Factors Leading to Low Reporting of Domestic Violence and Restricting Access to Service

Public version of Deliverable D1.1 "Factors leading to low reporting & restricting access to service" of the IMPROVE project

Funded by the European Union

Grant Agreement No. 101074010

About this document

Published on the IMPROVE project website in September 2023

Contributors

Marianne Mela[5], Jarmo Houtsonen[5], Ainhoa Izaguirre Choperena[8], Angelika May[6], Anna Juusela[10], Bettina Pfleiderer[11], Catharina Vogt[3], Dora Szego[4], Ellimari Kortman[10], Emanuel Tananau Blumenschein[9], Estíbaliz Linares Bahillo[8], François Bonnet[2], Gabor Hera[4], Hilde Hellbernd[6], Katja Kytölä[10], María Lopez Belloso[8], Natalie Köpsel[3], Norbert Leonhardmair[9], Paulina Juszczyk[11], Sandra González Cabezas[1], Seija Parekh[7], Stefan Hopf[9], Suvi Nipuli[7], Thierry Delpeuch[2], Ulla Koivukoski[10]

Institutions

No.	Acronym	Institution	Country
1	Askabi	Asociación Askabide Liberación	Spain
2	CNRS	Centre National de la Recherche Scientifique	France
3	DHPol	Deutsche Hochschule der Polizei	Germany
4	Foresee	Foresee Kutatocsoport Nonprofit Kozhasznu Kft	Hungary
5	POLAMK	Poliisiammattikorkeakoulu	Finland
6	SIG	S.I.G.N.A.L. e.V. – Intervention im Gesundheitsbereich gegen Häusliche und Sexualisierte Gewalt	Germany
7	THL	Terveyden ja hyvinvoinnin laitos	Finland
8	UDEUSTO	Universidad De La Iglesia De Deusto Entidad Religiosa	Spain
9	VICESSE	Vienna Centre For Societal Security – Vicesse, Wiener Zentrum für Sozialwissenschaftliche Sicherheitsforschung	Austria
10	WE	We Encourage Oy Ltd	Finland
11	WWU	Westfälische Wilhelms-Universität Münster	Germany

Contents

Content

Executive Summary

This report presents the results of Task 1.1 Factors leading to low reporting and restricting access to services. IMPROVE partners, POLAMK DHPOL, VICESSE, WWU, CNRS, THL, FORESEE, DEUSATO, WE, SIG, and ASKABI searched for information in the scientific literature about reasons and factors that constitute barriers to victims of domestic violence (DV) to report and seek help. The literature review included publications in six countries (Austria, Finland, France, Germany, Spain, and Hungary), published mainly during the past ten years.

The report presents factors under two main themes:

1. There are barriers related to victim-survivors, their perceptions, experiences, expectations, living conditions and social relations that potentially influence on whether the victim-survivors of DV or someone in their social sphere are capable to report about domestic violence and seek support from various service organisations, such as the police, courts, health care, social care, shelters and non-governmental support organisations.
2. There are also many structural or systemic barriers that influence the supply and quality of services, such as the distribution and availability of services, and the performance of service organisations and the quality of their services.

Most factors that lead to low reporting or restrict victim-survivors' access to services are relevant for most groups or categories of domestic violence victim-survivors. However, depending on the life situation, other barriers come into effect or are relevant when accessing support services. Therefore, the report presents in separate chapters specific factors that have a most significant influence for individuals in diverse life situations or belonging to minorities (the older victims, victims with children, victims with disabilities, migrant and refugee victims, male victims, LGBTIQ+ victims, victims who live in rural or remote areas, children and adolescents, victims from marginalised Roma communities, homeless victims, victims being in extreme poverty, sex workers as victims of DV and those victims of DV who have substance abuse problems.

The factors that relate to individual victim-survivors of DV encompasses victim-survivors' perceptions, experiences and expectations of services, victim-survivors' social, economic and cultural living conditions and the influence of other persons who constitute the victim's social relations. The victim-survivors of DV have many reasons for not reporting violence and seeking help from various services. Many victim-survivors do not want to disclose or report DV, especially sexual violence, because they regard it as a private matter. The taboo nature of violence is emphasised among various categories of victim-survivors, the older persons, victim-survivors with children, individuals with disabilities, male victim-survivors, people in rural areas and certain immigrant populations. Some victim-survivors are unaware of what constitute DV. Thus, certain forms of violence, such as manipulation and coercive control, are not reported. Furthermore, victim-survivors' lack of knowledge of service structures and victim-survivors' right for support constitute a major barrier for seeking help. Sometimes victim-survivors belittle the seriousness and consequences of violence or overestimate their own capability to control the situation. Such considerations lead victim-survivors to not report violence to the police.

Many victim-survivors assume that authorities will question the victim-survivor's credibility and will not be able to protect the victim-survivor's anonymity. Moreover, gender and ethnicity of a service professional may have an influence the victim-survivors' willingness to seek services. In addition, negative past experiences with service providers, such as negative experiences of victim-survivors at the health care setting, are the cause of victim-survivors to feel frustrated and not well served. In the same way, the victim-survivor's willingness to report DV to the police is undermined by the victim-

survivor's perception of the police not being proactive and capable of effective intervention and protection. Of those victim-survivors who had previous experiences with the police, some felt that the police have been insensitive and disrespectful. Many victim-survivors assume that the legal measures, such as restraining orders or sentences cannot protect them.

Victim-survivors of DV go through multiple feelings and states of mind, which can influence their willingness and capability to report about violence to authorities and to seek help from various support services. A large number of victim-survivors may feel ashamed and guilty of their situation. Victim-survivors may have feelings of inferiority, worthlessness and failure. They may even blame themselves for the 'failure' of not being able to maintain family relations or partnerships. When such feelings of failure are associated with anticipations of humiliation, the victim-survivor's motivation to report about violence and seek help is likely very low.

It is also common that the victim-survivor is afraid for several reasons. First, victim-survivors may fear a negative reaction from a perpetrator, relatives or other significant others. In particular, if the victim-survivor is socially, economically and emotionally dependent on the abusive partner, the likelihood of reporting is reduced by the victim-survivor's fear of social rejection or a loss of meaningful social relations. Violence constitutes a stressful situation, which may paralyse the victim-survivor's cognitive capacity so that she or he is not able to process information effectively. In a situation of embarrassment and uncertainty the victim-survivor would require a supportive and safe encounter with service providers. Authorities' failures to interact with the victim-survivor increase the risk of victim-survivor's experiencing a post-traumatic stress disorder.

The victims' social relationships can not only constitute a barrier to seeking support but can also support and empower victims. Here, the victim-survivor's closest relationships, relatives, colleagues and neighbours, are among the most important factors that support disclosing violence. Furthermore, informal support networks are extremely important for the recovery of victim-survivors.

Structural barriers that restrict the victim-survivors of DV from reporting and seeking support arise from the service system and the performance of service organisations. Lack of funding and resources undermine the supply of services, which result in a shortage of certain services. This lack can be seen nationally, regionally, or locally for instance by a low number of shelter places or qualified staff, or systems incapability to treat all victim-survivors in need of care. Services are not always easy to reach. Victim-survivors may need to visit multiple services, but service points can be dispersed all over the place.

An important prerequisite for victim-survivors' help-seeking activity is service organisations' capacity to meet the needs of various victim-survivors of DV. Inadequate service quality, such as lack of time and lack of switch responses, undermines service system's capacity to meet victim-survivors' needs. Incapacity of service organisations to respond to various needs of the victim-survivors is pronounced in the case of vulnerable and marginalised groups, such as the older persons, or people living with a disability, or those who have a migration background.

Victim-survivors' access to services, justice and protection depends also on legislation and the functioning of the judicial system. However, legal resources available to them can be complex and limited. The amount for compensation for inflicted injuries and mental suffering cannot be predicted. The protection of the victim-survivors of DV in the form of a restraining order is not always utilised effectively. Moreover, the police have difficulties to detect other forms of violence than physical violence, to detect aggravating circumstances and to protect the victim. Failings have been observed in the health care setting in the securing evidence on crimes related to DV. Legislation can constitute a tangible barrier by defining certain types of victim-survivors of DV outside some services. Alternatively, complex bureaucratic procedures make the acquisition of services cumbersome and uncertain. Anyway, not all types of victim-survivors of DV have an inclusive and universal right to

support and services. For instance, entitlements to social benefits may be dependent on certain preconditions.

Shared cultural beliefs about gender roles and stereotypical expectations about proper behaviour can also function as structural barriers by influencing victim-survivors' access to services and the quality of services. Beliefs and stereotypes held by professionals can have a bearing on how different types of victim-survivors and different forms of violence are perceived and how effectively DV is detected and prevented.

Standard operating procedures and their effective implementation in the day-to-day professional work influence the performance of service organisations. The lack of standards, protocols and guidelines has an effect on the service quality and the way the victim-survivors of DV experience their services. Management and oversight of professional work, including the cooperation between different service organisations, are usually needed to support the quality of work, but professionals also require sufficient resources and a modern work environment to accomplish their tasks effectively.

There are certain factors that constitute barriers for reporting violence and seeking help for different groups of victim-survivors, including the older victim-survivors, victim-survivors with children, victim-survivors with disabilities, migrant and refugee victim-survivors, male victim-survivors, LGBTIQ+, victim-survivors who live in rural or remote areas, and some specific vulnerable victim-survivor categories. For most of victim-survivors, being ashamed of violence and regarding it as a private taboo-like matter are even stronger factors that preclude the victims from reporting violence and seeking support. Shame and fear are pronounced for instance among the older victim-survivors, immigrant and refugee women, male victim-survivors, gender minorities and rural women. Many victim-survivor groups are socially, economically and emotionally dependent on the perpetrator and therefore tend not to report violence nor contact service agencies. Victim-survivors with children and immigrant women can be frightened that the perpetrator will take revenge on children, or somehow make victim-survivor's life difficult. Older victim-survivors may not want to expose the perpetrator who is responsible for their long-term care and welfare. Thus, older victim-survivors can prefer to refrain from prosecution and restraining orders.

Victim-survivors with disability or impairment are often afraid that their fears and experiences will be ignored and disbelieved – so they prefer not to report violence and seek support. Many victim-survivors with disabilities are dependent on care, and live in social isolation, which makes contacting service organisations difficult.

In the same way, many migrants (refugees) and rural women can be socially and spatially isolated, and thus perceive only limited options to report and seek help. When such perceptions are associated with beliefs about women's responsibilities to maintain family coherence and toleration of violence it is highly unlikely that such victim-survivors of violence will contact authorities, report violence and seek support services. Moreover, the feelings of shame and fear together with expectations and experiences of discrimination underline victim-survivor's refraining from various services. Victim-survivor's negative anticipations and experiences of discrimination and disbelief in service professionals' capability or willingness to provide effective interventions to DV is regrettably common among many categories of vulnerable victim-survivors, such as LGBTIQ+ and male victim-survivors.

Victim-survivors who have special physical, psychological or language-related needs are often uninformed about violence and support services. Many service organisations cannot meet the specific requirements of certain categories of victim-survivors, including those of older persons, or of victim-survivors with a disability or impairment. In the same way, services may struggle to satisfy the needs of victim-survivors with children, and the migrant and refugee victim-survivors. Ineffective legal practice and law enforcement can also undermine victim-survivors' protection. Language and communication constitute a barrier especially to migrant and refugee victims. Many vulnerable victim-

survivors can also be barred from services because of cultural beliefs and stereotypical conceptions held by themselves, people in their social environments or professionals working in the service organisations.

From the victim-survivor's perspective, reporting violence to some authority or seeking support and care depends on the victim's judgement and anticipation of the consequences of such contact. For most individuals such consideration is not straightforward, but the victim-survivor has to process intellectual and emotional issues and consider reactions – blame, indifference or support – of persons who belong to the victim-survivor's social networks. The victim-survivor also anticipates the availability of various services and how the services providers would react to disclosure and the request for help. The structural foundation of institutional response to DV depends on the availability of services and organisational capability to meet multiple needs of DV victim-survivors. Capability hinges on the day-to-day management, the competence of the staff and the quality of delivery of services. This also includes an effective implementation of procedures by first responders and referral of victim-survivors to other support services, for instance to protect the victim-survivor from further violence or improve her health and well-being.

1. Introduction

This report presents the results of *Task 1.1 Factors leading to low reporting and restricting access to services*. There are several individual and social reasons that potentially influence whether victim-survivors of DV or someone in their social sphere are capable and willing to report about DV and seek support from various service organisations. There are also many structural or systemic factors that influence the access to and quality of services, such as the distribution of service points, and the performance of service organisations. To accomplish the task, POLAMK asked IMPROVE partners DHPOL, VICESSE, WWU, CNRS, THL, FORESEE, DEUSATO, WE, SIG, and ASKABI to search the scientific literature for such reasons and factors that constitute barriers to reporting and help-seeking. The search included publications during the past ten years, although some significant earlier publications were also included. POLAMK and CNRS (WP1 lead), provided guidelines on the analysis and presentation of the research results and reporting of country specific results (see Appendix 1). Research utilised scientific databases, but also other relevant sources such as official statistics, population surveys in addition to studies and reports commissioned by relevant ministries, public agencies, parliaments, and NGOs.

Partners were instructed to review published information that could be found in their country about how victims' socio-cultural characteristics and disadvantages, victims' perceptions of frontline response and services, and the real opportunities offered by the service structure influenced on reporting DV seeking help. Partners were also guided to analyse various thresholds to report, such as the severity of violence, extent of harm, supportive third parties, accessibility of services and exposure to an awareness campaign. The partners were specifically asked to consider the position of under-served and marginalised populations and note whether any solutions were introduced in any of the partner countries to activate reporting and help-seeking behaviour regarding domestic violence. Furthermore, partners were also requested to mark down information about methodology utilised in each publication included in the national report.

The information that was gathered in six partner countries – Austria, Finland, France, Germany, Hungary, and Spain – was collected and presented in five tables (blocks), which can be found in the Appendix 2 of this report. The Tables 1–5 describe information about various barriers and enablers of access to services in a condensed form, so that information can be easily utilised in the subsequent phases of the IMPROVE project. The purpose is to utilise the results from Task 1.1 in Task 1.2 (Victim interviews), WP 2 (Chatbot development), WP3 (training development) and WP4 (Policy enhancement), as well as WP5 (awareness raising).

From the victim's perspective reporting about violence to some authority or seeking support and care depends on the victim's judgement and anticipation of the consequences of such contact. For most individuals such consideration is not straightforward, as the victim may have to master intellectual and emotional issues and consider outside reactions – such as denouncement, indifference or support – of persons who belong to the victim's social networks. The victim has often negative perceptions about the availability of various services and how the services providers would respond to disclosure and the request for help. The structural base of institutional response to DV depends on the availability of services (police, courts, health care, social care, support) and their capability to meet multiple needs of DV victims. Capability hinges on the day-to-day management, the competence of the staff and the quality of delivery of services. This also includes an effective implementation of procedures by first responders and referral of victims to other support services, for instance to protect the victim from further violence or improve her health and well-being.

In this report, we have clustered the factors (or barriers and enablers) influencing victims' access to services into two broader themes. The first theme related to victim-related factors, i.e., the factors that influence the victim's demand of services. This angle illustrates how victims' perceptions, expectations

and experiences of services and service organisations can influence their readiness to report violence and seek help from official sources. This theme discusses also victims' living conditions, such as their social, economic, and cultural context, and social relationships that may influence their motivation and capability to seek services and report about violence.

The second theme relates to system related factors, i.e., the supply of services, which consists of the financial and other resources allocated to the service system, and the actual availability and distribution of services. Theme also covers the quality of services and the performance of service organisations, organisations' capability to respond to various needs of victims, and the implementation of established procedures. Under these structural and organisational barriers, we don't discuss the gaps in policy and strategy, and shortcomings in training, unless these relate closely to other structural and organisational barriers of access to services that are the subject of this report. Gaps in policy and strategy, deficits in training and competence of frontline responders were already discussed in the Horizon 2020 project entitled as IMPRODOVA[1] and its publications (see e.g., Lobnikar et al. 2021; Kersten et al. 2023).

In this report, the main chapters from 2 to 9 are organised around different groups of victims. The first chapter discusses such barriers to access that are relevant for most victims or victims in general. Other main chapters concentrate on special groups of victim-survivors, including the older victims, victims with children, victims with disabilities, migrant and refugee victims, male victims, LGBTIQ+, victims who live in rural or remote areas. Chapter 9 describes some other vulnerable victim categories – children and adolescents, Roma, homeless, victims in extreme poverty, sex workers and victims who have substance abuse problems.

Each of the eight main chapters is divided into two sub-chapters. The first sub-chapter consists of different factors that constitute barriers that relate to the victim, her/his perceptions, experiences, expectations, but also the living conditions and social relations of the victim. The second sub-chapter consists of various structural barriers, which are system-related factors consisting of the distribution and availability of services, and their quality. The presentation is organised around different victim categories rather than service providers because in the subsequent phase of the project the purpose is to develop a Chatbot (WP2) that would improve and increase DV victims' possibilities and readiness to seek services more often. Certainly, this depends on the structural factors too, but many of the structural factors, such as an allocation of resources to support services, are outside the potential direct impact of the IMPROVE project. However, the review material was gathered and presented in tables (see Appendices) in a way that indicates also to which service sector or organisation – police, courts, health care, social care, other support services – certain subjective or structural barriers are related. Therefore, the information that is represented in the form of these tables can be later utilised in subsequent work packages that aim at developing the institutional response to DV, that is, by developing trainings (WP3) and accelerating policy implementation (WP4).

The reader should also remember that the distinction between the victim's side and structural side of barriers to disclose and access services is analytic. In other words, in real life these two types of factors often interweave. For instance, the quality of service might be poor because of insufficient resources and inadequate training of staff. The service system has objective deficits, which can also be perceived, experienced, or anticipated by the service users who decide not to seek for support from the official sources. This type of analytic structure of the report means that there is some overlap of material presented in the chapters that focus first on the victim's side and then on the system's side of the barriers. In addition, the repetition of information in different chapters comes from the fact that

[1] www.improdova.eu; IMPRODOVA received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 787054.

many factors and barriers that restrict access to services have a negative impact on most victim groups.

In addition to conventional bibliographical notes, the IMPROVE partners contributing to this report were also requested to make certain methodological notes of each publication that they included in the material of the national material. Methodological notes consisted of information on research design and methods including sample size, and procedures of data collection and analysis applied in each publication reviewed for the national report. This information was important for the assessment of the reliability and quality of the information presented in the publication. Because the purpose of this report is not to assess validity of knowledge on some conceptually well-defined scientific problem, but rather to provide reliable and practically useful information for subsequent phases of the project, we encouraged the partners to include also other types of material than scientific peer-reviewed publications. Therefore, the report also includes information that is obtained, for instance, from assessment studies and reports commissioned by relevant ministries, public agencies, and non-governmental organisations.

2. Victims in general

2.1 Victim's perceptions, socio-economic characteristics and social relations

2.1.1 Victims hide DV because they regard it as a taboo topic and a private matter

Despite the increased awareness of DV in societies, studies show that DV is still regarded by many victims as a **private matter** (FRA 2014; Müller et al. 2004; Nägele et al. 2009; Wetzels & Pfeiffer 1995; Wippermann 2022) and a **taboo** topic that is not willingly disclosed (Döge 2012; Fiedeler 2020a; Löbmann & Herbers 2004; Müller et al. 2004; Ohms 2020b; Schouler-Ocak et al. 2017; Wippermann 2022). According to Schröttle and Ansorge (2009) the taboo nature of DV applies in particular to victims in **higher educational and social classes**. Victims are unwilling to share problems with strangers or public officials and believe that private problems should be kept inside the family circle (Topkaya 2015). Experiences of **sexual violence** are particularly difficult to address (e.g., Döge 2012; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle et al. 2011). These sentiments are strong among all victims of DV, but are highlighted among particular groups of victims, such as older persons, victims with children, individuals with disabilities, male victims, individuals in rural areas and some immigrant populations.

2.1.2 Victims are unaware of available services and certain forms of DV

Many studies have identified that many victims are unaware **of certain forms of DV** and the existence of various support services that are available. Such unawareness is one major reason behind the low reporting of DV (Döge 2012; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Löbmann & Herbers 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Schröttle & Ansorge 2008; Schröttle et al. 2011; Schouler-Ocak et al. 2017; Wippermann 2022). Some victims may have difficulties in identifying abusive behaviour as violence. Lack of societal discussion and awareness campaigns may lead victims to believe that only clearly physical abuse, such as hitting or kicking, is counted as violence. In addition, many victims do not understand that the available support services are also for individuals who have not experienced physical violence. Insufficient understanding of **what constitutes violence** hinders victims' ability to identify violent behaviour in their relationships as abuse and to admit that they might need help. (Wright et al. 2022.) This may prevent victims from seeking care early on. Psychological violence might be known as a concept, but victims may be unaware of many other forms of violence, such as economic and religious violence, as well **manipulation and coercive control**. However, the difficulty to be able to demonstrate psychological abuse hinders reporting (García Campoy 2019).

Media representations and cultural stereotypes imply that violence is mostly random and committed by strangers (Best 1999; Dietz & Martin 2007), thus telling women to fear strangers instead of their husbands, partners, dates, or former intimates (Madriz 1997 as cited in Dietz & Martin 2007). Consequently, women's fear of crime focuses on people whom they do not know, who may attack them unexpectedly. However, women are most at risk for violence at homes and by people they know, especially intimates or ex-intimates (Hollander 2004; Saunders 2002 as cited in Dietz & Martin 2007).

Lack of knowledge of existing support structures is a strong barrier of help-seeking (Fiedeler 2020a; Müller et al. 2004; Ohms 2020). Victims may **not understand their rights for legal aid**, and they may think that it is not within their reach. Additionally, many studies show that unawareness of psychological services lead people not to seek for these services (Pullmann et al. 2010; Yorgason et al. 2008 as cited in Topkaya 2015). Dispersion of services forces victims to search for help in many different locations. According to a Finnish study by Röntynen (2021), the interviewed victims (n = 17) underlined the importance of their own activity in expressing the need for support and in obtaining

services. In addition, the victims talked about their own effort in finding the right services because no support had been offered to them. From the victims' perspective this was burdensome because they were not aware of support services and the possibility of receiving them. (Röntynen 2021.)

Enablers

Dissemination of information about support services would first improve awareness of DV and then likely also increase reporting. Women who have more experience with the criminal justice system, especially those protected by a restraining order or who have experienced more severe abuse, are more likely to call police. The seriousness of injury does not automatically lead the victim to report if she/he is incapable of doing so. In such situations the presence of a third-party calling the police may increase. (Klein 2009.)

There are some suggestions that **raising awareness** of DV facilitates help-seeking behaviour. First, easy access to psychological help services is a major agent in facilitating psychological help seeking (Lord-Flynn 1989; Wong 2006 as cited in Topkaya 2015). Surprisingly, restrictive forms of support such as child protection may significantly change the victim's situation. Some victims benefit from an outside party persuading them to seek help for their situation for the sake of children. (Röntynen 2021.)

2.1.3 Victims minimize the seriousness and consequences of DV

It seems typical for victims of violence to **belittle the experiences of violence** as well as its consequences, which may inhibit victims from discussing violence with service agencies. For example, studies indicate that victims will not report violence if the perpetrator had **apologised and promised** that it would not happen again, if they perceive the case too minor or if they considered violence as an isolated incident (Hellmann 2014; Müller et al. 2004). In addition, victims reason concealment by thinking that they do not need any support or that they have '**got it under control**' (ibid.; FRA 2014). The analysis of an EU-wide survey by FRA showed, 34 percent of intimate partner violence (IPV) victims (n = 42,000) indicated that they did not report violence to the police because they did not consider the **incident to be serious enough**, and that the idea of reporting to the police did not occur to them. This finding is worrying as it suggests that for many victims, DV is 'normalised' and considered to be a 'private' matter. (Goodey 2017.)

2.1.4 Victims have negative expectations and experiences of services and professionals

According to numerous German studies, victims have doubts about the encounter with the service agencies if they disclose violence. Firstly, there are expectations of not being taken seriously. In addition, victims wish that the professionals would show understanding and not **question their credibility**. (Birkel et al. 2022; Brzank et al. 2005; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Hellmann 2014; LN-W 2020; Müller et al. 2004; Schröttle et al. 2011; Wippermann 2022.)

Victims also suspect that professionals would present unpleasant questions (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2008; Wippermann 2022). In addition, doubts about careful protection of their anonymity seems to prevent victims from seeking help (Müller et al. 2004; Schouler-Ocak et al. 2017; Schröttle & Ansorge 2008). Some victims fear of being mistaken for the perpetrator (Forschungsverbund Gewalt gegen Männer 2004). Further, victims may suspect that they lose autonomy and control of their lives when seeking care (Feder et al. 2006). Finally, it may be difficult for victims to leave their homes and normal daily routines to live in a shelter (Hackenberg et al. 2021).

The sex and ethnic origin of the professionals and the translators also influence victims' motivation and ability to disclose. Female victims find it difficult to tell male police officers about sexual abuse (especially when they are asked for a detailed account), and they are uncomfortable when a male gynaecologist has to examine that sexual violence has occurred (Nagy et al. 2020). In a study by Müller et al. (2004), the victims wished that conversation and questioning should be conducted by a female (or in some cases, by a male) professional, or that there were more female interpreters and/or contact persons from the same cultural group.

Health care

Surprisingly, often victims are not always asked about violence by health care professionals (Brzank et al. 2005; Müller et al. 2004). Even though the majority of victims of DV attend health care services frequently, often making multiple visits, only a low number of victims are identified (Hackenberg et al. 2021; Hegarty et al. 2020; Siltala 2021). However, health care professionals are the main group of first line responders to whom patients would want to disclose their situation, besides, the victims want to be asked directly about DV (Feder et al. 2006 as cited in Hegarty et al. 2020).

Many health care professionals often lack required skills and experience to respond appropriately (Hegarty et al. 2020), and victims' disclosure of DV is sometimes ignored. Victims in Hungary reported that healthcare professionals are often indifferent towards the victims and do not believe their testimonies (HRW 2013; Nagy et al. 2020). Röntynen (2021) described how victims' experiences of violence were belittled and how the victims had wondered whether they had raised the matter in the wrong service. Moreover, even during the review of child protection reports, the social workers did not ask nor talk about violence. Further, at the child health centre, the experiences of violence were sometimes attributed to imbalance of hormones. (ibid.) Poor communication or failures in responding appropriately push the victims to feel unworthy, and undeserving for professionals' attention and time. As a study of Wallin et al. (2018) indicated, perception of lack of time in the services and the lack of interest shown by the professionals increase frustration with and distrust of the healthcare system among the victims of DV in Spain.

The problem is not always that the victims do not report DV to a healthcare professional, but reporting does not lead to intervention, as shown in the Finnish study by Hackenberg et al. (2021): despite the seriousness of the situation, only 19% of IPV victims (n = 146) were referred to advocacy (typically to child welfare services), and only 1% utilised shelter services.

Interviewees (n = 17) in the study by Röntynen (2021) hoped that their experiences would not be diminished, but they would be believed. Professionals should make a clear statement that violence is wrong, and that the situation can be improved. Confidential relationship with the health care professional was considered important. For example, the interviewees appreciated if the same nurse works with a client for several years. (Röntynen 2021.)

Police and court

The judicial system is not a highly trusted institution among victims of violence. In fact, the perception or anticipation of justice system's response is one of the most significant barriers to seeking help. (Aronson et al. 1995; Dugan et al. 2003; Grigsby and Hartman 1997; Lutenbacher et al. 2003 as cited in Beaulaurier et al. 2007). Several studies indicated that violence against women is systematically under-reported to the police authorities. For example, according to the criminal victimisation survey in the USA in 2020, only 41 % of intimate partner victimisations were reported to police in 2020 (Morgan & Thompson 2021). In a study conducted in Australia in 2013, approximately half (48.2 %) of the 300 interviewed victims answered that they did not report their most recent violent incident to the police. Victims were less likely to report the violence if they were pregnant or if they had experienced more than five previous incidents of abuse. The primary barrier to reporting, according to the interviewed, was that police either do not understand or are not proactive in handling DV

(17.1%). (Birdsey & Snowball 2013.) In an EU-wide survey by FRA, between 5% and 13% of the respondents (*n* = 42,000) indicated that they have not reported to the police because of the assumption that the police would not or could not do anything. This suggests that police intervention is not an option for most women. (Goodey 2017.) Furthermore, several German studies reported that victims do not trust the police's capability to do anything about violence or that there is a low rate of success when going to court (FRA 2014; Hellmann 2014; Müller et al. 2004; Wetzels & Pfeiffer 1995).

According to a representative public survey conducted in Hungary by Hoffmann (2021), people generally do not trust Hungarian legislative framework and criminal procedures. This and lenient sentences even for IPV cases involving serious physical abuse are some of the reasons for the reluctance to report abuse (Garai 2019).

According to a representative public survey made by Hoffmann (2021) in Hungary, people, in general, do not trust the Hungarian police and court performance. The reluctance to report can be related to the mistrust in the judiciary and criminal procedure as the verdicts are rather mild even in cases of serious physical violence in IPV cases (Garai 2019). A study in the USA indicates that victims who reported prior victimisation and considered the response of criminal justice as insufficient or endangering, were less likely to report victimisation subsequently (Klein 2009).

In Hungary, victims have experienced that police officers on the spot often do not act against the abusers. In addition, victims often complained about the passivity, insensitivity, and victim-blaming attitude of police officers. Several victims mentioned that the police were the first to come to their minds in case of emergency, but they finally did not take any further action because they felt that the police would not be able to give appropriate support. All in all, victims were generally critical towards the work of the police and lack of confidence constitutes a major barrier to reporting abuse and seeking protection. (HRW 2013; Nagy et al. 2020.)

Low reporting rates may also be explained with the fact that some victims do not perceive the police as an effective agent of protection (Müller et al. 2004). Victims can be poorly protected during the protracted criminal proceedings, and they live in constant fear and threats. Moreover, the hearing may often be a traumatising experience, which may be carried out frequently and by persons with inadequate professional qualifications. Treating victims with disbelief or disrespectfully results in the experience of humiliation. (Hornyik 2020.) The EU-wide survey (*n* = 42 000) by FRA revealed that women who were in contact with the police or some other services after the most serious incident of physical and/or sexual violence, reported that they were less satisfied with the police than with any other services (Goodey 2017).

Due to these experiences or assumptions, victims may also be afraid of the police contact and legal proceedings (see e.g., Hellmann 2014) and therefore they may prefer to avoid the police (Müller et al. 2004). For example, in a study conducted in the United States, the respondents (women aged 45–85, *n* = 134) mentioned that they were afraid of police brutality towards the victim. The victims also expected that jail as a punishment, arrest, restraining orders and court interventions do not help or they make things even worse. The victims believed that police would not understand the situation and feared that police would ridicule the victim. (Beaulaurier et al. 2007.)

2.1.5 Victims' education and employment associated with greater propensity to report DV

Employment is a complex factor in facilitating reporting of violence. The findings of the reviewed research are somewhat contradictory. For example, as a study conducted in Spain showed, the probability of a woman responding to violence with a distancing strategy (seeking outside help or leaving temporarily) is almost three times greater if they are employed (Montero et al. 2012). A report

from Lower Saxony in German, describes that employed women are more likely to be victims of (ex)partner violence (State Criminal Police Office Lower Saxony 2020).

Yet, some other studies indicate that the risk of violence is double for women who are not in employment, which implies suffering social isolation (Brown et al. 2020; Wicky et al. 2021). Indeed, Flotzinger et al. (2021) emphasise that exclusion from the labour market and public life increases the social isolation of the victims.

In a study conducted in France, Wicky et al. (2021) found that women with higher educational degrees tend to report more violence, probably because they have better access to information campaigns and prevention tools. Education generally contributes to victims' use of support services, but the relationship between the educational degree and the extent of service-use are not straightforward. An Austrian study by Kapella et al. (2011) showed that persons with a compulsory school-leaving certificate as well as persons with a vocational school-leaving certificate make the greatest use of the various support services. An exception is the use of counselling or therapy services which is more often sought by persons with a university degree (Kapella et a. 2011).

2.1.6 Shame, fear and traumatic experiences restrain from reporting and seeking help

Victim's feelings of shame have been identified as an obstacle for reporting DV in many studies (Birkel et al. 2022; Forschungsverbund Gewalt gegen Männer 2004; FRA 2014; Hellmann 2014; LN-W 2020; Müller et al. 2004; Nägele et al. 2009; Ohms 2020a; Schouler-Ocak et al. 2017; Schröttle & Ansorge 2008; Wetzels & Pfeiffer 1995; Wippermann 2022). Shame is more likely felt by victims in incidents of IPV (19.6%) than parental violence (9.79). Feelings of shame or embarrassment are the reasons for women to hide DV, especially in cases of sexual violence (Hellman 2014; Goodey 2017).

It is important to look behind the concept of shame. First, shame has been identified as one of the key factors underlying many trauma symptoms (López-Castro et al. 2019; Saraiya & López-Castro 2016 as cited in Bailey et al. 2023). Victims may be ashamed of their own 'irresponsible action' in allowing the dangerous situation to develop. Moreover, perhaps due to the social dimension of shame, older women tend to feel shame more often than younger women. An individual may bear shame because of feelings of inferiority or feelings of being less valuable (Giddens 1991; Ronkainen 1999 as cited in Piispa 2004.) If the person is dependent on the abusive spouse, shame may be associated with fear of loss or rejection (Ronkainen 1999 as cited in Piispa 2004.)

As victims often feel guilty and are ashamed of their situation, they are inclined to observe and listen carefully what happens in encounters with the professional and sense professionals' judgemental or diminishing attitudes (Röntynen 2021). For instance, among the victims in Spain the feelings of being safe and listened to by professionals were considered crucial aspects in a positive encounter (Wallin et al. 2018). In other words, failures to interact with the victims appropriately and sensitively may lead to secondary victimisation which may exacerbate an already difficult situation of the victims (Hill 2009). Negative experiences with professionals increase the risk for post-traumatic stress symptoms (Campbell et al. 1999 as cited in Hill 2009) and decrease the likelihood of reporting (Monroe et al. 2005 as cited in Hill 2009). In the worst case, a victim may be further traumatised by the response of the professional (ibid.)

Some victim-survivors do not want to be stigmatised as victims (Ebert & Steinert 2012; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022; Wright et al. 2022). Asking for help may feel uncomfortable and embarrassing because by simply asking for help, the help-seeker risks exposing their vulnerabilities (see e.g., Collins and Feeney 2000; Downey and Feldman 1996 as cited in Bohns & Flynn 2010). Shame is

often linked in complex ways to other feelings, such as guilt and fear. A victim may not seek help because she anticipates humiliation if violence is made known to the victim's social environment (García Campoy 2019).

Fear of the perpetrator is one major limitations in victim's help-seeking behaviour (Birke et al. 2022; FRA 2014; Forschungsverbund Gewalt gegen Männer 2004; Goodey 2017; Müller et al. 2004; Schröttle & Ansorge 2008; Wetzels & Pfeiffer 1995; Wright et al. 2022). Fear paralyses the victim and reinforces dependency by compromising higher level processing of brain by e.g., reducing problem-solving capacity and limiting cognitive processing. In some cases, victim's caring for the perpetrator or appeasement can be seen as a survival strategy, not always as intentional, but as a response of the victim's autonomic nervous system. (Bailey et al. 2023.)

Victim's concern for the situation of the perpetrator may also contribute to lower reporting of violence. For example, several German studies have indicated that victims may not disclose violence because they partly blame themselves for the incident. For example, they may feel guilt for upsetting the partner with their behaviour or they may have tried to change their own behaviour (Birkel et al. 2022; FRA 2014; Forschungsverbund Gewalt gegen Männer 2004; Hellmann 2014; LN-W 2020; Müller et al. 2004; Nägele et al. 2009; Ohms 2020a; Schouler-Ocak et al. 2017; Schröttle & Ansorge 2008; Wetzels & Pfeiffer 1995; Wippermann 2022). Moreover, victims' decision-making may be influenced by their feelings of obligation towards the partner and feelings of failure in managing the partnership (Nägele 2009; Wippermann 2022). In some cases, the victim may not want the perpetrator to be punished (Hellmann 2014; Wetzels & Pfeiffer 1995).

In addition to fear of a perpetrator or retaliation, there are other sources of fears that may prevent victims from help-seeking or reporting. Victim may be afraid of losing contact with the children, of loneliness, or of endangering family cohesion as reported in many German studies (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022). According to Beaulaurier et al. (2007), women (n = 134) were afraid of talking about DV, because they would anticipate that their family members would not be supportive. In fact, most often their families did deny the abuse, blamed the victim, or were hostile to the idea of "breaking up the family".

Furthermore, mental wellbeing of victims affects their ability to act, and consequently, to the contents of their decisions. Lack of courage, unwillingness to take risks and experiencing powerlessness and hopelessness lead to decisions not to disclose violence (Fiedeler 2020b; Nägele et al. 2009; Ohms 2020a; Wippermann 2022). In addition, there are several reasons why many victims having a trauma seem to be reluctant to seek professional help, especially from psychological services. First, they may have doubts about the effectiveness of the treatment of trauma. Second, they may have repressed memories. Third, concerns about re-experiencing the traumatic events make them avoid traumatic reminders, and therefore they are concerned about dealing with certain memories in treatment. (Kantor et al. 2017.)

However, the availability of free psychological services, the belief in the benefits of psychological services, and trust in mental health professionals prompt victims to turn to services. In addition, the victim's willingness to seek psychological help has been found to be predicted by the willingness to disclose personal problems indicated that comfort with disclosing personal problems (Topkaya 2015; Vogel & Wester 2003), the ability to express emotions (Vogel et al. 2007) and victims' general attitude toward seeking psychological help (Cantazaro 2009).

