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Battered Woman Syndrome: The Iceberg of Domestic Violence

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Abstract

As per its definition, Battered Woman Syndrome (BWS) is an unfortunate clinical condition related to woman's prolonged and repeated exposure to the domestic violence. Most of the battered women do not ask for help (neither legal protection or therapy due to sustained psychological trauma) because of the children's safety, and/or unsupportive legal and community services. Sadly, but vast majority of severe domestic violence became highlighted in the courtroom; however, not because of the batterer's abuse and battery (which often include children) but because that battered woman is accused of killing her partner or caused grievous body injuries to him.

Keywords

Battery, Violence, Torture, Liability, Complex Trauma Syndrome

1. Introduction

As psychological trauma, Battered Woman Syndrome (BWS) for the first time was introduced by the USA psychologist Walker (Walker, 1978) as a syndrome of the *learned helplessness* which woman experienced as an aftermath of the repeated and prolonged violence by the batterer. The *learned helplessness* is a theory which suggests that the randomness and apparent unavoidability of a woman's beatings led her to accept it is "reasonable" and she develops number of common characteristics, such as low self-esteem, self-blame for the violence, anxiety, fear, depression, general suspiciousness and the belief that only she can change her predicament (McPherson, 2019). Although the BWS existed and was present in the courtroom a long before being introduced in clinical practice, the law adopted that "battery occurs when physical force is *inflicted* upon the victim" with no need for the victim to *apprehend* violence (Loveless, 2012).

The law also defines that "battery is any contact by which person A, intentionally or recklessly, inflicts unlawful personal violence upon person B" (Ormerod, 2011). The major obstacle with this definition is used word *unlawful* giving a room for an existence of the *lawful* violence? Thus, the law accepts that cannot draw line between different degrees of the violence, and therefore prohibits that first and lowest stage of it; every man's person is sacred, and no other has a right to meddle with it, in any the slightest manner. In some respects, the problems faced by battered woman are wider problems within the principles of the criminal law in general (criminal defences in particular), and society in general (such as gender, culture, race, politics, social structure, etc.).

Thus, the label and the identification of the BWS by the law unfortunately are not discussed in this paper. This is not surprising given that the law principles of battering are, often, exclusively related to the proceedings against battered woman who committed an assault against her batterer in order to defend herself, and/or her children. Notwithstanding the reservation to employ *battered woman syndrome* in this paper generates up an image which we are familiar and thus provides us with a common starting place from which we can construct this problem before being brought in the courtroom.

Certainly, domestic violence is not a new phenomenon, nor spousal killing; historical records show that many men killed their wives and, also but less often, it is the wife who killed her husband. Due to the fear of social stigma, domestic violence could be hidden from the public eye for a long time but could have serious health consequences for the individual, family, and society—physical and psychological forms of domestic violence and abuse in male-female intimate relationship (Rakovec-Felser, 2014). However, most statistical analysis of the women sentenced for killing husbands revealed that they are in the jail only because she managed to kill him before he would kill her. For many, it is either their own death or goal and if we believe in the concept of volition, then we may say that they (women) select the lesser of the available evils (Zepinic, 2021b).

While sketching the picture of the domestic violence and the abused spouse who kills, it is evident that the abused woman has been denied of being subjected to an abuse by her dead partner. Reading judgments closely, it is only evidenced in the medico-legal reports that she was battered but often courts are unmoved by the reports. Historically, the background of abuse was regarded as irrelevant and therefore inadmissible to the question of whether the woman had acted voluntarily and intentionally, and without lawful excuse (Bartal, 1998).

Evidently, the BWS has been differently treated in the medicine and the law; in medicine, this syndrome is considered as an aftermath of the woman's multiple and repeated victimisation by her partner's violence (physical, sexual, psychological) which often resulted in developed *learned helplessness*. However, the medicine was short to classify BWS as an independent diagnostic entity and this syndrome is left within diagnosis of PTSD. For battered woman, the violence is a universal method of terror (abuse) and it is based upon systematic and repetitive long-term infliction of psychological trauma (often with severe physical injuries)

designed to install helplessness and to destroy the victim's sense of self.

Clinicians are united that repeated traumatic experience has impact upon all structures of the self; one's image of the body, the internalised images of the others, and one's values and ideals. Such traumatic experience often leads to a sense that the self-coherence and one's self-continuity is systematically broken down. Zepinic (2021b) is of opinion that vulnerable self-structure of severely traumatised individuals is evident in the following ways:

1) Difficulties in self-regulation, such as self-maintenance, affect tolerance, and the sense of self-continuity, or sense of one's personal agency. Such difficulties with self-regulation are the "developmental 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 physical integrity; and

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

Walker (2017) recognised that the BWS is identified with seven factors: 1) re-experiencing the trauma events intrusively; 2) high levels of arousal and anxiety; 3) high levels of avoidance and numbing of the emotions; 4) cognitive difficulties; 5) disruption in interpersonal relationships; 6) physical health and body image problems: and 7) sexual and intimacy issues. Due to the repeated and long-term trauma experiences, the battered woman has developed *learned helplessness* with depleted ability to predict that any action to protect from the trauma will deliver any result. Instead, the battered woman chooses responses how to reduce the pain from battering. The battered woman's perception of external danger is authentic and became even more concrete over time.

