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Trapped in an Abusive Relationship with an Organized Crime Offender: the Importance of Mental Health Support

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Abstract
This study aims to get more insight into experiences in the process towards mental recovery and the feasibility of providing mental health support to victims of intimate partner violence (IPV) committed by organized crime offenders in The Netherlands. 150 female victims were identified and, when reached, offered the option for safe and anonymous mental health support for their trauma-related symptoms. We used a mixed-method design involving information from police files ($n=150$), patient files ($n=7$), focus groups with therapists involved in the mental health support program ($n=4$) and in-depth interviews with patients themselves ($n=4$). Results showed that participants in the interviews experienced many mental health complaints, but limited access to mental health support. They were trapped in a relationship characterized by violence, psychological warfare and a forced dependency. All interviewed participants were isolated from social support and society in general. Escaping the criminal partner was extremely difficult and even when the participant successfully regained some form of independency, true separation appeared to be almost impossible. The participants felt little support from governmental and non-governmental aid organisations in this process. The mental health support in the current project proved challenging but feasible. Findings suggest that victims of IPV committed by organized crime offenders urgently need professional help. Actions to ensure their safety and to overcome barriers that hamper access to aid organizations are required.

Keywords Organized crime offenders · Intimate partner violence · Mental health support · Qualitative research · Mental recovery · Organized crime

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Introduction

Intimate partner violence (IPV) is a debilitating interpersonal prolonged and repeated traumatic experience and involves physical or sexual violence, stalking or psychological harm by a current or former partner (Centers for Disease Control and Prevention, 2020). IPV is the most common form of violence against women (Olff & Wall, 2014; WHO, 2021), with prevalence estimates of around 5% in the past five years in the general population in The Netherlands (Van Eijkern et al., 2017). Females are more often victims of IPV than males (Hien & Ruglass, 2009; Sugg, 2015; Van Eijkern et al., 2017). A large survey study in 28 countries in the European Union found that 22% of the women with a current or former partner experienced IPV since the age of 15 (FRA, 2014).

IPV has many detrimental outcomes for victims including physical health problems (e.g., sexually transmitted infections, chronic pain, somatic disorders and gynaecological problems); mental health problems (e.g., depression, anxiety, self-harm, Posttraumatic Stress Disorder (PTSD) and Complex PTSD which includes emotion regulation difficulties, interpersonal problems and a negative self-concept in addition to core PTSD symptoms); and general problems in (social and professional) functioning (Campbell et al., 2002; Dillon et al., 2013; Dokkedahl et al., 2021; Fernández-Fillol et al., 2024; Fillol et al., 2021; Lagdon et al., 2014; Li et al., 2014; Stubbs & Szoeke, 2022). These findings underline the importance of accessible mental health support for victims of IPV to prevent (more) harm, stop further violence and strengthen mental health to support the victim in leaving the abusive relationship (Sprague & Olff, 2014).

However, despite the significant negative impact of IPV, victims often face difficulties in leaving the relationship. A review showed that limited external resources, such as having an income, being employed and having access to transportation are among the most important factors preventing victims from leaving the relationship (Anderson & Saunders, 2003). Commitment to the relationship has also been related to difficulties in leaving the relationship (e.g., in the form of time invested in the relationship, love for the partner, or legal ties) as well as safety issues (e.g., fear of retaliation by the partner). Most studies view leaving the violent relationship as a process, where victims go through multiple stages before deciding to leave the relationship (Anderson & Saunders, 2003; Baholo et al., 2015). The process of leaving often starts with emotional and cognitive changes in victims and a phase of preparation (starting with basic needs like finding a safe shelter, mobilizing at least some social support, making safety plans and trying to obtain external resources such as money) before they actually try to leave the relationship (Anderson & Saunders, 2003; Baholo et al., 2015; Bermea et al., 2020; Cerulli et al., 2014; Hien & Ruglass, 2009). Even after leaving the abusive relationship, victims often face violence through for example stalking, and leaving the relationship is often characterized by returns to the abuser (Anderson & Saunders, 2003; de Wit et al., 2023). The complete process of leaving (i.e., from preparing and fleeing until potentially being exposed to stalking after discontinuing the relationship) is related to an increased risk of femicide (Garcia-Vergara et al., 2022). Importantly, both professional and informal external social support seem relevant contributors to successfully leaving the relationship (Anderson & Saunders, 2003; Heron et al., 2022).

Although important, victims of IPV face significant barriers in accessing professional support. A recent systematic review identified six main barriers: lack of awareness (i.e., either about resources or the severity of their own situation), access challenges (e.g., related

to the location of the support or time required to access the support), consequences of disclosure (e.g., fear for retaliation from partner), lack of material resources (e.g., finances or transportation), personal barriers (e.g., self-blame or embarrassment) and system failures (e.g., not being taken seriously by help organization; Robinson et al., 2021). This emphasizes the need for effective and innovative support strategies tailored to the situation of victims of IPV.

Previous research showed that there are many types of perpetrators of IPV with different attributions for the violence including getting attention, control, anger, inability to express oneself verbally and influence of drugs (Neal & Edwards, 2017; Norlander & Eckhardt, 2005). A previous longitudinal cohort study demonstrated a large overlap between IPV and other criminal acts with varying severity. For example, in chronic offenders about 86% also committed IPV (Piquero et al., 2014). Generally, a high-rate, chronic and violent offending trajectory is strongly related to committing not only IPV in general, but to more severe IPV as well (Hilton & Eke, 2016; Piquero et al., 2014; Verbruggen et al., 2020). And lastly, a criminal record from the abusive partner is also one of the most consistent predictors of IPV recidivism (Cattaneo & Goodman, 2005) and intimate partner femicide (Garcia-Vergara et al., 2022).

A particular subgroup of individuals committing criminal acts are *organized crime offenders* who are part of a criminal organization compromising of a family, gang, cartel or other criminal network structurally engaging in violent and serious criminal activities (e.g., drug trafficking, human trafficking, firearms trading or organized fraud) for financial gain (Finckenauer, 2005). Social ties providing access to (transnational) criminal opportunities are crucial in organized crime and set it apart from regular (high-volume) crime (Kleemans & de Poot, 2008). IPV committed by organized crime offenders is both likely underexposed because organised crime itself is often underexposed, and potentially more severe (Roks et al., 2022; van Dijk et al., 2019). Organized crime offenders show a criminal career with a higher number of previous judicial contacts which are far more serious compared to regular offenders (van Koppen et al., 2010). They also tend to persevere in their criminal career even when opportunities arise to desist the criminal activities. For example, employment is considered to be an important factor promoting regular offenders to stop their criminal career, while organized crime offenders show increased crime rates when they are employed (van Koppen et al., 2022). Importantly, family members of organized crime offenders endure more violence than general offenders including domestic violence, killings and shootings (van Dijk et al., 2019). Children, especially boys, of organized crime offenders are at a very high risk to become involved in organized crime themselves (van Dijk et al., 2019). These characteristics of organized crime offenders strengthen the perceptions of their IPV victims that their situation is hopeless, and they cannot be helped by authorities. At the same time, these characteristics should underline the importance for these family members to receive professional support.

Effective treatment programs have been developed to help victims of IPV with safety issues, basic resources and system changes both in primary and secondary care (Bair-Merritt et al., 2014; Sprague et al., 2017; Trabold et al., 2020). Interventions focused on empowering victims as well as cognitive (behavioural) interventions show positive results. The latter also showed reduced IPV after treatment, although most studies included few follow-up measurements (Trabold et al., 2020). Mental health complaints resulting from IPV such as (Complex) PTSD and depression can also be effectively treated (Bisson & Olff, 2021; Cui-

jpers et al., 2013; Lewis et al., 2020; Mavranezouli et al., 2020; Saito et al., 2024). However, as outlined above, victims of IPV by organised crime offenders might experience barriers to access such support programs. Moreover, the violent reputation of organized crime offenders often leads to hesitation in the application of regular interventions provided by support organizations such as child protective services out of fear for the offender and his network (van Dijk et al., 2019).