2.1.7 Supportive social relations encourage victims to report violence and seek help

The victim's closest relationships and networks are among the most important factors that facilitate disclosing DV. Sylaska and Edwards (2014) showed that victims prefer their immediate social network

such as friends, relatives, classmates, co-workers and neighbours as “service providers”. In addition, Sanz-Barbero et al. (2022) stated that informal support networks are the most used resource by all women regardless of their age. A Spanish study by Garcia et al. (2021) indicated that the relationships between women, ties of sorority and social resources are extremely important and necessary for the recovery and healing of women. In a study conducted in Hungary (Garai 2019), only 55% of the analysed DV cases was reported by the victims. In the rest of the cases, the most frequent reporters were relatives, official bodies and neighbours.

In the EU-wide study of FRA, women (*n* = 42 000) were asked why they did not contact the police after the most serious incident of physical and/or sexual violence they had experienced by either a partner or non-partner. The main reasons given were that women had dealt with the matter themselves or had a friend or family member involved. (Goodey 2017.) Interestingly, the number of people in whom the victims confide, is also relevant. According to a study by Zähring and Stiller (2016), if victims spoke to three or more other people about stalking, crimes were more likely to be reported.

2.2 Structural and organisational barriers

2.2.1 Scarcity of funding and resources constrain the supply of services

Victims of DV may have difficulties in accessing various services simply because the supply of services is short, and the supply of services is financed and resourced insufficiently. For instance, in Germany, there is not only a shortage of shelter places for women, but shelter places are also limited for men, women with children, the older persons and persons living with a disability. In addition, some shelters are understaffed or staffed with personnel that does not have required competencies and qualifications.

The lack of shelters for providing protection and support may force the victim to return to the abuser, or choose to stay in temporary shelters, with friends or relatives or even becoming homeless (BMFSFJ 2022; FHK 2022).

The service situation can be unacceptable in some health care settings too. There is often a lack of human, time and technical resources that undermine the detection of DV, and the attention needed by the victims (Brzank 2022; Lancharro-Tavero et al. 2022; Löbmann and Herbers 2005; Schellong 2019). In addition, inadequate working conditions may undermine frontline responders' capability to support the victims of DV. For instance, based on a survey among health care professionals (n = 659) in Berlin, Brzank (2022) urges for better financing of health care for the victims of DV. In France, Nublat and Karzabi (2017) report that psychological care for victims of DV is unable to respond to all requests. The supply of psychological care has a long waiting list and a low capacity to respond to emergencies. Another indication of the scarcity of staff is service organisation's inability to provide the victim with an agent having a gender of the victim's choice. (Rasch et al. 2022; see also Czibere 2012).

Social and support services for female victims of DV tend to be underfinanced in France. Funding sources can be very fragmented, and the securing of funding requires the service provider to invest significant amounts of time to secure funding, which takes precious time from the core activities, that is, supporting the victims. The role of NGOs is crucial especially in providing specialised services that can address the specific needs of some vulnerable groups that fall outside the mainstream population. However, the supply of such specialised services is insufficient to meet the demand due to lack of funding. NGOs providing specialised support services lack continuity and stability in service delivery because they have not sufficiently guaranteed public funding and constantly face potential funding cuts. This financial uncertainty hinders their ability to plan activities and development on a long-term basis. (Assemblée Nationale 2019a, 2019b). It is suggested that budget data should be publicized, and funding increased especially for specialised accommodations and specialised associations. To improve the financing, contributions from private funding in addition to state and local authorities is recommended in France by Craviotto et al. (2018). BMFSFJ's (2022) report on Germany also points out that the private sector is rarely involved in financing services for the victims of DV.

Many victims of DV are financially dependent on the perpetrator or are otherwise in a vulnerable economic position. Yet, financial services for the victims are often underdeveloped and weak. Therefore, BMFSFJ (2022) recommends improving the financial situation of the victims in Germany. In France, Haut Conseil à l'Égalité (HCE 2020) and Assemblée Nationale (2019a, 2019b) have called for strengthening the financial autonomy of victims in France. A report by Assemblée Nationale (2021) on economic violence highlights that banks and notaries are unable to react and have few tools to support the victims.

2.2.2 Inadequate service quality undermines capacity to meet victims' needs

Even if there are services, these are often spread out in various locations in population centres. Services can be hard to reach if "service counters" are scattered in many localities, or if service locations are physically far away from the victim's place of residence.

Even if some services are available and rather conveniently located the content of the support and help may not be well adapted to various needs and experiences of specific victim groups. For instance, it was noticed by FHK (2022) that often women must travel far away from their home in order to reach the nearest shelter in Germany. The Senate of France (2018) has remarked that there are not enough one-stop shops for DV victims as required by the Istanbul Convention (BMFSFJ 2022; Sénat 2018). One improvement would be the establishment of so-called multidisciplinary teams, which are now mostly lacking (Assemblée Nationale 2019; Durán-Martín et al. 2022). In practice, this would mean for instance that there would be psychologists and social workers who work in association with the police in dealing with victims (Sénat 2021).

There is not in every country binding nationwide quality standards for NGOs regarding personnel, premises, and operations in shelter. One aspect of service quality is speed (waiting times). The other aspect of quality is the timing and coordination of several services. Victims of DV need services often rather quickly, and the timing of implementation of several services should be well coordinated in order to achieve effectiveness and avoid unwanted negative outcomes, for instance, endangering the victim's safety and well-being. Durán-Martin et al. (2022) have noticed slowness of services and referrals in the services for the young women who are victims of DV.

In Germany, Müller et al. (2004) have identified following structural barriers behind the victims' decisions to not seek help: too young to get help, too long waiting times, opening hours do not suit, administrative burden, support was too expensive, and waiting for therapies took too long. Even if the victim has a formal access to services, in reality she may not have an opportunity to speak openly. The studies conducted in Hungary state that the victims usually do not talk openly about their problems when meeting a health care professional because the abuser is often present during visits and examinations (HRW 2013; Nagy et al. 2020).

Moreover, when multiple vulnerabilities such as disabilities, homelessness, psychological disorders, and addictions have accumulated to a victim, women's shelter is not always accessible for her. First, women are required to be independent. Second, such women are perceived as bringing about higher potential for conflicts, and the protection of other women is considered more important. (Koch et al. 2018.) Furthermore, poor language skills and/or reading and writing skills hamper the acquisition of information about violence in general or about available support services. Also, being financially dependent on the partner hinders reporting (FHK 2022; Hellmann 2014; Löbmann & Herbers 2004; Nägele et al. 2009; Wippermann 2022).

The capacity of services to respond to various needs of vulnerable and marginalised victims will be discussed in more details in subsequent chapters. In the context of victims in general, there are also challenges in adapting to different types of victims' needs. In Spain, Sanz-Barbero et al. (2022) urge to adapt the response of formal victim services to the specific needs of women in different life stages. For instance, service organisations may not have established procedures to deal with children who accompany the victims of DV. Space, infrastructure, and services provided by service organisations may not be specifically adapted to the needs of the various victim groups (Brzank 2022; FHK 2022; Nublat & Karzabi 2017; Nägele et al. 2009; Rasch et al. 2020; Schröttle et al. 2013).

In many localities, there are not enough professional first line responders and too many unpaid volunteers to deliver the support services, due to lack of funding adequate quality of services presupposes that the staff is qualified and trained. At the moment, there is a shortage of trained

personnel in general and specialists in particular in many localities. (Coll-Vinent et al. 2008; Lancharro-Tavero et al. 2022; Murillo et al. 2018.) Many shelters in Germany lack resources to deal with traumatized women and their children. In addition, service organisations do not necessarily demand that those who work with the victims of DV have formal qualifications and training in detection and prevention of DV. The consequences of unprepared and understaffed service organisations are most strongly seen in inadequate support of victims with special needs and limitations. In the worst case, the service staff may show signs of disrespect and lack of empathy towards vulnerable and marginalised victims (Schouler-Ocak et al. 2017; Schröttle et al. 2013).

It would also be important for the organisation to manage human resources well. Caring and supporting the victims of DV easily accumulates stress among the staff. Yet, many service organisations do not provide sufficient psychological assistance to the staff who deals with DV victims (Rasch et al. 2020).

2.2.3 Gaps in legislation and enforcement undermine victim's protection and rights

Victim's access to justice and protection from violence depends also on legislation and the functioning of the judicial system. However, legal resources can be limited in the first place as shown in the study of 23 DV cases in the Balearic Islands by Ferrer Pérez and Bosch Fiol (2016). Legal procedures can be quite complex and thus impose challenges functioning as barriers to victims' access to the judicial system, for instance, to get compensation for damages, pain, and suffering (Sénat 2018). For instance, to prove the connection between damages and violence can be problematic and the outcome of the judicial process can be uncertain. Moreover, individuals who have been affected by IPV are not necessarily granted compensation, because they can be regarded partly responsible for the damages by exposing themselves to danger (FHK 2022).

Certain forms of DV may not be criminalised in all jurisdictions. For instance, BMFSFJ (2022) has pointed out that psychological violence is not criminalised in Germany, and the situation is the same in most EU jurisdictions. Moreover, BMFSFJ (2022) considers that the gender dimension should be fully considered in the development of laws, policies, and measures to prevent and combat violence against women. It is challenging to be able to demonstrate psychological abuse and its consequences (García Campoy 2019).

The protection from violence, e.g., in the form of restraining orders, is not always applied effectively. The application of a restraining order is not successful without credible evidence such as medical proof or witnesses, which can be difficult. In particular, certain types of violence, such as stalking and mental abuse, are not always regarded as requiring urgent protection of the victim. (Gabler et al. 2016). The police fail to properly detect other forms of violence than physical violence, detect aggravating circumstances and take prompt action and adequate measures to protect the victim. Existing protection mechanisms such as restraining orders are under-utilised or ineffective in the present form. (Centre Hubertine Auclair 2019; Gendarmerie Nationale 2021; HCE 2020; Héra 2022; Hornyik 2020; HRW 2013; Ministère de la Justice 2019; Müller et al. 2004; Sénat 2018; Solt 2022.)

It has been argued that court sentences are excessively lenient in France (HCE 2020) and Hungary (Garai 2019; Hornyik 2020; Solt 2022). Moreover, court sentences tend to place part of the responsibility for the violence on the victim (Jouanneau & Matteoli 2018). FHK (2022) notices that civil proceedings are underutilised in the DV case in Germany. Also, health care services may fail to take adequate measures to protect the victim (Hornyik 2020), particularly when the staff does not share information about risk factors with other frontline agencies (Hackenberg et al 2021; Röntynen 2021). Berthier and Karzabi (2021) discuss how health care services, such as psychological care, can fail to provide adequate support to victims who have children. Thus, emergency medical services are recommended to offer possible co-admission of children and hire staff that is qualified in child protection issues.

An important procedure that influences investigation and legal practice is the preservation of evidence on crimes related to DV. Health care and emergency medical services are sometimes criticised for not producing forensic documentation that would be usable in court. Some emergency departments leave it to staff members to decide individually whether to offer forensic documentation beyond regular medical documentation. Furthermore, health care organisations may not have capacity to securely archive evidence. (Rasch et al. 2020.)

In certain contexts, legislation may leave the victim-survivors without some services or complex bureaucratic procedures make the acquisition of services cumbersome and uncertain (Schouler-Ocak et al. 2017). In some countries and regions, not all victims of DV have an unambiguous universal right to access support and services. For instance, free shelter accommodation may be dependent on rules of residency or the women's entitlement to social benefits. Women without entitlement to social benefits may have to bear all or some costs of the stay in a women's shelter themselves. In some cases, the victim's access to services depends on the type of residence permit of the abusive partner. Consequently, bureaucratic rules may lead to the turning away of some victims of DV. (BMFSFJ 2022; FHK 2022.) Some victims needing emergency accommodation are sent to a homeless shelter, while this is not a suitable solution for the women victims of DV. Instead, the number of specialised support shelters for the victims of DV should be increased.

Regulation that controls the work of frontline responders may turn out to be malfunctioning and leading to ineffective outcomes. For instance, the mandate for action in the cases of DV can be ambiguous in health care settings in Germany (Brzank 2022). In such conditions, the decision to react is left to the individual member of the staff. In France, the Ministry of Justice (2019) has notified that the current legislation on the reporting of DV by healthcare professionals is insufficient, as the current legislation does not allow the doctors, without risk of legal action against them, to report serious violence observed without the consent of victims.

2.2.4 Cultural beliefs and stereotypes about gender and class as barriers to access

Shared cultural beliefs and stereotypical expectations about gender roles and behaviour held by professionals in various service organisations can function as structural barriers by influencing victims' access to services and the quality of services. Stereotypes can influence particularly strongly on how service providers perceive those victims of DV who are seen as "belonging" to various vulnerable and marginal groups based on their ethnicity, sexual orientation, language, abilities, or any other characteristic that makes them distinct from the mainstream population (Briones-Vozmediano et al. 2014a, 2014b, 2014c; Darley & Gauthier 2014; Hackenberg et al. 2021; Löbmann & Herbers 2004; Schröttle & Khelaifat 2008).

Cultural beliefs can touch the very phenomenon of DV. In other words, DV can be framed as an individual rather than a social problem. Cultural beliefs may lead in constructing support services that are designed to a "mainstream victim". Thus, services in many locations may not meet the varied experiences and needs of specific victim groups. The lack of in-depth training among the staff on how to understand and manage different types of vulnerabilities and victims of intersectional discrimination and the lack of strategies and standard procedures to deal with vulnerable individuals add to organisational incapability to deal with the diversity of DV victims. (Sénat 2019.) Many NGOs supporting the victims of DV have experience and expertise in working with various vulnerable and marginalised individuals, but these NGOs are often left out of inter-agency cooperation.

The cultural beliefs may contribute, for instance, to the low performance of the police organisations in detecting and investigating certain cases of DV and protecting specific categories of victims. For instance, Darley and Gauthier (2014) argue that police institutions and some investigative officers are gender biased and reproduce the perception of virile masculinity of the police which may contribute to the processing of DV cases. Certain cultural beliefs and expectations regarding gender roles and

the normalisation of DV may lead some police officers to exercise a victim-blaming attitude (Nagy et al. 2020), or to have discriminatory attitudes towards minority groups (Durán-Martín et al. 2022).

In the same way, the ability of health care staff to detect DV is conditioned by cultural beliefs, and stereotypes. For instance, expectations may direct health care professionals to perceive DV more easily among the socially disadvantaged groups than among the middle or higher social classes. It has also been suggested by Schröttle and Khelaifat (2008) that social norms make it easier for the victims from lower social strata to share their experiences about violence with the third parties. Even if healthcare personnel can be sensitive to the problem of intimate partner violence, they may not consider it as a health problem (Coll-Vinent et al. 2008). In the context of disclosure of gender-based violence, Goicolea et al. (2022) concluded that the professionals have expectations that lead to shaming the victims for failing not to leave the partner or to file a denunciation.

Certain cultural beliefs and stereotypes frame the perception of DV among the staff in social and support services. Many professionals consider that service intervention is not necessary if there are no visible injuries, or if violence is not physically, psychologically, or financially very threatening or stressful. (LN-W 2020; Schröttle & Ansorge 2008). Röntynen (2021) observes that there is tendency among the Finnish service providers not to initiate actions if the victim has not suffered serious damages.

2.2.5 Flaws in management, procedures and implementation reduce performance

The performance of the service organisations and the quality of the services depends on the validity of procedures and their actual implementation in practice. For instance, BMFSFJ (2022) notices that lack of protocols and guidelines that set standards in treating cases of violence and providing various social, support and health services to the victims is unsatisfactory in Germany. Furthermore, the cooperation between different agencies is crucial in the effective service provision for the victim and the successful detection and prevention of DV.

The management of an organisation has the responsibility to ensure that policy is implemented in the organisational procedures and daily activities of the organisations. Yet, in many organisations it can still be unclear who is in charge of responding to DV. In principle, the management is responsible for providing guidelines for the staff and setting of criteria for evaluation and assessment of organisational performance and the impact of services. Yet, many research reports notify that there is a lack of regular evaluation of organisational performance and impact of services (Brzank 2022; Maquibar et al. 2017; Schellong 2019, Schellong et al. 2021). Furthermore, service organisations may not implement effective guidelines on how to deal with the cases of DV (Brzank 2022; Rasch et al. 2020). Gendarmerie Nationale (2021) reports that the investigation of the cases of DV is not sufficiently controlled within the organisations. The police can be regarded as an expert organisation, which needs to find an optimal balance between autonomy and control of professional work. The managers may also not sufficiently support the staff and encourage frontline agents to detect DV (Husso et al. 2021).

When the organisational procedures are not inscribed into organisational structures and systematic standard operating procedures of organisations, the detection of DV can be haphazard and the support of the victims is too much dependent on the discretion of the individual employee (Hackenberg et al. 2021; Lancharro-Tavero et al. 2022; Ministère de la Justice 2019). Research has shown defects in formal procedures of various services and their implementation. Husso et al. (2021) have observed that first line responders in Finland do not systematically proceed to a targeted questioning of persons suspected of - or identified as - being victims of DV (screening for violence), perhaps with the exception of LEAs. In health care settings, there is a lack of standardised patient management procedures and care paths that include identification of victims, evaluation of their situation (risk

assessment), medical care, screening, diagnosis and treatment, documentation of injuries and referral to the appropriate support services (BMFSFJ 2022; Hackenberg et al. 2021; Sénat 2018).

One of the most important procedures in preventing DV is risk assessment and the subsequent risk management and the protection of victims. Risk assessment and management presuppose cooperation between frontline agencies, which is unfortunately often unsatisfactory. The police often have the key role in the cooperation between frontline organisations towards risk assessment and management. Yet the police have been observed to fail to properly assess the risks and take adequate measures to manage the risk posed by the perpetrator. The police fail to properly detect other forms of violence than physical violence, detect aggravating circumstances and take prompt action and adequate measures to protect the victim. Existing protection mechanisms such as restraining orders are sometimes underutilised or poorly implemented (Centre Hubertine Auclair 2019; Gendarmerie Nationale 2021; HCE 2020; Héra 2022; Hornyik 2020; HRW 2013; Ministère de la Justice 2019; Müller et al. 2004; Sénat 2018; Solt 2022). The protection of a victim can also be jeopardised during the court proceedings (HRW 2013). Lack of monitoring of perpetrators by probation services can also pose risk of recurrence of violence (Ministère de la Justice 2019).

Without standard operating procedures, supporting guidelines and training, the staff tend to decide individually whether to ask questions about violence. Several research reports have pointed out that the lack of internal guidelines regarding how to process cases of DV lead to uncertainties in addressing violence and dealing effectively with the victims (;Brzank 2022; Nägele et al. 2009; Rasch et al. 2020; Schellong et al. 2021). Addressing DV can be left to the discretion of staff (Lancharro-Tavero et al. 2022). Procedures and guidelines may not cover all types of violence and situations. For instance, these gaps may contribute to the fact that not enough is done to detect psychological harassment and digital violence. Even if violence is detected and right questions are posed to the victim, the first line responder may not assess the well-being of children living with the victim.

Even if formal procedures and guidelines have been established in frontline and service organisations, the staff may not follow these systematically. Héra (2022) and Garai (2019) describe how the police too often do not report cases as intimate partner violence (IPV) and may even discourage victims to report violence. The police can also request a victim to file a criminal report herself/himself, even though the law requires the police to file a crime report for IPV. The quality of police work can also vary too much, as is indicated by Centre Hubertine Auclair's (2019) report regarding the reception of complaints regarding DV in France. When the case is investigated, the process takes too long (Gendermerie Nationale 2021).

DV is a delicate situation that presupposes the protection of privacy and processing of intimate and emotionally challenging issues. Yet surprisingly many research reports point out situations where organisations cannot offer safe environments in which the victims of DV could interact confidentially with the service agents (Centre Hubertine Auclair 2019; Döge 2012; Durán-Martín et al. 2022; Hackenberg et al. 2021; Rasch et al. 2020; Schouler-Ocak et al. 2017). The lack of training and of specialised competence may contribute to secondary victimisation if the police officers, for instance, are not able to implement sensitive questioning of the victims of DV and build up relations of trust with the victims (HCE 2020; HRW 2013; Durán-Martín et al. 2022).

The cooperation between different service providers and frontline responder organisations has been a target of constant complaints even though progress has been made in this area. There are weaknesses in the coordination of managerial and operational activities between stakeholders, leading to many types of inconsistencies and unintended negative outcomes. Often no coordinating body or mechanism has been developed for supporting inter-agency cooperation, even when it is required by law. (Nägele et al. 2009; Potkanski-Palka 2021.) Nägele et al. (2009) notice that inter-agency cooperation between the health sector and specialised services is not standardised. Cooperation between different agencies would require standards, guidelines and models which are

unfortunately often insufficient. If cooperation is unclear it can contribute to uncertainties regarding the division of responsibilities between the different first line responders. If such uncertainty concerns the follow-up of the victims, this could even compromise victims' well-being and safety.

Cooperation usually requires information sharing between stakeholders involved in handling a victim's case, which is also too often underdeveloped (Ministère de la Justice 2019). Cooperation between the police and social work including victim support NGOs has improved during part years, but the cooperation of medical services with other service providers is insufficient. Health professionals do not systematically report to other stakeholders when DV cases have been detected although it would be possible and necessary. (Assemblée Nationale 2019.) In Finland, Hackenberg et al. (2021) and Röntynen (2021) have observed that the detection of a DV case does not always systematically lead to specific action, even if the victim is in serious danger.

2.2.6 Failures in communication and information constitute barriers to access

Clearly presented information about availability and content of different services is a precondition for the effective delivery in all service sectors working with DV. Yet, research has shown weaknesses and failures to take adequate measures to communicate and provide information and guidance to the victims.

To begin with, courts and prosecutors do not inform victims about the procedures and its consequences in easy-to-understand language. This may interfere with the victim's ability to receive judicial services and protection (Mandl & Sprenger 2015). Reports by Centre Hubertine-Auclair (2019) and Assemblée Nationale (2019) note that the police too often fail to give proper information and guidance to the victims of DV in France. Sometimes sufficient or adequate information about victim's rights about available support services is not provided (Sanz-Barbero et al. 2022). The barriers of access that relate to language and information in the context of victims who are migrants and/or disabled are discussed in depth in the subsequent chapters on special victim groups.

2.2.7 COVID-19 lockdown hindered delivery of services and pushed to invent solutions

COVID-19 epidemic and subsequent lock-down measures created exceptional circumstances that influenced the dynamics of DV and the functioning of all services from detection and prevention to support and protection. COVID-19 and related lockdowns restricted the movement of individuals and forced them to close or limit many public services. Many women who needed and sought help lived in exceptional situations. For instance, social and financial pressures were increasing in many households and families. The women who were already in a violent relationship tended to experience more violence, heavier violent outbursts, increased aggression, and irritability of their partners. Women with migration background or with lack of knowledge of German language became more isolated and their private supporting network got smaller. Numbers of consulting with translators or in other languages (than German) increased due to contact restrictions. (BAFzA 2021.)

The challenges in maintaining services related to DV in Europe have been huge (Kersten et al. 2023). The access to various services was limited and only a few establishments were allowed to be open. Above all, there were difficulties to receive face-to-face counselling for the victims of DV. However, at the same time online counselling could not be always utilized because of the potential controlling presence of the perpetrator (BAFzA 2021; Steinert & Ebert 2020). The functioning of criminal justice systems was affected. Courts were closed and there were delays in prosecutions. Police officers are engaged in implementing COVID-19 ordinances and probation officers could not meet clients face-to-face (Kersten et al. 2023, 85).

In these conditions, officials had to be creative and invent new opportunities for the victims of violence to report and ask for help. For instance, in Spain supermarkets and pharmacies remained open. During lockdown women could go to any pharmacy and ask for a “Mask 19” (Mascarilla 19) that would alert the pharmacy staff who could call the emergency number 112. Similar measures were established in France (see Kersten et al. 2023). New online services – hotlines, helplines, and chats – for the victims of DV were established and the existing online services were strengthened in many European countries. Although in some hospitals, NGOs and victim services, including shelters, reported increasing figures, in many places the access to services were restricted and shelters were not open for new entrants (Kersten et al. 2023, 86). Furthermore, many support services, such as language services, support networks, self-help groups, day clinics and therapies could not function (BAFzA 2021, 2022). Administrative processes became slow and difficult, and there were problems with coordinating the work of agencies and accessing information (Vives-Cases et al. 2021).

3. Older persons as victims of DV

3.1 Victim's perceptions, socio-economic characteristics and social relations

3.1.1 Older victims are ashamed by DV and regard it as a private matter

The factors that constitute barriers for the victims in general to seek help and support for DV are naturally also relevant among the older victims. Then, for instance, shame is one of the major factors that prevent older victims from talking about violence (Birkel et al. 2022; FRA 2014; Forschungsverbund Gewalt gegen Männer 2004; Hellmann 2014; LN-W 2020; Müller et al. 2004; Nägele et al. 2009; Ohms 2020a; Schouler-Ocak et al. 2017; Schröttle & Ansorge 2008; Tamutiene et al. 2013; Wetzels & Pfeiffer 1995; Wippermann 2022). In addition, older victims tend to perceive violence more strongly as a private and confidential matter that should not be shared publicly with the outsiders (FRA 2014; Hellmann 2014; Müller et al. 2004; Nägele et al. 2009; Wetzels & Pfeiffer 1995; Wippermann 2022). For instance, in Finland, younger women more commonly speak about their experiences about violence with a friend and with the abusive partner than older women (Piispa 2004).

A survey that collected DV experiences from 2 880 older women (60 years or older) across five European countries (Austria, Belgium, Finland, Lithuania, and Portugal), Austrian respondents (*n* = 593) were the least likely to report violence to formal institutions. One reason for this was that they "did not want anyone to get involved" (44.3%). In fact, less than half of all the victims disclosed violence to any informal or formal agency. Most Austrian victim-survivors (54.8%) chose to not seek help. When help was sought, it was done overwhelmingly from informal networks (42.9%) in contrast to formal institutions (6.3%). Effects of violence on mood and health (anger, tension, sleeping difficulties and concentration difficulties), type of abuse (physical abuse and violation of personal rights), higher abuse intensity, and density led victims to seek help. (Tamutiene et al. 2013.)

3.1.2 Older victims have false assumptions about support services

Older victims of DV may have wrong assumptions about the availability of support services. Beaulaurier et al. (2007) showed that older women (45–85 years old, *n* = 134) tend to believe that there is no help for older DV victims or the victims of emotional abuse, or that what is available is difficult, unpleasant, or confusing to use. Most victims did not know how to get help. According to paramedics in Finland, older persons acting as a caregiver for their older spouses do not necessarily know how to seek help and support (Salminen-Tuomaala et al. 2022).

Religious beliefs seem to be particularly important for older women regarding coping with DV as well as in determining whether to stay in or leave an abusive relationship (Zink et al. 2003). Beaulaurier et al. (2007) note that many religious older women prefer to disclose violence to a member of the clergy although they do not think that disclosure to the clergy would lead to intervention. Religious beliefs seem to be a very important coping strategies for women who leave their abusing spouses as well as those who stay in the relationship. Despite the emotional strength that the victims may find in religion, Beaulaurier et al. (2007) point out that some religious beliefs may actually function as barriers to help-seeking. For example, the priest or ministers may encourage the victim to stay in an abusive relationship by saying that the violence is the victim's burden to bear. Clergy responses may also aim to maintain the status quo, offering little effective help. Priests may encourage the victim to believe that praying would change the violent behaviour of the perpetrator. None of the respondents (*n* = 134) in the study by Beaulaurier et al. (2007) had been referred by clergy to the social service or justice system.

3.1.3 Dependencies limit older victims' options for services

Older women tend to be dependent on their partners and their social relations in many ways. In such conditions, in particular if the perpetrator is also providing valuable resources, the victim tends to believe that seeking help may put her in a worse situation. Such dependency can be strengthened by the victim's sense of responsibility towards the partner as a reason for not disclosing violence to physicians, psychosocial services, and the police, as shown in a German study among the older women victims of DV (Nägele et al. 2009; Wippermann 2022). Dependency to the perpetrator can stem, for instance, from the victim's ill health and fear of loneliness (see e.g., FHK 2022; Fiedeler 2020b; Hellmann 2014; Löbmann & Herbers 2004; Nägele et al. 2009; Nägele et al. 2010 in Stöckl & Penhale 2015; Ohms 2020a; Wippermann 2022). Victim's lack of financial resources is another reason for not reporting violence (Stockl & Penhale 2015).

In addition, no availability of informal help (e.g., lack of social network or trusted persons) is mentioned to be a reason for not reporting violence (Fiedeler 2020; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Puchert et al. 2013; Wippermann 2022). Older victims are even more dependent on their partners if they are disabled (Rossiwal 2016) and in a social setting that is unlikely to change, unless the victims themselves actively search for help. Sometimes the stagnant situation might be partially due to family members fearing that they must take over or finance care work, especially if it is the violent partner who needs care. (Amesberger & Haller 2012.) Seeking help may also be prevented by the caregiver's or family member's sense of guilt and feeling that they have failed if they are unable to take care of their loved ones (Salminen-Tuomaala et al. 2022). In addition, one should not underestimate long-term marital and family relationships that are characterised by imponderable psychological processes, feelings of obligation and life-historical memories that are incomprehensible to those on the outside but make it very difficult to break through the dynamics of violence (Hörl et al. 2015).

3.1.4 Older victims do not report violence out of fear of retribution

The older victims have mentioned the fear of the perpetrator's retribution as a reason not to disclose violence. In fact, the study of Tamutiene et al. (2013) indicated that respondents experiencing abuse from partners were the least likely to report abuse, when perpetrators were spouses or partners. Moreover, a reason often mentioned by older persons for not disclosing or reporting violence to formal institutions is the fear that no one would believe them and the violence they experience is not serious enough (ibid).

Moving out of home may be extremely difficult for those victims, who have cultivated strong emotional and social bonds to their place of residence (Nägele et al. 2010 as cited in Stöckl & Penhale 2015). Moving away from home is associated by the victims to the anticipation of loneliness (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Nägele et al. 2009; Ohms 2020a). For the professionals, such a situation is ethically challenging, because the client's right to self-determination must also be considered. Many older persons want to be able to live at home until the end of their lives (Salminen-Tuomaala et al. 2022). Older individuals may also be concerned of institutionalisation, which is shown to be a strong barrier to any kind of help-seeking (Beaulaurier and Taylor 2001; Hudson 1986 as cited in Beaulaurier et al. 2007).

3.2 Structural and organisational barriers

3.2.1 Services cannot to meet the specific needs of older victims

Many service organisations and agencies have difficulties when it comes to special circumstances of the older victims of DV. To begin with, service providers may struggle in trying to distinguish between the consequences of DV such as neglect of elderly care, disability and illnesses versus physical and mental limitations and impairments that are naturally related to old age (Löbmann and Herbers 2022).

The whole service infrastructure is oriented towards the young and the middle-aged victims. On the one hand, social and support services are not always easily accessible and tailored for the specific needs of the older persons who may have physical and communicative limitations or other health problems. On the other hand, the staff working in the settings specifically designed for the elderly may have only little knowledge about the dynamics of DV (Celdrán 2013; Nägele et al. 2009; Salminen-Tuomaala 2022). Shelters are not commonly designed and prepared to receive clients who have significant health or functional limitations or need specific barrier-free equipment or related support (FHK 2022; Nägele et al. 2009). Home care and home nursing care tend to be reluctant to intervene when detecting DV, if the abusive partner is also a victim's caregiver. Such situations are not systematically reported to proper stakeholders (Salminen-Tuomaala 2022). Moreover, for instance in Austria, the lack of available services is an accentuated challenge in rural areas, where the alternative care of senior citizens is often much more difficult to organise (Hörl et al. 2015).

Outpatient care services for the older victims of DV are insensitive to the special circumstances and needs of the elderly. Violence towards the older persons occurring in outpatient care and at home care is not effectively detected. Physicians are in principle well positioned as they should be familiar with the patient's situation and could therefore fulfil an important role in detecting and preventing violence. (Nägele et al. 2009.) In the similar way, Henrion (2001) recommends the strengthening of the role of medical doctors in detecting DV in France. Improvements should be made in documenting the history of violence, assessing the seriousness of violence, advising victims about their rights, and referring victims to other services.

3.2.2 Older victims prefer to refrain from prosecution restraining orders

The situation of older victims of DV is complicated in situations when a perpetrator is also the provider of permanent care for the victim and there are no easy and affordable alternatives for the current arrangement of care. In these circumstances the police are quite powerless. The separation of the victim and the perpetrator can only be a temporary solution. Indeed, the older victims of DV may not even want to make an official report about DV and terminate the long-term relationships of care. (Nägele et al. 2009.)

The criminal justice system in Germany has not been able to forcefully prosecute violence in domestic care relationships. It has been recommended that age-related issues are given stronger emphasis in legal education and training. (Nägele et al. 2009.) Legal measures and restraining orders may fail to protect the older victims especially in the rural areas because it is quite difficult to organise affordable alternative care. In rural areas police officers are more likely to dismiss reports of DV as an intra-marital issue (Amesberger and Haller 2017). Courts are more likely to be reluctant to prosecute, issue a restraining order, and separate the victim from the perpetrator if he/she is also the victim's caregiver (Nägele et al. 2009). If a caregiver may live in the same household and be indispensable for managing the victim's life, it is difficult to replace this type of social and emotional dependencies and life-historical bonds. Applicability of a restraining order can also depend on the place of residence of victims according to law (Hörl et al. 2015).

Service professionals may find it difficult to understand that an older victim prefers to continue living with an abusive partner or relative who is also a long-term caregiver. Should the support service staff accept that older victims of DV may not want to make an official report about the violence and be separated from their close relationships with the perpetrator if that relationship involves care. All in all, victims of DV are less likely to end violent relationships due to economic, social, and emotional dependencies to the place of residence. (Nägele et al. 2009.)

4. Victims with children

4.1 Victim's perceptions, socio-economic characteristics and social relations

4.1.1 Victims are frightened of threats, violence and losing their children

The reasoning of the victims of DV who have children is strongly influenced by anticipation of how the perpetrator would behave if violence is disclosed (Birkel et al. 2022; Forschungsverbund Gewalt gegen Männer 2004; FRA 2014; Müller et al. 2004; Schröttle & Ansorge 2008; Wetzels & Pfeiffer 1995). Propensity to report and seek help is decreased especially if the victim anticipates further risks and difficulties, such as threats of physical violence or killing of the victim or family members (HRW 2013; Nagy et al. 2020.) The perpetrator may also threaten to abduct the child, or the victim may have concerns about the perpetrator abducting children abroad, in a country where the father has more rights and from where it would be difficult to get children back (Gabler et al. 2016).

Victims may also be afraid of losing contact with children and therefore are not willing to report DV to authorities (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022). For example, the victim may be afraid that the Guardianship Office/Youth Welfare Service removes the children because of DV in the family. Thus, the victim chooses to remain in the abusive environment, which puts the children and the victim at further risk of violence. (Nagy et al. 2020; HRW 2013.) Especially fathers are afraid of courses of actions and allegations, such as withdrawal of children or counter accusations of violence, against which they feel helpless or inferior because of their gender (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022).

Research has shown that families with children may face specific challenges in the context of DV. Pregnant and parenting survivors of IPV are especially vulnerable to coercive threats by their abusive partner, particularly threats to disclose their substance use to child protective services or law enforcement (Phillips et al. 2021). If the perpetrator is a relative of the victim and/or the persons to be questioned by the police as witnesses are also members of the family, a child might face influence and retaliation especially if they live in a joint household with the offender (Hegyi 2022). Mothers with children may have difficulties accessing support services, in particular to shelters (Berthier & Karzabi 2001). Silvestre et al. (2017) discusses how the concern for the dependent minors complicates the victim's situation and increases their feelings of guilt and frustration.

4.2 Structural and organisational barriers

4.2.1 Services struggle to satisfy the needs of victims with children

The service infrastructure is not always able to identify and meet the specific needs of child victims and adult victims with children. For instance, BMFSFJ (2022) calls attention to the lack of nationwide support for children who have witnessed violence in Germany. The staff at specialised counselling centres are unaware of the situation and needs of children affected by DV. There is also a shortage of resources to offer children qualified and gender-specific activities during the stay and the lack of specific tools and supporting services for children (Brzank 2022; Schellong 2019; Schellong et al. 2021). An increase in the number of targeted offers specifically for children has been recommended also by Brzank (2022). In the similar way, children's specific needs are not satisfactorily addressed in support services in France and women with children have difficulties obtaining services, especially shelters. In particular, the access to psycho-trauma care is limited (Berthier & Karzabi 2021). In addition, Nublat and Karzabi (2017) report that there is little capacity to offer psychological care for

children who are co-victims of DV. Berthier and Karzabi (2021) argue that Child Protection in France is not sufficiently committed in detecting DV.

The victims with several children may have difficulties finding suitable shelters. Moreover, many shelters are not well equipped with comprehensive childcare facilities, play corners, technical equipment, and staff, including social workers. (FHK 2022.) Women with older (teenage) sons cannot enter the shelter (BMFSF 2022). In France, a report by HCE (2020) and Assemblée Nationale (2019) note that there are not enough support services for the victims' children.

A particular problem must be highlighted in relation to victims with children. The risks involved in custody practices after separation are not always detected in the service organisations. Visitation and custody rights after DV must not endanger the rights and safety of the victims and the children in shelter contexts. (Assemblée Nationale 2019; Berthier & Karzabi 2021; BMFSFJ 2022; FHK 2022.)

The establishment of Barnahus Houses, for instance in Hungary, have improved the services and protection of child victims and the quality of criminal investigation. Barnahus houses with child-friendly facilities have been opened in several Hungarian cities (Hegyi 2022). The criminal investigations can be conducted within the premises of Barnahus, including the forensic interviews. The procedural safeguards of both the child and the defendant are respected.

