syndrome, while being presented in the courtroom by the expert in mental health, may deliver a danger of encouraging court to find battered woman mentally ill, with the consequences that the accused's own psychological condition, rather than underlying domestic violence, will be blamed. This apparent risk that inculpation of woman being mentally ill may result in the strengthening of the stereotype about a woman as "irrational and emotional", and rather mad than bad.

Additionally, considering that the term insanity is not medical but the law definition, if the presumption that women are "irrational and emotional" is accepted by the court, then as a result of the clinician's testimony that the accused had been exposed to repeated trauma causing battered women syndrome, the woman could be put away in a mental institution indefinitely. This old style of the court's finding focuses attention on internal not on external issues of the criminal conduct.

Before the authority of battered women syndrome theory was introduced, female defendants accused of killing their abusers avoided self-defence and instead would argue evidence on the ground of insanity. The relative deficiency of female murders had resulted in a paradigmatically male ideal model of dealing with a murder and this, together with the incompatibility of the idea of aggressive force when related to stereotypical femineity, meant that the apparent gender-neutral concept of *reasonableness* was actually weighted against the female defendant—(*Smith v State*, [1981] GSC 2 47 Ga 612).

Under an old system of defence, some courts in the USA have been so uneasy about finding women's use of a force reasonable that, even in the cases fitted with the traditional model of self-defence, it was for the defendants to introduce evidence of prior severe or life-threatening attacks by the abuser. This request was required by the courts in order that the defender must allow the concept that the women are mad rather than bad—the problem which is exclusively woman's problem and not even evident aggressive behaviour by her abusive partner is a cause. In such situation, the women were, in fact, left to make defence which will make them psychiatric patient who, in order to protect public from a "mad woman", will be sentenced into the psychiatric institution or asylum indefinitely.

Considering that around 85% of all mental disorders appeared in the courts belong to PTSD and other stress-related disorders (including battered women syndrome), since 1980's the courts changed some approaches towards the accused's mental health. Since, the defendants use less defence on insanity but mostly on the automatism—a condition in which activity is carried out without conscious knowledge on the part of the subject. Automatic actions (i.e., in dissociated state of mind) are not directly noticed by the patient: he/she neither feels that he/she wishes to accomplish the action, nor that the action was executed.

However, in (*State v Janes*, [1993] 850 P.2d 495), the USA court permitted the introduction of the battered women syndrome as part of an insanity defence

plea. The trial judge observed:

"If defendant is charged with an offence involving the use of force against and the defendant enters a plea to the charge of not guilty by reason of insanity, the person may introduce expert testimony of the 'battered women syndrome' and expert testimony that the defendant suffered from that syndrome as evidence to establish the requisite impairment of the defendant's reason, at the time of the commission of the offence, that is necessary for a finding that the defendant is not guilty by reason of insanity…

Many courts have found that battered women syndrome is not a mental disease, defect, or illness. Rather the battered women syndrome is considered a form of posttraumatic stress disorder, which is 'an anxiety-related disorder' occurring in response to traumatic event outside the normal range of human experience."

One of the obstacles in the courts for battered women syndrome and other stress-related disorders, is a fact that definition "disease of the mind" is a law not a medical term, nor specific diagnosis, but it is used in the courts as an ordinary sense of the mental faculties of reason, memory and understanding. If the effect of disease (stress syndrome is a disease) is to impair faculties of reason and understanding so severely as to have either of the uncontrolled action, it matters not whether the aetiology of the impairment is organic, or functional, or whether the impairment itself is permanent, or is transient and intermittent. In medicine, there is an important distinction between "disease" and "illness" and disease refers to a definite morbid process having a characteristic train of symptoms or, put in another way, refers to objective physical or psychological pathology. The majority of psychiatric conditions which are potentially a subject of the court proceeding are best regarded as illnesses or disorders.