To summarize, compared to IPV in the general population it seems plausible that IPV committed by organized crime offenders distinguishes itself in terms of probability, severity, perseverance, and access to the societal institutions that should be able to provide mental health care, safety and practical support. There is however a lack of research focusing on this IPV population. In the current study, we aim to identify what difficulties these victims face in the relationship with their partner and his associated network; what barriers they experience for seeking help; and what process they go through towards mental recovery. We also aim to investigate whether it is feasible (at all) to provide psychological treatment to these victims and what conditions need to be met in order to achieve this.

Method

Study Design

We used a mixed-methods design involving information from police files ($N=150$), patient files ($n=7$) from the mental healthcare institute providing mental health support specifically designed for and delivered to victims of IPV committed by organized crime offenders, focus groups with therapists ($n=4$) and interviews with victims of IPV committed by organized crime offenders ($n=4$). We also used information about the number of victims of IPV committed by organized crime offenders contacting the mental health support program and accepting mental health support based on records for the mental healthcare institute to evaluate the feasibility of providing mental health support to this population. All data was processed completely separately to ensure confidentiality of the patient file data, so we do not know whether participants from the interview study also agreed on their patient files being used and vice versa. All procedures involving interviews with patients were approved by the medical ethical committee of the Amsterdam University Medical center (NL66745.018.18) and procedures involving patient (W18_221#18.265) and police (W21_359#21.397) files were exempted from formal review by the medical ethical committee of the Amsterdam University Medical center.

Participants

We included (ex)partners of organized crime offenders in this study. Inclusion criteria included: (1) female gender; (2) age of 18 years and older; (3) interpersonal traumatic experiences in a relationship with an organized crime offender; (4) psychological problems related to the interpersonal traumatic experiences. We had no further exclusion criteria.

Procedures

This study is part of a project in collaboration with the Dutch National Police, domestic violence support organizations and a mental healthcare institute specialized in the treatment of trauma-related disorders [names anonymised for safety reasons] aimed at providing psychological help for victims of IPV committed by organized crime offenders. The police selected one hundred and fifty female (ex)partners of organized crime offenders living in the Netherlands based on: (A) the criminal record of the offender (involving serious, ongoing and profit-driven criminal activities[1]), (B) the associated criminal network (the offender needed to have an active role in the network) and (C) significant indications of interpersonal traumatic experiences in the relationship between the offender and victim (illustrated by police reports which indicated IPV might be present). Domestic support organizations further checked whether IPV was taking place. Victims were contacted via the telephone or a home visit from domestic violence support organizations or the police (see Fig. 1 for flowchart) between the fifth of June, 2018 and the ninth of April, 2021. Not all victims could be found or contacted reached and sometimes contact had to be postponed due to an immediate safety threat. Once victims were contacted, they received information about the mental health support program. This included a phone number through which victims could contact the mental healthcare institute. They could immediately schedule an intake session (online or in-person) and start a short mental health support program (online or in-person) consisting of 5 to 15 sessions focussing on their trauma-related complaints. Mental health support was provided by licensed psychologists with at least a masters' degree in psychology. Treatment mainly included trauma-focused therapy (i.e., eye movement desensitization and reprocessing and prolonged exposure therapy with imagery rescripting), psychoeducation (e.g., about the psychological impact of traumatic events) and skills training (e.g., emotion regulation and anger management). The mental healthcare institute was located in another region in The Netherlands than where the victims lived. When the victims preferred to receive mental health support in another location in The Netherlands, psychologist of the project's mental health support program referred them to other mental healthcare facilities.

For safety reasons the psychologists in the current project used pseudonyms for all contacts with the victims. Patient files were saved in a secured system only accessible for healthcare professionals involved in the current project. No information was registered for the health insurance nor was any information fed back to the police. When the victims felt the need for guarded transport because the safety situation was not ensured, they could contact the police who arranged guarded transport when necessary.

For the current study, we used anonymized data from police files of the 150 female (ex) partners of organized crime offenders. Additionally, therapists asked victims who attended an intake at the mental healthcare facility for permission to share their patient files, and to share their contact information with researchers so they could be contacted for an interview on two separate forms. Subsequently, researchers contacted victims who agreed to this procedure and provided them with detailed information about the study procedures. Written informed consent was obtained from all participants who agreed for their patient files to be shared and who agreed to be interviewed. Interviews took place after the mental health

[1] Including: criminal homicide, kidnapping, drug trafficking, production of illicit drugs (heroin, amphetamine), human trafficking, organized immigration crime, extortion accompanied by threats of violence, membership of an outlaw motorcycle gang and arson punishable as a felony.

support ended. The interviews took about 90 min and included self-report questionnaires – filled out by the participants – and open-ended interview questions. The interview was audiotaped when the participant consented and written notes were made. Finally, we conducted interviews with the therapists in two online meetings of 60 min; one halfway through the project when 20 victims had contacted the mental healthcare institute and one towards the end of the project when 40 victims had contacted the institute.

Police Files, Patient Files, Interviews and Focus Groups

Police Files

For the purpose of this study, the following pseudonymous data was extracted from the police files of 150 female (ex)partners of organized crime offenders: (A) demographic information (such as age, home and work situation); (B) information about traumatic experiences including number and type of reported potentially traumatic events; (C) information about the partner including their criminal record, the type of criminal offences, possession of firearms and imprisonment and (D) potential criminal history of the victim.

Patient Files

For the purpose of this study, the following pseudonymous data was extracted from the mental health care patient files: (A) demographic information such as age, home and work situation; (B) information about the current status of the relationship with the partner; (C) trauma history; (D) the reason for seeking and accepting professional mental help; (E) mental health complaints; (F) the current received treatment at the mental healthcare institute including the number of treatment sessions and (G) how the victim experienced the current mental health support program and whether they were referred for further help after treatment.

Interviews with Women Experiencing IPV

A female researcher with a background in psychology administered the interviews at a location in another area in The Netherlands than the area where the participants resided. This enabled her to ensure the safety of the participants and create a safe atmosphere where participants can share their story. Prior to the interview, there was no contact between the interviewer and the participants. Furthermore, the interviewer was not involved in the treatment of the participants. Interviews were conducted following a topic list including: (A) demographic information (age, home and work situation); (B) the impact of the traumatic experiences; (C) steps towards mental recovery; (D) experiences with the police and domestic violence support organizations and (E) perception of the mental health care support program in the current project. Recorded interviews were transcribed verbatim by another researcher excluding any personal information referring to the participant or other people or places or specific crimes mentioned by the participant. For safety reasons, the victims were asked not to mention the name or any other identifying information of the partner. Nor were names of the victims or any other personal information recorded. The audio recordings were deleted after extracting the themes for the qualitative analyses. Recording of the interview was not

mandatory to ensure that all participants felt comfortable in the interview setting. All participants agreed to their interview being recorded.

Focus Groups with Therapists

Focus groups with the therapists were conducted online by one or two researchers. The focus groups consisted of the following two topics about the group of victims who accepted the invitation for mental health support: (A) therapist perspectives on the population in terms of demographics, traumatic experiences, clinical characteristics, and steps towards mental recovery, and (B) therapist experiences with delivering treatment in this population.