However, the BWS temporally and regionally has not always been well understood by the law—or has sometimes been simply ignored—it nevertheless is the case that every culture has a concept of the relatedness between intimate partners. The notions of violence (abuse) and obligations between intimate partners is often different between cultures, or even between courts of the same culture—this contributes to the more complex understanding of the BWS. Domestic violence which consequences affect quality of life not only of both participants (intimate partners) but also their children and enters in schools, police, health and social services, and in criminal justice system.

Legal problem with domestic violence is also public widespread belief which draws attention for a rethinking about stereotypes that partner violence (abuse) is an almost uniquely male and that when men assault their partner, it is primary dominate women, whereas violence, perpetrated by woman is always an act of self-defence or a response to male dominance and cruelty. It is suggested that such limitations in mind known also as gender paradigm, should be replaced (Rakovec-Felser, 2014). Some researchers (Hamel & Nicholls, 2007) suggest that only 1% - 2% of men who are assaulted by their female partner report the abuse to the police, although the men can also be in distress suffered from violence.

2. Domestic Violence: A Dilemma Faced by Court

Historically we have a pervasive problem involving the abuse of women who are trapped in violent relationships. Domestic violence is best described as a pattern of abusive behaviour (psychical and/or psychological) which is exhibited by one person to the intimate partner. As domestic violence often includes physical and aggressive behaviour, the term itself broadly encompasses emotional, sexual, and economic abuse as well as coercion, threat, isolation, and intimidation. It is undisputed that domestic violence has a profound impact on the person against whom the abuse is directed. However, in many cases of domestic violence against intimate partner it is neglected consideration of the implications the abuse has on children present at home.

It must be noted that the general public often has misconception of domestic violence and fails to understand why women choose to stay in a violent relationship. Walker (2017) conducted a study of several hundred battering incidents and found that in two-third of the cases was a cycle of repeated violence for a while. She found that violent relationship occurs within three phases: 1) the tension-building phase; 2) the acute battering incidents; and 3) the tranquil phase (honeymoon phase). It is evident that intimate partnership abuse can be found in all relationships, both same-sex and heterosexual. However, the main majority of it is perpetrated by men against women and makes because of its frequency and severity a large problem in public health term.

In tension-building phase only minor battering occurs (verbal abuse or slapping) in which the woman attempts to calm her abuser down. However, the abuse worsens during time and the cycle progresses. The verbal abuse and physical abuse became more intense during the second phase—the violence is more violent and often results in more severe injuries. During second phase, the battered woman has no control, she is unable to reason with her batterer and all her attempt to calm down batterer's violence likely fails. During tranquil phase, the abuser may remorse and begin to act loving and behaves gentle towards the victim of violence (abuse). The batterer often begs partner for her forgiveness and promises to never lay a hand on her again. This abuser's behaviour is often welcomed by the battered woman as she wants to believe that the abuser can change and she tries to convince herself that he will.

During the tranquil phase, the battered woman is often tells herself that this good man is the man she was blessed to marry or fell in love with him, or still loves him. In *Falconer* case about battered woman who was accused of killing her husband, the forensic psychiatrist in medico-legal reports provided: "*I think she was faced with an intolerable dilemma at the 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 was faced with what I would call a psychological conflict*."

Without doubt, the BWS is most often used in criminal cases where a woman is on trial due to killing or grievously injuring her intimate partner. In such case,

for her defence the battered woman should introduce that she was a victim of domestic violence and that the partner has been her abuser. From the criminal cases analyzed, the biggest problem for the battered woman to defend her case is when she killed or injured her intimate partner while he was asleep, or when she was under an immediate threat of attack. In most such cases, the prosecutor presents premediated condition of the accused to kill or injury the batterer. In these cases, it is common that the court does not afford the woman's claim of self-defence because the immediacy element was missing. However, the cases when woman killed or injured her batterer while he was attacking her are simpler because the defendant would likely assert of the self-defence.