The amendment provision of the Criminal Procedure Act in Hungary allows support from a counsellor or a psychologist when an investigation involves a person under 18 years of age. Although Barnahus Houses have improved the situation of children as victims of DV in Hungary, there are still problems with support services for children. In particular, communication and cooperation between the Guardianship Office, the Child Welfare Centre and the Child Welfare Service should be more effective (Hornyik 2020).

5. Victims with disability or impairment

5.1 Victim's perceptions, socio-economic characteristics and social relations

5.1.1 Victims have fears and experiences of being ignored and disbelieved

Women with psychological disorders or cognitive disabilities fear of being regarded as less credible or trustworthy individuals (BMFSFJ 2018) so that their claims of abuse will not be believed. An abuser can manipulate the victim to believe so, or the victim has past negative experiences with professionals (GCFV 15.02.2023). Unfortunately, victims' fears are not without foundation, as the Austrian study by Mandl et al. (2014) shows that people with disabilities are often seen as less credible and reliable by authorities when reporting violence, especially sexual violence. The behaviour of police, court and social services staff is often characterised by negative stereotypes about the sexuality of women with disabilities, which can seriously undermine the successful prosecution of sexual offences. Deaf women in particular are less likely to report cases of sexual violence and bring them to court (Schröttle et al. 2011).

People with an intellectual disability may not understand their legal rights and therefore they may be afraid of the consequences if they disclose (French 2007). Moreover, sometimes a disabled person is expected to be content with what they have and not ask much from their relationships (BMFSFJ 2018).

5.1.2 Victims are dependent on care and live in social isolation

Individuals with disabilities or impairment who have experienced DV may believe that they do not have any feasible options for action (Fiedeler 2020b; Nägele et al. 2009; Ohms 2020a; Wippermann 2022). Many disabled women are dependent on daily assistance provided by perpetrators (Mandl et al. 2014; Rossiwal 2016). Such women may need permanent daily care while they are also socially and emotionally dependent on the perpetrator. Disabled victims may not have imaginable alternatives for care (Gabler et al. 2016). Fear of not receiving adequate alternative support may deter them from reporting violence to authorities (Mandl et al. 2014). Victims who are dependent on their abuser for financial support may also lack the economic resources they believe are needed to acquire help for safety (GCFV; see also Mandl et al. 2014).

Individuals with disabilities may have limited number of social contacts and thus social support (Schröttle et al. 2018). Living with a disability can be isolating as such, and physical and emotional violence tends to reinforce victim's social isolation. If their support networks are small, victims are hardly aware of available support services. Disabled persons often identify strongly with other disabled individuals. Therefore, leaving their community is not considered as an option, regardless of safety. Reluctance to speak out against someone else from within the community, even when that person is being abusive, may lead to social isolation. (GCFV 15.02.2023.) This is particularly worrying as a large number of studies show that non-reporting of violence is due to the lack of help and the fact that the victim does not have a network or trusted person (Fiedeler 2020; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Puchert et al. 2013; Wippermann 2022).

While disabled victims have difficulties in seeking help, they are also more vulnerable to abuse. Victim survivors of IPV with disabilities tend to experience violence at multiple stages of life history from a variety of people in proximity, starting with a father, then a partner or ex-partner, and finally a caregiver. Disabled individuals can be targets of multiple types of abusive behaviour, such as withholding food, medication, or medical care, breaking or hiding communication devices or adaptive technology, injuring a victim's service animal, giving the victim drugs without their knowledge, or

forcing drugs or medications. If the victims seek help after a violent incident, abusers may claim the victims' injuries are related to the disability rather than violence. Such experiences further hinder the victims' ability to get help and affect victims' efforts to evade the abusers' power and control. (GCFV 15.02.2023.)

5.2 Structural and organisational barriers

5.2.1 Services struggle to meet the needs of victims with disabilities

Women with disabilities and victims of gender-based violence are forgotten and invisible (Región de Murcia 2017). Victims with physical, intellectual, or sense-impaired disabilities are often unable to utilize support services on their own (Nägele et al. 2009; Senate of France 2019). Their access to specialist support services is often strongly dependent on the level of independence of the victims and the initiative of their caregivers, or whether they live in an institution (Schröttle et al. 2018).

However, when a victim is in a long-term care setting, there may not be established structures to report violent incidents (BMFSFJ 2018). Moreover, there can also be a shortage of social and support services for disabled persons living in institutions. For instance, Nublat and Karzabi (2017) reported a shortage of psychological care for people with reduced mobility. Patients with dementia and those who are intellectually and/or physically unable to use help on their own are in a vulnerable position (Nägele et al. 2009; Senate of France 2019).

Furthermore, organisations providing services and support for the victims of DV are not well prepared for meeting various needs of the individuals with disabilities. Individuals with disabilities and impairments may encounter multiple barriers when seeking help and support for DV. To begin with, the built environment and physical structures may lack accessibility and impose several barriers impeding the passage to buildings with a wheelchair (Federal Ministry for Family Affairs 2018; Mandl & Sprenger 2015). Even all shelters are not well adapted to those clients who have significant health or functional limitations. The physical space of shelters may have barriers, including limited passages, stairs, narrow doors, and non-wheelchair access, and neither assistive technology/equipment, nor appropriately trained support staff (FHK 2022; Gabler et al. 2016; Nägele et al. 2009; Senate of France 2019).

Language and communication challenges can also make it difficult to access service facilities. Mandl et al. (2014) highlight how inadequate information may make access to facilities difficult. Especially noticeable hurdles exist for victims who are vision or hearing impaired, as well as for persons who have learning or comprehension disabilities. For instance, Mandl & Sprenger (2015) criticise Austrian service institutions for being largely unprepared for the needs of persons subjected to multiple forms of discrimination, such as gender- and disability-based discrimination. Information constitutes a barrier if advice for the victims is not made available in accessible language adjusted to the victim's disabilities.

Disabled victims may have great difficulties communicating with supporting professionals (e.g., police, health care). Language and communication barriers leave an enormous gap for victims with hearing impairment and other communication challenges. Certified sign language translators are crucial to victim safety by ensuring that the interaction and communication between professionals and victims is based on correct information (GCFV 15.02.2023). Moreover, individuals with disabilities may have received little personal development and sexuality education. Therefore, victims do not always know the right words to use to describe the experiences of abuse. (French 2007.)

A study by the Senate of France (2019) showed that the disabled women are relatively more often than other women victims of physical or sexual violence by their partners. In addition, violence seems to be relatively widespread in care institutions. Experts interviewed for the study considered that

personal and financial dependencies increase the risk of violence towards women with disabilities. Therefore, the study urged strengthening the financial and personal autonomy of victims with disabilities.

Disabilities can increase an individual's dependency in several ways on their partners, other close caregivers or formal care provided at the institution (Mandl et al. 2014). If the caregiver is also a perpetrator, the situation becomes complex for the victim who may not want to cut off the relationship.

Personnel, including group leaders and contact persons do not have adequate training and qualifications in dealing with violence, although they may have adequate competences working with disabled persons (Mandl & Sprenger 2015; Schröttle et al. 2013). For instance, wrong assumptions are held among the staff in shelters about the disabled such as physical disability implies mental disability (Schröttle et al. 2013).

5.2.2 Ineffective legal practise and law enforcement undermine victims' protection

The legal instruments intended at protecting the victims against the possible further violence are under-utilised in the context of DV victims with disabilities, particularly in the case of persons with disabilities who live in care institutions (Nägele et al. 2009). In addition, the access to services, for instance to law enforcement agencies and courts, may turn out to be challenging for individuals with disabilities due to barriers in the physical environment (Senate of France 2019).

For instance, the police and other agencies may have difficulties in distinguishing between the consequences of a crime and the consequences of various disabilities. The situation is complicated when the victim with disabilities needs constant care which is provided by the perpetrator, and there are no affordable alternative provisions available. The separation of the victim from the perpetrator can be utilised only to a limited extent.

Nägele et al. (2009) have noticed that the cases of violence in domestic care relationships are rarely prosecuted. This observation is particularly acute in the case of the individuals with disabilities who live in care institutions. In the care institutes there is also a tendency not to report about violence, but to solve problems internally (Gabler et al. 2016). The Senate of France (2019) observes too that the access of disabled women to courts is difficult. The report urges improvements to disabled women's access to courts and strengthening the autonomy of individuals with disabilities.

Judiciary tend to have negative stereotypes about the sexuality of women with disabilities, which may undermine prosecution. Disabled individuals are not often considered credible and reliable as witnesses. (Mandl et al. 2014.)

6. Migrant and refugee victims

6.1 Victim's perceptions, socio-economic characteristics and social relations

6.1.1 Victims do not report DV because regard it as a private matter

As described above, for many people DV is a confidential matter that is not told to outsiders. For many migrants and refugees, the aspect of privacy of violence that occurs in the family circle is even more accentuated by the cultural beliefs and social norms of the family and the community. It is being noted that the family, especially the parents-in-law, often exert massive pressure on women to stay in the violent relationship. Sometimes relatives are closely involved and part of the DV situation itself, thus acting as accomplices. Disclosure of violence to strangers can be perceived as shameful, especially if the listener does not belong to one's own community or have a different cultural background. (Flotzinger et al. 2021.) However, the Sheffield Domestic Homicide Review of 'the Adult G' as well as the Guidelines for the use of the interpreter drawn up from its results point out that besides the gender of the interpreter, if the interpreter sourced locally represents the same community as the abused person, this may impact on the ability of the victim to speak freely. The Review and the Guidelines recommend using the staff of e.g., general practitioners as interpreters. Furthermore, it is advisable for the professionals to consider whether there are any cultural barriers to working with a family – but not to assume that workers and service users from the same ethnic or religious community will work together effectively. Most importantly, the feelings and wishes of the service user must be considered. (Sheffield DACT 2015; Sheffield DACT 2016.)

The communities of colour may share a strong cultural identity, which involves loyalty to the family and the community. The flipside of this belief is a strong hesitation to share private matters with outsiders. Disclosing unfavourable subjects, such as abuse inside the family and community, may reinforce negative stereotypes of the community and its members. In addition, victims may be reluctant to report the abuser to the criminal justice system, which is considered to have a long history of being an oppressor of the community. (GCFV 15.02.2023.)

6.1.2 Victims are uninformed about DV and support services

Individual action in a social context depends strongly on the beliefs about that context. Beliefs about contexts allow individuals to act fast upon incomplete knowledge, which benefits their survival (Seitz & Angel 2020). The formation and content of such beliefs that can fill in the gaps in knowledge about social environment is a starting point in analysing the informational barriers of reporting violence among individuals with migrant or refugee background.

There are multiple studies on informational barriers that complicate help seeking and reporting violence for migrants and refugees. Unawareness of the availability of support services among migrants has been demonstrated in many studies (see e.g., Fiedeler 2020a; Müller et al. 2004; Ohms 2020). For instance, Zakar et al. (2012) reported that Pakistani immigrant women (n = 32) in Germany were largely unaware about the possibilities of care, and that the structure and functioning of the care-providing institutions.

6.1.3 Fears and stress inhibit victims from reporting and help-seeking

Research has shown the victim's traumatisation and feelings of helplessness undermine her ability to seek help and report violence (see Fiedeler 2020b; Nägele et al. 2009; Ohms 2020a; Wippermann 2022). The life of a refugee is loaded with negative experiences and conditions that contribute significantly to stress and trauma. According to BMFSFJ (2022), refugees are often exposed to severe psychological and physical strain as a result of experiences of violence and deprivation in their home

countries and during their flight route. Kantor et al. (2017) point out that many trauma survivors may be reluctant to seek professional help because of the treatment-related doubts of traumatised persons and repressed memories. In addition, trauma survivors face specific trauma-related barriers to mental health service use. As an example, they may have concerns about re-experiencing traumatic events. Moreover, many trauma survivors avoid traumatic reminders and may therefore be worried about dealing with certain memories in treatment. (ibid.)

6.1.4 Migrant and refugee victims are socially and spatially isolated

Social and spatial isolation has been identified as one of the reasons for low reporting of DV among migrants and refugees (Löbmann & Herbers 2004; Müller et al. 2004; Schouler-Ocak et al. 2017; Wippermann 2022). Apart from unawareness, language barriers, informational deficits as well as an exclusion from the labour market and public life increase the risk of social isolation (Flotzinger et al. 2021).

Having close friends to talk to is recognised as one of the most important supportive factors among immigrant women. Support from friends increases the likelihood of victim's help-seeking. Often friends or family members are involved in occasions as the victim reports violence to authorities. (Hoppe & Heubrock 2013.) In fact, the majority of victims of DV disclose to at least one informal support such as a friend, family member, classmate, or neighbour. In general, friends and female family members are considered the most helpful informal support. (Sylaska & Edwards 2014.) As an example, in Zakar et al. (2012) Pakistani immigrant women in Germany contact parental family for support, hoping that these would have an influence on the abusive husband. At the same time, women may refrain from reporting or filing a complaint because they anticipate negative consequences from the family members residing in their country or origin.

However, a lot of immigrant women lack supportive social networks, such as parental family members or other trustworthy persons (Fiedeler 2020; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Puchert et al. 2013; Wippermann 2022; Zakar et al. 2012). Weak social networks are particularly worrying because supportive social resources have been found to mitigate risk for mental health symptoms in general (Sehmi et al. 2020). Intersectional vulnerabilities, consisting of multiple disadvantages, such as poor mental health, low education, precarious employment situation, and substance abuse increase the risk for social isolation. For instance, Rossiwal (2016) reported that non-German sex workers had very few social contacts outside their context of sex work.

When analysing the impact of social networks on the immigrant women's propensity to report violence, researchers should be careful not to overgeneralize results. There is a risk of underestimating the strengths and enabling factors possessed by individuals, but also the structural barriers the victims face. Indeed, not all migrant or refugee women who do not report violence are socially isolated. Royo et al. (2017) reminds that migrant women who faced discrimination may have generated their own synergies and strategies, constituting associations of migrant women.

Holtmann's (2022) study indicates that immigrant women are no more likely to experience family violence than non-immigrant women in Canada. However, immigrant women are less likely to seek formal help. Instead, immigrant women strategically harnessed social networks to support and care for one another and their families.

6.1.5 Victims have negative anticipations and experiences of support system

Experiences of racism, discrimination, and mistreatment increase distrust among the members of the minority communities towards the support organisations and institutions. In some countries, many institutions, such as the criminal justice system, are perceived negatively among the minority groups due to oppressive historical experiences. (Flotzinger et al. 2021; Vann 2003 as cited in GCFV 15.02.2023).

Women of colour[2] in the United States may share the common experiences of violence their white counterparts but they seldom seek help from the traditional DV programs and services. Despite the similar experiences of violence, women of colour may have different perceptions and responses to violence and their needs can be very different. If the usual programs and services are based largely on the values, beliefs, culture and worldviews of white, middle-class women, the needs of women of colour may not be met within these services. (Vann 2003.) For instance, according to Holtmann (2022), immigrant women refrain from reporting of violence because family violence interventions in Canada prioritise individualist values. As interventions provide only short-term safety, they actually increase immigrant women's vulnerability too.

In a study by Kjaran & Halldórsdóttir (2022), immigrant women (*n* = 10) living in Iceland experienced the language barrier as a tool to keep them outside of the dominant culture. Women were not fully recognized at institutions and workplaces. They felt they were not being heard, valued, or trusted. They felt silenced and excluded from the dominant knowledge community, and not valued as active agents because of their immigrant status. In the context of DV, immigrant women were not perceived as knowledgeable and believable subjects who have experienced abuse.

The anticipation of not being taken seriously leads to nondisclosure of violence among immigrants (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2008; Wippermann 2022). Furthermore, many studies show that trust towards the police among individuals with immigrant backgrounds is lower than among the mainstream population. Distrust towards the police is often founded on the past experiences with the police institutions in the native countries of the immigrants (Gabler et al. 2016). For instance, according to Zakar et al. (2012) Pakistani immigrant women avoid contacting the police in Germany because of distrust built on their past experiences with Pakistani police. Pakistani immigrant women tend not to trust in the police capacity and commitment to solve the problems. Women were suspicious about the unknown and unpredictable consequences of contacting supportive institutions. (Zakar et al. 2012; see also Hoppe & Heubrock 2013).

To meet the needs of victims with immigrant or ethnic minority background, the mainstream DV programs must be culturally responsive and cater for the varied values and life experiences of victims. Marginalised or discriminated abused women may be experiencing complex and competing life issues including poverty, generational cycles of abuse, mental health challenges, and criminal justice system involvement. (GCFV 15.02.2023.) Among the multiple issues the victims are experiencing, DV may not be the most pressing one (Vann 2003).

6.1.6 Victims are socially dependent and perceive limited options to report and seek help

Migrants often assume that they have limited options for action due to their particular legal situation and residence status and therefore do not want or dare to report DV. The fear of deportation or losing residence permits is a powerful barrier to reporting of DV (Gabler et al. 2016; Zakar et al. 2012). In addition to this, victims living under distressing conditions such as refugee shelters may not have mental resources to seek help for violence (Löbmann & Herbers 2004; Müller et al. 2004; Schouler-Ocak et al. 2017; Wippermann 2022).

Migrants who do not have a legal right to stay in a given country are particularly at risk for DV, as they often are in risky dependencies and unstable living conditions. In addition to the emotional burden resulting from family rejection and cultural uprooting, they face beliefs that condition them to normalise abuse (Salazar 2009). Homberger and Güntner (2022) describe the vulnerability of homeless women

[2] Even though women of colour in United States do not represent individuals with immigrant or refugee background, Vann's article is referred in this chapter for its' insightful way to discuss the oppressed communities' experiences.

who have not been officially documented, as they stay with relatives, acquaintances, and other contacts. Another important factor contributing to the vulnerability of homeless immigrant women is their fear of having to move, should the victim break off a relationship or quit their work.

Language barriers hinder reporting of DV (Löbmann & Herbers 2004; Schouler-Ocak et al. 2017). For example, Zakar et al. (2012) describe the Pakistani immigrant women's (*n* = 32) challenges to explain their problems and convince people of their need for appropriate help in Germany. In parallel, Kjaran and Halldórsdóttir (2022) write about immigrant women's experiences of not being believed when speaking Icelandic.

One major barrier for seeking help that has been identified in research is victim's financial dependency on the perpetrator (FHK 2022; Flotzinger et al. 2021; Hellmann 2014; Löbmann & Herbers 2004; Nägele et al. 2009; Wippermann 2022). For example, Pakistani immigrant women in Germany reported that because they are economically dependent on their husbands, they fear that husbands seek divorce if they report violence (Zakar et al. 2012).

6.1.7 Perceptions on family and gender roles restrict from reporting and help-seeking

As many other victims of DV, failure in the responsibility for the success of the partnership is a reason for not to seek help or report violence among immigrant victims. (Nägele et al. 2009; Wippermann 2022). For example, among some Syrian refugee women (*n* = 10) who live in Germany, divorce and leaving relationship has been seen as shameful, stigmatised and breakage of sacred familial bonds (Ahmad et al. 2022). Some victims fear that seeking help or disclosing violence to outsiders would endanger family cohesion (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Nägele et al. 2009; Ohms 2020a). For instance, Pakistani immigrant women in Germany perceive the primacy of family as a huge value. If the husband seeks divorce, the consequences reach the victims' parental family, too (Common cultural stigma labels divorced women as 'loose", 'immoral' and 'unlucky' persons. The studied Pakistani women wanted to use the "power of silence" hoping that the "circumstances will teach a lesson" to the perpetrator. Relatedly, women shared a belief that they should be strong, patient, and wise. (Zakar et al. 2012.)

Gender roles and traditional perceptions of family are often obstacles to reporting. Due to cultural expectations and socialisation into gender roles, a woman from a country with a strong patriarchal culture may not perceive herself as independent actors similar to an average Western woman.

In a study by Hoppe and Heubrock (2013) on Eastern European victims of stalking, the victims reported following barriers: concept of family and gender roles, higher social acceptance by intact family, strong familial cohesion within generations and concept of love being compatible with violence. Sometimes violence was justified as "man's right". Among Syrian refugee women in Germany IPV was seen as a "normal act" in marriage and it was justified as "man's right" (Ahmad 2022). Thus, support services should be easily approachable for victims whose motivation and values are based on religion.

6.2 Structural and organisational barriers

6.2.1 Services struggle to meet the needs of the migrant and refugee victims

Migrant and refugee women tend to have a heightened risk of being exposed to violence if they flee from a war zone, or from a region characterised by social disorganisation and violence, or if they have experienced violence during the migration process (Wicky et al. 2021; Schouler-Ocak et al. 2017). Briones-Vozmediano et al. (2014a, 2014b, 2014c) argue that supporting migrant victims is not a priority for stakeholders and public policies in Spain, although this type of victim is more at risk and needs more assistance to be protected from DV. Similarly, Sanz-Barbero et al. (2014) highlight that immigrant women have a higher prevalence of IPV and probably suffer from more severe cases. Immigrant women's likelihood of being killed due to IPV is five times greater than that of Spanish women. Thus, it is urgent and necessary to make formal services more accessible to immigrant women.

Unlike in Spain, Schröttle and Khelaifat (2008) interestingly reveal how some migrant women are more often than native German women asked about the causes of their injuries in health care settings. The difference might be related to migrant women having more serious injuries on average. Alternatively, the staff is more inclined to detect and ask about violence among the migrant women than someone associated with the mainstream population. Yet, there are no nationwide uniform guidelines in Germany for procedures and criteria to identify victims of DV in the asylum application process. Public officials dealing with asylum procedures are not sufficiently trained to detect DV and to refer/direct victims to proper support services. (BMFSFJ 2022.)

Asylum seekers who have experienced DV, often encounter bureaucratic barriers, such about rules of residence, when seeking social or health care services or shelter accommodation. For instance, In Germany, the Asylum Seekers' Benefits Act provides only acute medical treatment. Regarding other social and support services is the fact that often only basic services are offered to migrants whereas specific services must be applied for, justified, and approved separately. Other benefits, including the treatment and care for effects of torture, rape or psychological, physical, or sexual violence, must be applied for, justified, and approved separately. Moreover, formal procedures for applying benefits can be cumbersome as the formal procedures between federal states in Germany differ from one federal state to another. (Schouler-Ocak et al. 2017.)

Although migrant women may more frequently denounce their intimate partners to authorities than native women, as in Spain, it does not guarantee effective outcome because of various access barriers to social and health services (Vives Cases et al. 2009). To begin with, many services are tailored to so-called mainstream victims rather than adapted to sub-categories of victims with their specific needs, such as migrants. Social and support services do not fit the cultural specificities of the migrant victims. Furthermore, the staff in service organisations may lack intercultural skills. Briones-Vozmediano et al. (2014a, 2014b, 2014c) recommend adapting the mainstream support services to the specific needs of immigrant women.

Barriers resulting from social policy legislation can impose restrictions to migrants and refugees to receive certain types of services (Briones-Vozmediano et al. 2014a, 2014b, 2014c). Irregular migration status and homelessness increase individual migrant's vulnerability. Moriana Mateo (2021) has observed in Spain that irregular migrants without residence status end up in precarious work positions in the black economy and do not have social rights and institutional support. Similarly, in Austria, the services for the migrants in precarious living situations (irregular, homeless) are only partly funded by the state. Therefore, NGOs that are providing services to irregular migrants need constant donations to bridge the funding gap. (Homberger & Güntner 2022; Mandl & Sprenger 2015.)

Also shelter services require a residence status for refugee women, and residence requirements may cause difficulties. Often the women must leave the assigned place of residence, e.g., for security reasons or capacity reasons of the facilities. This usually involves lengthy redistribution of applications, possibly taking several weeks or even months. During the application process it could remain unclear which organisation or agency is responsible for the financing, and whether the woman is allowed to resettle. Women without their own residence title face risks and challenges. In Germany, they must observe the legally prescribed three-year period of marriage before they are entitled to a residence title independent of their spouse. This means that migrant women are dependent on their partners, which makes it difficult to escape from a violent relationship. (FHK 2022.)

It may also be unclear what administrative agency is responsible for the funding of shelter services. Women's shelters thus either take a financial risk or cannot accept women with residence requirements. Against the background that refugee women are exposed to a relatively high risk of violence, especially in collective shelters, this is particularly problematic. (FHK 2022.)

The question of distrust towards official institutions and authorities may also be regarded as a structural barrier when considered as a widely held cultural belief, although trust and distrust are also personal experiences. Legal protection of migrants from DV can be impaired by the fact that migrants may not trust the law enforcement agents due to their experiences with the institutions in their country of origin (Gabler et al. 2016). In addition, migrant victims may prefer not to be involved with the police out of fear of losing their residence permits or being afraid of the perpetrator abducting their children.

6.2.2 Language and communication constitute a barrier to migrant and refugee victims

Migrants and refugees tend to have limited knowledge about what kind of services are available for them (Briones-Vozmediano et al. 2014a, 2014b, 2014c). The lack of knowledge is underlined by the fact that the migrants and refugees may not be fluent in the language of their new country, which can create limitations to their actions. In addition to judicial services mentioned in the previous chapter, migrant victims of DV may have difficulties obtaining various social, support and health care services in their own language. For instance, Nublat and Karzabi (2017) report that there is little capacity to offer psychological care for those who do not speak French. Inability to use local language and nonavailability of interpreters has serious consequences to access to justice for migrants (Kjaran & Halldórsdóttir 2022). Studies about the role of language in the context of policing services are not many, but García (2014) has noticed that the migrants' and refugees' right of information, recognized both in European and national legislation, is not guaranteed to the victims of IPV if they are not fluent in Spanish.

The migrants' weak situation in the context of communication about the available social, health and legal services is exacerbated by many migrants' social isolation and the loss of social support networks in the new country. The victim of DV may not receive much support from their close relations, since some migrant communities may continue to preserve cultural beliefs originating from their place of departure which may be more permissive towards IPVE (Briones-Vozmediano et al. 2014a, 2014b, 2014c).

A study using few narrative analyses in Iceland suggest that learning a local language strongly influences the subjective and objective belonging of migrants to a receiving society (Kjaran and Halldórsdóttir 2022). An inability to use their own language and non-availability of linguistic support may contribute to migrants' non-access to important services such as the police. In such conditions, migrants are silenced as knowledgeable subjects. Yet, the victims of DV tend to be aware of how their immigrant status intersects with issues of race, ethnic origin, and gender and how the interplay of

these social categories influence their recognition and treatment in the institutional context of a receiving country.

To conclude, language constitutes a strong barrier that can restrict the access to support, social health care and shelter services in many countries. Inability to understand local language, the lack of information about the services in their own language and scarcity of interpreters can impede immigrants' use of many services (Flotzinger et al. 2021). When the resources for professional language interpreters and translators are lacking, service agencies have to rely on translations and interpretations done by the victims' relatives or acquaintances (FHK 2022; Pozo-Triviño & Toledano-Buendía 2017). This may jeopardise the victim's rights for information (Antón Garcia 2014), but also protection in the case of honour related violence exercised by the family members, relatives, or the community of the victim.

7. Male victims

7.1 Victim's perceptions, socio-economic characteristics and social relations

7.1.1 Male victims of DV feel ashamed

Male victims of DV share with other types of victims groups the feelings of shame, especially about sexual violence (Hellman 2014), which is particularly difficult to address (Döge 2012; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle et al. 2011). Varga and Bálint (2020) showed in a study in Hungary that most male victims are ashamed of being abused by their partners. In addition, male victims may feel responsibility for the success of the relationship and are then ashamed of the failure (Nägele et al. 2009; Wippermann 2022). Men victims tend to belittle the violent incident and think that the case would be too minor to be reported (Hellmann 2014).

7.1.2 Stereotypes of gender roles and unawareness of services

Certain stereotypes and unawareness lead to non-reporting among male victims. A surprisingly widely held stereotype presumes that a man cannot be a victim of domestic abuse. A closely related stereotype assumes that a physically bigger or stronger looking person cannot be a victim. Some individuals seem not to be able to conceive that also women are held responsible for abusing their partners. (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022.)

Male victims may not have complete knowledge of where to find formal assistance and support (Fiedeler 2020a; Müller et al. 2004; Ohms 2020). In addition, male victims may lack informal social networks and significant others to whom they can turn to for help (Fiedeler 2020; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Puchert et al. 2013; Wippermann 2022).

7.1.3 Male victims are afraid of ignorance and disbelief

Male victims of DV share many of the fears with other types of victims. Men may have a fear that they are not being believed, which is often associated with a more general idea of masculinity and ignorance of DV against men (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004).

Male victims of DV are often afraid of losing contact with their children. Male victims often expect that because of their gender authorities tend not to believe them and treat them unfairly in comparison with women partners as perpetrators. (Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Wippermann 2022.)

7.2 Structural and organisational barriers

7.2.1 Cultural beliefs about masculinity constitute a barrier to male victims

Support services are always not tailored to the specific needs and experiences of male victims of DV. Cultural beliefs and stereotypes regarding the role and behaviour of gender may influence how some police officers perceive DV and treat victims and perpetrators in DV situations. Löbmann and Herbers (2005) indicate in a study in Germany that the police are more likely to send offenders away in the case of a female rather than a male victim and if children live in the household. In France, Darley and Gauthier (2014) argue that police institutions are gender biased and reproduce the masculinity of the police. Varga and Bálint's (2020) online survey (n = 95) indicate that male victims may become targets

of ridicule and disbelief in their own social milieu and front-line responders, including as the police if they want to seek support.

Counselling centres are generally perceived by the public as women's counselling centres that provide services for women. Consequently, the police are less likely to refer male victims to these services and men themselves are less likely to turn to these services. (Löbmann & Herbers 2004). Support services are not always considered necessary, if violence is not regarded as serious or threatening enough in terms of physical, psychological, or financial consequences (LN-W 2020; Schröttle & Ansorge 2008).

8. LGBTIQ+ victims

8.1 Victim's perceptions, socio-economic characteristics and social relations

8.1.1 DV is a taboo in LGBTIQ+ community

Martin et al. (2023) showed that rates of DV are higher among sexual minority victims compared to heterosexual victims. The study revealed that bisexual persons' risk for becoming victims of DV was three times higher than lesbian and gay persons – and eight times higher than heterosexual persons. Bisexual rates of victimisation by other relatives were also the highest in terms of victims' sexual identity (Martin et al. 2023). Other studies have also shown that rates of DV are highest among male and female bisexual victims compared to male and female gay, lesbian, and heterosexual victims (Bender & Lauritsen 2021 as cited in Martin et al. 2023). Martin et al. (2023) highlights the fact that victims who belong to sexual minorities cannot be grouped into a single category, but we should think in terms of multiple sexual identities.

However, among LGBTQ+ individuals and community, domestic and sexual violence are taboo subjects and invisible and private matters (Ohms 2020a; Ohms 2020b). Hiding DV from the outsiders applies especially to sexual violence and victims in higher educational and social classes (Döge 2012; Fiedeler 2020a; Forschungsverbund Gewalt gegen Männer 2004; Ohms 2020a; Schröttle & Ansorge 2008; Schröttle et al. 2011).

Within the LGBTQ+ communities, the topic of domestic or intimate partner violence is difficult to address. For many individuals, lesbian and queer scenes are assumed to be safe spaces that are important for socialising, celebrating together and providing mutual support. The assumptions of a space without violence and fear make it difficult to address relationship violence within the community. (Schwarz & Häfele 2011.) Therefore, there may be fears of being excluded from the scene if the victim discloses violence (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b).

When it comes to accessing support services, social prejudices and the expectations of a hegemonic male role represent one of the main barriers. A "man as victim" contradicts widely held ideas about the typical gender of the victim and the perpetrator. In violent conflicts, men are usually perceived as opponents, which can and then be regarded as winners or losers rather than as perpetrators and victims. These widely held beliefs about masculinity may lead to ignoring dangers, playing down illnesses and enduring the physical and psychological (consequences of) violence and aggression. In addition, such beliefs may prevent male victims from seeking appropriate support services. (Losehand 2012.)

8.1.2 LGBTIQ+ victims are unaware of services and support facilities

Low reporting of violence among LGBTQ+ individuals is partly resulting from the lack of knowledge of available support structures (Fiedeler 2020a; Müller et al. 2004; Ohms 2020). A study by Kurdyla et al. (2021) showed that transgender survivors (n = 187) most commonly sought help from their friends (76.7 %). Respectively, lack of network or trusted persons explain low reporting (Fiedeler 2020; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Ohms 2020a; Ohms 2020b; Puchert et al. 2013; Wippermann 2022).

Sexual identity influences victims' decision to seek services and victims' anticipation of how they would be treated in various service organisations. The majority of lesbian and gay DV victims are

male, who commonly have fewer options for accessing victim services. There is also a higher risk that the safety of males who belong to sexual minorities may be compromised. (Martin et al. 2023.) Furthermore, other studies indicate that when victims, who belong to a sexual minority, seek support from formal services, they prefer discrete, privacy-protecting services such as those provided by mental health professionals (Hardesty et al. 2011; Santoniccolo et al. 2021 as cited in Martin et al. 2023).

A study by Kurdyla et al. (2021) showed that 39.5% of transgender survivors sought help from mental health care providers and 30.2% from family members. The study also identified that the experiences of support facilities not being trans-inclusive and the lack of professionals with connection to LGBTIQ+ community led to non-disclosure of violence. Among transgender communities, many of the formal support services are underutilised and perceived negatively. Therefore, services should be tailored and advertised specifically for transgender individuals, and service staff should be trained, and the services accommodated to the needs and requirements of transgender communities. (Kurdyla et al. 2021.)

8.1.3 LGBTIQ+ victims are afraid of discrimination

Sexual minority victims do not want to report violence because they would expose their sexual orientation at the same time. LGBTQ+ individuals are afraid of discrimination and homophobia if they report about DV. LGBTQ+ victims of DV may even prefer not to expose their partner to homophobia by stigmatising him/her additionally as a perpetrator (Forschungsverbund Gewalt gegen Männer 2004; Losehand 2012; Ohms 2006; Ohms 2020a; Ohms 2020b).

Homosexual men often suffer from social violence in the form of devaluation, stigmatisation, and discrimination, which contributes to the exclusion and marginalisation of this group and its needs. Such devaluation is especially inflicted by heterosexual men. Turning to the police – an organisation built on hegemonic images of masculinity and clearly delimited from male homosexuality – is thus made more difficult or fearful. (Losehand 2012.)

A central problem in the reporting of violence in lesbian relationships is the social devaluation and discrimination of lesbian and transgender individuals. Violence in lesbian relationships is a taboo because many lesbians and transgender individuals fear that publicising violence will confirm prejudices and reinforce discrimination. (Schwarz & Häfele 2011.)

8.2 Structural and organisational barriers

8.2.1 Flawed procedures and cultural beliefs weaken the supply of services to LGBTQ+

Support services, such as those provided by counselling centres, are not available, or they are not tailored to the needs and experiences of gender minorities and LGBTIQ+ individuals. Staff working in various service providers may not have adequate knowledge about LGBTIQ+ life contexts and issues of sensitiveness. Moreover, gender minority and LGBTIQ+ services are concentrated in the bigger cities but are not available in smaller localities and rural areas. In addition, services that are specifically directed on gender minorities and LGBTIQ+ may receive only municipal funding and therefore limit their services to the residents only.

Gender minorities may experience discrimination due to mainstream cultural beliefs about gender and sexuality. Losehand (2012) argues that the Austrian police officers tend to maintain a hegemonic image of masculinity. Stereotypes and expectations about masculine disposition and behaviour can lead to discrimination of homosexual men as victims. It can also lead to underestimating and ignoring

the danger in the living conditions on homosexual men, and the physical and psychological consequences of violence.

9. Victims in remote and rural areas

9.1 Victim's perceptions, socio-economic characteristics and social relations

9.1.1 Rural women prioritise family responsibilities and tolerate DV

Many (rural) women may assume responsibility for the family's well-being and experience divorce not only as personal failure, but also as socially stigmatising. Commonly women start a difficult process of separation, which the man may try to make difficult, for instance, the woman and her children are the ones who must leave their home. In some traditional rural communities, divorce is viewed negatively, and the community may demand for forgiveness and tolerance even in a violent relationship. Violence can be perceived as a normal part of life. This perception may be based on experiences of intergenerational violence in the community's history. (Lindqvist 2009.)

9.1.2 Rural women are tied to relations of dependence and prefer informal support

Several studies indicate that among rural women a significant reason for not disclosing DV is financial dependence on the partner (FHK 2022; Hellmann 2014; Löbmann & Herbers 2004; Nägele et al. 2009; Wippermann 2022). Many DV victims in rural areas are afraid of the uncertain future after separation (Lindqvist 2009). Victims in rural and remote areas anticipate isolation from social relations if they have to move away from home to escape a violent partner (Sénat 2016). In rural areas, women prefer to flee violence primarily to neighbours and friends, but because of depopulation of the countryside, neighbours may no longer be close (Lindqvist 2009).

9.2 Structural and organisational barriers

9.2.1 Services are few and far away in rural and remote areas

A report by the Senate of France (2021) describes how the women victims of DV have additional problems in accessing care and services in rural areas. Generally speaking, women who live in the rural areas are relatively more often exposed to violence, more isolated from services, less informed and less protected from violence.

The availability and accessibility of police and protection structures is weaker in rural than urban areas (Haller 2014; Hörl et al. 2015; Lindqvist 2009; Sorgo 2013). Moreover, support services, counselling centres and contact points tend to be less available and less specialised in rural than urban areas (Franco-Rebollar & Guilló Girard 2012; Goodey 2017; Koch et al. 2018; Müller et al. 2004; Ohms 2006; Sorgo 2013). Furthermore, women in rural areas tend not to have shelters in the proximity of their place of residence (Koch et al. 2018; Müller et al. 2004; Ohms 2006; Senate of France 2021). Women in rural areas have to travel considerable distances to receive specialised counselling. Thus, women in rural and remote areas have greater difficulties in accessing services, such as filing a complaint, because of long distances to the closest service point (Asociación pro Derechos Humanos Argituz 2015). The provision of public transportation is not well developed, and women may not own a car. There is some decentralised counselling available, but fixed counselling hours are an exception. (BMFSFJ 2022.)