Measures

The following four self-report questionnaires were taken during the interviews with victims: Life events checklist for DSM-5 (LEC-5) to determine the trauma history of the participants (Gray et al., 2004). The LEC-5 consists of 17 items about exposure to potentially traumatic events (e.g., natural disaster, fire or explosion, physical violence and sexual violence). For the current study, we summed the number of potentially traumatic events which participants experienced themselves (range 0–17).

The Primary Care PTSD screen for DSM-5 (PC-PTSD-5) was used to measure probable PTSD (Prins et al., 2016). The PC-PTSD-5 consists of five items on a binary scale (yes versus no) which can be combined in a sum score reflecting the number of endorsed items (0–5). In a previous validation study, a cut-off of the sum score of three resulted in an optimal sensitivity (0.95) combined with a good specificity (0.85; Prins et al., 2016).

The Patient Health Questionnaire for depression and anxiety (PHQ-4) was used to measure probable depression and generalized anxiety disorder (GAD; Kroenke et al., 2009). The PHQ-4 consists of two items assessing depression and two items assessing GAD, all on 4-point Likert scales from 0 (“not at all”) to 3 (“nearly every day”). The total depression and GAD scores are calculated by summing the item scores (both ranging from 0 to 6) with higher scores indicating more symptoms of depression and anxiety. Previous validation studies showed that a total score of three indicates probable depression (sensitivity = 0.83; specificity = 0.92) and GAD (sensitivity = 0.95; specificity = 0.64) with a reasonable accuracy (Kroenke et al., 2003, 2007).

Psychological resilience was measured using the Resilience Evaluation Scale (RES; van der Meer et al., 2018). The RES consists of nine items on five-point Likert scales from completely disagree (0) to completely agree (4). A total score can be calculated by adding up all items ranging from 0 to 36 with higher scores indicating greater psychological resilience. The RES demonstrated good construct validity, internal consistency and convergent validity in a previous validation study (van der Meer et al., 2018).

Analysis

We performed the analyses with R version 3.6.2 (R Core Team, 2018). Data from the police files and qualitative data from the interviews with the patients and patient files were used to describe demographic characteristics, clinical characteristics, trauma history, and the criminal record of the victims and their (ex)partners using descriptive statistics. We used grounded

theory to develop main categories based on emergent themes from the qualitative interviews with the participants using R package RQDA (Huang, 2016). We originally organized data around the concepts of: 'the relationship with the organized crime offender', 'the process of getting out of the relationship' and 'the process of getting professional help'. Afterwards, we decided to organize data around the chronological order of the process towards (potential) mental recovery. We started data processing with open coding (i.e. labelling segments in the text with the same theme), followed by axial coding (combining similar themes and deriving main categories from themes) and selective coding (constructing central categories). Two researchers performed this process independently from each other and from the interviewer of the participants. Thereafter, we compared the findings and resolved differences by discussion and consensus. We checked the interpretation of the interviews by involving two of the therapists from the mental healthcare institute who provided the treatment. We finally compiled the group-level information from the participant-interviews, therapist-focus sessions, patient files and police files to verify that the process resulting from the interviews with the four participants well represents the larger population of victims if IPV committed by an organized crime offender: we first checked whether the general themes and steps in the model which emerged from the interviews corresponded to the information provided via therapists focus sessions, patient files and – when available – police files. We then checked whether the information from the therapists focus sessions, patient files and police files pointed towards any potential missed themes or steps, which was not the case.

Results

Descriptive Statistics

The 150 identified female victims of IPV by organized crime offenders were on average 34.7 years old ($SD=9.1$) and were usually separated ($n=96$; 64%) from the organized crime offender or in the process of separation ($n=27$; 18%) while only four (3%) of the victims still lived together with the organized crime offender. For 23 victims (15%) the current living situation with the organized crime offender was unknown. Thirty-one (21%) of the victims were employed, 29 (19%) unemployed and for 90 victims (60%) this information was unknown.

For 130 organized crime offenders, detailed historic information was available from police files about the criminal record. For 20 organized crime offenders this information was unavailable due to ongoing police investigations, which did not allow for sharing of the data. Based on the police files, all 130 perpetrators for whom data was available were convicted for crimes. On average, they were convicted 32 times (median=22; range 1-271) most often for property crimes ($M=12$; $Mdn=4$; range 0-234) followed by violence ($M=6$; $Mdn=4$; range 0–27) and opium trafficking ($M=2$; $Mdn=1$; range 0–14). One-third ($n=49$) of the organized crime offenders were convicted in the past year, 37 (25%) 1–2 years ago, 43 (29%) between 2 and 11 years ago and for 21 (14%) this was unknown.

Half of the victims of whom information about convictions was available (69 out of 139) were convicted for crimes themselves (mean number of convictions=3; $Mdn=0$; range=0–30). Of these, twelve were convicted in the past year, eight between 1 and 2 years ago and 49 between 2 and 27 years ago. See Table 1 for other characteristics based on

the police and patient files. In total, 42 female (ex)partners of organized crime offenders contacted the mental healthcare institute, of whom 26 received an intake and 14 started treatment at the mental healthcare institute focusing on their trauma-related complaints (see Fig. 1). Half of those women ($n=7$) agreed on their patient files being used for this study. They received on average 9.6 ($SD=6.2$) therapy sessions in the current project.

We found that participants from the interviews ($n=4$) endorsed on average 7.3 types of self-experienced LEC-5 events ($SD=3.3$). All participants still met criteria for probable depression or GAD and half of the participants met criteria for probable PTSD during the interview. Note that interviews were administered after the treatment. Participants in the interviews scored relatively high on the RES ($M=30.4$; $SD=1.1$) compared to a Dutch norm population ($M=25.95$; $SD=4.11$).

The Development of the Relationship and Mental Recovery Process of Female Victims of IPV by an Organized Crime Offender

We constructed a model describing a process starting from the development of the relationship towards the mental recovery process of female victims of IPV by an organized crime offender based on interviews with four participants (see Fig. 2). This process was in line with information from police and patient files and interviews with the therapists.

Prior Traumatization

All interviewed participants experienced multiple interpersonal traumatic events prior to the relationship with the organized crime offender including physical or sexual violence during childhood and violence during prior romantic relationships. Some participants were wondering why they repeatedly ended up in violent relationships and expressed the wish to change this pattern. Three participants also experienced emotional neglect during their childhood where one or both of their parents were absent.

Start of the Relationship

All interviewed participants were at a vulnerable moment in their life when they met the organized crime offender. They often longed for (social) support, safety or to be seen and loved by someone. One participant also experienced financial problems because a previous partner left her with a debt. At the start of the relationship, the partners typically helped and supported the participants. All interviewed participants fell in love and quickly became dependent on the partner as he appeared to fulfil an unmet need (e.g., be loved). In this stage, the participants felt like they owed something to the partner and wanted to please and support him and show their gratitude. One participant described that her partner used this loyalty to get her involved in criminal activities. Later the organized crime offender used her involvement in his criminal activities to blackmail her and prevent her from going to the police. All interviewed participants still felt in control here and able to make their own decisions. There was a large variation in the length of this stage. Some participants experienced the relationship positively for years, others only for weeks.