The BWS was not admitted in the English court until *Ahluwalia* case. In this court case, the woman was accused of killing her husband after prolonged serious domestic violence and humiliation. Despite receiving two injunctions he continued to assault her, threaten her with weapons, attempted to strangle her and to run her over. On the night in question he held a hot iron to her face threatening to burn her. That night, she pored petrol over him whilst he was in bed asleep and ignited it. The accused then left the house and husband died six days later. After being convicted she appealed to the Court of Appeal which ruled out any judicial attempt to redefine provocation, stating that such a task should be left to legislature's discretion to change the law, not the court's. While delivering judgment, Taylor LCJ stated that: "*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 recognised that BWS was a form of diminished responsibility and to the extent, the decision was in benefit for the accused woman. The *Ahluwalia* decision was important for recognition of the court's admission of the "reasonableness" requirement (immediate loss of self-control) and "immediacy" of provocation. Granting these requirements, the court upheld that the psychological characteristics of a battered woman in the form of expert testimony of the BWS could be useful in court proceedings considering the requirements of self-defence and provocation. Thus, the court was now given to consider the effects of long-term abuse as it is applied to the reasonable person standard.

Another effect of the *Ahluwalia* case was that the defence on self-defence and provocation could be used instead of *diminished responsibility* which had not previously been employed as the requirement of the defence. The decision indicates that within the judiciary there is sympathy for, although perhaps not complete understanding of, the abused woman who faces trial, having reached the situation where is no longer acceptable to hold the judge to face with a dilemma about the abused woman who is on trial. The court realizes that there is little point in sentencing the abused woman to imprisonment for a long period, or perhaps at all. Sentencing the abused woman for killing or manslaughter upon her abuser is powerful conflicting consideration. On one hand is no danger of

the commission of similar offences by the other prisoners, and crimes of passion are not deterred by the punishment of those who are convicted.

In many court cases, the judges faced with dilemma of what is appropriate as a punishment for the killing or manslaughter for the abused woman (Bartal, 1998). On the other, the court should not be seen as condoning violence, when the passions have exploded and a person acting without self-control, as a solution and the court must be seen to uphold the sanctity of human life. Thus, court should express through the imposition of appropriate sentences the seriousness of which the society regards violence which destroys human life, and must to deter others from embarking upon violent behaviour which may have fatal consequences.

Even in severe battered woman syndrome, the court upholds its position that there is not right to take the life of a person because their conduct is outrageous and despicable. Thus, the court leans towards the batterer's right for life who, on the other hand, did not care at all about the battered woman's life while seriously torturing her (physically and psychologically), frequently and extensively?! What are implications of not allowing the issue of self-defence by a person (battered woman) being tortured by her batterer? Analysing cases of the accused battered women it is clear an acquittal might amount the acceptance of self-help and that this would go against well-established principle of the sanctity of human life.

Certainly, there are undeniable contradictory considerations and, also, conflicting interest operation for the battered women. It is clear using term of *self-help* instead of *self-defence* illustrates the wider problem which, whilst the judiciary is undeniably becoming much more understanding of and more sympathetic towards, the problem faced by battered women is that they have not reached a position of sympathy. As such, it is question what of the message is to the batterer who may be seen as killing his spouse's personality by the repeated installments of violence? Does the message become one which states that a woman has the same right as a man to act in self-defence and that the abuser should continue to act on peril of exercising her right?

In case of accused battered woman for killing or manslaughter, the court's point of view is to consider the imminence, proportionality, and lawfulness of the threat by her batterer. It is common ground that the issue involved in delivering judgment (either by the trial judge or the jury) is whether the woman's acting was occasioned by the real threat, bodily harm, or provocation that no reasonable person could be expected to foresee. It has been held that bodily harm is not limited to physical injury; it includes psychiatric injury too. While physical injury is within the ordinary experience of a jury, psychiatric injury is not; so, if the prosecution wishes to rely on it, they must call expert evidence to prove that the alleged condition amounts to psychiatric injury (Ormerod, 2011).

The doctrine of self-defence before courts traditionally applied to situations involving persons of equal physical force. The battered woman may perceive danger and imminence differently from man, and her perceptions of using force very unlikely will conform to the traditional concept of self-defence. Be-

cause the batterer is someone with whom battered woman has an intimate relationship and a pattern of battering, she is particularly attuned to signs of danger—reasonableness of her perception of an imminent and lethal threat to her life such as would justify the use of a deadly force. These factors, however, have not usually been considered during the trial. Thus, the key to the woman's self-defence, lies in the definition of what perceptions are reasonable for a female victim of violence (Hudsmith, 1987).

When the defendant is a battered woman, the very intimacy of the relationship explains the reasonableness of her perception of a danger. The battered woman learns to recognise even small signs that precede periods of the escalated violence; she learns to distinguish subtle changes in tone of voice, facial expression, and forthcoming levels of danger. Due to her intimate relationship with the batterer, she is in a position to know, with greater certainty than someone attacked by a stranger, that the batterer's threat is real and will be acted upon. When a battered woman does fight back and uses deadly force, she typically does so because she perceived the violent assault as somehow different from the ones before.