9.2.2 Rural women have limited access to justice

Senate of France (2021) reports that women in rural areas have limited access to the judicial system. In addition, the implementation of specific legal measures such as restraining orders may be ineffective in rural areas, if the perpetrator is the caregiver who lives in the same household as the

victim. This may be the case of the older victims because affordable alternative care and services are not available. (Haller 2014; Hörl et al. 2015; Lindqvist 2009.)

9.2.3 Cultural norms and beliefs in rural areas normalise DV

There are differences between rural and urban conceptions of DV. In rural areas the police tend to normalise DV. This type of conception of CV aligns with cultural expectations that frame DV as mere family disputes and private matters that fall outside official criminal procedure and police powers. Common cultural expectations among the rural individuals and social and financial dependencies of the victims of DV to their partners may also drive women victims of DV stay away from official sources of help and support. (Hörl et al. 2015; Lindqvist 2009.) In Austria, Amesberger and Haller (2012) showed that in rural areas police officers were more likely to dismiss reports of abuse as mere marital issues. Furthermore, “only very few physicians had made serious attempts at talking about the assaults” or referring victims to relevant services. However, experiences with organisations for protection against violence as well as with women’s and psycho-social counselling institutions were highly satisfactory. (ibid.) Nevertheless, Franco-Rebollar and Guilló Girard (2012) criticise Spanish associations in rural areas for the tendency to help women by assisting them, not empowering them.

9.2.4 Flaws in organisational cooperation in rural areas

Cooperation between different service agencies is ineffective in rural areas. A report by the Senate of France recommends improvements, such as installing social workers in the gendarmerie and creating more contact points to the victims among the local authorities. A study by the Senate of France (2019) reports that although health care professionals form the front line in rural areas and could potentially play an important role, their actual involvement in DV prevention and detection is not satisfactory.

10. Other vulnerable victims

In addition to the categories of DV victims described in the previous chapters, there are many others who may experience barriers when seeking help and support. In the country report of Germany, BMFSFJ (2022) highlights the vulnerable position of sex workers, Roma women and women with addiction problems. In addition to these categories, Koch et al. (2018) mentions homeless individuals and the fact that many vulnerabilities, such as homelessness, disability, mental illness, and addictions may interact and accumulate in the case of a particular individual.

1. Young victims

Younger women victims of DV, those *in dating relationships*, and *those with little prior contact* with the criminal justice system are less likely to call the police (Klein 2009). Several structural barriers can make it more difficult for the young to enter into social and support services. To begin with, there are not enough suitable services that would accommodate the specific needs and experiences of the young (Bundock et al. 2020; Dacoreggio & Latourès 2016; Durán-Martín et al. 2022). In particular, services do not cover well the needs of those young victims of DV that do not have children and who do not live in a cohabiting relationship (Dacoreggio & Latourès 2016).

Young women are particularly vulnerable to different forms of digital violence. The Ministry of Equality in Spain reported in 2020 that young women face a strong sexual pressure and control via social media. Finnish university students (*n* = 298) who had become victims of violent stalking reported the incident most often to family and friends for protection (37.2%). Of all victims (including violent and non-violent stalking), about one third of victims turned to family and friends for help, but only a small minority reported using official resources in response to their stalker, such as professional help or legal actions. Of legal actions, victims reported most often to the police. (Björklund 2010.)

Various campaigns have been launched, but Maquibar et al. (2017) note that the mass media campaigns do not fit young people's needs. The available services for the young can be inconveniently located and there is not enough information about the availability of different services. If the young won't get support from their social environment, the seeking for services becomes difficult. Finally, accessing services results in costs, such as travelling and time. (Durán-Martín et al. 2022.) Especially in the rural areas separate gender-based residence facilities for the young women and girls are rare (BMFSFJ 2022).

2. Roma people

For *Roma women*, mistrust of the authorities runs deep because of the general discrimination experienced by the Roma community which makes them less likely to seek protection from the police when they experience DV. For instance, women belonging to Hungary's Roma minority are disadvantaged in accessing protection from DV. They experience difficulties reaching out for help in their communities, where poverty, unemployment, and social exclusion further fuel the risk of violence against women. As mentioned above, social and health care services are usually tailored to the needs of a mainstream victim. Consequently, the needs and the experiences of specific types of individual victims may not be satisfactorily met. The experiences of discrimination, distrust and poor socio-economic living conditions drive Roma women in Hungary less likely to seek help or support because of being a victim of DV. Roma women are particularly disadvantaged in receiving protection from DV. (HRW 2013.)

3. Homeless people

Homeless people are in a very vulnerable situation regarding reporting DV. The reasons for not reporting of violence are multiple among the homeless. Gabler et al. (2016) have studied the access of homeless individuals to various services for the victims of DV in Germany. According to their findings, police response to DV in the context of homelessness is challenging because of the negative

experiences of the homeless women regarding the police. In addition, homeless women have had negative experiences with psychiatrists. Shelters cannot offer permanent support (Koch et al. 2018) for homeless victims. Homelessness is often associated with addictions and mental health problems, which are perceived as causing conflicts. Thus, intoxicated persons or people suffering from substance addiction have difficulties to be admitted to shelters. (Gabler et al. 2016.) In addition, the access for homeless people to services is also difficult because without a registered address they cannot be admitted because of the current rules (BMFSFJ 2022).

4. Individuals living in extreme poverty

DV is quite common and even accepted among many people who live *in extreme poverty*. This cultural pattern, associated with harsh living conditions, undermines DV victims' capabilities to think otherwise, escape the conditions and contact professional service providers (Nagy et al. 2020).

5. Sex workers

Rossiwal (2016) identified many reasons for low reporting of violence among *sex workers* in Germany: fear of the perpetrator, being financially and emotionally dependent on the pimp, perception of no alternative options for action due to lack of education, social isolation, and lack of support from other sex workers who want to avoid troubles with pimps.

6. Individuals with substance abuse issue

According to Phillips et al. (2021), IPV is a common problem among *people with opioid abuse*. There are multiple barriers to help-seeking including an abusive partner who controls money and resources, fear of retaliatory violence, and victims' concerns about police and child welfare services. Pregnant and parenting victims were especially vulnerable to coercive threats by their abusive partner. These threats were related to disclosure of substance use to child welfare authorities or law enforcement. However, the actual experience of many support services was positive among these individuals. The participants reported being treated well at DV shelters, and opioid abuse treatment programs helped them make positive changes. (Phillips et al. 2021.)

Support services are not adapted to the needs of the *DV victims with alcoholism or drug addiction*. The staff does not have training and competence on the consequences of a double burden of violence and a problematic use of addictive substances. There is not enough coordination between the first line responders and youth welfare services to deal with mother's fear of losing the custody of their children due to addiction problems. In addition, the lack of coordination between the agencies can also put children's safety at risk. (Galvani 2006.)

11. Conclusions

The literature reviewed in this report stems mainly from six EU countries (Finland, Austria, France, Hungary, Germany and Spain), with a few exceptions from e.g., United States, Australia and Iceland, and since most of the studies are national, no conclusions can be drawn from them to e.g., generalise about similar organisations in other countries. Nevertheless, a more detailed description of the functions of the service systems in several EU countries are described in the reports of IMPRODOVA project.

However, the report is able to provide insight into the barriers that prevent victims from reporting violence. The report gathers the challenges that victims face when trying to get help from fragmented service systems, as well as the victims' subjective experiences of e.g., a wide range of fears, exhaustion and unmet needs.

The literature review also brought out how some groups of people are invisible in certain aspects also in research. For instance, there was not much research on barriers to reporting DV among inmates, neurodivergents and those with mental health problems. Therefore, it is important to aim study the needs of these people in the next work phases of the project.

The planned objectives of the task are achieved. All the partners fulfilled their duty satisfactorily. Deviations from workplan: with the approval of the project officer, the date of return of the report was delayed by 2 weeks.

12. Alphabetical References

ABC

- Ahmad, A., Benson-Martin, J., Jahn, A., and Beiersmann, C. (2022). A Qualitative Study into Perception, Experience, and Response of Intimate Partner Violence among Syrian Refugee Women in Heidelberg, Germany. *Research Square*, Preprint. https://doi.org/10.21203/rs.3.rs-1416813/v1
- Alencar-Rodrigues, R. and Cantera, L.M (2013). Intervention in gender violence in couples: the role of institutional resources. *Athenea Digital*, 13(3): 75–100. http://dx.doi.org/10.5565/rev/athenead/v13n3.1058
- Amesberger, H. and Haller, B. (2012). Intimate partner violence against older women: Findings from Austria. *Ex aequo*, 26, 57-70
- *American Journal of Public Health* 111, 318-326. https://doi.org/10.2105/AJPH.2020.306017
- Antón García, L. (2014). Barrera idiomática y derecho a la información de las víctimas de violencia de género. *InDret: Revista para el Análisis del Derecho*, 2. https://www.raco.cat/index.php/InDret/article/view/289831/378140
- Aronson, J., Thornewell, C., and Williams, K. (1995). Wife assault in old age: coming out of obscurity. *Canadian Journal of Aging*, 14(2): 72–88. https://doi.org/10.1017/S0714980800005602
- Assemblée Nationale (2019a). *Rapport d'information sur la proposition de loi relative aux violences au sein des couples et aux incidences de ces dernières sur les enfants et la proposition de loi visant à agir contre les violences faites aux femmes*. By Fiona Lazaar; Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. Paris: Assemblée nationale. https://www.assemblee-nationale.fr/dyn/15/rapports/ega/l15b2280_rapport-information
- Assemblée Nationale (2019b). *Rapport d'information sur l'élaboration du Livre Blanc de la Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes portant sur la lutte contre les violences conjugales*. Tome I and Tome II. By Marie-Pierre Rixain; Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. Paris, Assemblée nationale. https://www.assemblee-nationale.fr/dyn/15/rapports/ega/l15b2396-ti_rapport-information.pdf and https://www.assemblee-nationale.fr/dyn/15/rapports/ega/l15b2396-tii_rapport-information
- Assemblée Nationale (2021). *Rapport d'information sur son colloque consacré à la lutte contre les violences économiques dans le couple*. By Marie-Pierre Rixain; Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. Paris: Assemblée nationale. https://www.assemblee-nationale.fr/dyn/15/rapports/ega/l15b3809_rapport-information
- Asociación pro Derechos Humanos Argituz (2015). *Identificación de necesidades y obstáculos encontrados por las mujeres víctimas de violencia de género del área rural de Bizkaia en el acceso efectivo a los servicios y prestaciones de apoyo, atención y justicia*. Bilbao: Asociación pro Derechos Humanos Argituz. https://www.bizkaia.eus/documents/880299/7139949/Mujeres_rurales_VG_c.pdf/e5d88ebe-4fe0-60af-a386-3bb9a20c5375?t=1604919887030
- BAFzA (2022). *Das Jahr 2021 in Zahlen. Hilfetelefon Gewalt gegen Frauen*. Köln: Bundesamnt Bundesamt für Familie und zivilgesellschaftliche Aufgaben.
- https://www.hilfetelefon.de/fileadmin/content/04_Materialien/1_Materialien_Bestellen/Jahresberichte/2021/HilfetelefonGewaltgegenFrauen_Das-Jahr-2021-in-Zahlen_web.pdf
- BAFzA (2021). *Jahresbericht des Hilfetelefons Gewalt gegen Frauen 2020*. Köln: Bundesamnt Bundesamt für Familie und zivilgesellschaftliche Aufgaben.
- https://www.hilfetelefon.de/fileadmin/content/04_Materialien/1_Materialien_Bestellen/Jahresberichte/2020/501_Jahresbericht_2020_web.pdfhttps://www.hilfetelefon.de/fileadmin/content/04_Materialien/1_Materialien_Bestellen/Jahresberichte/2020/501_Jahresbericht_2020_web.pdf
- Bailey, R., Dugard, J., Smith, S.F. and Porges, S.W. (2023). Appeasement: replacing Stockholm syndrome as a definition of a survival strategy. *European Journal of Psychotraumatology*, 14(1). DOI: 10.1080/20008066.2022.2161038
- Bajwa, J. K., Couto, S., Kidd, S., Markoulakis, R., Abai, M., and McKenzie, K. (2017). Refugees, higher education, and informational barriers. *Refuge*, *33*(2): 56-65. https://doi.org/10.7202/1043063ar
- Beaulaurier, R.L., Seff, L., Newman, F. and Dunlop, B. (2008). Barriers to Help Seeking for Older Women Who Experience Intimate Partner Violence. *Journal of Family Violence*, 22(8): 747-755. https://doi.org/10.1007/s10896-007-9122-y
- Beaulaurier, R. L., and Taylor, S. H. (2001). Dispelling fears about aging with a disability: Lessons from the disability rights community. *Journal of Gerontological Social Work*, 35(2): 81-98.
- Beclin, K. (2014). Aussage gegen Aussage – häufige Pattstellung bei Strafverfolgung häuslicher Gewalt? *juridikum*, 3:360-372. https://elibrary.verlagoesterreich.at/article/99.105005/juridikum201403036001

- Bender, A.K., and Lauritsen, J.L. (2021). Violent Victimization Among Lesbian, Gay, and Bisexual Populations in the United States: Findings from the National Crime Victimization Survey, 2017–2018.
- Berthier, Z. and Karzabi, I. (2021). *Mieux protéger et accompagner les enfants co-victimes des violences conjugales*. Rapport Préconisations. Observatoire régional des violences faites aux femmes. Saint-Ouen-sur-Seine: Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes-hommes, Région Île-de-France. https://solidaritefemmes13.org/wp-content/uploads/2022/02/rapport-enfantscovictimesviolencesconjugales-2021.pdf
- Best, J. (1999). *Random violence: How we talk about new crimes and new victims*. Berkeley: University of California Press.
- Birdsey E., and Snowball L. (2013). *Reporting violence to police: A survey of victims attending domestic violence services*. Issue paper No. 91. Sydney: NSW Bureau of Crime Statistics and Research. https://apo.org.au/sites/default/files/resource-files/2013-12/apo-nid37075.pdf
- Birkel, C., Church, D., Erdmann, A., Hager, A. and Leitgöb-Guzy, N. (2022). *Sicherheit und Kriminalität in Deutschland – SKiD 2020*. Bundesweite Kernbefunde des Viktimisierungssurvey des Bundes-kriminalamts und der Polizeien der Länder. Wiesbden: Bundeskriminalamt https://www.bka.de/SharedDocs/Downloads/DE/Publikationen/Publikationsreihen/Forschungsergebnisse/SKiD2020_Ergebnisse_V1.2.pdf?__blob=publicationFile&v=20
- Björklund, K. (2010). *Stalking and violence victimization among Finnish university students*. Dissertation. Helsinki: University of Helsinki. http://hdl.handle.net/10138/19721
- BMFSFJ (2018). *Gewalt gegen Frauen mit Behinderungen.* [Violence against women with disabilities], [Federal Ministry for Family Affairs, Senior Citizens, Women and Youth]. Referred 2nd of January 2023. https://www.bmfsfj.de/bmfsfj/service/publikationen/lebenssituation-und-belastungen-von-frauen-mit-beeintraechtigungen-und-behinderungen-in-deutschland-80576
- BMFSFJ (2022). *Verhütung und Bekämpfung von Gewalt gegen Frauen und häuslicher Gewalt. Erster Bericht des Expertenausschusses (GREVIO) zur Umsetzung des Übereinkommens des Europarats vom 11. Mai 2011 (Istanbul-Konvention) in Deutschland*. Berlin: Federal Ministry for Family Affairs, Senior Citizens, Women and Youth]. https://www.bmfsfj.de/resource/blob/202386/3699c9bad150e4c4ff78ef54665a85c2/grevio-evaluierungsbericht-istanbul-konvention-2022-data.pdf
- Bohns, V.K. and Flynn, F.J. (2010). “Why didn’t you just ask?” Underestimating the discomfort of help-seeking. *Journal of Experimental Social Psychology*, 46(2): 402-409. https://doi.org/10.1016/j.jesp.2009.12.015
- Bonomi, A. E., Holt, V. L., Martin, D. P. and Thompson, R. S. (2006). Severity of intimate partner violence and occurrence and frequency of police calls. *Journal of Interpersonal Violence*, 21(10): 1354-1364. https://doi.org/10.1177/0886260506291656
- Both, L.M., Favaretto, T.C. and Freitas, L.H.M. (2019). Cycle of violence in women victims of domestic violence: Qualitative analysis of OPD 2 interview. *Brain and Behavior*, 9(11): e01430. https://doi.org/10.1002/brb3.1430
- Brown, E., Dupuis, J. and Mazuy, M. (2020). Au sein du couple, des situations de violence genrées et asymétriques. Pp. 183-216 in E. Brown, A. Debauche, C. Hamel and M. Mazuy (eds.). *Violences et rapports de genre - Enquête sur les violences de genre en France*. Paris: INED Editions.
- Brown, E. and Mazuy, M. (2021). Violences conjugales subies par les femmes. Persistance du continuum des violences et de l’asymétrie de genre. *Terrains/Théories*, 14. https://doi.org/10.4000/teth.3809
- Brzank, P. (2022). *Umgang mit Gewalt in Paarbeziehungen. Umfrage unter Berliner Gesundheitsfachkräften zur Patient*innenversorgung nach Gewalt in Paarbeziehungen*. Runder Tisch Berlin - Gesundheitsversorgung bei häuslicher und sexualisierter Gewalt am 18.05.2022. https://www.signal-intervention.de/sites/default/files/2022-05/Brzank_Befraung%20des%20RTB_RTB_18052022.pdf
- Brzank, P., Hellbernd, H., Maschewsky-Schneider, U., and Kallischnigg, G. (2005). Häusliche Gewalt gegen Frauen und Versorgungsbedarf. Ergebnisse einer Befragung von Patientinnen einer Ersten Hilfe/Rettungsstelle. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 48: 337–345. https://doi.org/10.1007/s00103-004-1002-5
- Briones-Vozmediano, E., La Parra, D. and Vives-Cases, C. (2014a). Barriers and facilitators to effective coverage of Intimate Partner Violence services for immigrant women in Spain. *Health Expectations*, 18(6): 2994–3006. https://doi.org/10.1111/hex.12283
- Briones-Vozmediano, E. Goicolea, I., Ortiz-Barreda, G. M., Gil-González,D. and Vives-Cases, C. (2014b). Professionals’ Perceptions of Support Resources for Battered Immigrant Women: Chronicle of an Anticipated Failure. *Journal of Interpersonal Violence*, 29(6): 1006–1027. https://doi.org/10.1177/0886260513506059
- Briones-Vozmediano, E., Agudelo-Suarez, A.A., Goicolea, I. and Vives-Cases, C. (2014c). Economic crisis, immigrant women and changing availability of intimate partner violence services: a qualitative study of professionals´ perceptions in Spain. *International Journal for Equity in Health*, 13(79): 1–9. https://doi.org/10.1186/s12939-014-0079-1
- Bundock, K., Chan, C. and Hewitt, O. (2020). Adolescents’ Help-Seeking Behavior and Intentions Following Adolescent Dating Violence: A Systematic Review. *Trauma, Violence, & Abuse*, 21(2): 350–366. https://doi.org/10.1177/1524838018770412

- Campbell, R., Sefl, T., Barnes, H.E., Ahrens, C.E., Wasco, S.M. and Zaragoza-Diesfeld, Y. (1999) Community services for rape survivors: enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology* 67(6): 847-858.
- Cantazaro, A. E. (2009*). Predicting help-seeking attitudes and intentions in a Latino/a sample. Doctoral dissertation*. Ames: Iowa State University. https://doi.org/10.31274/etd-180810-822
- Celdrán, M. (2013). Violence against older women: a review of the literature. *Papeles del Psicólogo*, 34(1): 57–64. https://www.papelesdelpsicologo.es/English/2170.pdf
- Centre Hubertine-Auclert (2019*). Diagnostic collaboratif sur l'accueil des femmes victimes de violences conjugales et/ou sexuelles et l'évaluation du danger dans trois commissariats de Paris et de la petite couronne.* Synthèse Étude. Saint-Ouen-sur-Seine: Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes-hommes, Région Île-de-France. https://www.prefecturedepolice.interieur.gouv.fr/sites/default/files/Documents/SYNTHESE_etude_commissariat_VFF_version_septembre.pdf
- Chan, K. L., Emery, C. R., and Ip, P. (2016). Children with disability are more at risk of violence victimization: Evidence from a study of school-aged Chinese children. *Journal of Interpersonal Violence*, 31(6): 1026–1046. https://doi.org/10.1177/0886260514564066
- Child Welfare Information Gateway (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/
- Collins, N. L., and Feeney, B. C. (2000). A safe haven: an attachment theory perspective on support seeking and caregiving in intimate relationships. *Journal of personality and social psychology*, 78(6): 1053-1073. https://doi.org/10.1037/%2F0022-3514.78.6.1053
- Coll-Vinent, B., Echverría, T., Farràs, U., Rodríguez, D. Millá, J. and Santiñà, M. (2008). El personal sanitario no percibe la violencia doméstica como un problema de salud. *Gaceta Sanitaria*, 22(1): 7-10. https://doi.org/10.1157/13115103
- Craviotto, N. et al. (2018). *Où est l'argent contre les violences faites aux femmes?* Rapport de recherche. Paris: le Conseil économique, social et environnemental (CESE), la Fondation des femmes, le Fonds pour les Femmes en Méditerranée (FFMed), le Haut Conseil à l'Égalité entre les femmes et les hommes (HCE) et Women's Worldwide web (W4). https://www.haut-conseil-egalite.gouv.fr/IMG/pdf/rapport-ou_est_argent-vf.pdf
- Czibere, I. (2012). *Nők mélyszegénységben. Személyes életvilágok és cselekvési perspektívák a mélyszegénységben élő nők mindennapjaiban*. Budapest: L'Harmattan. https://mek.oszk.hu/15100/15169/15169.pdf

DEF

- Dacoreggio, A. and Latourès, A. (2016). *Situation et parcours des jeunes femmes entre 18 et 25 ans victimes de violences en Île-de-France. Recherche-action Jeunes femmes victimes de violences*. Observatoire régional des violences faites aux femmes. Saint-Ouen-sur-Seine: Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes-hommes, Région Île-de-France. https://www.yumpu.com/fr/document/read/56529167/synthese-jeunesfemmesvictimesviolences-web
- Darley, M. and Gauthier, J. (2014). Une virilité interpellée? En quête de genre au commissariat. *Genèses*, 97(4): 67-86. https://doi.org/10.3917/gen.097.0067
- Déroff, M. L., and Potin, É. (2013). Violences conjugales dans l'espace familial: que fait-on des enfants? Pratiques professionnelles au croisement des champs de la protection de l'enfance et des violences conjugales. *Enfances Familles Générations. Revue interdisciplinaire sur la famille contemporaine*, 18: 120-137. https://doi.org/10.7202/1014577ar
- Dietz, N. A. and Martin, P. Y. (2007). Women Who Are Stalked: Questioning the Fear Standard. *Violence Against Women*. 13(7): 750–776. https://doi.org/10.1177/1077801207302698
- Downey, G., and Feldman, S. I. (1996). Implications of rejection sensitivity for intimate relationships. *Journal of Personality and Social Psychology*, 70(6): 1327-1343.
- Dreßing, H., Grass, P., Schultz, K., and Kuehner, C. (2020). The Prevalence and Effects of Stalking - a replication study. *Deutsches Ärzteblatt*, 117 (20): 347-353. https://doi.org/10.3238%2Farztebl.2020.0347
- Drug Policy Alliance (2018). *The drug war, mass incarceration, and race*. New York: Drug Policy Alliance. http://www.drugpolicy.org/sites/default/files/drug-war-mass-incarceration-and-race_01_18_0.pdf
- Dugan, L., Nagin, D. S., and Rosenfeld, R. (2003). Do domestic violence services save lives? *National Institute of Justice Journal*, 250: 20–25. https://www.ncjrs.gov/pdffiles1/jr000250f.pdf
- Durán-Martín, E., Vives-Cases, C., Otero-García, L., Castellanos-Torres, E. and Sanz-Barbero, B. (2022). Do we have friendly services to meet the needs of young women exposed to intimate partner violence in the Madrid region? *Health Expectations*, 25: 1058–1068. https://doi.org/10.1111/hex.13453

- Döge, P. (2012). *Männer – die ewigen Gewalttäter? Gewalt von und gegen Männer in Deutschland*. Wiesbaden: Springer VS. https://doi.org/10.1007/978-3-531-19665-7
- Ebert C. and Steinert J.I. (2021). Prevalence and risk factors of violence against women and children during COVID-19, Germany. *Bulletin of the World Health Organization*, 99(6): 429–438. http://dx.doi.org/10.2471/BLT.20.270983
- Feder, G., Hutson, M., Ramsay, J., and Taket, A. (2006). Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of International Medicine*, 166(1): 22–37. doi:10.1001/archinte.166.1.22
- Ferrer Pérez, V.A., and Bosch Fiol, E. (2016). Análisis psicosocial de las barreras que dificultan la denuncia: el caso de los femicidios íntimos en España. *ex æquo*, 34: 59-76. https://doi.org/10.22355/exaequo.2016.34.05
- FHK (2022). *Bundesweite Frauenhaus-Statistik. 2021. Deutschland*. Berlin: Frauenhauskoordinierung e.V. https://www.frauenhauskoordinierung.de/fileadmin/redakteure/Publikationen/Statistik/2022-11-01_Langfassung_Frauenhaus-Statistik_2021_FHK.pdf
- Fiedeler, G. (2020a). Partnerschaftsgewalt gegen Männer. Pp. 59–67 in M. Büttner (ed.). *Handbuch Häusliche Gewalt*. Stuttgart: Schattauer Verlag.
- Fiedeler, G. (2020b). Beratung von Männern, die Gewalt in der Partnerschaft erleben. Pp. 254 – 262 in M. Büttner (ed.). *Handbuch Häusliche Gewalt*. Stuttgart: Schattauer Verlag.
- Fleming, C.J., and Resick, P. (2017). Help-Seeking Behavior in Survivors of Intimate Partner Violence: Toward an Integrated Behavioral Model of Individual Factors. *Violence and Victims*, 32(2): doi: 10.1891/0886-6708.VV-D-15-00065
- Flotzinger, M., Liebeswar, C., Schmied, G., Stark, M., and Steiner, K. (2021). *Gewalterfahrungen von Frauen mit Migrations¬hintergrund im Kontext von Covid-19*. Wien: Österreichischer Integrationsfonds. https://www.integrationsfonds.at/fileadmin/content/AT/Downloads/Publikationen/OEIF_Forschungsbericht_Gewalterfahrungen_COVID-19.pdf
- Forschungsverbund Gewalt gegen Männer (ed. 2004). Gewalt gegen Männer in Deutschland. Personale Gewalterfahrnisse von Männern in Deutschland [Violence against men in Germany. Personal experiences of violence by men in Germany]. Bundesministerium für Familie, Senioren, Frauen und Jugend. https://www.bmfsfj.de/blob/84590/a3184b9f324b6ccc05bdfc83ac03951e/studie-gewalt-maenner-langfassung-data.pdf
- FRA (2014). Violence against women: An EU-wide survey. European Union Agency for Fundamental Rights. Luxembourg: Publications Office of the European Union. https://fra.europa.eu/sites/default/files/fra_uploads/fra-2014-vaw-survey-main-results-apr14_en.pdf
- Franco-Rebollar, P., and Guilló Girard, C.I. (2012). ¿Qué pasa fuera de las ciudades? violencia de género y ruralidad. *Revista Europea de Derechos Fundamentales*, 19: 215–243. https://dialnet.unirioja.es/descarga/articulo/4055504.pdf
- French, P. (2007). *Disabled Justice: The barriers to justice for persons with a disability in Queensland*. Brisbane: Queensland Advocacy Incorporated. https://qai.org.au/wp-content/uploads/2021/04/Disabled-Justice-The-Barriers-to-Justice-for-Disabled-Persons-in-Queensland.pdf

GHIJ

- Gabler, A., Görgen, T., Kotlenga, S., Nägele, B., and Nowak, S. (2016). *Polizeiliche Wegweisung und zivilrechtlicher Gewaltschutz in Fällen von Nahraumgewalt-die Situation von Frauen mit spezifischen Bedarfen*. Göttingen: Zoom – Gesellschaft für prospektive Entwicklungen e.V. Münster-Hiltrup: Deutsche Hochschule der Polizei. https://www.cora-mv.de/images/dokumente/2019-2000/2016_SNaP_Laenderbericht_Deutschland.pdf
- Galvani, S. (2006). *Safety first? The impact of domestic abuse on women's treatment experience*, Journal of Substance Use, 11:6, 395-407, DOI: 10.1080/14659890600708225
- Garai, R. (2019). A kapcsolati erőszak bűncselekményének jogalkalmazási gyakorlata - a jogerős ítéletek tanulságaiIn. *Kriminológiai Tanulmányok*, 56: 20–47.
- https://www.okri.hu/images/stories/KT/KT56_2019/kt56_sec.pdf
- García Montes, R., Corral Liria, I., Jimenez Fernandez, R., Rodriguez Vázquez, R., Becerro de Bengoa Vallejo, R., and Losa Iglesias, M. (2021). Personal Tools and Psychosocial Resources of Resilient Gender-Based Violence Women. *Environmental Research and Public Health*, 18(16): 1-12. https://doi.org/10.3390/ijerph18168306
- García Campoy, A. (2019). Características y problemáticas del maltrato psicológico: barreras que dificultan la denuncia. *La Acción social. Revista de Política social y Servicios sociales*, 3: 27–44. http://hdl.handle.net/10201/67299
- Gendarmerie Nationale (2021*). Améliorer l'accueil des victimes de violences conjugales dans les unités de gendarmerie. Resultats de l'audit 2021*. Paris: Gendarmerie Nationale, Inspection générale de la Gendarmerie nationale. https://www.interieur.gouv.fr/sites/minint/files/medias/documents/2022-10/IGGN-rapport-2021-accueil-des-victimes-violences-conjugales_0.pdf

- Georgia Commission on Family Violence (GCFV) (15.02.2023). *Key goals. Improve access to culturally relevant services for victims from marginalized communities*. The Georgia Domestic Violence Fatality Review Project. Referred 15th of February 2023. Retrieved from: http://georgiafatalityreview.com/key-goals/improve-access-to-culturally-relevant-services-for-victims-from-marginalized-communities/
- Giddens, A. (1991). *Modernity and self-identity. Self and society in the late modern age*. Cambridge: Polity Press.
- Grigsby, N., and Hartman, B. (1997). The barriers model: An integrated strategy for intervention with battered women. *Psychotherapy*, 34, 485–497.
- Goicolea, I., Vives-Cases, C., Castellanos-Torres. E., Briones-Vozmediano, E., and Sanz-Barber, B. (2022). Disclosing Gender-Based Violence: A Qualitative Analysis of Professionals' and Women's Perspectives through a Discursive Approach*. International Journal of Environmental Research and Public Health*, 19, 14683. https://doi.org/10.3390/ijerph192214683
- Gosset, M. et al. (2022). *Former les forces de sécurité à l'accueil des femmes victims de violences conjugales*. (Rapport de recherche: Bilan du Projet regional de formation 2021-2022), Observatoire régional des violences faites aux femmes, Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes hommes, Saint-Ouen-sur-Seine, Région Ile-de-France, octobre 2022, 48 p.
- Goodey, J. (2017). Violence Against Women: Placing Evidence from a European Union–Wide Survey in a Policy Context. *Journal of Interpersonal Violence*, 32(12): 1760–1791 https://doi.org/10.1177/0886260517698949
- GREVIO (2022*). GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention). Germany*. Strasbourg: Council of Europe. https://rm.coe.int/report-on-germany-for-publication/1680a86937
- Hackenberg, E. A. M., Sallinen, V., Handolin, L. and Koljonen, V. (2021). Victims of Severe Intimate Partner Violence Are Left Without Advocacy Intervention in Primary Care Emergency Rooms: A Prospective Observational Study. *Journal of Interpersonal Violence*, 36(15–16): 7832–7854. https://doi.org/10.1177/0886260519837649
- Haller, B. (2014). Gewaltschutz in Österreich. *juridikum*, 3: 338–348. https://elibrary.verlagoesterreich.at/article/99.105005/juridikum201403033801
- Hardesty J. L., Oswald R. F., Khaw L. and Fonseca C. (2011). Lesbian/bisexual mothers and intimate partner violence: Help seeking in the context of social and legal vulnerability. *Violence Against Women*, 17(1): 28–46. DOI: 10.1177/1077801209347636
- Harms, B. (2013). *Menschen mit Opfererfahrung. Wege im Hilfesystem, psychische Belastung und Bewertung von Beratung*. Doctoral dissertation. Hamburg: Universität Hamburg. https://ediss.sub.uni-hamburg.de/handle/ediss/5122
- HCE (2020). *Violences conjugales - Garantir la protection des femmes victimes et de leurs enfants tout au long de leur parcours*. Rapport n°2020-09-22 VIO-43. Paris: Haut Conseil à l'Égalité entre les femmes et les hommes. https://www.egalite-femmes-hommes.gouv.fr/sites/efh/files/migration/2020/10/HCE-RAPPORT-VIOLENCES-CONJUGALES-2020.pdf
- Hegarty, K., McKibbin, G., Hameed, M., Koziol-McLain, J., Feder, G., Tarzia, L. and Hooker, L. (2020). Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis*. PLoS ONE* 15(6): e0234067. https://doi.org/10.1371/journal.pone.0234067
- Hegyi, V. (2022). Néhány gondolat az ügyész szerepéről a kapcsolati erőszak és a kiskorú veszélyeztetésének bűntette miatt folytatott nyomozásokban, különös tekintettel a gyermek jogainak biztosítására. *Belügyi Szemle*, 70(8): 1613–1626. https://doi.org/10.38146/BSZ.2022.8.2
- Hellmann, D. F. (2014). *Repräsentativbefragung zu Viktimisierungserfahrungen in Deutschland*. Forschungsbericht Nr. 122. Hannover: Kriminologisches Forschungsinstitut Niedersachsen.
- Hellmann, D.F., and Blauert, K. (2014). Häusliche Gewalt gegen Frauen in Deutschland. *Sws-rundschau*, 54, 78–89.
- Henrion R. (2001). *Les Femmes victimes de violences conjugales, le rôle des professionnels de santé: rapport au ministre chargé de la*. Paris: Commission médicale d'établissement, Institut de l'humanitaire, Fédération Solidarité femmes. https://www.vie-publique.fr/rapport/24751-les-femmes-victimes-de-violences-conjugales-le-role-des-professionnels
- Héra, G. (2022). A kapcsolati erőszak eseteinek rendőri kezeléséről. *Belügyi Szemle*, 70(8): 1627–1640. https://doi.org/10.38146/BSZ.2022.8.3
- Hill, J. (2009). *Working with victims of crime: a manual applying research to clinical practice* (2nd edition). Department of Justice, Canada. https://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/res-rech/hill.pdf
- Hirsch, R. D. and Brendebach, C. (1999). Gewalt gegen alte Menschen in der Familie. Untersuchungsergebnisse der "Bonner HsM-Studie". *Zeitschrift für Gerontologie und Geriatrie*, 32(6): 449–455. https://doi.org/10.1007/s003910050142
- Hollander, J.A. (2004). "I Can Take Care of Myself": The Impact of Self-Defense Training on Women's Lives. *Violence Against Women*, 10(3): 205-235. https://doi.org/10.1177/1077801203256202

- Holtmann, C. (2022). Vulnerability and Resiliency: Immigrant Women, Social Networks and Family Violence. Pp. 163-185 in J. Freedman, N. Sahraoui, and E. Tastsoglou (eds.*). Gender-Based Violence in Migration*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-031-07929-0_7
- Homberger, A. and Güntner, S. (2022). *Antworten auf Migrant: innen mit prekärem Aufenthaltsstatus in Wien: Rahmen, Strategien und innovative Praktiken*. Local Response to Precarious Migrants. https://ec.europa.eu/migrant-integration/system/files/2023-01/LoReMi_Vienna_report_DEU%202022.pdf
- Hoppe, R. and Heubrock, D. (2013). Osteuropäische Stalking-Opfer in Deutschland. Kultureller Hintergrund, Viktimologie, Anzeigeverhalten und Lösungen. *Kriminalistik*, 67(11): 676–679.
- Hornyik, Z. (2020). Családon belüli erőszak Magyarországon. Interjú Solt Ágnessel. *Belügyi Szemle*, 68(2): 123–129. https://doi.org/10.38146/BSZ.2020.2.10
- Hudson, M. F. (1986). Elder mistreatment: Current research. Pp. 125-193 in K. A. Pillemer and R. S. Wolf (eds.). *Elder Abuse: Conflict in the Family*. Dover: Auburn House.
- HRW (2013). *Unless Bloods Flows. Lack of Protection from Domestic Violence in Hungary*. Human Rights Watch. https://www.hrw.org/sites/default/files/reports/hungary1113_ForUpload.pdf
- Husso, M., Notko, M., Virkki, T., Holma, J., Laitila, A., and Siltala, H. (2021). Domestic Violence Interventions in Social and Health Care Settings: Challenges of Temporary Projects and Short-Term Solutions. *Journal of Interpersonal Violence*, 36(23–24): 11461–11482. https://doi.org/10.1177/0886260519898438
- Hörl, J., Ganner, M. and Scholta, M. (2015*). Gewaltschutz für ältere Menschen. Befragung von Expertinnen Und Experten Über Möglichkeiten Und Hindernisse Bei Der Umsetzung Gesetzlicher Regelungen in Österreich*. Wien: Bundesministerium für Arbeit, Soziales und Konsumentenschutz. https://www.sozialministerium.at/dam/jcr:04c86930-0b59-4d9a-a060-f94cd8e41cee/Gewaltschutz-fuer-aeltere-Menschen.pdf
- Hoffmann, K. (2021). *Egy biztonságos otthonért. Kvantitatív kutatási jelentés, Magyarország*. Inter IKEA system B.V. 20. https://www.ikea.com/hu/hu/files/pdf/63/b6/63b690de/ikea_egy-biztonsagos-otthonert_kutatasi-eredmenyek_2021.pdf.
- Jones L., Bellis M. A., Wood S., Hughes K., McCoy E., Eckley L., Bates G., Mikton C., Shakespeare T. and Officer A. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, 380(9845): 899–907. https://doi.org/10.1016/S0140-6736(12)60692-8
- Jouanneau, S. (dir.) (2019). *Violences conjugales – Protection des victimes - Usages et conditions d'application dans les tribunaux français des mesures de protection des victimes de violences au sein du couple* (Rapport de recherche), Paris, Mission de recherche Droit et Justice, octobre 2019, 604 p.
- Jouanneau, S. and Matteoli, A. (2018). Les violences au sein du couple au prisme de la justice familiale. Invention et mise en œuvre de l'ordonnance de protection. *Droit et société*, 99: 305–321. https://doi.org/10.1007/978-3-031-15335-8