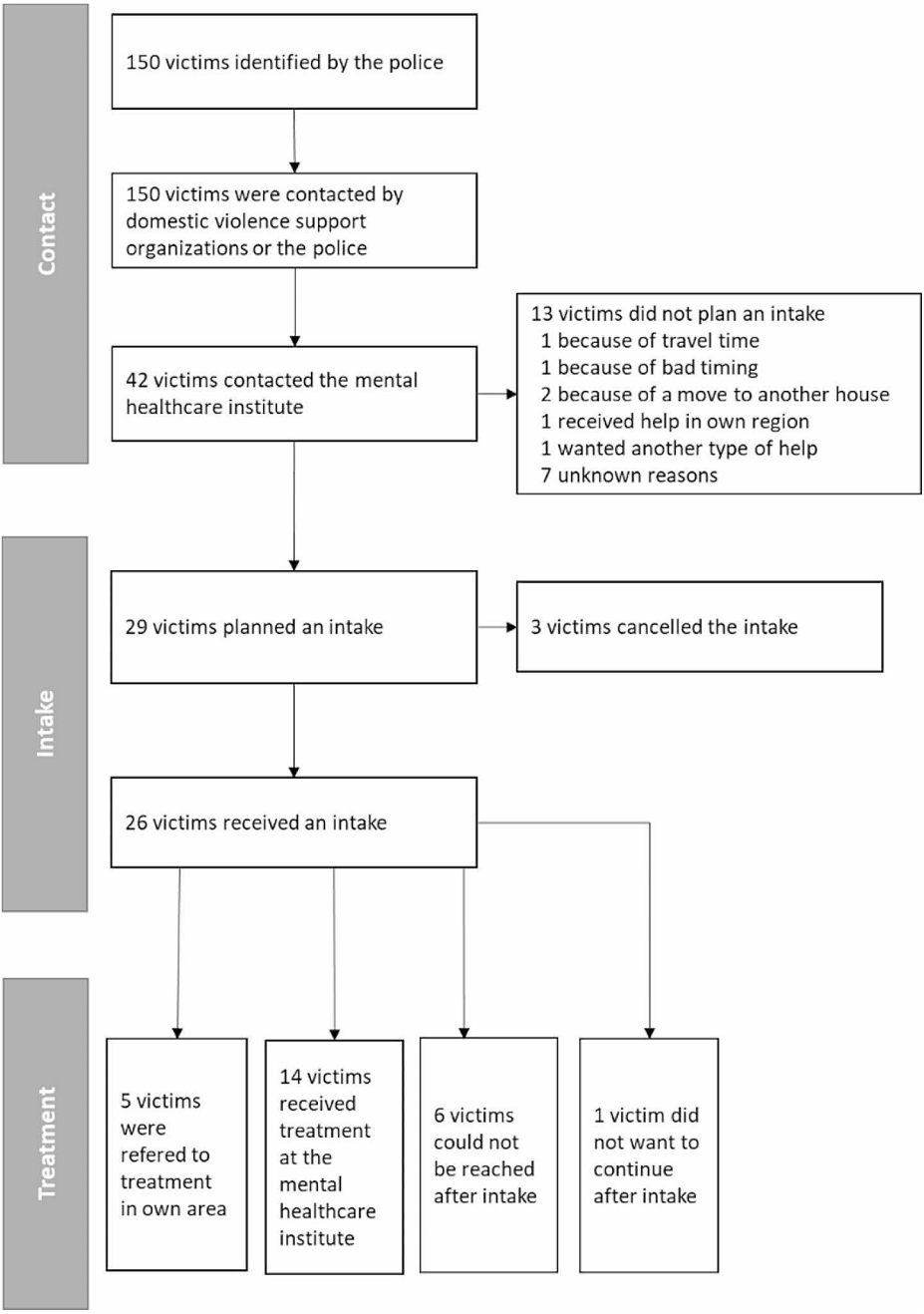

Fig. 1 Flowchart from female victims of IPV committed by organized crime offenders from the police files to treatment. Note that victims were able to contact the mental healthcare institute anonymously so we cannot verify whether they were all part of the 150 victims identified by the police

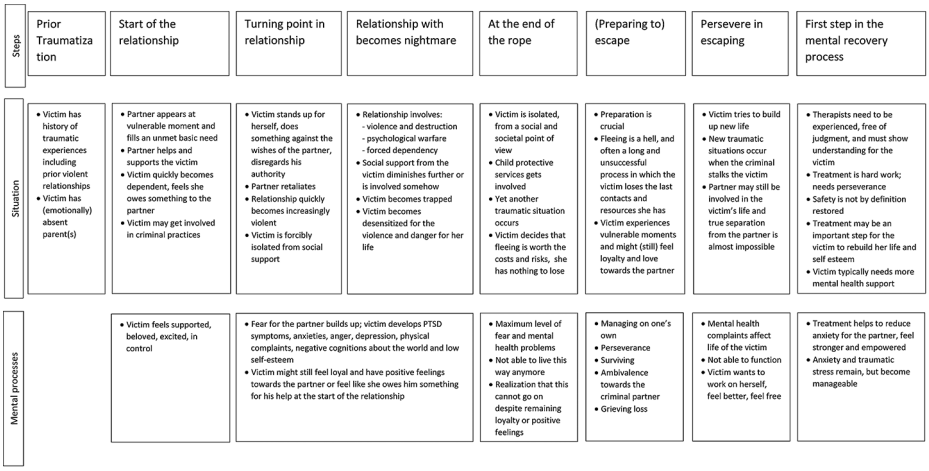

Fig. 2 A model representing the development of the relationship and mental recovery process of female victims of IPV committed by organized crime offenders based on the interviews with patients ($n=4$) and verified by two group interviews with two therapists each

Turning Point in the Relationship

All interviewed participants described a turning point in the relationship with the partner where the relationship started to involve violence. Although three participants did not know the reason for this turning point, they often mentioned that it started when they did something seemingly insignificant against the wishes of the partner, thereby disregarding his authority. The partner responded with violence, sometimes directly life-threatening, and from that point onwards the relationship quickly became increasingly violent. All interviewed participants were forced to distance themselves from their social support network. They seem to make a clear distinction between 'good' followed by 'bad' periods in the relationship, which in some cases depended on the mood of the partner. They often still felt loyal to the partner because he helped and supported them at the start of the relationship and one participant justified the violence by her (ex)-partner's (mental) health complaints and his traumatic past. From the turning point onwards, fear for the partner increased and participants gradually developed mental health complaints such as symptoms of PTSD, anxiety, and depression.

Relationship Becomes Nightmare

Over time, the relationship with the organized crime offender became more dangerous and interviewed participants felt trapped and became isolated. Several themes in the relationship with the partner emerged throughout all interviews. Firstly, the relationships were characterized by violence and destruction where partners destroyed property of participants, stole valuable items from participants, physically assaulted participants and used weapons against participants. Even after severe incidents, such as shootings or assaults which resulted in injuries which required hospitalization, participants were unable to mobilize help from aid agencies and remained trapped in the dangerous and harmful situation. Secondly,

Table 1 Characteristics of female (ex)partners of organized crime offenders based on police and patient files

Police files ($n=150$)	No. (%)
Age, mean (SD), years	34.7 (9.1)
Has children	
No	22 (15)
Yes	113 (75)
Unknown	15 (10)
Employment	
No	29 (19)
Yes	31 (21)
Unknown	90 (60)
Relationship with the partner	
Living together	4 (3)
Separated	96 (64)
In process of separation	27 (18)
Unknown	23 (15)
Trauma exposure by the partner	
Physical abuse	
No	11 (7)
Yes	97 (65)
Unknown	42 (28)
Emotional abuse	
No	11 (7)
Yes	115 (77)
Unknown	24 (16)
Duration of trauma exposure by the partner[1]	
< 1 year	23 (15)
1–2 years	20 (13)
2-5 years	36 (24)
> 5 years	8 (5)
Unknown or unclear	63 (42)
Patient files ($n=7$)	No. (%)
Age category (years)	
20–30	3 (43)
31–40	0
41–50	3 (43)
Unknown	1 (14)
Has children	5 (71)
Employment	
No	2 (29)
Yes	2 (29)
Unknown	3 (43)
Currently living together with the organized crime offender	0
Currently in a new romantic relationship	3 (43)
Received treatment in past for trauma-related complaints	1 (14)
Reason for seeking professional help	
Mental health complaints	3 (43)
Stalking from the partner	3 (43)