The law on self-defence requires that the person attacked must believe that he/she is in imminent danger of losing his/her life or receiving serious personal injury, and that the belief is a reasonable one. Because of the non-traditional nature of the battered woman's use of deadly force, the reasonableness of her perceptions of danger and imminence may not be fulfilled apparent requirements. Expert testimony is often necessary, or mandatory, to explain the complexity of the violent relationship and the effects of the battering which made woman's perceptions of danger. The expert testimony would help the court (trial judge or the jury) to elucidate haw a bettering relationship generates different, but entirely reasonable, perceptions of danger, imminence, and necessary force.

The expert testimony also helps to defeat the myths and/or judge's dilemma related to the battered woman—why this woman stayed in violent relationship, why she did not seek any help from police or friends, or why she feared increased violence? On the other hand, the trial judge or jury should bear in mind that battered woman is a victim of physical, psychological, and/or sexual abuse prolonged in nature: a force inflicted upon her. The testimony can be used to counter assumptions that battered woman stayed in the abusive relationship and did not seek any help because the abuse was not serious or, perhaps, she enjoyed it, or that she unreasonably feared repeated or escalated abuse.

In essence, the expert testimony should explain that the battered woman's response to the danger did not develop and cannot be understood in a nothingness. Rather, her response was outcome by the passivity in which woman has been trained; she did not leave her husband, seek help, or fight back, and was behaving according to the societal expectations (*learned helplessness*). The expert testimony about the battered woman syndrome allows the courts to judge defendant on all the facts of the case and more accurately determine her claim of self-defence (Zepinic, 2022).

As battered women suffer significant changes on their personality: cognitive, emotional, and social disturbances, it is common that while facing terror they react in dissociative state of mind. In the joint cases *T v United Kingdom* and *V v United Kingdom*, the medico-legal expert found that the accused suffered from severe PTSD effects, extreme distress and guilt that made them very difficult to think or talk about the event before the court. Expert reports in *Ahluwalia* and *Falconer* cases revealed that battered women's defence against battering was under impaired consciousness. During the time of 20th century, the courts of English Law began to adopt a restricted approach to the sorts of mental condition which could rise to defence of impaired consciousness. The key decision was delivered in *Savage* case, and then a major change to the judicial approach to diminished responsibility was delivered in the *Galbraith* case.

3. Battered Woman's Disturbances of Consciousness

Disturbances of consciousness, as an altered state of one's self-awareness, has been well-known in medicine: apperception is perception modified by an individual's own emotions and thoughts, sensorium in the state of social dysfunction, incomplete clear-mindedness with disturbances in attitudes, unawareness of surroundings, restless and confused reaction associated with fear, dreamlike state of mind, impaired sense of self, the disturbances in environmental stimuli, hypervigilance, and disturbances in cognitive functions. Janet (1907) defined term *consciousness* as one's awareness of internal and external stimuli. Alterations (disturbances) of the consciousness are pathological when they are excessive, frequent, inflexible, and cannot be consciously controlled by a person.

We are of opinion that disturbances of consciousness are the most recognisable in the area of sense of self. When individual experiences disturbances of consciousness, his/her sense of self remains unstable and inconsistent, confused and altered across time and surroundings ("*I'm not a person. I'm nothing*"), or being fixed ("*I'm not real, I don't feel anything*"). It should be noted, however, that disturbances of consciousness affect one's personality and sense of self wider than dissociation. The attentional focus of dissociative parts of personality is well restricted by the limited range of the action systems (i.e., focusing on daily functioning) which often avoid attention on traumatic reminders—a cause of disturbances of consciousness.

The clinicians (Briere & Spinazzola, 2009; Courtois & Ford, 2009; McPherson, 2019; Wilson & Drozdek, 2004; Zepinic, 2016) are agree that severe and/or repeated psychological trauma is associated with adverse, complex, and enduring sequelae of disturbances of consciousness. The loss of coherent sense of self and capacity for relational engagement are unavoidable and these self-regulatory impairments Herman (1992), van der Kolk et al. (1996) and Zepinic (2011) called complex PTSD. Herman (1992) is of opinion that severe stressful experience (such as repeated battering, sexual and physical abuse) causes alteration of self-regulation and psychological functioning: 1) affect and impulse regulation;

2) somatic self-regulation; 3) consciousness; 4) perception of perpetrator; 5) self-perception; 6) relationships; and 7) systems of meaning.

In theory, it is simple to distinguish between symptoms of dissociation and pathological levels of conscious awareness (disturbances of consciousness): the dissociation involves division of the personality and the disturbances of consciousness do not. However, these phenomena are easily confused because they often occur simultaneously in those individuals who are the victims of severe (complex) psychological trauma. In addition, some forms of the disturbances of consciousness are often phenomenologically similar to the dissociative symptoms. It often requires careful observations to discern the difference between manifestation of dissociation and an alteration of the consciousness. Severe alteration in the consciousness usually occur during traumatic experience and these phenomena may, or may not, be related to the development of dissociation (Zepinic, 2021a).