The most important is to find out that the disease of the mind subsisted at the time of commission of the act when the accused (battered woman) may apply for "not guilty by reason of insanity or automatism". The person's temporary impairment (nor being self-induced by consuming alcohol or drugs) results from some external factors (such as physical assault, torture, or other severe psychological stress) which may cause the trauma victim's dissociate state of mind (Douglas, 1987; Herman, 1992; van der Kolk et al., 1996; Zepinic, 2018a, 2019a). The battered women syndrome is a collection of specific characteristics and effects of domestic abuse upon the woman, and self-destructive behaviour may also be coping response to the inescapable violence.

Clinicians are agreed that the effects of domestic violence and terror, humiliation and sexual abuse, are similar to the other severe (complex) PTSD: learned helplessness, intrusive recollections, generalised anxiety and fears, lowered self-esteem, social withdrawal, and suicidal behaviour. Even more, unlike the other stress-related disorders, the battered women syndrome is not timely resolved; it is ongoing horror which all time "adds oil on the fire". On the other hand, the prosecution's argument that battered woman still "loves a filthy bastard" should be seen throughout process of identification with the aggressor—a well-known

theoretical concept of the psychoanalysis (Freud, Adler, Erikson, Klein, Kohut) within we can find an explanation of how battered women cope a long-term relationship with a potentially lethal other (Zepinic, 2018, 2021).

In early 1990's, many judicial systems broadened the *battered victims* to include battered children who killed abusive parents, battered men who killed homosexual partners (*R v Brown*, [1993] 2 ALL ER 75), battered women who killed their women partners, rape victims who killed their rapists, and even battered roommates. Testimony has also been introduced in cases of child abuse that resulted in the violent man's killing the child (often called "murder by omission" because of the battered woman being unable to protect a child).

The common relation among these cases was acceptance of the psychological knowledge concerning the dynamics of an abusive relationship and thus psychological impact of the accused's state of mind helping to meet the legal standard of the self-defence. The key elements of the self-defence are presence of an imminent and inescapable danger or threat, a reasonable victim's perception, and an equal or a reasonable victim's force to repel serious bodily damages (physical and/or psychological), or death.

However, in many court cases the prosecution used arguments that the accused (battered woman) has had a long-time relationship with the abuser, or even idealised him. Idealisation of the abuser is related to the strength of the continued attachment with the aggressor even after relationship was terminated. Such perceptual responses of self-derogation and idealisation of the abuser could be related to two structural features of the abusive relationships: a power of differential and intermittency of the abuse. Idealisation of the abuser is a victim's defence—the person's needs to merge with, or be close to someone who potentially may make safe and comfortable attachment (Zepinic, 2019a).

In numerous studies and observations in clinical practice, these features have been found to increase the victim's maladaptive attachment to an abusive (aggressive) other. The critical assessment of the battered women syndrome is self-defence due to the existing stressor. A forensic assessment should focus on three main sequelae of the battered woman: the trauma symptoms, self-esteem deficits, and traumatic bonding or paradoxical attachment to the abuser (Avina & O'Donohue, 2002; Douglas, 1987; Zepinic, 2021). Any assessment of battered woman's condition should establish the extent to which factors intercorrelate and thus to constitute battered women syndrome. Confining liability to cases where a wilful act (domestic violence) intended or likely to produce bodily harm and/or impact upon victim's mental health (and psychiatric damages resulted)—the persons who perpetrate acts do not escape liability.

A turning point in the law regarding domestic violence, including battered women syndrome, is consideration of the trauma-victim's psychiatric damages caused by an intentional act. The trauma is a result of the abuser's deliberate wrongdoing wilfully aimed to cause psychological harm (usually also physical) to the woman—that is to say, to infringe her safety, impact upon her personality, with developed feelings of hopelessness and helplessness. That proposition

without any doubt appears to state a good cause of action before repeated act of torture results in murder or severe injuries either upon the abuser or the battered woman. There is no justification alleged for the act and, despite that many courts recognised liability for the intentional shock and psychiatric damage, the problem of battered women syndrome appears mostly when criminal case is brought in the court due to a murder of the batterer by his victim.