Table 1 (continued)

Police files ($n=150$)	No. (%)
Concerns about safety/health children	1 (14)
Referred for further treatment	5 (71)

SD = Standard deviation; y = year; No. = number

[1]Duration of trauma exposure was based on the first and last police report and might therefore be an underrepresentation of the actual duration

the relationships were characterized by psychological warfare where the organized crime network was often involved to increase the threat. This included threatening participants and their family and friends with weapons or by using a hitman; threatening to kidnap participants; let another person from their criminal network sexually assault participants; or intimidating participants, including blackmailing and framing participants for crimes. The relationships were also characterized by a forced dependency. The partner took money and other possessions from participants such as their car to ensure they were not able to get away. Two participants became seemingly desensitized for the violence and danger and described the violence as if it was a 'normal' part of life. At this point, all interviewed participants experienced a heavily diminished social support network. Some participants chose to distance themselves from their social network because either they wanted to protect their friends and family from the partner, they were afraid that their social support would be used against them by the partner, or they felt ashamed or embarrassed that they were stuck in a violent relationship for so long. The social support network around participants sometimes also chose to distance themselves out of fear for the (criminal network of the) partner since they often faced physical abuse and (death) threats. One participant reported that her social support network was also involved in the organized crime network. This led to even more isolation since she could not trust her social support network with incriminating information about her partner or his organized crime network. At this point, participants did not feel in control of their own life and felt trapped in the relationship. Fear for the partner and his organized crime network increased further as did mental health complaints.

At the End of the Rope

All interviewed participants described an absolute low point in the relationship with the organized crime offender where participants felt completely isolated from a social and societal point of view. Sometimes child protective services were involved and participants' children got evicted from home. When yet another traumatic situation occurred where the partner used violence which sometimes required hospitalization of the participant, they realized that the situation had to change no matter the costs, despite the desensitization to the violence or any remaining loyalty towards the partner. Two participants reported reaching out to the police at this point. All participants felt that they had nothing to lose as they had no normal life anymore, were completely isolated, not able to function anymore and experienced a fear for their life. Despite the danger of escaping or involving the police, participants decided it was worth the costs and risks. The participants experienced maximum levels of fear for the partner and his organized crime network and multiple mental health complaints.

(Preparing to) Escape

For all interviewed participants, escaping came with a high cost. Participants described fleeing as 'a hell' with a significant chance of getting killed and to lose their last contacts and resources. When participants had children living at home, this further complicated this process as the partner sometimes tried to get custody. Two participants needed several fleeing attempts and one participants still felt some loyalty and love for the partner which made it hard to stay away. Incarceration of the partner was a natural moment for the participants to get away, but the threat of his crime network often remained. For example, some participants described that people were paid to watch them or watch their house. Participants described that preparation for the flight is key. This preparation included saving some money in order to be able to take care of themselves when they lost all their possessions or included a process in which they tried to distance themselves from the partner bit by bit because a sudden leave would elicit most negative emotions and in their opinion lead to the highest chance of violence. Participants noted that they had a lot of perseverance, which helped them to get out of the relationship. They were surviving at this point and managing this process on their own. Participants also reported grieving the loss of their partner, father of their children, house and life.

Persevere in Escaping

When participants succeeded in escaping, they tried to build up their life. The partner often stalked participants which led to new traumatic situations. 'True' separation from the partner seems almost impossible, as he often remains involved through stalking, through custody of children or through financial constructions. Three participants reported that the partner stalked and terrorized them, for example by breaking into their new house. One participants reported difficulties in keeping the ex-partner outside her house when he showed up because she still felt some loyalty towards him. At this point, all interviewed participants felt that they regained some of the control over their life. However, they often still experienced a lot of fear for the ex-partner and his network, which affected their life even when the partner was not around anymore. This led to problems in their daily functioning such as not being able to leave their house or feeling like they cannot think clearly anymore. All interviewed participants described suffering from severe symptoms of PTSD and depression (re-experiencing symptoms of traumatic events, nightmares, hyperarousal, inability to feel love and other positive emotions, low self-esteem) and two participants reported physical complaints (e.g., pain from injuries or headaches). Negative cognitions about the world were also apparent and during the interview participants still expressed these beliefs such as the belief that the world is a dangerous place and the belief that other people cannot be trusted. Participants accepted mental health support in the current project to feel better or to deal with the (re)appearance of the ex-partner in their life.

First Step in the Mental Recovery Process

None of the interviewed participants received professional mental health support for their trauma-related complaints prior to the current project. One participant mentioned seeking help, but she was told that they could not help her given the extraordinary situation and

safety issues for the patient and therapist. All participants reported positive experiences with the mental health support in the current program. They described that they felt understood by the therapists, felt safe and not judged and that the therapists could get through to them and got to their feelings. Although the treatment consisted of a limited amount of sessions (mentioned by one participant as disadvantage), participants experienced a reduction in their PTSD symptoms, physical symptoms and felt less anxious towards the ex-partner. They also felt stronger; better able to stand up for themselves. For two participants, anxiety and traumatic stress remained but it became more manageable. After the mental health support, participants often needed further help for example with increasing their self-esteem and building up their life. In that sense, the mental health support in the current program was only a first step towards long-term mental health treatment. At this point, safety is not per definition restored for participants, as the ex-partner is often still involved in their life in some way.

Experience with the Police and Domestic Violence Support Organizations

All participants had contact with the police and/or domestic violence support organizations at some or more point(s) during their process of getting out of the relationship with the organized crime offender. Usually, participants were very stressed at that time and primarily longing for safety. One theme emerging from the interviews was a disbelief that the police would or could offer protection. Two participants received (death) threats from their (ex) partner or his associated criminal network after declaring at the police and felt like the contact with the police only led to danger and did not result in the partner getting imprisoned. Participants also did not feel properly informed by the police about developments in their case, which might have consequences for their safety. Although participants wished that declaring at the police would immediately lead to the partner being incarcerated without any risk for them, they had no confidence that this would actually happen. One participant reported filing complaints against the partner, which were dismissed by the police hence further reducing her confidence in the police. Another emerging theme was the feeling that the police had conflicting interests. On the one hand, participants were told that the police would help them. On the other hand, participants felt that the police wanted to gather information about the criminal activities of the (ex)-partner. Three participants felt like the police were not prioritizing their interest. They also felt that the police and domestic violence support organizations did not sufficiently understand the dangerous situation they were in. Additionally, participants often experienced a mismatch between the approach of the police or domestic violence support organizations and their own preferred approach. This was especially problematic for participants when these organizations decided to act without discussing this with participants or when these organizations only provided help on their own terms. For example, participants might have to go into a safe house or witness protection program which forces them to leave their current life or they might have to terminate all contact with the offender while they feel that minimal contact would reduce the threat from the offender. Participants felt that this further reduced their sense of control over the situation. In some cases, participants decided to refrain from seeking further help because of this.