KLM

- Kantor, V., Knefel, M. and Lueger-Schuster, B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review, Clinical Psychology Review, Volume 52, 2017, Pages 52-68, ISSN 0272-7358, https://doi.org/10.1016/j.cpr.2016.12.001
- Kapella, O., Baierl, A., Rille-Pfeiffer, C., Geserick, C. and Schmidt, E-M. (2011). *Gewalt in Der Familie Und Im Nahen Sozialen Umfeld Österreichische Prävalenzstudie Zur Gewalt an Frauen Und Männern*. Wien: Österreichisches Institut für Familienforschung an der Universität Wien. https://services.phaidra.univie.ac.at/api/object/o:1162297/download
- Karzabi, I. and Lemière, S. (2016). *Améliorer l'accès à l'emploi des femmes victimes de violences. Guide à destination des acteurs et actrices de l'emploi*. Saint-Ouen-sur-Seine: Observatoire régional des violences faites aux femmes, Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes hommes, Région Île-de-France. https://www.centre-hubertine-auclert.fr/sites/default/files/medias/egalitheque/documents/guide-orvf-femmesemploi-web.pdf
- Kersten, J., Burman, M., Houtsonen, J., Herbinger, P. and Leonhardmair, N. (eds.) (2023). *Domestic Violence and COVID-19. The 2020 Lockdown in the European Union*. Cham: Springer. https://link.springer.com/book/10.1007/978-3-031-15335-8
- Kjaran, J.I. and Halldórsdóttir, B.E. (2022). Epistemic Violence Toward Immigrant Women in Iceland: Silencing, Smothering, and Linguistic Deficit. *Nordic journal of Migration Research*, 12 (3): 346-360. https://doi.org/10.33134/njmr.499
- Klein, A. R. (2009). *Practical implications of current domestic violence research: For law enforcement, prosecutors and judges*. Washington: USA Department of Justice, Office of Justice Programs. Practical Implications of Current Domestic Violence Research. https://www.ojp.gov/pdffiles1/nij/225722.pdf

- Koch, U., Meyer, T., Deremetz, A. and Rayment-Briggs, D. (2018). *Bedarfsanalyse zur Vorhaltung eines bedarfsdeckenden Angebots an Frauen- und Kinderschutzhäusern und spezialisierten Fachberatungsstellen gegen Gewalt an Frauen in Baden-Württemberg*. Stuttgart: Institut für angewandte Sozialwissenschaften Stuttgart. https://sozialministerium.baden-wuerttemberg.de/fileadmin/redaktion/m-sm/intern/downloads/Downloads_Gegen_Gewalt_an_Frauen/IfaS-Bedarfsanalyse_2018_Abschlussbericht.pdf
- Koutaniemi, E. M. and Einiö, E. (2021). Seasonal variation in seeking help for domestic violence based on Google search data and Finnish police calls in 2017. *Scandinavian Journal of Public Health*, 49(3): 254–259. https://doi.org/10.1177/1403494819834098
- Kurdyla, V., Messinger, AM. and Ramirez, M. (2021). Transgender Intimate Partner Violence and Help-Seeking Patterns. *Journal of Interpersonal Violence*, 36(19/20): NP11046-NP11069. https://doi.org/10.1177/0886260519880171
- Lahtinen, H.-M. (2022). *Child abuse disclosure: From the perspectives of children to influencing attitudes and beliefs held by interviewers*. Publications of the University of Eastern Finland. Dissertations in Education, Humanities, and Theology, 181. http://urn.fi/URN:ISBN:978-952-61-4459-7
- Lancharro-Tavero, I., Romero-Serrano, R., Torres-Enamorado, D., Arroyo-Rodríguez, A., Macías-Seda, J. and Gil-García, E. (2022). Conflictos de las enfermeras comunitarias en la aplicación del Protocolo Andaluz para la Actuación Sanitaria ante la Violencia de Género. *Atención Primaria*, 54(3): 102213. https://doi.org/10.1016/j.aprim.2021.102213
- LN-W (2020). *Sicherheit und Gewalt in Nordrhein-Westfalen*. Forschungsbericht. Düsseldorf: Landeskriminalamt Nordrhein-Westfalen. https://www.mhkbg.nrw/sites/default/files/media/document/file/Forschungsbericht_Studie_Sicherheit_und_Gewalt_in_Nordrhein-Westfalen.pdf
- Linares Bahillo, E., Royo Prieto, R. and Silvestre Cabrera, M. (2019). Sexual and sexist cyber-harassment towards young girls. New online versions of patriarchal oppression of female sexuality and corporality. *Doxa Comunicación*, 28: 201-222. https://doi.org/10.31921/doxacom.n28a11
- Lindqvist, R. (2009). *Parisuhdeväkivallan kohtaaminen maaseudun sosiaalityössä*. Jyväskylä: Jyväskylä University Printing House. http://urn.fi/URN:ISBN:978-951-39-3527-6
- Lobnikar, B., Vogt, C. and Kersten, J. (eds.) (2021). *Improving Frontline Responses to Domestic Violence in Europe*. Maribor: University of Maribor, University Press. DOI: https://doi.org/10.18690/978-961-286-543-6
- López-Castro, T., Saraiya, T., Zumberg-Smith, K. and Dambreville, N. (2019). Association between shame and posttraumatic stress disorder: A meta-analysis. *Journal of Traumatic Stress*, 32(4): 484–495. https://doi.org/10.1002/jts.22411
- Lord-Flynn, D. J. (1989). *Help-seeking for mental health services: The relationship between perceived barriers to service utilization and need for services*. Doctoral dissertation. Washington State University ProQuest Dissertations Publishing. Order No. 9016004. https://www.proquest.com/openview/66eb62bcdb9940c8562f5f8c2d401d58/1?pq-origsite=gscholar&cbl=18750&diss=y
- Losehand, J. (2012). *Gewalt Zwischen Homosexuellen Männern. Dokumentation Und Evaluation Eines Alltäglichen Phänomens*. Wien: QWIEN - Zentrum für queere Geschichte. https://www.qwien.at/QWIEN_Gewalt_2012.pdf
- Lutenbacher, M., Cohen, A. and Mitzel, J. (2003). Do we really help? Perspectives of abused women. *Public Health Nursing*, 20(1): 56–64. https://doi.org/10.1046/j.1525-1446.2003.20108.x
- Löbmann, R. and Herbers, K. (2004). *Mit BISS gegen häusliche Gewalt. Evaluation des Modellprojektes Beratungs- und Interventionsstellen (BISS) für Opfer häuslicher Gewalt in Niedersachsen*. Hannover: Niedersächsisches Ministerium für Soziales, Frauen, Familie und Gesundheit. https://www.ms.niedersachsen.de/servlets/download?C=9488834&L=20
- Madriz, E. I. (1997). Images of criminals and victims: A study on women's fear and social control. *Gender & Society*, 11(3): 342–356. https://doi.org/10.1177/089124397011003005
- Mandl, S. and Sprenger, C. (2015). Gewalt an Frauen mit Behinderungen–allgegenwärtig und noch immer tabuisiert. *juridikum*, (4): 439–450.
- Mandl, S., Schachner, A., Sprenger, C. and Planitzer, J. (2014). *Zugang von Frauen Mit Behinderung zu Opferschutz- Und Unterstützungseinrichtungen Bei Gewalterfahrungen Deutschland, Großbritannien, Island Und Österreich*. Wien: Ludwig Boltzmann Institut für Menschenrechte, queraum. kultur- und sozialforschung.
- Manetta, A. A., Bryant, D. F., Cavanaugh, T. and Gange, T. A. (2003). The church—does it provide support for abused women? Differences in the perceptions of battered women and parishioners. *Journal of Religion & Abuse*, 5(1): 5–21. https://doi.org/10.1300/J154v05n01_02
- Martin, T. E., Gover, A. R. and Langton, L. (2023). The Relationship Between Formal Help-Seeking and Sexual Orientation Among Victims of Domestic Violence. *Journal of Interpersonal Violence*, 38(1–2): 156–182. https://doi-org.polamk.idm.oclc.org/10.1177/08862605221080150

- Maquibar, A., Vives-Cases, C., Hurtig, AK. and Goicolea, I. (2017). Professionals' perception of intimate partner violence in young people: a qualitative study in northern Spain. *Reproductive Health*, 14:86. https://doi.org/10.1186/s12978-017-0348-8
- Ministère de la Justice (2019). *Mission sur les homicides conjugaux*. Paris: Ministère de la Justice, Inspection générale de la Justice. http://www.justice.gouv.fr/publication/Rapport%20HC%20Publication%2017%20novembre%202019.pdf
- Ministère de l'Intérieur (2021). *Enquête Genese 2021*. Paris: Ministère de l'Intérieur, Service statistique ministériel de la sécurité intérieure (SSMSI). https://www.interieur.gouv.fr/Interstats/L-enquete-GENESE
- Monroe, L. M., Kinney, L. M., Weist, M. D., Spriggs Dafeamekpor, D., Dantzler, J., and Reynolds, M.W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence* 20(7): 767-776. https://doi.org/10.1177/0886260505277100
- Montero I., Ruiz-Pérez I., Escribà-Agüir V., Vives-Cases C., Plazaola-Castaño J., Talavera M., Martín-Baena, D. and Peiró, R. (2012). Strategic responses to intimate partner violence against women in Spain: a national study in primary care. *Journal of Epidemiology and Community Health*, 66(4): 352. http://dx.doi.org/10.1136/jech.2009.105759
- Morgan R. E. and Thompson A. (2021). *Criminal Victimization, 2020*. BJS Publication No. NCJ 301775. Washington: U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cv20.pdf .
- Moriana Mateo, G. (2021). Barreras que impiden a las migrantes institucionalizadas escapar de la violencia de género. *Revista de trabajo social*, 11(1): 20–37. https://dialnet.unirioja.es/descarga/articulo/8110510.pdf
- Müller, U., Schöttle, M., Hess, D. and Prussog-Wagner, A. (2004). *Lebenssituation, Sicherheit und Gesundheit von Frauen in Deutschland. Eine repräsentative Untersuchung zu Gewalt gegen Frauen in Deutschland*. Berlin: Bundesministeriums für Familie, Senioren, Frauen und Jugend. http://dx.doi.org/10.15496/publikation-4440
- Murillo P., Sebastián M.S., Vives-Cases C. and Goicolea I. (2018). Factores asociados a la respuesta a la violencia del compañero íntimo en atención primaria de salud en España. *Gaceta Sanitaria*, 32(5):433-438. https://doi.org/10.1016/j.gaceta.2017.03.003

NOP

- Nagy, B., Ercsey-Orbán, M., Galambos, L., Lukács, G. and Mézsáros, Z., (2020). *A kapcsolati erőszak eredményeként krízishelyzetbe kerülés megelőzését célzó országos, reprezentatív kutatás készítése*. Budapest: Családbarát Ország Nonprofit Kft. https://www.csaladbaratorszag.hu/dokumentumtar/2021/01/07/1610022602773.pdf
- Nagy, S. I. and Petrus, M. (2022). A keresztyén egyházak és a bűnüldöző szervek együttműködésének lehetőségei a családon belüli erőszak elleni küzdelemben. *Belügyi Szemle*, 70(8): 1641-1652. https://doi.org/10.38146/BSZ.2022.8.4
- Netherland, J. and Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties*, 12(2), 217–238. https://doi.org/10.1057/biosoc.2015.46
- Nublat, M. and Karzabi, I. (2017). *Améliorer l'offre de prise en charge psychologique des femmes victimes de violences. Rapport de recherche*. Saint-Ouen-sur-Seine: Observatoire régional des violences faites aux femmes, Centre Hubertine-Auclert, Centre francilien de ressources pour l'égalité femmes-hommes, Région Île-de-France. https://www.centre-hubertine-auclert.fr/sites/default/files/fichiers/rapport-ameliorer-loffre-de-prise-en-charge-psychologique-des-femmes-victimes-de-violences.pdf
- Nägele, B., Kotlenga, S., Görgen, T. and Mauder, B. (2009). Ambivalente Nähe: Eine qualitative Interviewstudie zur Viktimisierung Pflegebedürftiger. Pp. 208–480 In T. Görgen (ed.). *"Sicherer Hafen" oder "gefahrvolle Zone"? Kriminalitäts- und Gewalterfahrungen im Leben alter Menschen. Ergebnisse einer multimethodalen Studie zu Gefährdungen älterer und pflegebedürftiger Menschen*. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend. https://www.bmfsfj.de/blob/94186/727885d90cc7178a738226f533bce61d/kriminalitaets-gewalterfahrungen-leben-alter-menschen-langfassung-data.pdf
- Ohms, C. (2020a). Gewalt in cis-gleichgeschlechtlichen und trans* Partner*innenschaften. Pp. 81–90 in M. Büttner (ed.). *Handbuch Häusliche Gewalt*. Stuttgart: Schattauer Verlag.
- Ohms, C. (2020b). Beratung und Therapie bei Gewalt in Beziehungen von cis-gleichgeschlechtlichen oder trans*Personen. Pp. 292–301 in M. Büttner (ed.). *Handbuch Häusliche Gewalt*. Stuttgart: Schattauer Verlag.
- Ohms, C. (2006). *Broken Rainbow. Gewalt gegen Lesben und häusliche Gewalt in lesbischen Zusammenhängen - Auswertung der Erhebungsbögen der Lesbenberatungsstellen und Lesbentelefone*. Bundesministerium für Familie, Senioren, Frauen und Jugend. https://web.archive.org/web/20150122090604/http://www.broken-rainbow.de/material/BR_Bundeserhebung_02_04.pdf
- Phillips, H., Lyon, E., Krans, E., Warshaw, C., Chang, JC. and Pallatino, C. (2021). Barriers to help-seeking among intimate partner violence survivors with opioid use disorder. *International Review of Psychiatry*, 33 (6): 534–542. 9. https://doi.org/10.1080/09540261.2021.1898350

- Piilola, H. (2018). *Nettiturvakodissa: Verkossa tehtävä lähisuhdeväkivaltatyö*. Pro Gradu Thesis. University of Helsinki, Faculty of Social Sciences, Department of Social Research. http://urn.fi/URN:NBN:fi:hulib-201901171052
- Piispa, M. (2004). Age and Meanings of Violence: Women's Experiences of Partner Violence in Finland. *Journal of Interpersonal Violence*, 19(1): 30–48. https://doi-org.polamk.idm.oclc.org/10.1177/0886260503259048
- Potkanski-Palka, M. (2021). Domestic Violence and COVID-19 in Austria. *SIAK-Journal - Zeitschrift für Polizeiwissenschaft und polizeiliche Praxis*, 18(2): 53-65. http://dx.doi.org/10.7396/2021_2_E
- Pozo-Triviño, M. D., and Toledano-Buendía, C. (2017). Training interpreters to work with foreign gender violence victims in police and court settings*. Language and Law / Linguagem e Direito*, 3(2): 192-203 https://ojs.letras.up.pt/index.php/LLLD/article/view/1760
- Puchert, R., Jungnitz, L., Schröttle, M. and Hornberg, C. (2013). *Lebenssituation und Belastung von Männern mit Behinderungen und Beeinträchtigungen in Deutschland – Haushaltsbefragung. Abschlussbericht*. Berlin: Bundesministerium für Arbeit und Soziales. https://www.bmas.de/SharedDocs/Downloads/DE/Publikationen/Forschungsberichte/fb435.pdf?__blob=publicationFile&v=1
- Pullmann, M. D., VanHooser, S., Hoffman, C. and Heflinger, C. A. (2010). Barriers to and supports of family participation in a rural system of care for children with serious emotional problems. *Community Mental Health Journal*, 46(3): 211-220. https://doi.org/10.1007%2Fs10597-009-9208-5

RST

- Rasch, L., Plamp, L. and Tezcan-Güntekin, H. (2020). *Abschlussbericht. Befragung zur Versorgung von Menschen nach Gewalt in Paarbeziehungen und nach sexualisierter Gewalt in Berliner Notaufnahmen*. Berlin: S.I.G.N.A.L. e.V. https://signal-intervention.de/sites/default/files/2022-05/2021_01_12_Abschlussbericht_FINALE%20Version.pdf
- Región de Murcia (2017). *Plan de Atención Personalizada de violencia de género. Edición con pautas de atención a mujeres con discapacidad*. Comunidad Autónoma de la Región de Murcia. Consejería de Familia e Igualdad de Oportunidades Dirección General de Mujer. http://www.codajic.org/node/3669
- Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., Hegarty, K., Taft, A. and Feder, G. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Systematic Review*, 3 (12):CD005043. https://doi.org/10.1002/14651858.cd005043.pub3
- Ronkainen, S. (1999). Subjektius, häpeä ja syyllisyys parisuhdeväkivallan elementteinä. Pp. 131–154 in S. Näre (ed*.). Tunteiden sosiologiaa I. Elämyksiä ja läheisyyttä*. Helsinki: Suomalaisen kirjallisuuden seura
- Rossiwal, M. (2016). *Spezifische Opferbedürfnisse und polizeiliche Maßnahmen in Fällen häuslicher Gewalt: eine empirische Untersuchung am Beispiel des Polizeipräsidiums München*. Master thesis. https://snap-eu.org/report/Masterthesis.pdf
- Royo, R., Silvestre, M., González, L., Linares, E. and Suárez, M. (2017). Mujeres migrantes tejiendo democracia y sororidad desde el asociacionismo. Una aproximación cualitativa e interseccional. *Investigaciones feministas*, 8 (1): 223-243. https://doi.org/10.5209/INFE.54496
- Ruiz-Pérez, I. and Pastor-Moreno, G. (2021). Medidas de contención de la violencia de género durante la pandemia de COVID-19. *Gaceta Sanitaria*, 35 (4): 389–394. https://doi.org/10.1016/j.gaceta.2020.04.005
- Röntynen, S. (2021). *Lähisuhdeväkivallan puheeksi ottaminen ja ohjaaminen – Asiakkaan kokemuksia palvelujärjestelmässä*. Bachelor's Thesis. Savonia University of Applied Sciences. https://www.theseus.fi/bitstream/handle/10024/502070/Rontynen_Saara.pdf?sequence=2&isAllowed=y
- Salazar, C. (2009). La situación de las mujeres latinoamericanas víctimas de la violencia de género en España en función de su situación administrativa. *Revista de Estudios Juridicos*, 9. https://revistaselectronicas.ujaen.es/index.php/rej/article/view/127/114
- Salminen-Tuomaala, M., Tiainen, J. and Paavilainen, E. (2022). Ensihoitajien kokemuksia ikääntyneiden kaltoinkohtelusta. *Gerontologia*, 36(1): 49–69. https://doi.org/10.23989/gerontologia.108078
- Santoniccolo, F., Trombetta, T. and Rollè, L. (2021). The help-seeking process in same-sex intimate partner violence: A systematic review. *Sexuality Research and Social Policy*, 22(5): 391–411. https://doi.org/10.1007/s13178-021-00629-z
- Sanz-Barbero, B., Briones-Vozmediano, E., Otero-García, L., Fernández-García, C. and Vives-Cases, C. (2022). Spanish Intimate Partner Violence Survivors Help-Seeking Strategies Across the Life Span. *Journal of Interpersonal Violence*, 37(11–12): NP8651–NP8669. https://doi.org/10.1177/0886260520976213
- Sanz-Barbero, B., Rey, L. and Otero-García, L. (2014). Estado de salud y violencia contra la mujer en la pareja. *Gaceta Sanitaria*, 28(2): 102–108, https://doi.org/10.1016/j.gaceta.2013.08.004.
- Saraiya, T., and Lopez-Castro, T. (2016). Ashamed and afraid: A scoping review of the role of shame in post-traumatic stress disorder (PTSD). *Journal of Clinical Medicine*, 5(11): 94. https://doi.org/10.3390/jcm5110094

- Saunders, D.G. (2002). Are physical assaults by wives and girlfriends a major social problem? *Violence Against Women*, 8(12): 1424-1448. https://doi.org/10.1177/107780102237964
- Schellong, J. (2019). *Fachkräfte im Gesundheitswesen und das Thema häusliche Gewalt. Drei Befragungen in Sachsen 2009, 2010 und 2015*. Dissertationsschrift. Dresden: Medizinischen Fakultät Carl Gustav Carus, der Technischen Universität Dresden. https://tud.qucosa.de/api/qucosa%3A72390/attachment/ATT-0/
- Schellong, J., Epple, F., Lorenz, P., Ritschel, G., Croy, I., Lenk, M., Maertes, G., Böhm, U. and Weidner, K. (2021). Häusliche Gewalt und Partnerschaftsgewalt - eine Herausforderung im Gesundheitssektor. Ergebnis einer landesweiten Ärztebefragung. *Psychiatiache Praxis*, 49(7): 359–366. DOI: 10.1055/a-1630-4619
- Schouler-Ocak, M., Kurmeyer, C., Jesuthasan, J., Abels, I., Sönmez, E., Oertelt-Prigione, S., Zier, U., Kimbel, R., Wollny, A., Krüger, A., Gutermann, J., Starck, A. and Richter, K. (2017). *Study on Female Refugees. Abschlussbericht. Repräsentative Untersuchung von geflüchteten Frauen in unterschiedlichen Bundesländern in Deutschland*. Die Beauftragte der Budesregierung für Migration, Flüchtlinge und Integration. https://female-refugee-study.charite.de/fileadmin/user_upload/microsites/sonstige/mentoring/Abschlussbericht_Final_-1.pdf
- Schröttle, M. and Ansorge, N. (2009). *Gewalt gegen Frauen in Paarbeziehungen - eine sekundäranalytische Auswertung zur Differenzierung von Schweregraden, Mustern, Risikofaktoren und Unterstützung nach erlebter Gewalt*. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend. https://pub.uni-bielefeld.de/download/1859151/2653842/gewalt-paarbeziehungen_kurzfassung.pdf
- Schröttle, M. and Khelaifat, N. (2008). *Gesundheit – Gewalt – Migration: Eine vergleichende Sekundäranalyse zur gesundheitlichen Gewaltsituation von Frauen mit und ohne Migrationshintergrund in Deutschland*. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend. https://www.bmfsfj.de/blob/93964/588d6d5da075d2803f8696dfbbe3d35c/gesundheit-gewalt-migration-langfassung-studie-data.pdf
- Schröttle, M., Hornberg, C. and Glammeier, S. (2011). *Lebenssituation und Belastungen von Frauen mit Beeinträchtigungen und Behinderungen in Deutschland*. Repräsentative Untersuchung im Auftrag des Bundesministeriums für Familie, Senioren, Frauen und Gesundheit https://www.bmfsfj.de/blob/94206/1d3b0c4c545bfb04e28c1378141db65a/lebenssituation-und-belastungen-von-frauen-mit-behinderungen-langfassung-ergebnisse-der-quantitativen-befragung-data.pdf
- Schröttle, M., Glammeier, S., Sellah, B., Hornberg, C., Kavemann, B., Puhe, H. and Zinsmeister, J. (2013). *Lebenssituation und Belastungen von Frauen mit Beeinträchtigungen und Behinderungen in Deutschland. Ergebnisse der quantitativen Befragung Endbericht*. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend. https://www.bmfsfj.de/blob/94206/1d3b0c4c545bfb04e28c1378141db65a/lebenssituation-und-belastungen-von-frauen-mit-behinderungen-langfassung-ergebnisse-der-quantitativen-befragung-data.pdf
- Schwarz, A. and Häfele, E.M. (2011). *Gegen Gewalt in lesbischen Beziehungen: Information – Bestärkung - Auseinandersetzung*. Wien: Wiener Antidiskriminierungsstelle für gleichgeschlechtliche Lebensweisen. https://www.frauenberatenfrauen.at/download/gegen-gewalt-broschuere.pdf
- Sehmi, R., Maughan, B., Matthews, T. and Arseneault, L. (2020.) No man is an island: social resources, stress and mental health at mid-life. *British Journal of Psychiatry*, 217(5): 638-644. https://doi.org/10.1192/bjp.2019.25
- Seitz, R.J. and Angel, H-F. (2020). Belief formation – A driving force for brain evolution. *Brain and Cognition*, 140: 105548. https://doi.org/10.1016/j.bandc.2020.105548
- Sénat (2021). *Rapport d'information sur la situation des femmes dans les territoires ruraux*. By Jean-Michel Arnaud et al. Paris: Sénat, Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. http://www.senat.fr/rap/r21-060-1/r21-060-11.pdf
- Sénat (2019). *Rapport d'information sur les violences faites aux femmes handicapées*. By Roland Courteau, Chantal Deseyne, Françoise Laborde, Dominique Vérien. Paris: Sénat, Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. https://www.senat.fr/rap/r19-014/r19-0141.pdf
- Sénat (2018). *Rapport d'information sur les violences faites aux femmes*. By Laurence Cohen et al. Paris: Sénat, Délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes. http://www.senat.fr/rap/r17-564/r17-5641.pdf
- Seppälä, P., Vornanen, R. and Toikko, T. (2021). Are Children with a Number of Disabilities and Long-Term Illnesses at Increased Risk of Mental Violence, Disciplinary Violence, and Serious Violence? *Journal of Interpersonal Violence*, 36(23–24): 11409–11434. https://doi.org/10.1177/0886260519898440
- Sheffield DACT (2015). Domestic Homicide Review of Adult G. Learning brief. Referred 29th of March. Retrieved from https://sheffielddact.org.uk/domestic-abuse/wp-content/uploads/sites/3/2016/06/Adult-G-DHR-Learning-Brief-August-2015.pdf
- Sheffield DACT (2016). Guidance for the use of interpreters in situations involving domestic violence and abuse. Referred 29th of March 2023. Retrieved from: https://sheffielddact.org.uk/domestic-abuse/wp-content/uploads/sites/3/2016/08/Sheffield-Guidance-for-Use-of-Interpreters-in-situations-of-Domestic-and-Sexual-Abuse-FINAL-May-16.pdf
- Siltala, H. (2021.) *Family violence as a public health problem: Effects and costs in Finnish health care*. Jyväskylä University Dissertations. Jyväskylä: University of Jyväskylä. http://urn.fi/URN:ISBN:978-951-39-8808-1

- Silvestre, M., Díez, A., Gónzalez, L., Linares, E., Mosteiro, A., Rodriguez, A., Royo, R., Sobremonte, E. and Suárez, M. (2017). *Evaluación de los recursos en materia de violencia contra las mujeres de la DFB según las usuarias*. Investigación subvencionada por Diputación Foral de Bizkaia, y realizada por Deusto Valores Sociales.
- State Criminal Police Office Lower Saxony (2020). *Bericht zu Gewalterfahrungen in Paarbeziehungen in Niedersachsen im Jahr 2020, Sonderbericht zur Befragung zu Sicherheit und Kriminalität in Niedersachsen.* Hannover: Landeskriminalamt Niedersachsen. https://www.lka.polizei-nds.de/download/75823/Sondermodul_Gewalterfahrungen_in_Paarbeziehungen_2021.pdf
- Steinert, J. and Ebert, C. (2020). *Gewalt an Frauen und Kindern in Deutschland während COVID-19-bedingten Ausgangsbeschränkungen: Zusammenfassung der Ergebnisse*. Technische Universität München and RWI – Leibniz-Institut für Wirtschaftsforschung. https://www.gesine-intervention.de/wp-content/uploads/Zusammenfassung-der-Studienergebnisse_6_2020.pdf
- Solt, Á. (2022). Otthoni erőszakosságok. *Belügyi Szemle*, 70(8): 1671–1686. https://doi.org/10.38146/BSZ.2022.8.6
- Sorgo, M. (2013). Gewaltschutzarbeit als eine organisationsübergreifende Aufgabe. Eine qualitative Studie zur Rolle interorganisatorischer Kooperation staatlicher und nichtstaatlicher Organisationen im Rahmen des Opferschutzes bei häuslicher Gewalt. Pp. 267–300 in Rainer Loidl (ed.). *Beiträge zur Sozialarbeitsforschung*. Wien Köln Weimar: Verlag Böhlau.
- Stöckl, H. and Penhale, B. (2015). Intimate Partner Violence and Its Association with Physical and Mental Health Symptoms Among Older Women in Germany. *Journal of Interpersonal Violence*, 30(17): 3089–3111. https://doi.org/10.1177/0886260514554427
- Swaine-Williams, K. (2022). *Double standard - Ending the unjust criminalisation of victims of violence against women and girls*. Executive summary. London: Centre for Women's Justice. https://www.centreforwomensjustice.org.uk/s/Double-Standard-Exec-Summary-FINAL.pdf
- Sylaska, K. M. and Edwards, K. M. (2014). Disclosure of Intimate Partner Violence to Informal Social Support Network Members: A Review of the Literature. *Trauma, Violence & Abuse*, 15(1). 3–21. https://doi.org/10.1177/1524838013496335
- Tamutiene, I., De Donder, L., Penhale, B., Lang, G., Ferreira-Alves, J. and Luoma, M. L. (2013). Help seeking behaviour of abused older women: Cases of Austria, Belgium, Finland, Lithuania and Portugal. *Filosifija sociologija*, 24(4): 217–225.
- Tiainen, T. (2018). *Lähisuhdeväkivallan kokijoiden kokemuksia Keski-Uudenmaan avopalvelumallista*. Bachelor's Thesis. Laurea University of Applied Sciences. https://urn.fi/URN:NBN:fi:amk-201803263821
- Topkaya, N. (2015). Factors Influencing Psychological Help Seeking in Adults: A Qualitative Study. *Educational Sciences: Theory and Practice*, 15(1), 21-31. https://doi.org/10.12738/estp.2015.1.2094
- Turell, S. C. and Herrmann, M. M. (2008). Family support for family violence: Exploring community support systems for lesbian and bisexual women who have experienced abuse. *Journal of Lesbian Studies*, 12(2-3): 211–224. DOI: 10.1080/10894160802161372

UVW

- Vann, A. A. (2003). *Developing Culturally Relevant Responses to Domestic Abuse: Asha Family Services, Inc*. Harrisburg: National Resource Center on Domestic Violence. https://vawnet.org/sites/default/files/materials/files/2016-09/NRCDV_Asha.pdf
- Varga, S. and Bálint, Á. D. (2020). Családon belüli erőszak – amikor a férfi az áldozat. *Belügyi Szemle*, 68 (4): 9-51. https://doi.org/10.38146/BSZ.2020.4.1
- Vives-Cases C., La Parra-Casado D., Briones-Vozmediano E., March S., García-Navas A.N., Carrasco J.M., Otero-García L. and Sanz-Barbero B. (2021). Coping with intimate partner violence and the COVID-19 lockdown: The perspectives of service professionals in Spain. *PLoS One*, 16(10): e0258865. https://doi.org/10.1371/journal.pone.0258865
- Vives-Cases, C., Gil-González, D., Plazaola-Castaño, J., Montero-Piñar, M.I., Ruiz-Pérez, I., Escribà-Agüir, V., Ortiz-Barreda, G. and Torrubiano-Domínguez, J. (2009). Violencia de género en mujeres inmigrantes y españolas: magnitud, respuestas ante el problema y políticas existentes. *Gaceta Sanitaria*, 23 (Supplement 1): 100-106. https://doi.org/10.1016/j.gaceta.2009.07.008
- Vogel, D. L. and Wester, S. R. (2003). To seek help or not to seek help: The risks of selfdisclosure. *Journal of Counseling Psychology*, 50(3): 351–361. https://psycnet.apa.org/doi/10.1037/0022-0167.50.3.351
- Vogel, D. L., Wester, S. R. and Larson, L. M. (2007). Avoidance of counseling: Psychological factors that inhibit seeking help. *Journal of Counseling & Development*, 85(4): 410–422. https://psycnet.apa.org/doi/10.1002/j.1556-6678.2007.tb00609.x
- Vogel, D. L., Wade, N. G. and Hackler, A. H. (2008). Emotional expression and the decision to seek therapy: The mediating roles of the anticipated benefits and risks. *Journal of Social and Clinical Psychology*, 27(3): 254-278. https://psycnet.apa.org/doi/10.1521/jscp.2008.27.3.254

- Wallin, I., Eulau, L., Bjanerby, F. and Westernotn (2018). Women's experiences with healthcare professionals after suffering from gender-based violence: An interview study. *Clinical Nursing*, 27(5-6): 949-957. https://doi.org/10.1111/jocn.14046
- Wetzels, P. and Pfeiffer, C. (1995). *Sexuelle Gewalt gegen Frauen im öffentlichen Raum. Ergebnisse der KFN-Opferbefragung 1992*. Hannover: Forschungsberichte des Kriminologischen Forschungsinstituts Niedersachsen, 37. http://dx.doi.org/10.15496/publikation-25593
- Wicky, L., Mazuy, M. and Latourès, A. (2021). *Violences vécues par les femmes et les hommes en Île-de-France: famille, conjugalité, travail, études et espaces. Rapport de recherche: Enquête Virage 2015*. Saint-Ouen-sur-Seine: Observatoire régional des violences faites aux femmes, Centre francilien de ressources pour l'égalité femmes hommes, Région Île-de-France, Institut National d'Études Démographiques. https://m.centre-hubertine-auclert.fr/sites/default/files/fichiers/cha-rapport-virage-2021-web.pdf
- Wippermann, C. (2022). *Gewalt und Milieus. Einstellungen zu Gewalt und Gewalterfahrungen in sozialen Milieus in Bayern*. Penzberg: DELTA-Institut für Sozial- und Ökologieforschung. https://bayern-gegen-gewalt.de/imperia/md/images/stmas/bayern-gewalt/service/downloads/abschussbericht_gewalt_und_milieus__bf.pdf
- Wong, C. C. (2006). *Examining barriers and facilitators to professional mental health help-seeking in Asian American youth*. Doctoral dissertation, University of Washington. Ann Arbor: ProQuest. https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/9153/3231073.pdf?sequence=1&isAllowed=y
- Wright, E.N, Anderson, J., Phillips, K. and Miyamoto, S. (2022). Help-Seeking and Barriers to Care in Intimate Partner Sexual Violence: A Systematic Review. *Trauma, Violence & Abuse*, 23(5):1510-1528. https://doi.org/10.1177/1524838021998305

XYZ

- Yorgason, J. B., Linville, D. and Zitzman, B. (2008). Mental health among college students: Do those who need services know about and use them? *Journal of American College Health*, 57(2): 173-181. https://doi.org/10.3200/jach.57.2.173-182
- Zakar, R., Zakar, M.Z., Faist, T. and Kraemer, A. (2012). Intimate partner violence against women and its related immigration stressors in Pakistani immigrant families in Germany. *SpringerPlus*, 1:5. https://doi.org/10.1186%2F2193-1801-1-5
- Zink, T., Regan, S., Jacobson, C. J. and Pabst, S. (2003). Cohort, period, and aging effects: A Qualitative Study of Older Women's Reasons for Remaining in Abusive Relationships. *Violence Against Women*, 9(12): 1429–1441. https://doi.org/10.1177/1077801203259231
- Zähringer, U. and Stiller, A. (2016*). Strafbarkeit von Stalking in Deutschland – Empirische Befunde zum Anzeigeverhalten und der Bekanntheit des § 238 StGB bei Betroffenen von Stalking*. Pp. 109-142 in D.F. Hellmann (ed.). *Stalking im Deutschland*. Baden-Baden: Nomos. https://doi.org/10.5771/9783845271569-109

13. Appendices

Country codes used in the tables (ISO 3166-1)

Austria	AUT
Canada	CAN
European Union	EU
Finland	FIN
France	FRA
Germany	DEU
Hungary	HUN
Spain	ESP
Turkey	TUR
United States	USA

Table 1: Victims' perceptions, experiences and expectation, and victims' socio-economic characteristics