While assessing damages to the battered woman, it is evident that domestic violence has been repeated and lasting, the abuser intended and foreseeable likely to make damages upon the woman's psychic equilibrium with the immediate consequences—fright or horror. The gradual extension of this liability, through avenues of the family, is also impact on children's psychological developments which is severely disturbed by domestic violence. Nowhere is the importance of this secondary (sometimes even primary) psychiatric damage victims stated in criminal courts. However, the acts of intentional violence are prone to cause damages not only on the primary victim (battered woman) but also on the secondary victims (traumatised children) who are often used by the abuser to silent primary victim to take any legal action against the abuser.

The primary victim (battered woman) is usually assaulted (even sexually) in the presence of her children who witness domestic violence. In clinical practice, it is evident that complex trauma syndrome is mostly developed as a result of the childhood trauma (Courtois & Ford, 2009; Herman, 1992; van der Kolk et al., 1996; Zepinic, 2019a). Where there are multiple acts of violence (what is common in battered women syndrome) there are likely to be many victims. In each case, the children are witnesses of the violence and it should be irrelevant to the courts whether abuser has or has not an intention to cause psychiatric damages upon children—the damages were inevitable and occurred.

For the courts, the potential of multiple claims for psychiatric injuries is as great, if not greater, in situation when battering occurs in front of the children. Needless to say, in an intentional act of violence the abuser is liable, not only for the injury (either physical or psychological, but usually both) caused directly to his victim, but for injury indirectly caused to those connected with his victim or those witnessing the injury to the victim. In any case, it is common sense to take into account that battered woman is most at risk of serious injury or even homicide when she attempts to leave an abusive partner, and it may take her a long time before she can finally do so. However, because of fear of what would happen to her children some battered women stay with abusive partner, and circumstances of repeated and prolonged abuse may cause *automatism* (an act without conscious thought) to protect herself and her children from the violence.

4. Conclusion

Domestic violence or abuse is not a new phenomenon—it is a problem historically evident and still widely existing. The *Battered Women Syndrome* is not an independent diagnostic entity (neither in the DSM-5 or the ICD-11), nor it is a

simple stress-related disorder. The problem of classification, in case of a transient person's malfunction of the severely traumatised patient's mind precipitated by the complex psychological trauma (such as battered women syndrome) lies in the difficulty while choosing between the reciprocal factors—the trauma and natural susceptibility of the mind to affection by the trauma—as the cause of the trauma victim's suffered disorder(s) and malfunction.

The aspect of domestic violence (and battered women syndrome itself) has been recognised as a severe problem mostly because of cultural emphasis on equal rights, but the problem itself is long-standing. The abuser's aggression is designed to humiliate, disrespect, and violate women to the levels of nihilation, worthlessness, and uselessness. Although being a subject of everyday abuse, many battered women very rare volunteer any information of domestic violence due to fear that the abuser will be even more aggressive; however, the most reason why this severe problem stays unreported, or report is minimised, is a fear for the victim's children safe. In clinical practice, the most important determinants of risk are the woman's level of fear and her appraisal of imminent and future safety.

Equally having dilemmas in medicine about classification, the law even has more headaches while having the battered woman in the courtroom accused of a murder, or attempted murder, or grievous bodily harm upon her batterer. The law shall postulate a standard of mental strength, in face of a given level of the psychological trauma, and one's capability of protecting the mind from malfunction to the extend prescribed in the respective definition of responsiveness, and the person's mental (in)capacity to know the wrongfulness of the conduct (defence) with the respect to the specific act with which the person is charged (Bartal, 1995; Douglas, 1987; Zepinic, 2019a). A standard must be the standard of the ordinary person: if the mind's strength is below that standard, the mind is infirm; if it is of or above that standard, the mind is sound or sane (Zepinic, 2019b).