Hyperalertness and hyperarousal during a traumatic experience (i.e., battering, sexual abuse) may exhaust the individual and bring a significant drop in the level of consciousness. Even an extreme level of consciousness (i.e., to the level of unconsciousness) may be an extreme retraction of the consciousness so that includes nothing but traumatic experience. The person whole field of attention is occupied by memory of the traumatic event(s) causing the mimicry of unconsciousness. Many survivors of severe traumatic experience (i.e., POW, brutal rape, severe violence) report that they experienced a severe drop of consciousness in the immediate wake of trauma episodes. They report of hiding under the blankets or other "safe places" describing themselves as unable to think, unable to concentrate, and sinking in the darkness, or closing off from own body.

In case of court proceedings, such individuals often have limited recollection of the traumatic event(s) with severe disturbances of consciousness related to the particular event(s). Certain jurisdictions have allowed the defence of diminished capacity or diminished responsibility due to disturbances of consciousness of battered woman. The criteria for a verdict of diminished capacity require that the accused has an underlying condition, an abnormality of mental functioning, that substantially impairs her ability for rational judgment, understanding of her actions, and self-control.

DSM-5 (APA, 2013) defines impaired consciousness (diminished responsibility or diminished rationality) as: "*syndrome characterised by clinically significant disturbances in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, and developmental processes underlying mental functioning*". Thus, this definition clear ruled out diminished responsibility caused by many other reasons than being part of the mental disorder: from the head injury, because of drugs abuse or alcohol consumption, hypoglycaemia, epilepsy or convulsions, or a broad range of the genetic factors (Zepinic, 2019).

Many individuals accused for wrongdoing have some mental abnormalities (i.e., psychopathic personality) which compromise their rationality; however,

they are criminally responsible for their actions because the lack of capacity for rationality not sufficiently detached them from reality. However, the battered person, when facing another terror and abuse, may experience *blackout* (loss of consciousness and rationality) or *clouding of consciousness*. In such situation, the victim of torture and abuse suffers lowering of consciousness with reduced awareness using only an automatism to protect herself.

Automatism is a condition in which battered woman's activity is carried out without conscious knowledge of the part of the action. The court should not make "psychological error" not taking into consideration the *clouding of consciousness* which had significantly compromised accused's rationality while defending herself from a danger. Legal solution is not to widen the insanity defence but to accept in the courtroom circumstances which caused impaired consciousness. Although the diminished responsibility can in principle be fully considered in trail, it is a matter of discretion; however, in many cases the courts do not consider reduced rationality in favour for the accused.

Finding red line between the insanity defence and defence on impaired consciousness is quite difficult. In both matters, the accused should provide medical evidence of the impaired condition in order to convince the court (either a trial judge or jury) on the *balance of probabilities*. However, under interpretation of the common law, the motion of diminished responsibility is left wholly to the judges, and medical evidence must relate to the state of mind at the time when the offence was committed. In case of defence on the impaired consciousness, the court may, for example, reduce murder to manslaughter (culpable homicide); however, as the penalty is fixed by law, the court may impose any sentence from the life imprisonment to absolute discharge, or may, if the required evidence is forthcoming, make a hospital order with or without restrictions, or discharge accused.

4. Is the BWS the Complex Trauma Syndrome?

From the medical point of view, BWS is an outcome of domestic violence characterised by willful intimidation, physical and/or sexual assault—a systematic pattern of power and control by intimate partner against another. It includes physical violence, sexual violence, financial abuse, threats, and emotional or psychological abuse (Karakasidou & Stalikas, 2017). The victims of abuse have developed a sense of shame, social isolation, emotional injuries, and their emotional entrapment increases depression and anxiety. Their self-esteem significantly decreased with a sense of lost self-coherence and self-continuity.

Being exposed to repeated abuse and violence (often on daily basis), the impact upon the woman's personality became a chronic in nature with evident difficulties to cope in everyday life. The level of the abused woman's chronic trauma syndrome is related to severity and intensity of abuse and violence, and her vulnerability. Defining complex trauma syndrome is difficult and complex, as well as the traumatic events themselves. However, we might allow any stressor to

count as traumatic if it terrifies the person and repeated battering is itself severe traumatic event. To explain the symptoms of complex trauma syndrome in a battered woman, it is important to take into accounts that a person is exposed to a life-threatening situation which become conditioned to a wide variety of the abuse and constant threat, fear, and anxiety to survive (McNally, 2003; Zepinic, 2016).

Zepinic (2011) defines complex trauma as involving traumatic events that are: 1) repetitive and prolonged; 2) have involved direct harm and/or direct threat to the trauma victim; 3) occur at a vulnerable time in the victim's life; and 4) have a severe impact upon the victim's entire life and personality, causing social, emotional, and cognitive dysfunctions. The victim's characteristic responses to severe traumatic events are thoughts, nightmares, emotional reactions, and recollections of the event(s) as a subsequent aftermath of trauma impact.