Victims in general	**BARRIERS** **Barrier 1:** Violence as a taboo and a private matter • Violence as a private, confidential matter (Wetzels & Pfeiffer 1995; Müller et al. 2004; Nägele et al. 2009; FRA 2014; Wippermann 2022) [DEU] • This reason is more likely used by victims in incidents of parental violence than in IPV (Hellmann 2014). [DEU] • Violence as a taboo topic (Müller et al. 2004; Löbmann & Herbers 2004; Döge 2012; Schouler-Ocak et al. 2017; Ohms 2020b; Fiedeler 2020a; Wippermann 2022). This applies especially to victims in higher educational and social classes (Schröttle & Ansorge 2009). [DEU] • Sexual violence experiences seem to be particularly taboo and difficult to address (e.g., Forschungsverbund Gewalt gegen Männer 2004; Döge 2012; Schröttle et al. 2011, Fiedeler 2020a, Ohms 2020a). [DEU] • Victims of exclusively sexual violence by a partner contacted one of the three services listed (medical+social, associations, security services) in the survey less often on average (Ministère de l'Intérieur 2021). [FRA] • Social stigma, unwillingness to share problems with an unfamiliar person, the belief that private problems should be kept in the family, one's belief that he/she can solve his/her problems, and not knowing enough about the psychological help process. (Topkaya 2015). [TUR] **Barrier 2**: Lack of knowledge about violence and support services; difficulties in identifying abusive behaviour as violence • Invisibility of DV (e.g., no discussion, no campaign) (Müller et al. 2004; Forschungsverbund Gewalt gegen Männer 2004; Löbmann & Herbers 2004; Schröttle & Ansorge 2009; Schröttle et al. 2011; Döge 2012; Schouler-Ocak et al. 2017; Ohms 2020a; Ohms 2020b; Fiedeler 2020a; Wippermann 2022) [DEU]

- Barriers in seeking care in IPSV included difficulty for individuals in identifying IPSV behaviours in their relationships as abuse. Literature review (17 articles). (Wright et al. 2022.)
- Media representations and cultural stereotypes imply that violence is mostly random, committed by strangers (Best 1999; Hollander 2000 as cited in Dietz & Martin 2007), thus telling women to fear strangers instead of their husbands, partners, dates, or former intimates (Madriz 1997 as cited in Dietz & Martin 2007). Consequently, women's fear of crime focuses on people whom they do not know, who may attack them unexpectedly. However, women are most at risk for violence at homes and by people they know, especially intimates or ex-intimates (Hollander 2004; Saunders 2002 as cited in Dietz & Martin 2007). [USA]

ENABLERS

Enabler 1: Increasing of awareness about DV and support services

- Easy access to psychological help services is a major agent in facilitating psychological help seeking (Lord-Flynn 1989; Wong 2006 as cited in Topkaya 2015). [TUR]
- Importance of marketing in preventing intimate partner violence because awareness of services encourages sharing experiences (Röntynen 2021). [FIN]
- Restrictive practices as forms of support such as child protection may be a significant part of the change in the victim's situation. Some victims said that their own understanding of the situation started to emerge only when an outside party forced them to stop, seek help and admit that for the sake of children, the family's situation cannot continue as it is. (Röntynen 2021.) [FIN]

BARRIERS

Barrier 3: Lack of knowledge about existing support structures (Müller et al. 2004; Fiedeler 2020a; Ohms 2020) [DEU]

- Lack of information about psychological services can cause people not to use them (Pullmann et al. 2010; Yorgason et al. 2008; as cited in Topkaya 2015). [TUR]
- Victims' own activity is crucial in expressing the need for support and in obtaining services. Often the victims must find the services themselves because no support is offered. Many victims are not aware about support services and the possibility of receiving them. (Röntynen 2021.) [FIN]

Barrier 4: Difficulties in reaching facilities

- Too young to get help / Too long waiting times / Opening hours do not suit / Administrative burden / Support was too expensive / Waiting too long for therapies (Müller et al. 2004). [DEU]
- When multiple vulnerabilities/struggles (disabilities, homelessness, psychological disorders, addictions) women's shelters are not accessible/suitable: 1) Women are required to be independent 2) Perceived as to bring higher potential for conflicts - protection of other women is more important (Koch et al. 2018). [DEU]
- If the victim must leave her or his home and normal daily routines and to live in a shelter, this may be difficult for her/him. (Hackenberg et al. 2021.) [FIN]

Barrier 5: Shame

- (Wetzels & Pfeiffer 1995; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2009; Nägele et al. 2009; FRA 2014; Hellmann 2014; Schouler-Ocak et al. 2017; LN-W 2020; Ohms 2020a; Birkel et al. 2022; Wippermann 2022) [DEU]

- The experience of sexual violence is especially shameful for victims (Hellmann 2014) [DEU]
- This reason is more likely used by victims in incidents of IPV (19.6%) than parental violence (9.79) (Hellmann 2014) [DEU]
- Victim of IPV is often ashamed of her own 'irresponsible action' in allowing the dangerous situation to develop. Moreover, shame is more common among older women perhaps because of the social dimension of shame (i.e., the person is ashamed of herself in the eyes of the others), feelings of inferiority or feelings of being less valuable (Giddens 1991, Ronkainen 1999, as cited in Piispa 2004.) [FIN]
- If the person is dependent on the abusive spouse, shame may be associated with fear of loss or rejection (Ronkainen 1999, as cited in Piispa 2004.) [FIN]
- Female victims find it difficult to tell male police officers about sexual abuse (especially when they are asked for a detailed account) and they are uncomfortable when a male gynaecologist has to conclude that sexual violence has occurred (Nagy et al. 2020). [HUN]
- Women felt shame or embarrassment as a result of the violence and they did not want anyone to know about it, both of which were more heightened in cases of sexual violence (Goodey 2017). [EU]

Barrier 6: Avoidance of stigma

- Do not want to be stigmatised as a victim (Ebert & Steinert 2021; Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2009; Ohms 2020a; Fiedeler 2020a; Wippermann 2022). [DEU]
- Asking for help from an expert may mean confessing weakness and that one is not able to cope with their own problems. Asking for help may feel uncomfortable. (Fischer et al. 1982 as cited in Vogel et al. 2007; as cited in Topkaya 2015.) [TUR]

ENABLERS

Enabler 3: Short-term counselling in individual meetings

- The respondents (n=6) felt that short term counselling provided in individual meetings was the most significant form of support (of the NGO). The victims felt very important that they were not blamed, judged, nor criticized. The professionals were approachable and reliable, which encouraged disclosure. The professionals had helped the victim to see the facts. According to the respondents, for victims of DV seeking for outside help, the prior need is to be heard and understood. Moreover, the NGO offered individual and long-term support, which public services have not been able to provide. Contact with the NGO professional gave the respondents strength to make decisions. This, combined with the use of antidepressants, had given some respondents strength 'to stand up'. In addition, a place to go was considered important, as some felt that they were stuck at their homes. Knowing that the victims can always contact the NGO worker later gave the respondents strength to survive through the acute crisis. (Tiainen 2018). [FIN]

BARRIERS

Barrier 7: Mental wellbeing; decreased ability to function

- Lack of courage, willingness to take risks / Experiencing powerlessness and hopelessness (Nägele et al. 2009; Fiedeler 2020b; Ohms 2020a; Wippermann 2022). [DEU]

- Impacts of trauma: Many trauma survivors seem to be reluctant to seek professional help due to: The treatment-related doubts of traumatised person / repressed memories / trauma survivors face specific trauma-related barriers to mental health service use, especially concerns about re-experiencing the traumatic events / many trauma survivors avoid traumatic reminders and are therefore concerned about dealing with certain memories in treatment. This meta-analysis is using data from studies that were typically conducted in the United States, but also covers studies done in Canada, Mexico, South Africa, United Kingdom, Georgia, and Germany (Kantor et al. 2017.)

ENABLERS

Enabler 4: Free-of-charge psychological support services

- The availability of psychological services, the belief in the benefits of psychological services, trusting in the mental health professional, and receiving help free of cost are facilitating factors. Comfort with self-disclosure predicts the victim's willingness to seek psychological help (Vogel and Wester 2003, as cited in Topkaya 2015.) Ability to express emotion is one of the factors effective in predicting victims' intention behind whether they would seek psychological help (Vogel et al. 2007, as cited in Topkaya 2015). Victims' comfortability in disclosing personal problems and general attitude toward seeking psychological help predicts their intention to seek psychological help (Cantazaro 2009, as cited in Topkaya 2015.) [TUR]

BARRIERS

Barrier 8: Victim belittles the violent incident and its consequences

- Does not need any support (Müller et al. 2004; European Union Agency for Fundamental Rights 2014; Hellmann 2014) [DEU]
- Case seemed too minor (Müller et al. 2004). This reason is more likely used by victims in incidents of parental violence than in IPV (Hellmann 2014). [DEU]
- 34% of IPV victims and 38% of victims of physical non-partner violence indicated that they did not report to the police because they did not consider the incident to be serious enough to warrant reporting, and that the idea of reporting to the police did not occur to them. This finding seems to indicate that for many female victims, violence against women is 'normalised' and perhaps considered to be a 'private' matter. (Goodey 2017). [EU]
- Difficulties to discuss IPV face-to-face, and it seems easier to discuss the topic online. However, online interaction is not considered as a complete replacement for face-to-face interaction. In addition, the respondents reported that they had not sought help for IPV from other places besides 'online shelter' because their situation seemed too slight/minor. The respondents had used online shelter to ask help for many different needs, but the majority had used service primarily to get information about IPV. (Piilola 2018.) [FIN]
- Violence as a one-time thing (Müller et al. 2004; Hellmann 2014). [DEU]
- Having got it under control (Müller et al. 2004; FRA 2014; Hellmann 2014). [DEU]

ENABLERS

Enabler 5: Education

- Education also impacts the use of support services. Persons with a compulsory school-leaving certificate as well as persons with a vocational school-leaving

	certificate make the greatest use of the various support services. An exception is the use of counselling or therapy services which is more often sought by persons with a university degree. (Kapella et al. 2011.) [AUT] ---------- **BARRIERS** **Barrier 9**: Pandemic • Cannot call help because the partner is often in proximity (BAFzA 2021). [DEU] • Women are less comfortable with email consulting (due to pandemic) (Ebert & Steinert 2021). [DEU] • Many help seeking women live in (familial) exceptional situations currently, rising financial loadings generate pressure: more violence experienced, violent outbursts are heavier, increase of aggression and irritability of partner (BAFzA 2021). [DEU]
Older victims	**BARRIERS** **Barrier 1**: Violence as a taboo and a private matter • Violence as a private, confidential matter (Wetzels & Pfeiffer 1995; Müller et al. 2004; Nägele et al. 2009; FRA 2014; Hellmann 2014; Wippermann 2022) [DEU] • In Finland, there is a general difference in conversational culture that relate to victims' age. Speaking about violence with a friend and with the abusive partner is more common among young women. (Piispa 2004.) [FIN] • Austrian respondents were consequently the least likely to report to formal institutions. One reason for this was that they "did not want anyone to get involved" (44.3%). (Tamutiene et al. 2013.) [AUT] **Barrier 2**: Lack of knowledge about existing support structures • According to paramedics, an elderly person acting as a caregiver for their elderly spouse does not necessarily know how to seek help and support (Salminen-Tuomaala et al. 2022). [FIN] • The external barriers of the older (45 - 85 years) victims of DV to disclose violence: i. Belief that disclosure to the clergy does not lead to intervention ii. There is not much research about this, but spiritual beliefs appear to be a particularly important factor for older women in terms of coping with and surviving DV as well as in determining whether to stay in or leave an abusive relationship (Zink et al. 2003 as cited in Beaulaurier et al. 2007). Spirituality is important for older people in general. iii. General belief that there is no help for older DV victims or the victims of emotional abuse. Most victims don't know how to get help. Belief that what is available is difficult, unpleasant, or confusing to use. (Beaulaurier et al. 2007.) [USA] **Barrier 3**: Shame • (Wetzels & Pfeiffer 1995; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2009; Nägele et al. 2009; FRA 2014; Hellmann 2014; Schouler-Ocak et al. 2017; LN-W 2020; Ohms 2020a; Birkel et al. et al. 2022; Wippermann 2022) [DEU] • Victim of IPV is often ashamed of her own 'irresponsible action' in allowing the dangerous situation to develop. Moreover, shame is more common among older women perhaps because of the social dimension of shame (i.e., the person is ashamed of herself in the eyes of the others), feelings of inferiority or feelings of

	being less valuable (Giddens 1991; Ronkainen 1999, as cited in Piispa 2004.) [FIN] **Barrier 4**: Victim belittles the violent incident and its consequences • The most common reasons for not reporting were considering the incident as being too trivial (71.8%), distrusting the ability of somebody to be able to do anything about it (56.2%) and not wanting to involve anybody (50.3%). Thinking the incident was too trivial was the most common reason provided in Austria (78.3%), Belgium (59.4%), and Finland (69.1%). (Tamutiene et al. 2013.) [AUT] **Barrier 5**: Fear the one must move from home • Emotional attachment to the place they may have lived in for their whole lives and where they have sustained social networks (Nägele et al. 2010 in: Stöckl & Penhale 2015). [DEU] • "According to the paramedics, the fact that the elderly client is not always willing to leave his home makes it challenging to intervene in the situation (even if the relative's resources to promote his survival at home are not sufficient or the home conditions are poor). The elderly feel it is important to be able to live at home until the end. The situation is also ethically challenging from the point of view of paramedics and home care because the client's right to self-determination must also be considered. (Salminen-Tuomaala et al. 2022). [FIN] • Fear of loneliness (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Nägele et al. 2009; Fiedeler 2020a; Ohms 2020a). [DEU] • Concern of getting into stationary care: The research literature has consistently shown that fear of institutionalization, which may be initiated as a result of a request for assistance from a family member, friend, physician, police officer, judge, or the victim, is a strong barrier for older persons in terms of seeking help for any kind of problem (e.g., Beaulaurier and Taylor 2001; Hudson 1986 as cited in Beaulaurier et al. 2007.) [USA]
Victims with disability or impairment	**BARRIERS** **Barrier 1**: Violence as a taboo and a private matter • This applies especially to victims in higher educational and social classes (Schröttle & Ansorge 2009). [DEU] • Sexual violence experiences seem to be particularly taboo and difficult to address (e.g., Forschungsverbund Gewalt gegen Männer 2004; Döge 2012; Schröttle et al. 2011, Fiedeler 2020a, Ohms 2020a). [DEU] **Barrier 2**: Decreased ability to function • Low self-esteem: Raised with low allowance to make interpersonal requests or to be satisfied with what they have instead of what they want (BMFSFJ 2018). [DEU] **Barrier 3**: Lack of knowledge about victim's rights • People with an intellectual disability may have a lack of knowledge about their rights. Disabled individuals may fear consequences if they disclose (French 2007). [Australia] **Barrier 4**: Fear that one must move home • Emotional attachment to the place they may have lived in for their whole lives and where they have sustained social networks (BMFSFJ 2018). [DEU] • Concern of getting into stationary care (Gabler et al. 2016). [DEU] **Barrier 5**: Communicational and informational challenges

	• Disabled victims' ability to communicate with helping professionals (e.g., police, health care) may be limited. (GCFV 15.02.2023.) [USA] • Systems are not prepared to respond in effective and appropriate ways. (GCFV 15.02.2023.) [USA] • Language and communication barriers leave an enormous gap for deaf and hard of hearing victims. Certified sign language translators are crucial to victim safety by ensuring that professionals and victims are provided with correct information, however, in the USA most agencies lack policies and procedures for accessing interpreters or for making other accommodations. (GCFV 15.02.2023.) [USA] • Not knowing the right words to use. Communication may be difficult for people with an intellectual disability and/or people may have received little personal development and sexuality education. (French 2007). [Australia] • Police do not make sufficient use of accessible/sign language where needed (Mandl & Sprenger 2015). [AUT] • Where victims of DV suffer from cognitive disabilities, police can fail to adequately communicate with victims. Furthermore, tendencies of police officers to disregard statements of said victims have been reported. (Amesberger & Haller 2016.) [AUT]
Migrant and refugee victims	Migrant populations are more exposed to violence, especially when migration is linked to fleeing violence in the country of origin or when violence was suffered during the migration process (Wicky et al. 2021). [FRA] **Barrier 1**: Violence as a taboo and a private matter • Violence as a private matter (Wetzels & Pfeiffer 1995; Müller et al. 2004; Nägele et al. 2009; FRA 2014; Hellmann 2014; Wippermann 2022). [DEU] • Violence as a taboo topic. This applies in particular to victims in higher educational and social classes (Schröttle & Ansorge 2009). [DEU] • Sexual violence experiences seem to be particularly taboo and difficult to address (e.g., Forschungsverbund Gewalt gegen Männer 2004; Döge 2012; Schröttle et al. 2011, Fiedeler 2020a, Ohms 2020a). [DEU] • Cultural taboo when talking about sexual violence (Ahmad et al. 2022). [DEU] • Some communities of colour have a strong sense of cultural identity which includes loyalty to family and community and a reluctance to discuss "private matters." In some cultures, there is a fear of reinforcing negative stereotypes, if abuse is revealed. Victims may face ridicule for calling the police on their abuser, essentially turning them over to a criminal justice system with a long history of oppression and abuse against their culture (Gill & Lovelace-Davis, 2016). (GCFV 15.02.2023.) [USA] • Disclosure of violence to strangers can be perceived particularly taboo and shameful, especially if they do not belong to one's own community or have a different cultural background. (Flotzinger et al. 2021.) [AUT] **Barrier 2**: Lack of knowledge about violence and support services • No knowledge of where to find help / Lack of knowledge about existing support structures (Müller et al. 2004; Fiedeler 2020a; Ohms 2020) [DEU] • Many Pakistani immigrant women don't know the possibilities of formal care-providing. Among Pakistani immigrant women the inability to understand the structure and functioning of the care-providing institutions. (Zakar et al. 2012.) [DEU] • Survivors of torture and/or war experienced pervasive lack of access to accurate and reliable information regarding the structures and financing on educational pathway, which complicated the making of informed decisions. Lack of informational resources may encourage the refugees to rely on word-of-mouth

	information, which may not always be trustworthy. Along with profound internal and external pressures to secure appropriate employment to support themselves and their families, these informational and structural barriers can harm the mental health of these already traumatised and vulnerable individuals. (Bajwa et al. 2017.) [CAN] **Barrier 3**: Perception of limited options and dependencies • Unable to react / helplessness / lack of alternatives (Nägele et al. 2009; Fiedeler 2020b; Ohms 2020a; Wippermann 2022). [DEU] **Barrier 4**: Fears, stress and mental wellbeing • Fear of contempt / Fear of psychological and verbal violence (Wippermann 2022). [DEU] • Some victims fear negative consequences from family members from their country of origin (Müller et al. 2004). [DEU] • Refugees are often exposed to severe psychological and physical strain as a result of experiences of violence and deprivation in their home countries and during their flight route (GREVIO) • Many trauma survivors are reluctant to seek professional help because of the treatment-related doubts of and repressed memories; trauma survivors face specific trauma-related barriers to mental health service use, e.g., they may have concerns about re-experiencing the traumatic events. They may avoid traumatic reminders and are therefore concerned about dealing with certain memories in treatment. The meta-analysis is using data from studies that were typically conducted in the United States, but also covers studies done in Canada, Mexico, South Africa, United Kingdom, Georgia, and Germany. (Kantor et al. 2017.) **Barrier 5**: Pandemic • Cannot call because partner is often in proximity (BAFzA 2021) [DEU] • Number of consulting with translators or in other languages (than German) increased due to contact restrictions: women with migration background or with lack of knowledge of German language are more isolated; private supporting networks got smaller (BAFzA 2021). [DEU]
Male victims	**BARRIER** **Barrier 1**: Violence as a taboo and a private matter • Sexual violence experiences seem to be particularly taboo and difficult to address (e.g., Forschungsverbund Gewalt gegen Männer 2004; Döge 2012; Schröttle et al. 2011, Fiedeler 2020a, Ohms 2020a). [DEU] **Barrier 2**: No knowledge of where to find help or not seeking help • No knowledge of where to find help / Lack of knowledge about existing support structures (Müller et al. 2004; Fiedeler 2020a; Ohms 2020). [DEU] • Every fifth man also seeks medical support after violence, but only every tenth seeks the support of a counselling centre or a therapist (Kapella et al. 2011). [AUT] **Barrier 3**: Shame • (Wetzels & Pfeiffer 1995; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2009; Nägele, et al. 2009; FRA 2014; Hellmann 2014; Schouler-Ocak et al. 2017; LN-W 2020; Ohms 2020a; Birkel et al. 2022; Wippermann 2022). [DEU] • The experience of sexual violence is especially shameful for victims (Hellmann 2014). [DEU]

	• This reason is more likely used by victims in incidents of IPV (19.6%) than parental violence (9.7) (Hellmann 2014). [DEU] • Most male victims are ashamed of being abused by their partners. If an abused man decides to seek help, he often meets with contempt and disbelief. It may also happen that they become an object of ridicule, not only in their private life but also at the police or support services. (Varga & Bálint 2020.) [HUN] **Barrier 4**: Victim belittles the violent incident • Case seemed too minor. This reason is more likely used by victims in incidents of parental violence than in IPV (Hellmann 2014). [DEU] • Lack of awareness that it is an injustice when a woman beats her partner / Stereotype that a man cannot be a victim / Stereotype that the physically bigger or stronger looking person cannot be a victim (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2009; Ohms 2020a; Fiedeler 2020a; Wippermann 2022). [DEU] **Barrier 5**: Fear of not being believed: • In the case of male victims, this reason is intensified by the lack of awareness and social ignorance of DV against men and where what is experienced is in contradiction to the social construction of masculinity. (Forschungsverbund Gewalt gegen Männer 2004; Fiedeler 2020a). [DEU]
LGBTQ+ victims	**Barrier 1**: Violence as a taboo and a private matter • This applies especially to victims in higher educational and social classes (Schröttle & Ansorge 2009). [DEU] • Sexual violence experiences seem to be particularly taboo and difficult to address (e.g., Forschungsverbund Gewalt gegen Männer 2004; Döge 2012; Schröttle et al. 2011, Fiedeler 2020a, Ohms 2020a). [DEU] • High taboo in LGTBIT+ community, invisibility of violence (Ohms 2020a; Ohms 2020b). [DEU] • Fear of being excluded from the scene (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b). [DEU] • Even within their own community, however, the topic is often not easy to address. For many, lesbian and queer scenes are important meeting places and are experienced as places to celebrate together, to support each other and as safe places. The need for violence- and fear-free spaces often makes it difficult to address relationship violence within the community. (Schwarz & Häfele 2011.) [DEU] **Barrier 2**: No knowledge of where to find help / Lack of knowledge about existing support structures (Müller, Schöttle, Hess, Prussog-Wagner 2004; Fiedeler 2020a; Ohms 2020). [DEU] **Barrier 3**: Fear of discrimination and homophobia • (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b). [DEU] • Homosexual men are often affected by social violence in the form of devaluation, stigmatisation and discrimination, which contributes to the exclusion and marginalisation of this group and its needs. Such devaluation is especially inflicted by heterosexual men. Turning to the police in particular, which as an organisation is built on hegemonic images of masculinity, which are always clearly delimited from male homosexuality, is thus made more difficult/fearful. (Losehand 2012.) [AUT]

	• A central problem in the reporting of violence in lesbian relationships is the social devaluation and discrimination of lesbians and trans people, according to which violence in lesbian relationships is particularly taboo. When violence in lesbian relationships is made a public issue, many lesbians and trans people fear that this will confirm prejudices and reinforce discrimination. (Schwarz & Häfele 2011.) [DEU] • Do not want to expose their partner to homophobia by stigmatising him/her additionally as a perpetrator (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b). [DEU] • The focus here is not on the possibility of continuing the relationship, but on the collective experience of discrimination and violence in a heterosexist society (Ohms 2006, Ohms 2020a). [DEU] **Barrier 4**: Fear of coming out about one's sexual orientation • (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b). [DEU] • In addition to "conventional" forms of violence (physical or economic violence, forced isolation, etc.) violence between homosexual men, similar to lesbian relationships, also involves the threat of „outing" (Losehand 2012). [AUT] **Barrier 5**: High level of psychosocial distress because of minority stress and negative coping strategies (Ohms 2020a; Ohms 2020b). [DEU] **Barrier 6**: Heteronormative/binary concept of “gender violence” • Violence considered less severely important in “queer” relationships. (Ohms 2020a; Ohms 2020b). [DEU] • When it comes to accessing support services, social prejudices and internalised, hegemonic male role expectations represent a central barrier. First, the "man as victim" contradicts common ideas and attributions of perpetrator-victim roles. In violent conflicts, men are perceived more as opponents and as winners and losers than as perpetrators and victims. These internalised role models of men, which also include ignoring dangers, playing down illnesses and enduring the physical and psychological (consequences of) violence and aggression, can prevent men from seeking appropriate facilities for victim support and assistance. (Losehand 2012.) [AUT]
Victims in remote and rural areas	**BARRIER** **Barrier 1**: Perception that violence is part of normal life: In rural communities, there may be intergenerational violence, in which case the community may think that violence is part of normal life (Lindqvist 2009). [FIN]
Young women as victims	**BARRIER** Younger women, those in dating relationships, and those with little prior contact with the criminal justice system are less likely to call police. (Klein 2009.) Young women are strongly over-represented among victims of partner violence over the last five years. (Ministère de l’Intérieur 2022.) [FRA]
X Children	**BARRIER** **Barrier 1**: Victim belittles the experiences of violence • Case seemed minor. This reason is more likely used by victims in incidents of parental violence than in IPV (Hellmann 2014). [DEU] • Studies showed that the majority of children talked about their experiences of violence. However, less than half of them told an adult and even fewer of the experiences came to the attention of the authorities. The most common reason for not telling anyone about physical and sexual violence was that the experience was not considered serious enough to tell someone. (Lahtinen 2022.) [FIN]

Inmates	**BARRIER** • There is a gap in literature when it comes to disclosures of female inmates. According to a report of Centre of Women's Justice (2022), at least 57% of women in prison and under community supervision are victims of domestic abuse. The true figure may be higher because of barriers to women disclosing abuse.
Homeless victims	**BARRIER** **Barrier 1**: Negative experiences with institutions (as psychiatrics/police) **Barrier 2**: Ignorance of the legal situation **Barrier 3**: Difficult access to institutions: not barrier-free due to physical or mental restrictions as well as credibility problems **Barrier 4**: Co-dependency concerning living space (Gabler et al. 2016.) [DEU]
Victims with mental health issues	**BARRIER** **Barrier 1**: Shame and low self-esteem: Depressed person often has a poor impression of herself or himself and so the feeling of shame is reflected directly in low self-esteem (Giddens, 1991, p. 65; as cited in Piispa 2004). [FIN]

Table 2: Victims' interpersonal relationships with their immediate social environment, including the perpetrator, children, family, relatives, friends, etc., and forms of violence

Victims in general	**ENABLER** **Enabler 1**: Primacy of immediate networks • Services or service providers victims prefer immediate social network (60%): friends (72%), relatives (52%), neighbours (17%) [DEU] • The victim reported violence in only 55% of the analysed cases. In the rest of the cases, the most frequent reporters were relatives, official bodies and neighbours (Hornyik 2020.) [HUN] • Informal support networks are the most used resource by all women´s age groups (Sanz-Barbero et al. 2022). [ESP] • Pathways were identified according to the continuity or discontinuity of the support: personal network-based pathways (use of personal resources such as a network of friends) (Déroff & Potin 2013). • Of the survey respondents who had talked about intimate partner violence face to face, the majority had sought help from a friend (Piilola 2018). [FIN] • Some victims said that their own understanding of the situation would not have started to emerge if an outside party had not forced them to stop, seek help and admit that for the sake of children, the family's situation cannot continue as it is (Röntynen 2021). [FIN] • The number of people in whom the victim confided, is also relevant: If victims spoke to three or more other people about stalking, crimes were more likely to be reported (Zähringer & Stiller 2016) [DEU] • The majority of victims disclose to at least one informal support (e.g., friend, family member, classmate, co-worker, and neighbour. In addition, friends and female family members are the most utilised informal support and generally considered the most helpful/supportive. (Sylaska & Edwards 2014). [USA] • Women were asked why they did not contact the police with respect to the most serious incident of physical and/or sexual violence they had experienced by either a partner or nonpartner. The main reasons given were that women dealt with the matter themselves or with the involvement of a friend or family member. (Goodey 2017). [EU] • Victims who go to church sometimes prefer to seek help from priests (and not police officers) (Nagy & Petrus 2022). [HUN] **Enabler 2**: Education • Women with degrees tend to report more violence, probably because they have better access to information campaigns and prevention tools (Wicky et al. 2021). [FRA] • Education also impacts the use of support services. Persons with a compulsory school-leaving certificate as well as persons with a vocational school-leaving certificate make the greatest use of the various support services. An exception is the use of counselling or therapy services which is more often sought by persons with a university degree. (Kapella et al. 2011.) [AUT] ---------- **BARRIER**

Barrier 1: Care for perpetrator (or appeasement as a survival strategy)

- Reasons for not reporting & filing a complaint do not want the perpetrator to be punished (4%-22%), feelings of obligation towards the partner (Wetzels & Pfeiffer 1995; Hellmann 2014) [DEU]
- Perpetrator had apologised and promised that it would not happen again (14%-24%) (Müller et al. 2004; Hellmann 2014) [DEU]
- Feelings of obligation towards the partner / Failure in the responsibility for the success of the partnership (Nägele et al. 2009; Wippermann 2022). [DEU]
- Blaming oneself / feelings of guilt for having angered the partner with one's own behaviour / attempt to change one's own behaviour (Wetzels & Pfeiffer 1995; Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2008; Nägele et al. 2009; FRAs 2014; Hellmann 2014; Schouler-Ocak et al. 2017; LN-W 2020; Ohms 2020a; Birkel et al. 2022; Wippermann 2022) [DEU]

Barrier 2: Fear of perpetrator (e.g., by further violence against the victim or other persons, e.g., the children)

- (Wetzels & Pfeiffer 1995; Müller et al. 2004; Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; FRA 2014; Birkel et al. 2022) [DEU]
- Barriers in seeking care in IPSV included fear (Wright et al. 2022).
- In cases of IPV, women did not report to the police because of fear of the offender, the fear was higher in cases of sexual violence (…) women dealt with the matter themselves or with the involvement of a friend or family member (Goodey 2017). [EU]
- Barriers in seeking care in IPSV included social stigma, and difficulty for individuals in identifying IPSV behaviours in their relationships as abuse. (Wright et al. 2022.)
- Men in general suffer less serious violence, with fewer different or continuous acts or situations. The acts they report occur for shorter periods and in most cases correspond to a conflictual relationship with their partner. The notion of intimate partner violence has less relevance for describing their experience. The data thus sweep aside presuppositions on the symmetry of the acts reported by women and men, especially when the current prevalence viewpoint (previous 12 months) is widened to the life course; when taking in account affects, in particular fear and shame, the analysis shows indubitably that the experiences of men and women are not symmetrical. (Brown & Mazuy 2021). [FRA]
- Reason for not reporting DV: Perpetrator apologized (19,6 %), Victim scared of negative consequences/aggravation of cohabitation with perpetrator (16,7 %) (Hellmann & Blauert 2014). [DEU]
- Propensity to report and seek help is decreased especially if there are further risks and difficulties for the victims: physical violence: abuser threatens the victim or their family members with physical violence and even with murder. (Nagy et al. 2020; HRW 2013). [HUN]
- The victims usually do not talk openly about their problems when meeting a healthcare professional because of the feeling of shame and the abuser is often present during visits and examinations (Nagy et al. 2020; HRW 2013). [HUN]

Barrier 3: Dependence on perpetrator

- Reasons for not seeking help: being financially dependent on the partner (Löbmann & Herbers 2005; Nägele et al. 2009; Hellmann 2014; FHK 2021; Wippermann 2022) [DEU]

- Difficulties in mentalization, instability in relationships, emotional dependence, abandonment of her own life for her partners, difficulty in having a sense of identity (Both, Favaretto & Freitas 2019). [ESP]
- Lack of awareness of the seriousness of abuse (Ferrer Pérez & Bosch Fiol 2016). [ESP]

Barrier 4: Fear of the reaction of others

- Fear of losing contact with the children/ Fear of loneliness/ Do not want do endanger family cohesion (Forschungsverbund (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; Ohms 2020a; Fiedeler 2020a; Wippermann 2022) [DEU]
- One obstacle to accessing support services is often the family of the offender – in some cases also the family of the victim; especially the parents-in-law often exert massive pressure on women to stay in the violent relationship and sometimes are closely involved and part of the DV situation itself, thus acting as accomplices. (Flotzinger et al. 2021.) [AUT]
- One reason could be that in December, victims of DV want to spend Christmas together with their family and are less likely to search for solutions (Koutaniemi & Einiö 2021). [FIN]
- Elements of understanding of the difficulties encountered by medical doctors in carrying out these tasks are given fear of the reaction of the families if the perpetrator is punished (Henrion 2001). [FRA]
- The reasons for not filing a complaint were: "it would have been useless 56%, the stressful nature of the procedure 43%, fear of the consequences for the children 27%, fear of the consequences for the perpetrator 26%, fear of the gaze of others 15%, was dissuaded from doing so 7%, refusal to file a complaint 4%. (Wicky et al. 2021.) [FRA]
- Older women's belief that the response of the family and the justice system are negative. Most women in the study expressed fear that if they were to talk about experiencing DV, their family members would not be supportive. However, those who had talked about DV or separated from their abuser indicated that results had been mixed, as in some cases family members were supportive. Nevertheless, most often families denied the abuse, blamed the victim, or were hostile to the idea of "breaking up the family". (Beaulaurier et al. 2007.) [USA]

Barrier 5: Isolation

- Reasons for not seeking help: no availability of help (e.g., lack of network or trusted persons) (14%) (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiegeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022). [DEU]
- Stunted social and family networks, the lack of economic resources, the existence of children and the absence of institutional resources (Moriana Mateo 2015). [ESP]

Barrier 6: Type of violence

- When seeking help in the aftermath of sexual violence, the respondents were least satisfied with assistance received by any service (including the police and victim support). (Goodey 2017). [EU]
- The lack of serious injuries might lead both the victim and the ER personnel to underestimate the seriousness of the situation. (Hackenberg et al. 2021.) [FIN]
- Women with severe physical or psychological IPV or injury are more likely to call police than were other abused women. Women made 96% more calls if a

	weapon was involved, 58% more if they were severely sexually abused, and 40% more if they were severely physically abused. Women with children at home made 32% more calls. (Bonomi et al. 2006.) [USA] • Victimization is multiplied by 4.5 for women who have been exposed to violence or experienced poor relationships in childhood. Women report DV to relatives (80%) or health professionals (40%, doctor, psychologist), but take few steps to report the situation to the criminal justice system. (Wicky et al. 2021.) [FRA] • A minority of victims of physical or sexual violence by a partner declare that they have turned to medical and social services (27% of women victims and 10% of men victims), associations (14% and 7%) or the security services (25% and 9%) to talk about the events they have suffered. Serious physical and sexual violence is reported much more frequently by women than by men. Most talk to their friends or family, 69 %, 58 %. When the violence is repeated, the proportions of victims who have contacted at least one of this 3 services to talk to a professional are higher, but the differences between men and women remain the same (31% and 49% respectively; 33% of women victims reported the situation to the police or gendarmerie). Victims of exclusively sexual violence by a partner contacted one of the three services listed in the survey less often on average (16%). Certain categories of the population also appear to be over-represented among the victims: those with more than two years of higher education. To a lesser measure, this is also the case for people belonging to the 20% of households with lowest incomes. (Ministère de l'Intérieur 2021.) [FRA] *Other: Perpetrators unknown to the victim are reported more (31,3 %) than perpetrators known (16,0 %) or related to the victim (15,2 %) (Hellmann 2014). [DEU]*
Older victims	**ENABLER** **Enabler 1**: Primacy of immediate networks • Most Austrian victim-survivors (54.8%) chose to not seek help. When help was sought, it was done overwhelmingly from informal networks (42.9%) in contrast to formal institutions (6.3%). Austrian respondents were consequently the least likely to report to formal institutions. (Tamutiene et al. 2013.) [AUT] --- **BARRIER** **Barrier 1**: Dependence on partner • Older victims were often very dependent on their partners. With the longevity of a relationship comes increased dependence. This is furthered by additional factors that might come into play during old age, such as economic dependence and dependence on care, etc. (Amesberger & Haller 2012). [AUT] • Being financially dependent [on the partner] (Nägele et al. 2010 in: Stöckl & Penhale 2015); Löbmann & Herbers 2005; Nägele et al. 2009; Hellmann 2014; FHK 2021; Wippermann 2022). [DEU] • The study (Austria, Belgium, Finland, Lithuania, and Portugal) also highlights that respondents experiencing DV from partners were the least likely to report abuse (Tamutiene et al. 2013). [AUT] • Other practical problems are that violence between older partners or by adult children against older parents living in the same household often goes unreported. Among other things, this is due to the fact that perpetrators are

usually also caregivers/carers who are indispensable for managing the victims' lives. Especially when the only alternative to care by violent partners/relatives is a move to a home, reports are omitted. In addition, and this should not be underestimated, long-term marital and family relationships are characterised by imponderable psychological processes, feelings of obligation and life-historical memories that are incomprehensible to those on the outside but make it very difficult to break through the dynamics of violence (Hörl et al. 2015). [AUT]

- Reasons for not seeking help: feelings of obligation towards the partner (Nägele et al. 2009; Wippermann 2022) [DEU]
- Perception of a lack of options for action [due to health limitations] (Nägele et al. 2009; Fiedeler 2020b; Ohms 2020a; Wippermann 2022). [DEU]
- Older victims were often very dependent on their partners, as well in a social setting that might be more likely to maintain the status quo, unless victim survivors actively seek out help. This might be partially due to family members fearing that they might have to take over or finance care work if violent partners required care. (Amesberger & Haller 2012.) [AUT]
- No availability of help e.g., lack of network or trusted persons (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiedeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022). [DEU]
- Dependent on caregiving of their partners (even more dependent if the senior citizen is disabled) (Rossiwal 2016). [DEU]

Barrier 2: Relation to the family:

- A belief that the responses of the family are negative (Beaulaurier et al. 2007) [USA]
- Violence between older partners or by adult children against older parents living in the same household often goes unreported. Among other things, this is due to the fact that perpetrators are usually also caregivers/carers who are indispensable for managing the victims' lives. Especially when the only alternative to care by violent partners/relatives is a move to a [rest] home, reports are omitted. (Hörl et al. 2015.) [AUT]