The battered woman is exposed to the prolonged and repeated ongoing trauma experiences which cause disruption of her identity characterised by distinct personality traits. The clinical features involve marked discontinuity in sense of the own self and a sense of the agency, often accompanied by related alterations in affect, behaviour, consciousness, intra and interpersonal relationships, and sensory-motor functioning. The law recognised (i.e., *R v Ahluwahlia*; *R v Falconer*; *State v Janes*) that the battered women syndrome as posttraumatic stress disorder may amount to an abnormality of mind in the victim of domestic violence.

In the case of battered women syndrome, we can find that woman's traumatised personality is characterised as (1) unbidden intrusion into awareness and behaviour, with accompanying losses of self-wholeness and continuity (i.e., "positive" dissociative symptoms such as fragmentation of the identity, derealisation, depersonalisation); and (2) inability to access information or to central mental functions that normally are readily amenable to access or control (i.e.,

"negative" dissociative symptoms such as amnesias or fugue) (Zepinic, 2021). In most cases the battered women's behaviour is an automatism—a condition in which activity is carried out without conscious knowledge and not directly noticed by the woman herself.

It is usually being found that, as the aftermaths of severe trauma, the dissociative symptoms potentially disrupt every area of one's psychological functioning: a normal integration of the consciousness, memory, cognition, identity, emotions, perceptions, bodily representation, motor control, and behaviour (Janet, 1925; Silverstein, 2007; van der Hart et al., 2006; Zepinic, 2017, 2019a). Due to the severe traumatisation (battered woman experiences repeated and ongoing torture), the dissociative parts of one's personality are dysfunctional enduring in their functions and actions making a person's dysfunctional self-state.

Clinicians (Avina & O'Donohue, 2002; Courtois & Ford, 2009; Foa & Rothbaum, 1998; Herman, 1992; van der Kolk et al., 1996; Wilson & Drozdek, 2004; Zepinic, 2008, 2011, 2017) are of opinion that the dysfunctional self-state is strongly associated with unconscious traumatic memories; they may primarily be mediated by the trauma victim's action systems of the defence against the aggressor. Re-enactments include action tendencies of defence against perceived or actual *imminent* and *inescapable* threats to the victim's integrity of the body and the self, as well as action tendencies to achieve an attachment and fears of attachment loss. The battered woman's emotions and thoughts are actually fixed within the traumatic memories which frequently revoke experiences of physical, emotional, or sexual abuse, humiliation and degradation, emotional neglect, and frightening circumstances (Zepinic, 2019a).

Such dissociated self-state is mediated by the inner action systems (drives) of the defence against the threat which guides battered women into flight, freeze, submission, or extreme hypervigilance. However, despite being aware of disordered personality due to the repeated violence and horror, most battered women pretend that they are in a "normal shape" because of *learned helplessness*, and in an attempt to protect children or themselves from even more violence and abuse by the abusive partner. As the conduct of domestic violence is so outrageous in character and so extreme in degree, as to go beyond all possible bounds of decency and is utterly intolerable in a civilised society, the abuser's liability must exist. The distress inflicted upon the battered woman is usually so severe that no reasonable man could be expected to endure it.

The law accepted that repeatedly abused (battered) women sustained psychological damages resulting in battered women syndrome: a form of posttraumatic stress disorder leading to a condition of learned helplessness, low self-esteem, anxiety, depression, fear, and isolation (Loveless, 2012; Ormerod, 2011). The killing abusive partner is a response to repeated and continual domestic violence and torture, but also a fearful attempt to avoid future violence or an action to protect children from the abuser. The appropriate defence for the battered woman would be self-defence due to the imminent and unavoidable danger. However, in most court cases this is unavailable unless the killing or grievous

bodily harm were a reasonable response to the imminent threat and evident loss of control at the time of the performed act.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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