However, in clinical practice (as well as in the courtroom) the victims are often not able to recall traumatic event(s) completely and their memories about traumatic experience could be partial. There are two reasons for this phenomenon: 1) traumatic event(s) was so aversive that a person attempts to avoid engaging with the traumatic memories of the event(s) for any prolonged period, and 2) the trauma victims are ashamed enough about traumatic past to expose themselves to the upsetting event(s) discussing with others. Many clinicians reported that trauma victims expressed more emotions and trauma recollections long after the traumatic event(s) than immediately following the event(s).

This phenomenon is particularly evident with victims who have been exposed to actual or threatened death or serious injury. Such patients usually show psychopathology beyond the DSM-5 or ICD-11 diagnostic criteria for PTSD. Well-know triad of PTSD, numbing/avoidance, hyperarousal, and intrusion, do not include all features of symptomatology evident in severely traumatised individuals.

The secure sense of connection is the fundamental of one's normal self-coherence and self-continuity but due to severe trauma experience such connection is shattered; the trauma victim loses basic sense of the self. Even more, such traumatised individual (in particular when event(s) is repeated and with an extreme exposure) struggles with autonomy, competence, identity, and intimacy. It is well-known that severe trauma is an unpredictable experience which could change all structures of the personality wholeness and its impact is an open-ended matter. For those who had experienced either prolonged or repeated traumatisation (in battered women both types of traumatisation are evident at the same time) the life is almost not worth living.

Battered woman's life is usually affected in almost all areas of her functioning: daily living, relationship to the own self, relationship with others, including the intra-psychic conflicts and coping mechanisms. Severely traumatised woman suffers psychological pain related to the horrible traumatic memories which overwhelm her capacities to cope and to be a *person* which is often in dissocia-

tive state (Zepinic, 2021b). The lack of theoretical clarity regarding the effects of severe repeated trauma makes a coherent diagnostic taxonomy quite difficult to be achieved; in particular in the courtroom.

In the courts of English Law, it is broadly accepted reformulated plea of the diminished responsibility delivered in the *Galbraith* case: 1) the plea must be based on a condition of the accused at the time of the offence; 2) the condition must be an abnormality of mind which had to the effect that the accused's ability to determine or control his/her conduct was substantially impaired; 3) the condition need not to be one "bordering" on insanity; and 4) the condition must be one which can be spoken to by expert in the appropriate science. The criteria established in the *Galbraith* case received positive response from medicine with a notion that mental abnormalities and dissociative state could well impair an accused's ability to determine or control his/her acts and omissions. Certainly, repeated and severe battering, sexual or other abuse, inevitable cause some recognised abnormalities of the victim's self.

Any definition of complex trauma syndrome (such as the battered woman syndrome is itself) should, at the very least, address the findings of its specific and complex nature, severity, comorbidity, and symptomatology. There is without doubt agreement between clinicians that prolonged and repetitive trauma causes severe trauma-related disorders (PTSD, depression, personality disorder, dissociative disorder, etc.). To elaborate and formulate trauma-related syndrome (particularly for a legal purpose), it is important to consider how much exposition to a life-threatening situations had been upon a trauma victim and variety of stimuli that were present during traumatic experiences. Those who have been exposed to a life or body threatening had primarily been focused on the *survival skills* and self-protection during the event and had experienced a mixture of numbness, confusion, withdrawal, and distraction of self-structure that shattered capacity to function as a *person* (Zepinic, 2015).

It is reasonable to assume that the more traumatic stressor is, the worser trauma victim's suffering will be. Some clinicians (McNally, 2003; Zepinic, 2012) named this as *dose-response model* of trauma saying that symptoms worsen as the severity of the stressor increases. This correlation of *conditioning* (or *learned helplessness*) elicits an unconditional response of fear (or frozen response) to the trauma stimuli. The battering is a life-threatening condition which aftermaths are more complex and severe than in simple PTSD. The severity of trauma-related symptoms strongly affects the way battered woman remembers traumatic experience—the worse current symptoms. The battered women usually develop the personality changes, including deformation of relatedness and identity and they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others (Herman, 1992).

Severely traumatised battered women are overwhelmed with helplessness and passivity entrapped into violence, developing many other accompanying symptoms to the complex trauma syndrome (i.e., depression, fear, phobias, anger, shame, guilt, dissociation, emotional and cognitive dysfunction, and somatic

complaints). Chronic abuse of the prolonged and repeated trauma causes serious psychological harm with aftermath which are beyond current triad of PTSD diagnosis.

In the International Classification of Diseases—ICD-11 (WHO, 2019), the diagnosis of posttraumatic stress disorder (PTSD) has seen substantial changes with introduction of a new stress-related entity: Complex PTSD (CPTSD). PTSD in ICD-11 is defined by symptoms that relate to the core posttraumatic responses which describe fear-based reactions: 1) re-experiencing the traumatic event in the present in the form of nightmares, flashbacks, or vivid intrusive memories typically accompanied by strong emotions (i.e., fear or horror); 2) avoidance of reminders of the traumatic event(s); and 3) persistent perceptions of heightened current threat (hypervigilance).