Barrier 3: Fear of perpetrator

- In the study of Tamutiene et al. (2013), this reason was most often reported in Finland (41.9%) and Portugal (37.5%). Fear of retribution was the least reported reason for not reporting in Austria (5%). [AUT]

Barrier 4: Caring for perpetrator

- Feelings of obligation towards the partner (Nägele et al. 2009; Wippermann 2022) [DEU]
- Seeking help may also be prevented by the caregiver's or generally family member's sense of guilt and feeling that they are a bad relative if they are unable to take care of their loved ones (Salminen-Tuomaala et al. 2022). [FIN]
- Long-term marital and family relationships are characterised by imponderable psychological processes, feelings of obligation and life-historical memories that are incomprehensible to those on the outside but make it very difficult to break through the dynamics of violence. (Hörl et al. 2015.) [AUT]

Barrier 5: Fear that no one would believe

- This reason was very often reported in Portugal (73.9%) and Lithuania (59.7%). (Austria 11.5%). (Tamutiene et al. 2013.) [AUT]

Victims with children	**BARRIER** **Barrier 1**: Fear of the perpetrator • E.g., by further violence against the victim or other persons, e.g., the children (Wetzels & Pfeiffer 1995; Müller et al. 2004; Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; FRAs 2014; Birkel et al. 2022). [DEU] **Barrier 2**: Fear of losing children • Children involved: victims are afraid that the Guardianship Office removes their children because of DV in the family so they choose to remain in the abusive environment, putting their children as well as themselves at further risk of violence. (Nagy et al. 2020; HRW 2013) [HUN] • This is a lack of proper procedure: if the perpetrator is a relative of the victim and/or the persons to be questioned by the police as witnesses are also members of the family, a child might face influence and retaliation (especially if they live in a joint household with the offender) (Hegyi 2022). [HUN] • The issue of children as co-victims of violence and as making more difficult their mother's access to service providers, to shelter (Berthier & Karzabi 2021). • Households with one child or more than three children seem to be overexposed (Brown et al. 2020) [FRA] • Fathers: Fear of courses of action against which he feels helpless or inferior because of his gender (e.g., withdrawal of the children; counteraccusation) (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; Ohms 2020a; Fiedeler 2020a; Wippermann 2022). [DEU] • Pregnant and parenting survivors of IPV are especially vulnerable to coercive threats by their abusive partner, particularly threats to disclose their substance use to child protective services or law enforcement (Phillips et al. 2021). [USA] • Reasons for not seeking help: fear of losing contact with the children (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; Ohms 2020a; Fiedeler 2020a; Wippermann 2022). [DEU] • Renunciation of contacting the police for the children; Threat of child deprivation on the part of the perpetrator; Concerns about the perpetrator abducting the children to their native country in some of which the father has more rights (Gabler et al. 2016). [DEU] • Fear of losing custody over the child, as well as the possibility of children being used to exert control by the perpetrator can serve as factors dissuading victims to report DV. Furthermore, shared custody over the children can be used to reduce the efficacy of police measures, as they can infringe upon the right of the perpetrator to interact with the children. (Amesberger & Haller 2016.) [AUT] **Barrier 3**: Type of violence • Propensity to report and seek help is decreased especially if there are further risks and difficulties for the victims: physical violence: abuser threatens the victim or their family members with physical violence and even with murder. (Nagy et al. 2020; HRW 2013.) [HUN]
Victims with disability or impairment	**BARRIER** **Barrier 1**: Dependency and barriers • Women with disabilities face a variety of barriers to accessing support (Mandl et al. 2014). [AUT] • Dependent on caregiving of their partners (mainly regarding elder victims) (Rossiwal 2016). [DEU]

- Social, emotional, economical co-dependencies as well as the need for care. Co-dependencies due to certain circumstances such as lack of other social networks in case of separation. Limited care capability of the partner no imaginable alternatives. (Gabler et al. 2016.) [DEU]
- No availability of help (e.g., lack of network or trusted persons) (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiedeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022). [DEU]
- Women with disabilities face a variety of barriers to accessing support. Many women find themselves in a relationship of dependency on the perpetrators on whom they rely to (co-)manage their daily lives. This is true for people living independently as well as in institutional settings. As a result, they often hesitate to report the perpetrators. An important deterrent factor is fear of not receiving adequate alternative support. (Mandl et al. 2014.) [AUT]
- Where perpetrator and/or victim are responsible for the provision of care to the other, police interventions are restricted by the need for care and the available care facilities. Only where appropriate facilities and cooperations are in place, adequate options are available. Furthermore, the provision or dependency on care serves as a barrier to reporting. (Amesberger & Haller 2012.) [AUT]
- Perception of a lack of options for action [due to health limitations] (Nägele et al. 2009; Fiedeler 2020b; Ohms 2020a; Wippermann 2022). [DEU]
- Other barriers highlighted include the lack of financial resources (Mandl et al. 2014). [AUT]
- Victims who are dependent on their abuser for financial support may also lack the economic resources they believe are needed to acquire help for safety (GCFV 15.02.2023). [USA]
- Access to specialist support services often strongly depends on their level of independence and the initiative of their caregivers, or whether they live in an institution (Schröttle et al. in: GREVIO). [DEU]
- General lack of internal and external support and services for women with disabilities living in institutions (Schröttle et al. In: GREVIO). [DEU]
- Cognitive disabilities: access to general and specialist support services is hardly possible, as they largely depend on their parents or carers to contact the relevant entities (Schröttle et al. In: GREVIO). [DEU]

Barrier 2: Type of violence and relationship to the abuser

- Victim survivors of IPV with disabilities face additional forms of violence based on their disability, especially related to medical treatment and accessibility. Violence, according to respondents, also is experienced at multiple stages in life from various persons in proximity especially fathers, (ex)-partners and caregivers. (Mandl & Sprenger 2015.) [AUT]
- Increased parental violence, no trusted persons: child disability and child long-term illness are associated with child maltreatment (e.g., Chan et al. 2016; Jones et al. 2012 as cited in Seppälä et al. 2021). [FIN]
- One disability or long-term illness increases the risk of mental and disciplinary violence, compared with the children without a disability or long-term illness. It was not found that one disability or long-term illness would have increased the risk of serious violence. It was found that if a child has at least three disabilities or long-term illnesses, it increases the risk of all forms of violence multiple times compared with children without any disability. The risk of mental violence increased by 2.96-fold, the risk of disciplinary violence increased by 4.30-fold, and the risk of serious violence increased by 3.53-fold. Having two disabilities was not statistically significantly associated with any forms of violence. (Seppälä et al. 2021.) [FIN]

	• Disabled victims are more vulnerable to abuse, and they also face additional barriers to safety and services. Some barriers are clearly abusive tactics such as withholding food, medication or medical care, breaking or hiding communication devices and/or adaptive technology, threatening or injuring a victim's service animal, giving the victim drugs without their knowledge, forcing drugs or medications, or giving more or less than was prescribed. If the victims reach out for assistance after an abusive incident, abusers often claim the victim's injuries are related to the disability rather than violence. These kinds of tactics further impede the victim's ability to access help and impact the victims' efforts to evade the abusers' power and control. (GCFV 15.02.2023.) [USA] **Barrier 3**: (Fear of) Social isolation: • Limited amount of social contact and thus social support (BMFSFJ 2018). [DEU] • When in long-term care settings: limited amount of social contact and thus social support (BMFSFJ 2018). [DEU] • Physical and emotional abuse cause social isolation. In addition, living with a disability or as a deaf individual can be isolating. Victims' support networks may be small, and victims are seldom aware of available resources. Disabled individuals' identities are often closely tied with their connections to others with the same or similar disabilities. Therefore, leaving their community is not considered as an option, regardless of safety. Reluctance to speak out against someone else from within the community, even when that person is being abusive, may cause social isolation. (GCFV 15.02.2023.) [USA]

Migrant and refugee victims	**ENABLER** **Enabler 1**: Friends and family • Violence is often reported together with friends or family as support (Hoppe & Heubrock 2013). [DEU] • The majority of victims disclose to at least one informal support (e.g., friend, family member, classmate, co-worker, and neighbour. Friends and female family members are the most utilised informal support and in addition, generally considered the most helpful/supportive. (Sylaska & Edwards 2014). [USA] • Pakistani immigrant women contacted their parental family for support and hope that they'll influence their abusive husband (Zakar et al. 2012). [DEU] ---------- **BARRIER** **Barrier 2**: Dependence on partner • Reasons for not seeking help: being financially dependent on the partner Löbmann & Herbers 2005; Nägele et al. 2009; Hellmann 2014; FHK 2021; Wippermann 2022) [DEU] • One major difficulty reported was loss of social network and absence of support from parental family members (Zakar et al. 2012). [DEU] • Because Pakistani immigrant women are economically dependent on their husbands, they fear that their husbands will seek divorce if they report violence (Zakar et al. 2012). [DEU] **Barrier 3**: Small social network • No availability of help (e.g., lack of network or trusted persons) (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiegeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022). [DEU] • Syrian refugee women may have no societal structure to seek help (Ahmad et al. 2022). [DEU] • Among Pakistani women one major difficulty reported was loss of social network and absence of support from parental family members (Zakar et al. 2012). [DEU] • Non-German sex workers: barely social contacts outside of context of sex work (Rossiwall 2016). [DEU] • A limited amount of social contact was reported for every examined marginalized group, although having close friends to talk to was also reported as important support leading to the search for help (reported for eastern European women) (Hoppe & Heubrock 2013). [DEU] • Social isolation, which is brought about by the lack of knowledge, exclusion from the labour market and public life, as well as isolation brought about by perpetrators; language barriers, technical barriers and informational deficits; fear and threats; as well as economic dependencies. (Flotzinger et al. 2021.) [AUT] • Social and spatial isolation has been identified as one of the reasons for low reporting of DV among migrants and refugees (Müller et al. 2004; Löbmann & Herbers 2005; Schouler-Ocak et al. 2017; Wippermann 2022). [DEU] **Barrier 4**: Family members • One obstacle to accessing support services is often the family of the offender – in some cases also the family of the victim; especially the parents-in-law often exert massive pressure on women to stay in the violent relationship and sometimes are

	closely involved and part of the DV situation itself, thus acting as accomplices. (Flotzinger et al. 2021.) [AUT] • Fear of consequences for family: One of the reasons for not reporting & filing a complaint is the fear of negative consequences from family members from their country or origin (Zakar et al. 2012). [DEU] **Barrier 5**: Perceptions on family and gender roles • Do not want to endanger family cohesion (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Nägele et al. 2009; Fiedeler 2020a; Ohms 2020a). [DEU] • Pakistani immigrant women fear that husband would seek divorce because this could affect family life of women's parental family (parents, siblings, etc) / primacy of family as a huge value / Almost all women wanted to use the "power of silence" and hope that the "circumstances will teach a lesson" - belief that women shall be strong, patient and wise / Cultural stigma that divorced woman is 'loose", 'immoral' and 'unlucky' (Zakar et al. 2012). [DEU] • Failure in the responsibility for the success of the partnership (Nägele et al. 2009; Wippermann 2022). [DEU] • Among Syrian refugee women divorce and leaving relationships seen as shameful, stigmatized, breakage of sacred familial bonds / IPV is seen as a "normal act" in marriage, justified as "man's right" (Ahmad et al. 2022). [DEU] • Some religious or cultural contexts can frame the violence experienced by the victims as normal behaviour, as such, serving as a barrier to reporting cases of DV (Amesberger & Haller 2016). [AUT] • Barriers that Eastern European victims of stalking face: 1) concept of family and gender roles 2) higher social acceptance by intact family 3) strong familial cohesion within generations 4) concept of love being compatible with violence (Hoppe & Heubrock 2013.) [DEU]
Male victims	**BARRIER** **Barrier 1**: Most male victims are ashamed of being abused by their partners. • If an abused man decides to seek help, he often meets with contempt and disbelief. It may also happen that they become an object of ridicule, not only in their private life but also at the police or support services. (Varga & Bálint 2020.) [HUN] **Barrier 2**: No availability of help: e.g., lack of network or trusted persons (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiegeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022) [DEU] **Barrier 3**: Fear of losing contact with the children (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; Ohms 2020a; Fiedeler 2020a; Wippermann 2022). [DEU] **Barrier 4**: Fear of courses of action against which he feels helpless or inferior because of his gender (e.g., withdrawal of the children; counteraccusation) (Forschungsverbund Gewalt gegen Männer 2004; Schröttle & Ansorge 2008; Ohms 2020a; Fiedeler 2020a; Wippermann 2022) [DEU] **Barrier 5**: Failure in the responsibility for the success of the partnership (Nägele et al. 2009; Wippermann 2022) [DEU]
LGBTQ+ victims	**ENABLER**

	Enabler 1: Friends • Transgender survivors most commonly sought help from friends (76.7 %). Friends often represent the primary line of defence for transgender survivors seeking help, and thus bystander intervention training and education should be adapted to address not just cisgender but also transgender IPV (Kurdyla et al. 2021). [USA] **Enabler 2**: Mental health providers • Transgender survivors often sought help from mental health care providers (39.5%) (Kurdyla et al. 2021). [USA] **Enabler 3**: Family • Transgender survivors often sought help from family (30.2%) (Kurdyla et al. 2021). [USA] ---------- **BARRIER** **Barrier 1**: Reluctance to expose partners: Reasons for not seeking help: do not want to expose their partner to homophobia by stigmatising him/her additionally as a perpetrator. (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b) [DEU] **Barrier 2**: No availability of help, e.g., lack of network or trusted persons (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiedeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022). [DEU]
Victims in remote or rural areas	**Barrier 1**: Financial dependencies • Being financially dependent on the partner (Löbmann & Herbers 2005; Nägele et al. 2009; Hellmann 2014; FHK 2021; Wippermann 2022). [DEU] • The uncertain future and surviving financially is scary for many victims living in rural areas (Lindqvist 2009). [FIN] **Barrier 2**: Feelings of being responsible for family's wellbeing, failure in the responsibility for the success of the partnership • Women can experience divorce as socially stigmatizing and a personal failure, as the responsibility for the family's well-being is often thought to lie with women. Most often women are responsible to start a difficult process to separate, which the man may try to make difficult, e.g., the woman and her children are the ones who must leave their home. (Lindqvist 2009.) [FIN]
Young women as victims	**BARRIER** **Barrier 1**: Isolation • Some young women are particularly far from support providers: young women without children or in non-cohabiting couples (Dacoreggio & Latourès 2016). [FRA] **Barrier 2**: Type of violence • Finnish university students (n=298) who had become victims of violent stalking reported the incident most often to family and friends for protection (37.2 %). [Stalking was more frequent among female students (52.4 %) compared to male students 23.2 %).] Of all victims (including violent and non-violent stalking), about one third of victims turned to family and friends for help, but only a small

	minority reported using formal social resources in response to their stalker, such as professional help (violent stalking 11.7 %; non-violent stalking 3.1 %) or legal actions. Of the legal actions, the most common action was reporting to the police (6.7%; violent stalking 10.2%; non-violent stalking 3.7), yet twice as many threatened to call the police. (Björklund 2010.) [FIN]
Children	**ENABLER** **Enabler 1**: Disclosure of sexual abuse to adults was best predicted by the abuser's high age and the child's young age at the time of the incident. (Lahtinen 2022). [FIN] **Enabler 2**: Disclosure of violence to an adult was most strongly predicted by the child's younger age, female gender, absence of previous experiences of violence, and the fact that the parents knew with whom the child spends his free time (Lahtinen 2022). [FIN] ---------- **BARRIER** **Barrier 1**: Type of violence and relationship to the abuser • Mothers: Emotional violence committed by mothers decreased the probability of telling an adult (Lahtinen 2022). [FIN] • Increased parental violence, no trusted persons: child disability and child long-term illness are associated with child maltreatment (e.g., Chan et al., 2016; Jones et al., 2012 as cited in Seppälä et al. 2021). [FIN] • One disability or long-term illness increases the risk of mental and disciplinary violence, compared with the children without a disability or long-term illness. It was not found that one disability or long-term illness would have increased the risk of serious violence. It was found that if a child has at least three disabilities or long-term illnesses, it increases the risk of all forms of violence multiple times compared with children without any disability. The risk of mental violence increased by 2.96-fold, the risk of disciplinary violence increased by 4.30-fold, and the risk of serious violence increased by 3.53-fold. Having two disabilities was not statistically significantly associated with any forms of violence. (Seppälä et al. 2021.) [FIN]
Victims in extreme poverty	**Barrier 1**: Community demands the victim to tolerate violence • DV might be well-known and even accepted in specific disadvantaged communities where people live in extreme poverty. This cultural pattern hinders victims in many cases from thinking about escaping and getting in contact with professionals. (Nagy et al. 2020). [HUN]
Sex workers as victims	**Barrier 1**: Fear of the perpetrator **Barrier 2**: Being financially dependent [on the pimp] **Barrier 3**: Perception of a lack of options for action [due to lack of education] **Barrier 4**: Being emotionally dependent [on the pimp] **Barrier 5**: Social isolation **Barrier 6**: Sometimes no support from other sex workers: they don't want trouble with pimps (Rossiwal 2016). [DEU]

Table 3: Victims' relationships with their communities, such as neighbourhood, work, civil society, leisure, and sport associations, etc.

Victims in general	**ENABLER** **Enabler 1**: Churches and pastors • Services or service providers that some victims prefer are churches and pastors (Nagy & Petrus 2022). [HUN] **Enabler 2**: Employment • The probability of a woman responding with a distancing strategy (seeking outside help or leaving temporarily) is almost three times greater if she is employed (Montero et al. 2012). [ESP] **Enabler 3**: Sorority • It is found that the groups between women, the ties of sorority and all the social resources are extremely important and necessary for the recovery and healing of women (García Montes et al. 2021). [ESP] **Enabler 4**: Associations • Well-validated interventions targeted at abused women's needs and the circumstances of IPV remain a priority (Montero et al. 2012). [ESP] **Enabler 5**: Experience of criminal justice system • Some victims are more likely to report their victimization than others. Women who have more experience with the criminal justice system, especially those with protective orders or who have experienced more severe abuse, are more likely to call the police. The seriousness of injury does not automatically increase victim reporting because of incapacity. In these cases, the likelihood that a third party will call the police increases. (Klein 2009.) [USA] ---------- **BARRIER** **Barrier 1**: Employment • If victims are employed, they are also more likely to be victims of (ex)partner violence (State Criminal Police Office Lower Saxony 2020). [DEU] **Barrier 2**: Unemployment • Unemployment or inactivity as factors of vulnerability for victims (Karzabi & Lemière 2016). [FRA] • The risk of violence is doubled for women who are not in employment, which implies suffering social isolation (Wicky et al. 2021). [FRA] • It is not possible to prevent gender violence in a comprehensive manner without considering the increase in unemployment, temporary employment and job instability, economic dependency or the overload of reproductive tasks (Ruiz-Pérez & Pastor-Moreno 2021). [ESP] **Barrier 3**: (Social) isolation • Social isolation (e.g., unemployed) is a factor of overexposure of violence (Brown, Dupuis & Mazuy 2020) [FRA]

- Social isolation, which is brought about by the lack of knowledge, exclusion from the labour market and public life (Flotzinger et al. 2021). [AUT]

Barrier 4: The difficulty to be able to demonstrate psychological abuse hinders reporting (García Campoy 2019). [ESP]

Barrier 5: Reasons for not seeking help

- The guilt, shame and fear of making public in the social environment a behaviour for which they feel so degraded (García Campoy 2019). [ESP]

Barrier 6: Online activity

- On online social networks there are specific forms of cyber-violence against girls, who are more physically insulted, sexually intimidated, and receive more sexist comments than boys. Many forms of online violence are not diagnosed as GBV. (Linares et al. 2019.) [ESP]

Barrier 7: Perceptions and experiences of support system and institutions

- Fear of unpleasant questions and fear of not being believed (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2008; Fiedeler 2020a; Wippermann 2022). [DEU]
- Lack of anonymity (Müller et al. 2004; Schröttle & Ansorge 2008; Schouler-Ocak et al. 2017). [DEU]
- Victims wish that the professionals show understanding/the victims are taken seriously /the professional won't question the victim's credibility (Müller et al. 2004; Brzank et al. 2005; LN-W 2020). [DEU]
- Some victims fear of being mistaken for the perpetrator (Forschungsverbund Gewalt gegen Männer 2004). [DEU]
- The victim is not asked about violence (Müller et al. 2004; Brzank et al. 2005) [DEU]
- Fear of not being taken seriously: Victims wish that the professionals show understanding/the victims are taken seriously /the professional won't question the victim's credibility (Müller et al. 2004; Brzank et al. 2005; LN-W 2020; Forschungsverbund Gewalt gegen Männer 2004; Schröttle et al. 2011; Hellmann 2014; Fiedeler 2020a; Birkel 2022; Wippermann 2022) [DEU]
- Feeling of being unimportant or taking too much time [when meeting a professional]: The women emphasised the importance of healthcare professionals taking time out of their busy schedules for them. When they treated the women with respect and genuine interest, the women felt secure. When the healthcare professionals did not meet these expectations, feelings of frustration and mistrust were elicited. Feelings of being listened to and safety were considered important aspects in a positive encounter, whereas feeling a lack of time or interest often led to negative experiences such as frustration with and distrust of the healthcare system. These results imply that healthcare professionals may have deficiencies with regard to how these women are treated because these women do not feel that they receive the proper support. (Wallin et al. 2018.) [ESP]
- Women feel frustration, fear, insecurity, confusion... Thus, it becomes a necessity that the attention of the resources allocated to this problem be comprehensive, solid, coordinated and that the different areas that interact (judicial, educational, health, and police). Although they support the efforts and changes within the institutions, many women speak of a secondary victimization.

The study also focuses on minors as direct victims, and how the existence of dependent minors complicates the situation and invades feelings of frustration and guilt in women. (Silvestre et al. 2017.) [ESP]

Police and court:

- Between 5% and 13% of the respondents indicated that they have not reported to the police because of the belief that the police would not or could not do anything. The prospect of police intervention is not an option for many women. (Goodey 2017.) [EU]
- According to a representative public survey made by IKEA in Hungary, people, in general, do not trust the Hungarian police and court performance. Two third of respondents believed that less than 50 DV cases per year get to court. (IKEA 2021). [HUN]
- The victims think that the police could not do anything/indication of lack of prospects of success (Wetzels & Pfeiffer 1995; Müller et al. 2004; FRA 2014; Hellmann 2014) [DEU]
- Some victims do not perceive the police as an organ of protection (Müller et al. 2004) [DEU]
- Victims who reported prior victimisation and considered the response of criminal justice as insufficient or endangering, were less likely to report victimisation subsequently (Klein 2009). [USA]
- Victims are seldom protected during the protracted criminal proceedings, and they live in constant fear and threats. “The hearing is often a traumatizing experience, which is carried out unnecessarily frequently and by persons with inadequate professional qualifications. The condescending treatment, the perception of vulnerability, and the doubting of the authorities result in the experience of humiliation.” (Hornyik 2020.) [HUN]
- Women who were in contact with the police or some other service after the most serious incident of physical and/or sexual violence, indicated that they were least satisfied with the police than with other services (Goodey 2017). [EU]
- According to the victims' experiences, police officers on the spot often do not take action against the abusers. In addition, victims often complained about the passivity, insensitivity and victim-blaming attitude of police officers. Several victims mentioned that the police were the first to come to their minds in case of emergency, but they finally did not take any further action because they felt that the police would not be able to give appropriate support. All in all, victims were generally critical towards the work of the police and lack of confidence constitutes a major barrier to reporting abuse and seeking protection. (Nagy et al. 2020; HRW 2013.) [HUN]
- One reason behind the reluctance to report violence can be the lack of trust in the judiciary based on the typical outcomes of criminal procedures in intimate partner violence cases. According to the research results, verdicts are rather mild even in cases of serious physical violence in IPV cases. A further reason for low reporting can be insufficient police activity and information provision. Police do not provide information on victim support services and legal means (such as requesting a restraining order) and they tend to stay far from IPV cases. Although intimate partner violence is a chargeable crime, police often request a victim's report, which is an unlawful act. (Garai 2019.) [HUN]

- Justice system response is one of the most significant systemic barriers to seeking help, which also had been documented in earlier DV research with younger samples (Aronson et al. 1995; Dugan et al. 2003; Grigsby and Hartman 1997; Lutenbacher et al. 2003 as cited in Beaulaurier et al. 2007)
- Beliefs such as fear of police brutality toward the victim, negative thoughts about jail as a punishment, perceptions that arrest, restraining orders or court interventions don't help or make things even worse, concerns that police will not understand the situation and fear that police will ridicule the victim. (Beaulaurier et al. 2007). [USA]
- Some victims fear legal proceedings (Hellmann 2014). [DEU]
- Some victims have a desire not to have anything to do with the police (Müller et al. 2004). [DEU]
- Fear of losing control and autonomy: women who are victims of DV may feel fear and a loss of their autonomy and control when seeking care at the emergency department (Feder et al. 2006). [USA]
- The reasons for not filing a complaint were: "it would have been useless 56%, the stressful nature of the procedure 43%, fear of the consequences for the children 27%, fear of the consequences for the perpetrator 26%, fear of the gaze of others 15%, was dissuaded from doing so 7%, refusal to file a complaint 4%. (Wicky et al. 2021) [FRA]

Health care:

- According to the feedback, healthcare professionals are often indifferent towards the victims and do not believe their testimonies. In many cases, victims are in contact with their family doctor and nurse. The general feedback about the work of the professionals of the social sector (especially the family support services) and churches was rather positive. (Nagy et al. 2020; HRW 2013.) [HUN]
- The interviewees (n=17) hoped that they would not be downplayed or passed over but would be believed, that the professional would make a clear statement that violence is wrong, and that the situation can be helped. The victims listen carefully to the professionals' words and sense their attitudes, because they often feel guilty and are ashamed of their situation. (Röntynen 2021.) [FIN]

Barrier 8: Victim's disclosure is ignored or belittled

Health care:

- In health care, disclosure of DV was sometimes ignored. The interviewees (n=17) told how their experiences were belittled, and they had wondered if they had raised the matter in the wrong service. For example, during the review of child protection reports, the social workers did not ask nor talked about violence. At the child health centre, the experience of violence was sometimes incorrectly attributed to imbalance of hormones. (Röntynen 2021.) [FIN]
- Because victims of DV most often seek help from the health care sector, health care professionals play an important role in identifying violence and guiding victims to support services. The problem is not that the victims do not report DV but that even though they report this to the health care professional, reporting does not lead to intervention: despite the seriousness of the situation, only 19% of IPV victims were referred to advocacy, typically to child welfare services, and only 1% utilized a shelter for violence victims. The lack of suitable services may explain the low advocacy referral rates. However, patients who seek help in

health care might be more interested in health care than social services–based advocacy interventions (Hackenberg et al. 2021.) [FIN]

Barrier 9: The gender and origin of the professionals and the translators

- The victims wished that conversation/questioning should be conducted by a female/male professional or there were too many people at counselling (Müller et al. 2004). [DEU]
- Female victims find it difficult to tell male police officers about sexual abuse (especially when they are asked for a detailed account) and they are uncomfortable when a male gynaecologist has to conclude that sexual violence has occurred. (Nagy et al. 2020). [HUN]
- The victims wished for more female interpreters / contact persons from the same cultural group (Müller et al. 2004). [DEU]

ENABLER

Enabler 3: More effective legal intervention and protection

- In many countries, efficacy of police and court work in getting timely conviction, as well experience with police officers, prosecutors and judges, likely to impact victim survivors' use of legal means (Beclin 2014).
- Research indicates that actions of law enforcement, such as follow-up home visits after incidents, can encourage victim reports of DV. Victim confidence in police response leads to more reports of new violence. This is reinforced by a study of a police department DV unit, which documented that repeated victim contact with law enforcement officers assigned to a specialized DV unit significantly increased the likelihood of victim reports of revictimization. (Klein 2009.) [USA]

Enabler 4: Improving of professionals' skills on how to work with victims of violence

- Women, who participated in the survey (n=42000) were asked about their specific unmet needs because of the most serious incident of physical or sexual violence. The overwhelming majority of the participants said that they simply needed someone to talk to as a result of their victimization. Approximately 25 per cent of victims of sexual violence, perpetrated by a partner, and approximately 20 per cent of victims of sexual violence, perpetrated by a non-partner, indicated that they needed protection from further victimization and harassment. This result suggests that more women need protection by the police (or other services) than is currently possible given the number of women reporting to the police. (Goodey 2017). [EU]
- Feelings of being listened to and safety were considered important aspects in a positive encounter (Wallin et al. 2018). [ESP]
- Treating victims with empathy to overcome the fear of disclosing the IPV and to be able to continue to seek care:
    - respect the patients' autonomy: share decision making and respect those decisions and put patient-identified needs first
    - specifically address confidentiality issues when approaching DV victims
    - provide a safe and private environment
    - use an interpreter other than partner, be sensitive to the presence of a child when discussing DV issues

	○ be aware of the impact of their behaviours on patients ○ be non-judgmental, provide validation and empowerment, understand the woman's perspective ○ do not pressure the woman and give women time ○ develop trust and be trustworthy, listen to the patient, show concern and kindness, acknowledge what is said. (Feder et al. 2006.) [USA] **Enabler 5**: Confidential relationship with professional • In health care, a confidential relationship with the employee was considered important. The retention of employees influenced the level of trust. The interviewees appreciated if there was a same nurse working with a client for several years. (Röntynen 2021.) [FIN]
Older victims	**ENABLER** **Enabler 1**: Services or service providers that some victims prefer are churches and pastors (Nagy & Petrus 2022). [HUN] --- **BARRIER** **Barrier 1**: Isolation: • Maltreatment also manifests itself as limiting the living environment of the elderly, leaving them alone and social isolation (Salminen-Tuomaala et al. 2022). [FIN] **Barrier 2**: Churches not helping: Disclosure to the clergy does not lead to intervention • If the respondents were inclined to talk with anyone about DV, they'd prefer a member of the clergy. This type of response may be due to the linkage of religious beliefs and marriage in the minds of many older women ("Marriage is firstly a promise with God and secondly with your partner"). • Some religious beliefs may be a barrier to help-seeking. When comparing the attitudes of victims and non-victims, more "battered" women than "non-battered" women believed that church teaching contributed to DV (Manetta et al. 2003 as cited in Beaulaurier et al. 2007). This contrasts with numerous examples in the data indicating that belief in God helped women to find the emotional strength to transform their situations. • Spiritual beliefs were a very important coping strategy for women who reported leaving abusing spouses as well as those who reported staying. However, the aroused problems were often related to clergy rather than their beliefs. • The priest or ministers may say: "that's your burden to bear". In addition, very often they may turn people back away by saying: "sister, you've just got to pray on it. We're going to pray that God is going to change his heart". • None of the respondents had been referred by clergy to the social service or justice system. Clergy responses are most often encouraged to maintain the status quo, offering little practical help. (Beaulaurier et al. 2007) [USA] **Barrier 2**: No availability of help: • Especially in rural areas the alternative care of senior citizens is often much more difficult to organise (Hörl et al. et al. 2015). [AUT]

	• Support facilities did not exist in the country at the time (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Puchert et al. 2013; Fiedeler 2020; Ohms 2020a; Ohms 2020b; Wippermann 2022) [DEU]
Victims with children	
Victims with disability or impairment	**BARRIER** **Barrier 1**: Isolation: • Women with disabilities and victims of gender-based violence are forgotten about and made invisible. Quality institutional coordination mechanisms are required. (Región de Murcia 2017). [ESP] **Barrier 2**: Fear of being ignored or not believed • Women with psychological disorders or cognitive disabilities fear of being received as less credible/trustworthy (BMFSFJ 2018). [DEU] • Other barriers highlighted include the fear of being ignored or not taken seriously by social service staff or police (Mandl et al. 2014). [AUT] • The study shows that people with disabilities are often seen as less credible and reliable by authorities when reporting cases of violence, especially sexual violence. This is due to the fact that the behaviour of police, court and social services staff is often characterised by negative stereotypes about the sexuality of women with disabilities, which can lead to serious problems in the prosecution of sexual offences. (Mandl et al. 2014.) [AUT] • Deaf women in particular are less likely to report cases of sexual violence and bring them to court (Schröttle et al. 2011). [DEU] • Disabled victims may fear their claims of abuse will not be believed, either because the abuser told them so, or because of past negative experiences with helping professionals. (GCFV 15.02.2023). [USA] **Barrier 3**: (Support) services are not accessible • Legal supporting offers/institutions not barrier-free (e.g., when in wheelchair), not specified on women with special needs (BMFSFJ 2018). [DEU] • When in long-term care settings: no structures to report incidents (BMFSFJ 2018). [DEU] • When speaking and/or hearing impaired: no emergency call possible; mobility may be impaired - supporting services not accessible; social isolation of victims - no support. (Rossiwal 2016). [DEU] • Difficult access to institutions: not barrier-free due to physical or mental restrictions as well as credibility problems; limited accessibility of women with physical limitations and disabilities; lack of mobility as a restricting factor for the accessibility institutions; limited accessibility for women with physical limitations and disabilities; lack of knowledge of the German language or communication difficulties (Gabler et al. 2016). [DEU] • Other barriers highlighted include the lack of accessible facilities and information (Mandl et al. 2014). [AUT] • Generally, Austrian institutions are largely ill-equipped when dealing with persons who are subjected to multiple forms of discrimination, in this case gender- and disability-based discrimination. As such, institutional barriers, especially in regard to the legal proceedings, were present, including information

	that is not made available in accessible language accommodating a victim's disabilities. Similarly, services for IPV are also often at least partially in-/ not easily accessible; with accessibility depending on the disability. As such, especially noticeable hurdles exist for victims who are vision- or hearing-impaired; as well as persons who have learning-/comprehension-disabilities. (Mandl & Sprenger 2015.) [AUT] • Greater need for healthcare services, but at the same time only have limited access to these services, because of physical, practical and communication barriers (Schröttle et al. in: GREVIO). [DEU] • Barriers of physical accessibility to buildings. Information may not be accessible for those with hearing or sight loss. In some cases, disabled victims are denied services due to their disability. (GCFV 15.02.2023.) [USA] • When in long-term care settings: sometimes helping organizations / telephones were not available (limited time schedule or no one at the phone) (BMFSFJ 2018). [DEU]
Migrant and refugee victims	**ENABLER** **Enabler 1**: Associations • Migrant women associations help migrant women deal with gender-based violence (Royo et al. 2017). [ESP] **Enabler 2**: Culturally responsive DV programs • To meet the needs of victims with immigrant or ethnic minority background, GCADV reminds that mainstream DV programs must be culturally responsive and account for the varied values and life experiences of victims. (GCFV 15.02.2023; Vann 2003.) [USA] --- **BARRIER** **Barrier 1**: Lacking educational and health organisations • Victims have suffered the greatest institutional violence among the areas of education and health. Therefore, training of professionals is required. (Alencar-Rodrigues & Cantera 2013.) [ESP] **Barrier 2**: Exposure to violence • Migrant populations are more exposed to violence, especially when migration is linked to fleeing violence in the country of origin or when violence was suffered during the migration process (Wicky et al. 2021). [FRA] **Barrier 3**: Fear of isolation • Reasons for not seeking help: fear of being excluded from the scene (Forschungsverbund Gewalt gegen Männer 2004; Ohms 2006; Ohms 2020a; Ohms 2020b). [DEU] **Barrier 4**: Perceptions and experiences of society, support system and institutions • Fear of not being taken seriously (Forschungsverbund Gewalt gegen Männer 2004; Müller et al. 2004; Schröttle & Ansorge 2008; Fiedeler 2020a; Wippermann 2022). [DEU]

- According to the immigrant women' experiences, their recognition is denied in their interactions with institutions and at workplaces. They feel that they are not being heard, valued or trusted. They feel silenced and excluded from the dominant knowledge community, and not valued as subjects of knowledge and agency because of their immigrant status. Misrecognition is manifested in not being recognized as a person who has experienced abuse and violence, a human being or as a knowledgeable subject. Immigrant women's experiences that they were not believed when speaking the language, they encountered barriers to accessing the language. This resulted in a feeling that language barrier was used to keep them outside of the dominant culture. (Kjaran & Halldórsdóttir 2022.) [Iceland]
- No trust in police due to experiences with their native police institutions (Gabler et al. 2016). [DEU]
- Eastern European victims of stalking have low confidence in police (Hoppe & Heubrock 2013). [DEU]
- Pakistani immigrant women do not trust in police due to experiences with/expectations about Pakistani police. Among Pakistani immigrant women a lack of trust in the institutions' capacity and commitment to solve the problems. Among Pakistani immigrant women suspicion about the unknown and unpredictable consequences of the contact. (Zakar et al. 2012.) [DEU]
- Communities of colour: because of the history of racism, discrimination and mistreatment, there is mistrust toward systems. Therefore, victims may view traditional DV programs as being part of the same system which has marginalised and oppressed them for ages. (Vann 2003, as cited in GCFV 15.02.2023.) [USA]
- Lack of trust in society: Further hindering factors are experiences of racism, misanthropy, discrimination and hostility. These cause distrust in people and institutions, especially outside their own communities. (Flotzinger et al. 2021.) [AUT]
- Avoiding police contact for fear: victims don't want to increase vulnerability or take unnecessary risks. Pakistani immigrant women won't contact the police because they have no trust in police due to experiences with/expectations about Pakistani police (Zakar et al. 2012.) [DEU]
- Perception of limited options for action due to legal situation and residence status (Müller et al. 2004; Löbmann & Herbers 2005; Schouler-Ocak et al. 2017; Wippermann 2022). [DEU]
- In Austria, while victim-survivors whose legal status is dependent on the violent partners, are protected from losing their residence permit for another extension period of their residence permit; the generally applicable criteria for a residence permit that come into force after this grace period can see them losing said permit due to a lack of income. (Amesberger & Haller 2016.) [AUT]
- Migrants in precarious living situations, i.e., migrants who do not have a right to stay in a given country are particularly at risk, as they often find themselves in risky dependencies and unstable living conditions. The authors explicitly mention homeless women who have not been officially documented, as they stay with relatives, acquaintances and other contacts. Another important factor contributing to their vulnerability, is the fear of having to move, should the victim break off a relationship or quit their work. (Homberger & Güntner 2022.) [AUT]
- Fear of deportation/losing residence permits (Gabler et al. 2016). [DEU]