Therapist Perspective on the Mental Health Support Program

Therapists stated that access to regular mental health support is very limited for this population. Mental healthcare institutes are often not equipped to cope with (potential) safety issues for therapists and patients related to the organized crime offender and his crime network. For example, patients were often followed by members of this network and patients might have incriminating information about the crime network which – when told to therapists – make therapists a potential target. The therapists noted that safety precautions such as the use of pseudonyms, and guarded transport were crucial for a safe working environment. Before therapy started, safety was also extensively discussed with the patients including rules about what to do when they were followed on their way to therapy, whether their (e-mail) accounts were safe and whether their mobile phone was being traced. In addition to these safety issues, patients might not know about the possibility of mental health support or believe they cannot be helped or that treatment is too hard. In the current project, patients often reached out to the mental health support program months after receiving the contact information. They easily dropped out (and sometimes returned later), so it was important to quickly connect with them to build up trust and start treatment. Therapists noted that safety measures are important for mental health support programs for this population, as therapists might also become a target themselves. Therapists also mentioned that regular intervision with fellow therapists working with these patients is important to discuss safety issues, challenges during the treatment and the impact of the treatment on the therapist. Despite the difficulties in providing mental health support, therapists mentioned that they feel the support is helpful and should be accessible for all victims. They also felt that it is rewarding to help these victims which they would not be able to help outside the current program. Involving organisations which address housing and security issues might further facilitate the recovery process.

Discussion

We aimed to get more insight into difficulties victims of IPV committed by organized crime offenders face in the relationship with the partner and his associated network, what barriers they experience for seeking help and what process they go through towards mental recovery. We also evaluated the feasibility of providing mental health support to this population. We found that the victims gradually got stuck in a violent relationship and became isolated from a social and societal point of view. It was extremely difficult to get out of the relationship and even when they escaped, complete and sustained separation was almost impossible. The threat from the organized crime organization further complicated the process towards mental recovery and even incarceration of the organized crime offender did not end this threat. Interviewed participants generally felt little support from (non-) governmental organizations in this process and experienced limited access to mental health support. Mental health support nevertheless appeared to be feasible in the current project and offered a first step towards re-establishing access and confidence in societal aid organizations. The support from - and collaboration with - the police, domestic violence support organizations and other societal partners should be improved to facilitate these victims in getting out of the violent relationship and taking the first step towards mental recovery.

In the current study, we were able to construct a first model representing the road towards mental recovery of female victims of IPV committed by organized crime offenders.

The recovery process from the victims showed many similarities, but we also noticed heterogeneity in the duration of the process. The purpose and meaning of escaping from the partner differed between participants: some tried to stay completely hidden while others kept in contact with the partner. The help-seeking process of the victims in this study shows many similarities with the help-seeking process in victims of IPV in general with similar barriers for leaving the relationship, a gradual process of leaving (including preparatory behaviour) and often ongoing violence after leaving the relationship (Anderson & Saunders, 2003; Baholo et al., 2015; Bermea et al., 2020; Cerulli et al., 2014; Hien & Ruglass, 2009; Stige et al., 2013). However, what seems to differ between both groups, is the more central role of threat from the perpetrator and his associated network against the victims of IPV committed by organized crime offenders. In addition, specific forms of blackmailing (e.g., framing for crimes), threat towards the victim's social support network and/or involvement of the network and/or victim in criminal activities contribute to even more isolation of the victims. Since social support is an important contributor to successfully leaving the relationship, this might greatly complicate this process for this population and would render professional support even more important (Anderson & Saunders, 2003; Heron et al., 2022). Note that for victims of IPV committed by organized crime offenders, the threats expressed by the aggressor are likely more realistic compared to the population of IPV in general since the relationship with an organized crime offender is often characterized by many risk factors for femicide: high severity of the violence, victim's perception that the aggressor is capable of killing her, death threats, stalking, control from aggressor over victim's daily activities and access, possession and use of weapons and specifically guns by the aggressor (Garcia-Vergara et al., 2022).

Therefore, it stands out that that most victims were either separated from the abusive partner or in the process of separation. This might be explained by the common sense hypothesis in which a very high severity of IPV violence might predict the victim leaving the relationship due to basically the feeling that the choice might be either death or trying to escape (Anderson & Saunders, 2003).

Unfortunately, victims of IPV committed by organized crime offenders seem to experience additional barriers to professional support including safety concerns for the professionals themselves and conflicts of interest from the police (related to the goal of the police to incarcerate the offender). Thus, even when victims reach out for professional help, they might not be able to receive support due to safety issues for both victims and therapists. Victims were often followed and threatened by members of the organized crime network. These members were often concerned about the victims talking to anyone about the criminal network, even though most victims said they did not have incriminating information. Therefore, it could be dangerous for therapists in regular care settings to talk to these victims as it could make them potential targets for the crime network as well. In conclusion, the process of separation is specifically complicated and dangerous in victims of IPV committed by organized crime offenders. This underlines the need for targeted support by the police and a bespoke service that is equipped to deal with these circumstances and only have the best interest of the victims at heart.

We also identified some factors that contributed to the recovery process. Despite the difficulties and risks of fleeing, the participants from the interview study eventually chose to

get out of the relationship. They seemed to have concluded that the threat to their life was so high that they had to act. This illustrates the resilient and perseverant character of the participants. Self-report questionnaires also indicated that the participants were psychologically resilient compared to a general Dutch sample (van der Meer et al., 2018). Note that this may be a selective highly resilient subgroup that felt strong enough to participate in the study and there might very well be a substantial group of victims who do not succeed in getting out of the abusive relationship. Participants did not mention supportive networks at an early stage of their relationship with the organized crime offender such as friends, family or colleagues who tried to intervene. Such networks may help to reduce the 'wall of silence' around the victims of IPV by organized crime offenders (Roks et al., 2022). However, we do not know whether such networks might be able to intervene in these situations. Future studies might investigate whether such supportive networks exist and contribute to the recovery process.

Both the victims and therapists noted that access to regular mental healthcare is limited for the victims due to safety issues for both victims and therapists. Thus, collaboration between health care organizations, the police and support organizations for domestic violence seems vital. When safety precautions are taken, this pilot study indicates that mental health support is feasible for victims of IPV committed by organized crime offenders. Note that safety has to be addressed at the very first contact with the victims, since any contact comes with safety risks (e.g., even when e-mailing with the victim it is important to first know whether the organized crime offender might have access to the e-mail). Usually, safety could be improved with simple solutions (e.g., making a new e-mail address with a new password; buying a new phone with anonymous SIM card etc.). Throughout the project there have been a few minor incidents related to the safety of the victims. For example, one organized crime offender tried to get access to the treatment centre and sometimes the victims were followed on their way to treatment, but no adverse events occurred both for victims and therapists. Hence, from the present study we may conclude that, when specific conditions are met, targeted treatment can be feasible for victims of IPV in the context of organized crime. Future studies should systematically evaluate treatment effectiveness in a larger sample. Furthermore, future projects might try to reach victims at an earlier point of time in their relationship with the organized crime offender, for example when the partner is incarcerated. Future projects might also monitor any new challenges related to leaving the violent relationship which might arise. For example, cash is being used less often and therefore stashing little amounts of money over time might become increasingly difficult for victims. If this proves to be the case, some kind of financial support might be crucial to support the victims. Helping these victims to get out of the abusive relationship towards a safe environment outside criminal networks is not only important for them, but also for their children (van Dijk et al., 2019). This is an important area of research as their children have a high risk of getting involved in organized crime themselves (Perizzolo et al., 2022; van Dijk et al., 2021). We urge future studies to specifically focus on the children of victims of IPV committed by organized crime offenders since they might often face very complex and traumatic situations (violence, separation from parents etc.), while they might also potentially face specific barriers to accessing treatment similar to their mothers.