In its classification, the WHO introduced new category of Complex PTSD (CPTSD) organised in two major overarching groups of symptoms: 1) symptoms related to PTSD, and 2) symptoms related to *disturbances in self-organisation* (Moller et al., 2021; Lechner-Meichsner & Steil, 2021; Zepinic, 2022). The *disturbances in self-organisation* (*DSO*) domain describes three clusters of symptoms: 1) problems in affect regulation (i.e., heightened emotional reactivity, dissociative experiences, or emotional numbing); 2) negative self-concept (i.e., feelings of guilt, shame, unworthy, worthlessness); and 3) disturbances in relationships (i.e., difficulties sustaining relationships and feeling close to others). In fact, the division of PTSD into two qualitatively different disorders has been supported in several studies by the clinicians long before it was introduced in the ICD-11 (Briere & Spinazzola, 2009; Cloitre et al., 2011; Courtois & Ford, 2009; Foa & Rothbaum, 1998; Herman, 1992; Resnick et al., 2012; Van der Kolk et al., 1996; Wilson & Drozdek, 2004; Zepinic, 2021b).

The clinical studies had demonstrated that Complex PTSD (Complex Trauma Syndrome) is associated with more comorbidity, caused significantly worse functioning, and worse quality of life that *simple* PTSD described in DSM-5 (APA, 2013) and ICD-10 (WHO, 1992). However, despite not making distinction between complexity and exposition to the traumatic event(s), the DSM-5 in its diagnostic criteria for the PTSD requires to specify whether the individual, alongside with other PTSD symptoms, experiences the persistent or recurrent dissociative symptoms: depersonalisation and derealisation. Under the DSM-5 (APA, 2013) derealisation is defined as persistent or recurrent experiences of unreality of surroundings (i.e., the world around the individual is experienced as unreal, distant, or distorted). Depersonalisation is defined as persistent or recurrent experiences of feeling detached from, and as if one were outside observer of, one's mental processes or body (i.e., feeling a sense of unreality of self or body).

The studies suggested than Complex PTSD (i.e., war trauma, brutal rape, severe and repeated violence) is a more severe disorder that PTSD in clinically meaningful ways—Complex PTSD is particularly associated with victim's sense of self and emotional disorders (i.e., depression, anxiety, dissociation, sleep dis-

turbances, somatisation, aggression, dysthymia), cognitive and social dysfunctions. The severe traumatic experience is analogous to a high-velocity bullet piercing through the body, tearing apart internal organs critical for survival (Zepinic, 2012, 2022). Thus, the repeated and severe traumatic experience, such as exposure to constant battering, may lead to a de-centering of self, 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 causes consequences for the patient's psychological stability, well-being, and psychic integration, resulting to proneness to dissociation.

In ICD-11 symptoms of *disturbances in self-organisation* (*DSO*) are found to have overlapping with prominent symptoms of emotional disorders, especially depressive symptoms (feeling worthless, interpersonal withdrawal, emotional avoidance, feeling cut-off from others (including loved ones), and difficulty in staying close to others). The ICD-11 found that symptoms of Complex PTSD are also associated with the psychotic symptoms such as mind-reading, experiencing special messages sent to the patient, being under strict the control of some extraordinary power or feeling of having extra-special powers, feeling that others were following or spying patient, and auditory and visual hallucinations.

Our position is that severe domestic violence may impair person's capacity to integrate a range of the emotional and cognitive processes into a coherent whole. Severe trauma impairs natural self-organisational process toward complexity; emerging compound of the process of integration on the one hand, with the process of disintegration on the other. Under non-trauma condition self-integration is one natural process; however, during trauma the self-organisational capacities are impaired and haunted by the trauma-related disintegrated processes. By the trauma, the concept of self-regulation fails and disintegrates moving forward towards the imbalance of integration and differentiation within itself and others (Zepinic, 2016).

5. Conclusion

Although the BWS is not an independent diagnostic entity (neither in the DSM-5 nor in the ICD-11) nor a separate act within *assault and battery* category of crimes, it is an aftermath of the domestic violence historically evident and widely existing. The aspect of domestic violence has been recognized as a severe problem mostly because of cultural emphases on equal rights though the problem itself is long-standing. The abuser's violent behaviour and aggression are designed to humiliate, disrespect, and violate woman to the level of nihilation, worthlessness, and uselessness (Zepinic, 2021b).