This study has several limitations. Although a large number of victims of IPV committed by organized crime offenders were identified, and this provided a rich dataset describing this understudied population, only a subset received mental health support and provided permission to use their patient file data, and even fewer participants agreed to an inter-

view. This population was difficult to reach and was understandably distrustful towards contact attempts. The participants' interviews showed a coherent and homogenous story, but with four interviewed participants we probably did not reach data saturation – if that even exists (Braun & Clarke, 2021). Future studies into this population might further add to our proposed model and improve it further. Additionally, some victims might have been too afraid to participate in the current study resulting in selection bias. Alternatively, some victims might not have felt the need for psychosocial support and therefore not contacted the mental health support from the current study. Also, all potential participants were selected by the police. Therefore, any victims of organized crime offenders which are unknown to the police are not included in the current study. Moreover, in contrast to recommendations from guidelines for qualitative research (O'Brien et al., 2014), we did not use empirical data (e.g., quotes) to substantiate analytic findings. For this population, quotes might pose a risk for the safety of the participants. Finally, we could not address how the victims are doing on the long term, i.e. whether they remain safe and separated from the partner and whether their road towards mental recovery progressed further. Future studies may address these questions.

To our knowledge this is the first study addressing the feasibility of providing mental health care to female victims of IPV committed by organized crime offenders, and exploring their experiences and process towards mental recovery. We found that this population urgently needs professional help since they seem trapped in an abusive, life-threatening relationship with little resources to get out. The criminal network of the abusive partner appeared to make this population vulnerable and limits access to support organizations. The safe mental health support provided in the current project might be a first step towards professional mental health support. Collaboration between health care organizations, the police and support organizations for domestic violence appears mandatory to ensure the safety of these victims and further improve support for this vulnerable population.

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Data Availability Data are not available due to privacy and safety considerations.

Declaration

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References

Anderson, D. K., & Saunders, D. G. (2003). Leaving an abusive partner: An empirical review of predictors, the process of leaving, and psychological well-being. *Trauma Violence Abuse*, *4*(2), 163–191. https://doi.org/10.1177/1524838002250769.

Baholo, M., Christofides, N., Wright, A., Sikweyiya, Y., & Shai, N. J. (2015). Women's experiences leaving abusive relationships: A shelter-based qualitative study. *Culture Health & Sexuality*, *17*(5), 638–649. https://doi.org/10.1080/13691058.2014.979881.

Bair-Merritt, M. H., Lewis-O'Connor, A., Goel, S., Amato, P., Ismailji, T., Jelley, M., Lenahan, P., & Cronholm, P. (2014). Primary care-based interventions for intimate Partner Violence a systematic review. *American Journal of Preventive Medicine*, *46*(2), 188–194. https://doi.org/10.1016/j.amepre.2013.10.001.

Bermea, A. M., Khaw, L., Hardesty, J. L., Rosenbloom, L., & Salerno, C. (2020). Mental and active Preparation: Examining variations in women's processes of preparing to leave Abusive relationships. *Journal of Interpersonal Violence*, *35*(3–4), 988–1011. https://doi.org/10.1177/0886260517692332.

Bisson, J. I., & Olff, M. (2021). Prevention and treatment of PTSD: The current evidence base. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2020.1824381.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846.

Campbell, J., Jones, A. S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A. C., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, *162*(10), 1157–1163. https://doi.org/10.1001/archinte.162.10.1157.

Cattaneo, L. B., & Goodman, L. A. (2005). Risk factors for reabuse in intimate partner violence: A cross-disciplinary critical review. *Trauma Violence & Abuse*, *6*(2), 141–175. https://doi.org/10.1177/1524838005275088.

Centers for Disease Control and Prevention (2020). *Intimate partner violence*. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html.

Cerulli, C., Kothari, C. L., Dichter, M., Marcus, S., Wiley, J., & Rhodes, K. V. (2014). Victim participation in intimate Partner Violence Prosecution: Implications for safety. *Violence against Women*, *20*(5), 539–560. https://doi.org/10.1177/1077801214535105.

Cuijpers, P., Berking, M., Andersson, G., Quigley, L., Kleiboer, A., & Dobson, K. S. (2013). A Meta-analysis of cognitive-behavioural therapy for adult depression, alone and in comparison with other treatments. *Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie*, *58*(7), 376–385. https://doi.org/10.1177/070674371305800702.

de Wit, K., Begeman, M., Noordkamp, W., Sligte, I. G., Ghafoerkhan, R. S., & Kallen, V. L. (2023). The effect of individual characteristics on susceptibility to aggressive and/or intimidating approaches: Quantifying probability pathways by creating a victimization model. *Eur J Psychotraumatol*, *14*(2), 2263147. https://doi.org/10.1080/20008066.2023.2263147.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and Physical Health and Intimate Partner Violence against women: A review of the literature. *Int J Family Med*, *2013*, 313909. https://doi.org/10.1155/2013/313909.

Dokkedahl, S., Kristensen, T. R., Murphy, S., & Elklit, A. (2021). The complex trauma of psychological violence: Cross-sectional findings from a cohort of four Danish women shelters. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2020.1863580.

Fernández-Fillol, C., Hidalgo-Ruzzante, N., Perez-Garcia, M., Hyland, P., Shevlin, M., & Karatzias, T. (2024). The role of resilience in the relationship between intimate partner violence severity and ICD-11 CPTSD severity. *European Journal of Psychotraumatology*, *15*(1). https://doi.org/10.1080/20008066.2023.2285671.

Fillol, C. F., Pitsiakou, C., Garcia, M. P., Teva, I., & Hidalgo-Ruzzante, N. (2021). Complex PTSD in survivors of intimate partner violence: Risk factors related to symptoms and diagnoses. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.2003616.

Finckenauer, J. O. (2005). Problems of definition: What is organized crime? *Trends in Organized Crime*, *8*(3), 63–83. https://doi.org/10.1007/s12117-005-1038-4.

FRA. (2014). *Violence against women: An EU-wide survey. Main results report. P. O. o. t*. E. Union.

Garcia-Vergara, E., Almeda, N., Fernández-Navarro, F., & Becerra-Alonso, D. (2022a). Risk Assessment instruments for intimate Partner Femicide: A systematic review. *Frontiers in Psychology*, *13*, https://doi.org/10.3389/fpsyg.2022.896901.

Garcia-Vergara, E., Almeda, N., Ríos, B. M., Becerra-Alonso, D., & Fernández-Navarro, F. (2022b). A Comprehensive Analysis of Factors Associated with intimate Partner Femicide: A systematic review. *International Journal of Environmental Research and Public Health*, *19*(12). https://doi.org/10.3390/ijerph19127336.

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment*, *11*(4), 330–341. https://doi.org/10.1177/1073191104269954.

Heron, R. L., Eisma, M., & Browne, K. (2022). Why do female domestic violence victims remain in or leave Abusive relationships? A qualitative study. *Journal of Aggression Maltreatment & Trauma*, *31*(5), 677–694. https://doi.org/10.1080/10926771.2021.2019154.

Hien, D., & Ruglass, L. (2009). Interpersonal partner violence and women in the United States: An overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking. *International Journal of Law and Psychiatry*, *32*(1), 48–55. https://doi.org/10.1016/j.ijlp.2008.11.003.

Hilton, N. Z., & Eke, A. W. (2016). Non-specialization of criminal careers among intimate Partner Violence offenders. *Criminal Justice and Behavior*, *43*(10), 1347–1363. https://doi.org/10.1177/0093854816637886.

Huang, R. (2016). *RQDA: R-based Qualitative Data Analysis. R package version 0.2-8*. http://rqda.r-forge.r-project.org/.

Kleemans, E. R., & de Poot, C. J. (2008). Criminal Careers in Organized Crime and Social Opportunity structure. *European Journal of Criminology*, *5*(1), 69–98. https://doi.org/10.1177/1477370807084225.

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2003). The Patient Health Questionnaire-2 - validity of a two-item depression screener. *Medical Care*, *41*(11), 1284–1292. https://doi.org/10.1097/01.Mlr.0000093487.

Kroenke, K., Spitzer, R. L., Williams, J. B. W., Monahan, P. O., & Lowe, B. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine*, *146*(5), 317–325. https://doi.org/10.7326/0003-4819-146-5-200703060-00004.

Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Lowe, B. (2009). An Ultra-brief Screening Scale for anxiety and depression: The PHQ-4. *Psychosomatics*, *50*(6), 613–621. https://doi.org/10.1176/appi.psy.50.6.613.

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: a systematic review. *European Journal of Psychotraumatology*, *5*. https://doi.org/ARTN 24794.

Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-analysis. *European Journal of Psychotraumatology*, *11*(1). https://doi.org/10.1080/20008198.2020.1729633.

Li, Y., Marshall, C. M., Rees, H. C., Nunez, A., Ezeanolue, E. E., & Ehiri, J. E. (2014). Intimate partner violence and HIV infection among women: A systematic review and meta-analysis. *Journal of the International Aids Society*, 17. https://doi.org/10.7448/IAS.17.1.18845.

Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., Bhutani, G., Grey, N., Leach, J., Greenberg, N., Katona, C., El-Leithy, S., & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: A network meta-analysis. *Psychological Medicine*, *50*(4), 542–555. https://doi.org/10.1017/S0033291720000070.

Neal, A. M., & Edwards, K. M. (2017). Perpetrators' and victims' attributions for IPV: A critical review of the literature. *Trauma Violence & Abuse*, *18*(3), 239–267. https://doi.org/10.1177/1524838015603551.

Norlander, B., & Eckhardt, C. (2005). Anger, hostility, and male perpetrators of intimate partner violence: A meta-analytic review. *Clinical Psychology Review*, *25*(2), 119–152. https://doi.org/10.1016/j.cpr.2004.10.001.

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/Acm.0000000000000388.

Olff, M., & Wall, S. (2014). Intimate partner violence and mental health-remarks from two chief editors on a joint publishing venture. *European Journal of Psychotraumatology*, *5*, https://doi.org/10.3402/ejpt.v5.25679.

Perizzolo, V. C. P., Glaus, J., Stein, C. R., Willheim, E., Vital, M., Arnautovic, E., Kaleka, K., Serpa, S. R., Pons, F., Moser, D. A., & Schechter, D. S. (2022). Impact of mothers' IPV-PTSD on their capacity to predict their child's emotional comprehension and its relationship to their child's psychopathology. *European Journal of Psychotraumatology*, *13*(1). https://doi.org/10.1080/20008198.2021.2008152.

Piquero, A. R., Theobald, D., & Farrington, D. P. (2014). The overlap between offending trajectories, criminal violence, and intimate Partner violence. *International Journal of Offender Therapy and Comparative Criminology*, *58*(3), 286–302. https://doi.org/10.1177/0306624x12472655.

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The primary care PTSD screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, *31*(10), 1206–1211. https://doi.org/10.1007/s11606-016-3703-5.

R Core Team. (2018). *R: A language and environment for statistical computing*. R foundation for statistical computing.

Robinson, S. R., Ravi, K., & Schrag, R. J. V. (2021). A systematic review of barriers to formal help seeking for adult survivors of IPV in the United States, 2005–2019. *Trauma Violence & Abuse*, *22*(5), 1279–1295. https://doi.org/10.1177/1524838020916254.

Roks, R. A., Kruisbergen, E. W., & Kleemans, E. R. (2022). Walls of silence and organized crime: A theoretical and empirical exploration into the shielding of criminal activities from authorities. *Trends in Organized Crime*. https://doi.org/10.1007/s12117-022-09447-0.

Saito, A., Tsuruta, N., Arai, Y., Okamoto, K., Narisawa, T., Nozaki, M., Konno, N., & Asukai, N. (2024). Effectiveness of prolonged exposure (PE) after implementation at a crime victim support centre. *European Journal of Psychotraumatology*, *15*(1), 2302703. https://doi.org/10.1080/20008066.2024.2302703.

Sprague, S., & Olff, M. (2014). Intimate Partner Violence and Mental Health. *European Journal of Psychotraumatology*, *5*, https://doi.org/10.3402/ejpt.v5.25580.

Sprague, S., Scott, T., Garibaldi, A., Bzovsky, S., Slobogean, G. P., Mckay, P., Spurr, H., Arseneau, E., Memon, M., Bhandari, M., & Swaminathan, A. (2017). A scoping review of intimate partner violence assistance programmes within health care settings. *European Journal of Psychotraumatology*, *8*. https://doi.org/10.1080/20008198.2017.1314159.

Stige, S. H., Traeen, B., & Rosenvinge, J. H. (2013). The process leading to help seeking following Childhood Trauma. *Qualitative Health Research*, *23*(10), 1295–1306. https://doi.org/10.1177/1049732313503907.

Stubbs, A., & Szoeke, C. (2022). The effect of intimate Partner violence on the Physical Health and Health-related behaviors of women: A systematic review of the literature. *Trauma Violence & Abuse*, *23*(4), 1157–1172. https://doi.org/10.1177/1524838020985541.

Sugg, N. (2015). Intimate Partner Violence Prevalence, Health consequences, and intervention. *Medical Clinics of North America*, *99*(3), 629–649. https://doi.org/10.1016/j.mcna.2015.01.012.

Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2020). A systematic review of intimate Partner Violence interventions: State of the field and implications for practitioners. *Trauma Violence & Abuse*, *21*(2), 311–325. https://doi.org/10.1177/1524838018767934.

van der Meer, C. A. I., te Brake, H., van der Aa, N., Dashtgard, P., Bakker, A., & Olff, M. (2018). Assessing Psychological Resilience: Development and Psychometric Properties of the English and Dutch Version of the Resilience Evaluation Scale (RES). *Frontiers in Psychiatry*, *9*. https://doi.org/ARTN e169.

van Dijk, M., Kleemans, E., & Eichelsheim, V. (2019). Children of Organized Crime offenders: Like Father, like child? An explorative and qualitative study into mechanisms of intergenerational (dis)continuity in Organized Crime families. *European Journal on Criminal Policy and Research*, *25*(4), 345–363. https://doi.org/10.1007/s10610-018-9381-6.

van Dijk, M., Eichelsheim, V., Kleemans, E., Soudijn, M., & van de Weijer, S. (2021). Intergenerational continuity of crime among children of organized crime offenders in the Netherlands. *Crime Law and Social Change*. https://doi.org/10.1007/s10611-021-09970-1.

Van Eijkern, L., Downes, R., & Veenstra, R. (2017). *Slachtofferschap van huiselijk geweld: Prevalentieonderzoek naar de omvang, aard, relaties en gevolgen van slachtoffer- en plegerschap*. Wetenschappelijk Onderzoeks- en Documentatiecentrum, Ministerie van Veiligheid en Justitie. https://repository.wodc.nl/handle/20.50012832/2239.

van Koppen, M. V., de Poot, C. J., & Blokland, A. A. J. (2010). Comparing Criminal Careers of Organized Crime Offenders and General offenders. *European Journal of Criminology*, *7*(5), 356–374. https://doi.org/10.1177/1477370810373730.

van Koppen, V., van der Geest, V., Kleemans, E., & Kruisbergen, E. (2022). Employment and crime: A longitudinal follow-up of organized crime offenders. *European Journal of Criminology*, *19*(5), 1097–1121. https://doi.org/10.1177/1477370820941287.

Verbruggen, J., Blokland, A., Robinson, A. L., & Maxwell, C. D. (2020). The relationship between criminal behaviour over the life-course and intimate partner violence perpetration in later life. *European Journal of Criminology*, *17*(6), 784–805. https://doi.org/10.1177/1477370818825344.

WHO (2021). *Violence against women*. Retrieved 26-02-2024 from https://www.who.int/news-room/fact-sheets/detail/violence-against-women.