In most cases, the BWS became in spotlight when battered woman is on trial in courtroom due to committed murder or grievous bodily harm upon her batterer. In such situation, the court shall postulate a standard of *reasonableness* and *causality* of a "wrongful act" made by the woman, but also of a "wrongful insult" made by the abuser. A trial judge must also be mindful of the fact that the

question is not whether there is a reasonable doubt that the killing was unprovoked; it is a question for the jury. The jury should be instructed to put themselves, as the embodiment of the ordinary person, in the accused's shoes for the purpose of determining the possible affects of the wrongful act (by the accused) and wrongful abuse (by the abuser) upon the power of self-control of the ordinary person.

True, it is that the jury is a group of the individuals (the ordinary or reasonable persons) as representing the ordinary or average member of the public. To instruct jury to put themselves in the shoes of accused for the purpose of determining the wrongful act's *wrongfulness* and *causality* is of such nature as to deprive an ordinary person of the power of self-control. On the other hand, it involves the danger that it might be construed by an individual juror as an invitation to substitute himself/herself with his/her individual strengths and weaknesses for the hypothetical ordinary person. The result could be to displace the objective standard by a particular juror's subjective view of his/her personal power of the self-control regardless of whether it be greater or less than that should be attributed to a hypothetical ordinary person (*R v Stingel*).

Complex trauma syndrome is a catastrophic aftermath of prolonged and multiple phenomena of traumatic experience (such as constant battering and humiliation, sexual abuse) and includes profound disturbances in interpersonal relationships and estrangement from others, pervasive mistrust, hostility and suspiciousness, feelings of emptiness, and altered sense of meaning and purpose of life. The traumatised persons are overwhelmed by terror and helplessness; their whole mechanisms for concerted, coordinated and purposeful activity are smashed. Individuals (such as the battered women) subjected to extreme, prolonged, and repeated trauma develop an insidious, progressive from of complex trauma syndrome which invades and erodes the whole personality. The victims of severe and chronic traumatisation may feel that their self is changed irrevocably, or lose the sense that they have any self at all.

Women who are exposed to constant violence by their intimate partners show several psychological impacts: high level of depression, anxiety, fears and phobias, social isolation, suicidal thoughts or attempts, emotional emptiness and distress, and cognitive dysfunctions. In addition, domestic violence and abuse have also been linked with alcoholism and drugs abuse, poor self-esteem and loss of the self-continuity, pathological smoking, self-harm, unsafe sexual behaviour, and increased vulnerability to physical injuries. Numerous studies and clinical observations revealed that psychological abuse has more severe the long-term psychological effects on one's personality than physical abuse, and that psychological abuse normally occurs prior to the physical abuse.

The most diagnosis among victims of domestic violence is PTSD. Domestic violence and abuse are often on daily basis—prolonged and extensive. Any new abuse and violence are reminder of previous one which usually was with an excessive (physical) force, and/or sexual violence. As violent behaviour is a reminder of the experienced traumatic events, the victim (battered woman) often

tries to find *self-defence* in order to defend her existence (often also to defend her children) from the life-threatening situation. Expert testimony of her awareness of the imminent danger has been used to establish the necessary *state-of-mind* element of the *self-defence*, namely that the victim reasonably feared of imminent death or danger for her bodily integrity (Zepinic, 2017). Unlike in other forms of PTSD, for the battered woman, the imminent danger is real and caused objective feelings.

In numerous cases of battered women being accused of killing their batterers, the medico-legal reports revealed that severe battering destroyed the self-control of a reasonable person. Here is an individual (battered woman) who lost her self-control to the extent of being intentionally and repeatedly wounded by another (abuser) causing reactions which show a lack of self-control falling outside the ordinary or common range of the woman's personality. The most common findings by the expert in mental health are that woman was *panicking and released the full-blown dissociative state* and she acted as *her personality was a sort of segmented and not functioning as a whole; she was disrupted in her behaviour*, *without awareness of what she is doing* (Zepinic, 2022).

In classical (ordinary) dissociative state, a person can act normally so that other reasonable person would say "*this person appears normal enough to me*". However, the person who has been a victim of extended and severe stress (violence and abuse) may react in an automatic fashion facing uncontrollable inner conflict drives losing control of the mind and acting, perhaps quite briefly, in an automatic way (Steel et al., 2005; Ulman & Brothers, 1988; Van der Hart et al., 2006; Zepinic, 2017). As the aftermath of the prolonged and repeated ongoing violence and abuse, the battered woman suffers 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 woman's sensory-motor functioning (Zepinic, 2021b).

Battered woman is always under chronic apprehension of imminent doom, of something terrible to happen, and any symbolic or actual sign of potential danger results in increased activity, agitation, pacing, screaming, or crying. Nightmares are universal condition of the battered woman with themes of violence and danger, and seriously traumatised woman always remains vigilant, unable to relax or sleep. She usually does not have any baseline state of physical calm or comfort and, over time, she perceives her body as having turned against her. It is common that battered women complain of numerous types of somatic symptoms such as tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain, as well as of tremors, chocking sensations, or rapid heartbeat.

Conflicts of Interest

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

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