	• Pakistani immigrant women fear that abusive husbands may face deportation after being reported to police (Zakar et al. 2012). [DEU] • Cannot be addressed or averted when living under oppressive conditions (e.g., in refugee shelters) (Müller et al. 2004; Löbmann & Herbers 2005; Schouler-Ocak et al. 2017; Wippermann 2022). [DEU] • Lack of anonymity (Müller et al. 2004; Schröttle & Ansorge 2008; Schouler-Ocak et al. 2017) [DEU] • Language barriers (Löbmann & Herbers 2005; Schouler-Ocak et al. 2017). [DEU] • Among Pakistani immigrant women the women's inability to explain their problem and convince people of their need for appropriate help (Zakar et al. 2012). [DEU]
Male victims	
LGBTQ+ victims	**BARRIER** **Barrier 1**: Fear of losing social capital: The reporting of DV can be perceived to risk the loss of social capital. The introduction of external parties, i.e., police, into the family and, by extension, the community, which in turn could result in stigmatization and incurring social costs that could result in isolation from the community. This applies to not just migrant communities, but reportedly also to other communities experiencing marginalization, such as the LGBTQI and disabled communities. (Amesberger & Haller 2016.) [AUT] **Barrier 2**: Lack of support facilities, no professional consultants with background / no connection to LGBTIQ+ community; formal help-giving resource types appear to be underutilized and perceived more negatively by transgender survivors (Kurdyla et al. 2021). [USA]
Victims in remote or rural areas	**BARRIER** **Barrier 1**: Rural isolation: • Women in rural areas have greater difficulties in accessing resources, and especially in starting the first process of filing a complaint. Distances and lack of resources worsen their situation. In addition, isolation, and social judgment may have an important weight (Provincial Council of Bizkaia 2015.) [ESP] • Associations have the tendency to help women by assisting them, not empowering them (Franco-Rebollar & Guilló Girard 2012). [ESP] • Specific factors that explain the lower recourse to service providers in the overseas territories: high level of economic dependence of women, constraints linked to insularity; difficulty in moving away from a violent partner (Sénat 2016). [FRA] • In rural areas, women flee violence primarily to neighbours and friends. Due to the desolation of the countryside, neighbours may no longer be close. (Lindqvist 2009.) [FIN] **Barrier 2**: Negative experiences with institutions: • Geography was noted to play a role. Interviewees reported a more negative experience with the police in rural areas, where officers were more likely to dismiss reports of abuse as mere marital issues. Experiences with courts, attorneys and judges largely depended on the results of the case. Furthermore, "only very few physicians had made serious attempts at talking about the assaults" or referring victims to relevant services. Experiences with organisations for protection against violence as well as with women's and psycho-social

	counselling institutions were highly satisfactory. (Amesberger & Haller 2012.) [AUT] **Barrier 3**: Community demands the victim to tolerate violence: • In traditional rural communities, divorce may be viewed negatively, and the community may demand for forgiveness and tolerance even in a violent relationship (Lindqvist 2009). [FIN] • Certain specific factors explain the lower recourse to service providers in the overseas territories: higher tolerance level for violence, prevalence of certain sexist stereotypes, weight of certain traditions, high level of economic dependence of women, constraints linked to insularity (difficulty in moving away from a violent partner). (Sénat 2020.) [FRA] **Barrier 4**: Lack of support services • Lack of widespread supporting services mainly in rural areas (analysis of regional infrastructure, level of violence, socio-demographic data of local population (Koch et al. 2018). [DEU] • In rural areas the alternative care of senior citizens is often much more difficult to organise (Hörl et al. 2015). [AUT]
Young women as victims	**BARRIER** **Barrier 1**: Online activity • A strong sexual pressure and control via social media (Ministry of Equality 2020). [ESP] **Barrier 2**: Intersectional vulnerabilities: • Young women are exposed to multiple forms of violence, particularly sexual violence. They are more likely to have a combination of difficulties: precariousness, violence suffered as a child, etc. (Dacoreggio & Latourès 2016.) [FRA] • Young people are more likely to be in vulnerable situations (economic insecurity, dependence, isolation, etc.) which make them overexposed to violence. (Wicky et al. 2021). [FRA] --- **ENABLER** **Enabler 1**: Education • better access to information, Women with degrees tend to report more violence, probably because they have better access to information campaigns and prevention tools. (Wicky et al. 2021). [FRA]
Children	**ENABLER** **Enabler 1**: Education • Creating specific programmes and resources for the children (Ministry of Equality 2020). [ESP]
Roma as victims	**BARRIER** **Barrier 1**: Fear of being discriminated and lack of trust in society • For Roma women, mistrust of the authorities runs deep because of the general discrimination faced by the Roma community which makes them less likely to seek protection from the police when they experience DV. Women belonging to Hungary's Roma minority are particularly disadvantaged in accessing protection from DV. They experience difficulties reaching out for help in their communities,

	where poverty, unemployment, and social exclusion further fuel the risk of violence against women. (HRW 2013.) [HUN]
Victims with substance abuse issues	**BARRIER** **Barrier 1**: Negative experiences with institutions **Barrier 2**: Difficult access to institutions: not barrier-free due to physical or mental restrictions as well as credibility problems **Barrier 3**: Fear of losing contact with the children **Barrier 4**: Fear of perpetrator **Barrier 5**: Racism **Multiple barriers to help-seeking among people with opioid use disorder:** abusive partner control of money and resources, fear of retaliatory violence, concerns related to police and child welfare, pregnant and parenting survivors especially vulnerable to coercive threats by their abusive partner: threats to disclose their substance use to child protective services or law enforcement, negative consequences of criminal justice system involvement, abusive partners' threats to report survivors' substance use to law enforcement are both credible and deeply coercive, systemic racism and disparities in the criminalization of substance use as well as in child welfare involvement, survivors of colour are at an increased risk regarding coercive threats to call law enforcement or child welfare about their substance use. ---------- **ENABLER** **Enabler 1**: Support that helped to make positive changes: being treated with care, support from DV shelters and treatment programs. (Child Welfare Information Gateway 2016; Drug Policy Alliance 2018; Netherland & Hansen 2017 as cited in Phillips et al. 2021.) [USA]

Table 4: Structural barriers to access support services, such as financial resources, availability, distance, admission rules, opening hours, etc.

Victims in general	**Police** **Barrier 1**: Gender bias • Police organisation is gender biased and holds the idea virile masculinity (Darley & Gauthier 2014). [FRA] **Barrier 2**: Failures to implement protective measures • Restraining orders are not successful or not applied for if the evidence is not credible, for instance, if there are no other police measures, medical documentation of witnesses (Gabler et al. 2016). [DEU] • Certain types of violence, such as stalking and mental abuse, are not regarded as requiring urgent protection of the victim (Gabler et al. 2016). [DEU] • Despite the Protection from Violence Act, the use of coercive measures against the perpetrator by the police is very low (FHK 2021). [DEU] • In practice it is hard to separate a victim from a perpetrator who offers permanent care to the victim. Thus, the victim is dependent on the perpetrator. (Nägele et al. 2009.) [DEU]
	Courts and legislation **Barrier 1**: Compensation for damages, pain, and suffering is complex and presupposes the establishing as causal relationship between violence and damage (FHK 2021). [DEU]. **Barrier 2**: Information about court proceedings is not always available in easy language (Mandl & Sprenger 2015). [AUT] **Barrier 3**: No criminalization of psychological violence, verbal, and non-verbal sexual harassment (GREVIO 2022). [DEU] **Barrier 4**: Gender dimension is not fully considered in the development of laws, policies, and measures to prevent and combat violence against women (GREVIO 2022). [DEU] **Barrier 5**: Community and legal resources are limited (Ferrer Pérez & Bosch Fiol 2016). [ESP]
	Hospital emergencies & health services **Barrier 1**: The care of the DV victims is not particularly well financed in the health care system. [DEU] **Barrier 2**: The mandate for action / current legislation in the cases of DV is ambiguous, insufficient. [DEU, FRA] **Barrier 3**: Care (identification, screening, diagnosis, treatment, documentation, referral) is not standardized in health care settings. [DEU] **Barrier 4**: Interorganisational cooperation is not standardised (Nägele et al. 2009). [DEU] **Barrier 5**: Incapacity for detection and intervention • The ability to detect DV more easily among the socially disadvantaged may be conditioned by cultural beliefs, expectations and stereotypes held by health care staff about the prevalence of DV in different social and ethnic groups. It is also likely the victims from lower social strata share social norms that make it easier

for them to share their experiences about violence with the third parties. (Schröttle & Khelaifat 2008). [DEU]
- Healthcare personnel are sensitive to the problem of intimate partner violence but do not consider this issue to be a health problem. (Coll-Vinent et al. 2008). [ESP]
- Doctors are reported to intervene in cases of DV only rarely. As such, they rarely provide any information on available support structures for victim-survivors. (Amesberger & Haller 2012.) [AUT]

Social and support services

Barrier 1: Shortage of funding
- Social and support services for women victims of DV are underfinancing of services of women (Craviotto et al. 2018). [FRA]
- Financial services for the victims are insufficient [FRA]
- Lack of private sector involvement in and financing of social support and services (GREVIO 2022). [DEU]

Barrier 2: Services are scattered and therefore hard to reach for the victim [FRA]

Barrier 3: The management of victims' well-being and safety is only short-term (National Assembly 2019a, 2019b, 2020; Gosset el al. 2022). [FRA]

Barrier 4: Perception of DV is flawed, biased
- Culturally DV is often perceived as an individual problem, not a social problem. [DEU]
- The perception of DV is loaded with various stereotypes regarding gender roles, social background and ethnicity. [DEU]

Barrier 5: Services are not prepared to satisfy the needs of diverse victims
- Services are not tailored to the diversity of the experiences and needs of the victims. [DEU]
- Services not considered necessary if no visible injuries, or if not threatening or physically, psychologically, or financially stressful. (Schröttle & Ansorge 2009; LN-W 2020). [DEU]
- Professionals need to find ways to fully support women in a way that avoids shaming them for 'failing' in relation to what is expected of them. This can strengthen existing institutional responses to GBV. (Goicolea et al. 2022). [ESP]
- There is a need to improve visibility and adapt the response of formal services to the specific needs of women in different life stages (Sanz-Barbero et al. 2022). [ESP]

Shelters

Barrier 1: Shortage of services, resources, and funding
- There are not enough women's shelter places in each region (see also B 5) (FHK 2021; GREVIO 2022). [DEU]
- The funding of shelters is uncertain or insufficient (see also B 6). [DEU, FRA]
- Some shelters are understaffed and lack professional language interpreters. [DEU]
- Shelter stay must be paid partly or completely by the women themselves (FHK 2021). [DEU]

Barrier 2: Some women fall outside the services
- Not all victims of DV have a legal right for protection and support. [DEU]
- GREVIO (2022) points out several factors restricting the entrance to shelters in Germany. Factors include complex funding requirements, restrictions related to a

	woman's level of disability, residency status, age, number of children (also FHK 2021). **Barrier 3**: Often women must travel far away from their place of residence to go to a women's shelter (FHK 2021). [DEU, AUT] **Barrier 4**: Shelters are not adapted to clients with functional and health limitations, such as the elderly and persons with disabilities [DEU]
	National Policy as Barrier • No national policy or strategy with a common definition of violence against women and DV (GREVIO 2022). [DEU] • No national coordinating body leading to various kinds of inconsistencies (GREVIO 2022). [DEU] • Inter-agency cooperation and systematic and gender-sensitive risk assessment is not emphasized (GREVIO 2022). [DEU] • No national strategy and action plan to prevent and combat violence against women who are or may be exposed to intersectional discrimination (specifically women with disabilities, women belonging to minority groups, migrant and asylum-seeking women, Roma women, LBTI women, homeless women, older women, women in prostitution and women with addiction problems) (GREVIO 2022). [DEU]
	Barriers related to COVID-19 lock-down • The access to counselling services were limited [DEU] • There were difficulties to receive face-to-face counselling [DEU] • Online or telephone counselling was not usable due to partner's controlling presence (Steinert & Ebert 2020; BAFzA 2021). [DEU] • There were restrictions on the admission to women's shelters. [DEU] • Some services were not available: language services, support networks, self-help groups, day clinics and therapies (BAFzA 2021, 2022). [DEU] • difficult and slow administrative processes, and problems with coordination and access to information (Vives-Cases et al. 2021). [ESP]
Older victims	**Courts** **Barrier 1**: Legal measures and restraining orders for the elderly may fail especially in the rural areas because the caregiver-perpetrator who is indispensable for managing the victim's life lives in the same household with the victim and care cannot be organised alternatively. Thus, the victim is dependent on the perpetrator. (Hörl et al. 2015). [AUT] **Barrier 2**: Restraining order is only applicable to the place of residence of victims according to law. [AUT]
	Hospital emergencies & Health care **Barrier 1**: Outpatient care services for the elderly victims of DV in Germany are insensitive to the special circumstances and needs of the elderly (Nägele et al. 2009). [DEU] **Barrier 2**: Violence against the elderly is not effectively detected (Nägele et al. 2009). [DEU] *Liberal general practitioners*

	Shelters **Barrier 1**: Shelters are not usually prepared to receive clients who have significant health or functional limitations or need specific barrier-free equipment or appropriate support (Nägele et al. 2009; FHK 2021). [DEU]
	Social services, Support services **Barrier 1**: Services do not meet the specific needs of the elderly • Easily accessible services for the elderly with disabilities are not easily available. [DEU] • Outreach services are not organized for the needs of the elderly and their social environment (Nägele et al. 2009). [DEU] • Services are not tailored to the specific needs of the elderly, particularly those with health and functional limitations. [DEU] • Services for women should also include the needs of older women. it would be necessary to train professionals and technicians to raise awareness of the needs of older women and at the same time to offer support groups, counselling services, prevention campaigns in centres for the elderly (Celdrán 2013). [ESP]
Victims with children	**Shelters** **Barrier 1**: There is a lack of shelters for the victims with several children (FHK 2021; HCE 2020; Berthier & Karzabi 2021). [DEU, FRA] **Barrier 2**: Visitation or custody rights after DV must not endanger the rights and safety of the victim or the children (FHK 2021). [DEU, FRA]
Migrant and refugee victims	**Police** **Barrier 1**: Garcia (2014) observes that the criminal justice system in Catalonia does not guarantee the right of information for the migrants IPV victims who do not have language competencies. [ESP] (see also Iceland: Kjaran & Halldórsdóttir 2022)
	Shelters **Barrier 1**: Shelter services require a residence status for refugee women (FHK 2021). [DEU] **Barrier 2**: A migrant is not eligible to stay in a shelter without financially contributing (GREVIO 2022). [DEU] **Barrier 3**: Not enough resources for professional language mediation and thus must turn to lay interpreters such as relatives and acquaintances (FHK 2021). [DEU] **Barrier 4**: The safety of women and girls are in danger in collective refugee shelters for several reasons [DEU] **Barrier 5**: There is a lack of shelters for the victims with several children (FHK 2021; HCE 2020; Berthier & Karzabi 2021). [DEU, FRA] **Barrier 6**: Visitation or custody rights after DV must not endanger the rights and safety of the victim or the children (FHK 2021). [DEU, FRA]
	Health care **Barrier 1**: There are various bureaucratic barriers (rules about residence) and language barriers in getting health care. [DEU]
	Social services, social support **Barrier 1**: There is only limited capacity to offer psychological care for those non-native-language speakers. [FRA]

	Barrier 2: There is a lack of information / interpreters of the services for those who do not speak native, the language barrier (e.g., Flotzinger et al. 2021). [ESP, AUT, FRA, DEU] **Barrier 3**: Irregular migrants (not residents) do not have social rights and thus access to institutional support (Moriana Mateo 2021). [ESP] **Barrier 4**: Services for the migrants in precarious living situations (irregular, homeless) only partly funded by the state (Mandl & Sprenger 2015; Homberger & Güntner 2022). [AUT] **Barrier 5**: Benefits for specific services must be applied for, justified, and approved separately. [DEU] **Barrier 6**: To apply for services formal procedures differ between federal states. (Schouler-Ocak et al. 2017). [DEU] **Barrier 7**: Immigrant women more frequently denounce their intimate partners than Spanish women, but this action does not guarantee effective results. Other specific interventions have been identified in some autonomous regions of Spain, but these interventions need to be evaluated to ensure that they benefit immigrant women. (Vives Cases et al. 2009). [ESP] **Barrier 8**: The legislative barriers to accessing services, the absence of culturally adapted services, the lack of knowledge about service availability, the social isolation faced by the immigrant population and greater cultural permissiveness towards IPV (Briones-Vozmediano et al. 2014a). [ESP] **Barrier 9**: loss of social support after leaving their country of origin, and limited knowledge about available resources (Briones-Vozmediano et al. 2014b). [ESP]
Victims with disability or impairment	**Shelters** **Barrier 1**: Shelters are not easily accessible to disabled (women). Shelters' physical space and staff are not adapted or tailored to the specific experiences and needs of clients with functional or intellectual limitations (Nägele et al. 2009; FHK 2021: Senate of France 2019). [DEU, FRA]
	Social services **Barrier 1**: Due to physical structures, built environment and facilities services may not always be accessible for the disabled (Mandl et al. 2014) [FRA, AUT] **Barrier 2**: Information is not always available in accessible formats for the disabled, vision- or hearing-impaired, learning-/comprehension-disabilities (Mandl et al. 2014). [AUT]
	Health care **Barrier 1**: Barriers in the physical structures and spatial space may limit the choice of a physician. [DEU] **Barrier 2**. Information and help are not available for sense-impaired persons which cause problems for communication. (Schröttle et al. 2011). [DEU]
	Police **Barrier 1**: The separation of the perpetrator and the victim of DV can be used to a limited extent only if the victim needs constant care assistance provided by the perpetrator and there are no affordable alternatives available (Nägele et al. 2009). [DEU]

	Barrier 2: Disabled women have difficulties to access law enforcement agencies (Senate of France 2019). [FRA]
	Courts **Barrier 1**: Disabled women have difficulties to access courts (Senate of France 2019). [FRA] **Barrier 2**. Court proceedings were not adequately translated into sign language (Mandl & Sprenger 2015). [AUT]
LGBTIQ+ victims	**Support services** **Barrier 1**: Services and counselling centres are not available especially in the rural areas or not tailored to the special needs and experiences of gender minorities or LGBTIQ+. [DEU] **Barrier 2**: Many LGBTIQ+ counselling centres receive only municipal funding and therefore limit their services to the residents only. [DEU]
	Police **Barrier 1**: Cultural beliefs about masculinity, stereotypes and expectations about genders can lead to discrimination of homosexual men as victims, ignoring the danger they live in, and the physical and psychological consequences of violence (Losehand 2012). [AUT]
Male victims	**Support services** **Barrier 1**: Services are not tailored to the specific needs and experiences of men. [DEU] **Barrier 2**: Support is not considered always necessary, when violence is not regarded as physically, psychologically, or financially serious enough (Schröttle & Ansorge 2009; LN-W 2020). [DEU] **Barrier 3**: Counselling centres perceived as women's counselling centres. Thus, the police are less likely to refer male victims & men are less likely to turn to them [DEU]
	Police **Barrier 1**: The police practices indicate bias as they are more likely to send offenders away if female victims are involved compared to male victims and if there are children living in the households (Löbmann & Herbers 2005). [DEU] **Barrier 2**: Culture of masculinity in the police and related cultural beliefs and expectations may discriminate male victims (Darley & Gauthier 2014). [FRA] **Barrier 3**: Male victims can be ridiculed and not believed in their private lives and among various services, including the police (Varga & Bálint 2020). [HUN]
Victims in remote and rural areas	**Support services** **Barrier 1**: Lack of services in rural and remote areas • Services, counselling centres or contact points less available in rural areas. (Müller et al. 2004; Ohms 2006; Sorgo 2013, Goodey 2017). [DEU, FRA, AUT, FIN] • Women in rural areas are isolated from the social services (Senate of France 2021). [FRA] • In the Autonomous Communities identified as eminently rural, the resources made available to women tend to be inaccessible and their distribution can be improved. There are fewer specialized resources than in other Communities with a smaller proportion of rural territory. There is little visibility of actions towards the

	rural sector and the and the specific needs of rural women. Women are seen as victims, from an assistance approach rather than from an empowerment approach. (Franco-Rebollar & Guilló Girard 2012). [ESP] **Barrier 2**: Normalisation of DV and cultural expectation in rural areas: women do not seek help in the rural areas from official sources (Hörl et al. 2015; Lindquist 2009). [AUT, FIN] **Barrier 3**: If the perpetrator is the caregiver who lives in the same household as the victim, legal measures and restraining orders may fail in rural areas for the elderly, because affordable alternative care is not available. Financial dependencies and social bonds are difficult to break in the rural areas and rural women may not seek help and support from official services. (Hörl et al. 2015; Lindquist 2009). [AUT, FIN]
	Police **Barrier 1**: A recommendation of installing social workers in the gendarmerie and creating contact points among the local authorities implies that in the rural areas the policing of DV has not been effective (Senate of France 2021). [FRA]
	Courts **Barrier 1**: Women living in rural areas have restricted access to the judiciary (Senate of France 2021). [FRA]
	Health care **Barrier 1**: Health care professionals from the front line in rural areas, but their involvement in DV prevention and detection is weak (Senate of France 2021). [FRA]
	Shelters **Barrier 1**: Women in rural areas have restricted access to shelters. (Müller et al. 2004; Ohms 2006; Koch et al. 2018). [DEU]
Homeless victims	**Police** **Barrier 1**: Police response to DV in the context of homelessness is challenging due to the negative experiences of the homeless women with the police (Gabler et al. 2016). [DEU]
	Courts and judicial practice **Barrier 1**: Homeless people are often ignorant of their legal situation which influences their access to the judicial system (Gabler et al. 2016). [DEU
	Health Care **Barrier 1**: Homeless women have negative experiences with psychiatrists (Gabler et al. 2016). [DEU]
	Shelters **Barrier 1**: Shelters cannot offer permanent support for the homeless (Koch et al. 2018). [DEU] **Barrier 2**: Homelessness people are often associated with addictions and mental health problems. Addictions are perceived as causing conflicts, and thus intoxicated persons or people suffering from substance addiction have difficulties to be admitted to shelters. (Gabler et al. 2016.) [DEU]
Young women as victims	**Support services** Barrier: Specific needs of young women are not being met • Higher need for accommodation, not enough suitable facilities for the young (Dacoreggio & Latourès 2016). [FRA] • The young women who do not have children or who do not co-habit are not well catered by support services [FRA]

	• Several weaknesses have been identified regarding the services satisfying the specific needs of the young (Durán-Martín et al. 2022). [ESP] • Lack of specialized services and the limited capacity of existing services are barriers that young women face (Bundock et al. 2020) when they solicit support from social and/or health services. [ESP]
Roma as victims	**Barrier 1**: Due to discrimination, distrust and poor socio-economic living conditions Roma women in Hungary are less likely to seek help or are offered support due to DV. These women are particularly disadvantaged in receiving protection from DV. (HRW 2013.) [HUN]

Table 5: Organisational performance and the quality of service provided to the victims of DV

Victims in general	**Policy tools** *Strategic planning* Barrier1: Not all sub-state authorities (regions, municipalities, etc.) have action plans or strategic policy documents to develop DV prevention and mitigation as well as inter-agency co-operation. Some sub-state authorities have filled this gap by introducing their own local strategies. (GREVIO 2022.) [DEU] **Barrier 2**: Lack of continuity in DV programmes. [ESP] **Barrier 3**: Lack of evaluation of DV policies (Sénat 2019; Assemblée Nationale 2019). [FRA] *Training* **Barrier 1**: Lack of training of first line responders on other forms of violence than physical violence. Specialised training is not mandatory (Schellong 2019). [DEU] **Barrier 2**: The training provided in initial and in-service training is too basic. (Rasch et al. 2020) [DEU] **Barrier 3**: Not enough training manuals and guidelines made available to first line responders and service managers. [DEU] **Barrier 4**: Not enough evaluation of how training and guidelines are applied in the workplace. [DEU] **Barrier 5**: Training does not sufficiently address inter-agency cooperation. The development of training material does not sufficiently involve all stakeholders. [DEU]
	Organisational capacities **Barrier 1**: Lack of procedures and capacities to deal with children accompanying victims [DEU] **Barrier 2**: The organisation does not provide sufficient psychological assistance to its staff who have to deal with DV victims (Rasch et al. 2020). [DEU] **Barrier 3**: Lack of information sharing within the organisation. [FRA]
	Work practices *Management of organisational activities regarding DV* **Barrier 1**: Lack of regular evaluation of activities concerning DV (Schellong 2019; Schellong et al. 2021; Maquibar et al. 2017). [DEU, ESP] **Barrier 2**: Lack of regular assessment of the performance and impact of services provided (Brzank 2022). [DEU] **Barrier 3**: Lack of internal guidelines to deal with DV's cases (Rasch et al. 2020; Brzank 2022). [DEU] **Barrier 4**: Frontline agents are not sufficiently encouraged by their organisation to detect DV. [FIN, ESP]

	Barrier 5: Staff dealing with DV cases do not receive enough support from managers (Husso et al. 2021). [FIN, ESP] *DV detection* **Barrier 1**: Not enough is done to detect violence. First line responders do not systematically proceed to a targeted questioning of persons suspected of - or identified as - being victims of DV (screening for violence), with the exception of LEAs. (Husso et al. 2021.) [DEU, FRA, FIN] **Barrier 2**: Staff is left to decide individually whether to ask questions about violence. [DEU] **Barrier 3**: Not enough is done to detect psychological harassment and digital violence. [FRA, FIN] **Barrier 4**: Not enough follow-up visits at victim's home when a DV situation has been reported. **Barrier 5**: The question of living together with children is not systematically asked. **Barrier 6**: Lack of evaluation of the situation of the victim's children [DEU]. *Information and guidance of victims* **Barrier 1**: The organisation does not provide sufficient or adequate information in easy-to-understand language to victims on their rights and on available support services. [DEU, FRA] *Quality of the support provided to the victim* **Barrier 1**: The provision of services is too slow (Durán-Martín et al. 2022). [ESP] **Barrier 2**: Service intervention is not deemed necessary if no visible injuries [DEU, FIN]. An action is only initiated if the victim has suffered serious damage. (Röntynen 2021.) [FIN] **Barrier 3**: The organisation cannot provide victims with the possibility of dealing with an agent of the gender of their choice (Rasch et al. 2020). [DEU] **Barrier 4**: The organisation cannot provide enough confidentiality when its agents are interacting with victims of DV (Döge 2012; Schouler-Ocak et al. 2017, Rasch et al. 2020; Hackenberg et al. 2021; Durán-Martín et al. 2022; Centre Hubertine Auclair 2019). [DEU, FIN, ESP, FRA] **Barrier 5**: The bureaucratic procedures are too cumbersome and complicated to the victim (Schouler-Ocak et al. 2017). [DEU] **Barrier 6**: Not sufficient concern for the protection of the victim's children. In case of violence happening in the family children might face influence and retaliation by the intervention of FLR's. (Garai 2019.) [HUN, ESP]

Inter-agency cooperation

Barrier 1: Inter-agency cooperation is underdeveloped

- Lack of coordination between stakeholders, leading to various kinds of inconsistencies. Lack of proper coordinating bodies or mechanisms. [DEU, HUN]
- Inter-agency cooperation is not sufficiently developed, even when it is required by law (Nägele et al. 2009; Potkanski-Palka 2021). [DEU, AUT, ESP]
- Not enough standards, guidelines, and models for inter-agency cooperation [DEU]
- Lack of information sharing between stakeholders involved in handling a victim's case (Ministère de la Justice 2019). [DEU, FRA, HUN]
- Lack of interactions between organisations, especially legal stipulations are lacking. Missing feed-back loops. (Sorgo 2013.) [AUT]
- Lack of cooperation with care providers, including the provision of services, peer-consultation, and training (Amesberger & Haller 2016). [AUT]

Barrier 2: Not enough one-stop shops as required by the Istanbul Convention (Sénat 2018). [DEU, FRA]

Barrier 3: Lack of clear division of responsibilities between the different first line responders with regard to the follow-up of the victims. [DEU]

Police

Barrier 1: The police often do not report cases as intimate partner violence and discourage victims to report DV and request the victim to report the crime, although officially the police must investigate by law (Héra 2022; Garai 2019). [HUN]

Barrier 2: The police are too overburdened to pay enough attention to DV [DEU, HUN].

Barrier 3: Variable quality of the work of taking complaints (Centre Hubertine Auclair 2019). [HUN, FRA]

Barrier 4: Time taken to investigate is too long (Gendarmerie Nationale 2021). [FRA]

Barrier 5: Not enough internal control of police investigations of DV cases (Gendarmerie Nationale 2021). [FRA]

Barrier 6: The police officers are not sufficiently trained to sensitive questioning that prevent secondary victimization and facilitate to build up trust with the victim [DEU, HUN, ESP, FRA] (HRW 2013; Durán-Martín et al. 2022; HCE 2020)

Barrier 7: Police officers Police officers tend to have a victim-blaming attitude (Nagy et al. 2020). [HUN] They have discriminatory attitudes towards minority groups (Durán-Martín et al. 2022). [ESP]

Barrier 8: The police fail to give proper information and guidance to the victim (Centre Hubertine Auclair 2019; Assemblée Nationale 2019). [FRA]

Barrier 9: The police fail to properly assess the risk to the victim. [FRA]

Barrier 10: The police fail to properly detect other forms of violence than physical violence and detect aggravating circumstances (Centre Hubertine Auclair 2019; Sénat 2018). [FRA]

Barrier 11: The police fail to take prompt action and adequate measures to protect the victim. Existing protection mechanisms such as restraining orders are under-

	utilised or poorly implemented (Müller et al. 2004; HRW 2013; Héra 2022; Solt 2022; Hornyik 2020; Ministère de la Justice 2019; HCE 2020; Gendarmerie Nationale 2021; Centre Hubertine Auclair 2019) [DEU, FRA, HUN, FRA] **Barrier 12**: The police do not take adequate measures to manage the risk posed by the perpetrator [DEU, HUN, FRA] **Barrier 13**: Not enough psychologists and social workers work in association with the police in dealing with victims (Sénat 2021). [FRA] Lack of multidisciplinary teams (Durán-Martín et al. 2022; Assemblée Nationale 2019). [ESP, FRA] **Barrier 14**: The use of injunctions and restraining orders are not adequate in contexts where abuse is perpetuated by caretakers and victims are dependent on care. As such, police are less likely to intervene. (Amesberger & Haller 2016). [AUT] **Barrier 15**: Police does not sufficiently make use of translators. Sometimes relying on ad-hoc solutions for translations, such as online translators. This can disadvantage victims of DV, especially where perpetrators do speak the national language. (Amesberger & Haller 2016; Homberger & Güntner 2022) [AUT] **Barrier 16**: Victims of DV who suffer from problems with addiction or mental health problems can be perceived as less trustworthy and reliable by police. This tends to be more pronounced where mental health problems impair cognitive abilities, as well as where diagnoses are documented. (Amesberger & Haller 2016). [AUT]
	Courts **Barrier 1**: Court proceedings are too long. [HUN] **Barrier 2**: Victim is not adequately protected during the entire duration of court proceedings (HRW 2013; Hornyik 2020). [HUN] **Barrier 3**: Civil proceedings are underutilized. [DEU] **Barrier 4**: It is too complicated to get compensation for damages, pain, and suffering (Sénat 2018). [DEU, FRA] **Barrier 5**: Courts and prosecutors do not always inform victims about the procedures and its consequences in easy-to-understand language. [FRA, AUT] **Barrier 6**: Court proceedings are not organised in such a way to limit the stress suffered by victims (for example during confrontations with the perpetrator or caused by accusations of guilt and attacks by the perpetrator's defence lawyers or attorneys). [DEU] **Barrier 7**: The motivation of the sentence for the perpetrator does not sufficiently consider the sensitivity of the victim. [DEU] **Barrier 8**: Court sentences are excessively lenient. (HCE 2020; Garai 2019). Court sentences tend to place part of the responsibility for the violence on the victim (Jouanneau 2019). [FRA, HUN] **Barrier 9**: Lack of monitoring of perpetrators by probation services (Ministère de la Justice 2019). [FRA]

	Hospital emergencies & Health Services **Barrier 1**: Lack of trained personnel (Coll-Vinent et al. 2008; Lancharro-Tavero et al. 2022; Murillo et al. 2018). [DEU, ESP] **Barrier 2**: The training provided in initial and in-service training is optional. [DEU] **Barrier 3**: Lack of standardised patient management procedures and care paths that include identification of victims, evaluation of their situation (risk assessment), medical care, documentation of injuries and referral to the appropriate support services (Hackenberg et al. 2021; Sénat 2018). [DEU, FIN, HUN, ESP, FRA] **Barrier 4**: Lack of knowledge of existing policies and protocols. [ESP] **Barrier 5**: How and to what extent addressing DV is left to staff's discretion (Lancharro-Tavero et al. 2022). [ESP] **Barrier 6**: Lack of recognition of staff who are specifically in charge of responding to DV issues. [ESP, FRA] **Barrier 7**: Lack of a systematic detection policy (Hackenberg et al. 2021; Ministère de la Justice 2019). [DEU, FIN, ESP, FRA] **Barrier 8**: Lack of human, time, and technical resources to pay enough attention to DV detection (Löbmann & Herbers 2004; Schellong 2019; Brzank 2022: Lancharro-Tavero et al. 2022) [DEU, ESP] Working conditions are too poor for staff to be involved in the support of victims of DV. [ESP, FRA] **Barrier 9**: Staff are more likely to detect violence among disadvantaged segments of population. [DEU] **Barrier 10**: Health professionals do not systematically report to other stakeholders DV situations they have detected even if it were possible and necessary (Assemblée Nationale 2019). [FRA] **Barrier 11**: Lack of clear mandate for action in cases of DV detection (Brzank 2022). [DEU, HUN] The decision to do something is left to the staff individually. [DEU, ESP] **Barrier 12**: The detection of a case does not systematically lead to specific action, even if the victim is in serious danger (Hackenberg et al. 2021; Röntynen 2021). [FIN] **Barrier 13**: Lack of resources to properly deal with identified victims. [DEU] High waiting times. [FRA] **Barrier 14**: Lack of psychological care capacities (Rasch et al. 2020). [FRA, DEU] **Barrier 15**: The service fails to take adequate measures to provide information, guidance, and support to the victim. [DEU, HUN, ESP] **Barrier 16**: Lack of adequate support to victims of rape by an intimate partner. [FRA, HUN] **Barrier 17**: The service fails to take adequate measures to protect the victim (Hornyik 2020). [FRA, HUN] **Barrier 18**: Patients suspected of being victims are not systematically cared for without the presence of accompanying persons when DV is suspected. [DEU]

	Barrier 19: The service fails to take adequate measures to protect and provide support and care for the victim's children (Berthier & Karzabi 2021). [FRA, ESP] **Barrier 20**: Gaps in the production of forensic documentation that is usable in courts. [DEU, HUN, ESP]. Some emergency departments leave it to individual staff to decide whether to offer forensic documentation beyond regular medical documentation. **Barrier 21**: The organisation does not have the capacity to securely archive evidence (Rasch et al. 2020). [DEU] **Barrier 22**: Medical services are not sufficiently involved in inter-agency cooperation. [DEU] *Liberal general health practitioners* **Barrier 1**: Liberal general practitioners do little to detect violence and to provide information and guidance to identified victims. [DEU, FIN, AUT, HUN] They don't ask questions about experiences of violence as part of the medical history protocol on a routine basis. [DEU] **Barrier 2**: Liberal general practitioners are not sufficiently trained, so that they don't feel sufficiently qualified to adequately diagnose DV, assess its seriousness and address the situation. They are not able to provide early detection and to refer victims to relevant counselling and support services. [DEU, FRA] **Barrier 3**: Reporting of DV by health professionals is insufficient. [FRA]
	Social services **Barrier 1**: Not enough financial support is provided to the victims. [FRA] **Barrier 2**: Not enough support services to victims' children (HCE 2020; Assemblée Nationale 2019). [FRA] **Barrier 3**: Lack of psychological support capacities in social services (Nublat & Karzabi 2017). [FRA] **Barrier 4**: Child protection is not sufficiently committed in detecting DV (Berthier & Karzabi 2021). [FRA]
	Victim support NGOs **Barrier 1**: The fragmentation of funding sources, many of which do not ensure long-term funding, requires service providers to invest significant amounts of their time into applying for their funding, taking away precious time from their core activities. [DEU] **Barrier 2**: There are not enough professional first line responders and too many unpaid volunteers to deliver the support services, due to lack of funding. (DEU) Some shelters are understaffed. [DEU] **Barrier 3**: The supply of support services is insufficient to meet the demand, due to lack of funding, especially for smaller specialist NGOs addressing the needs of a specific vulnerable group [DEU] **Barrier 4**: There are not enough nationwide binding quality standards regarding shelters' personnel, premises, and operation.

	Shelters **Barrier 1**: Stay in the shelter must be paid partly or completely by the victim herself (when the victim is not entitled to social benefits). [DEU] **Barrier 2**: Some victims who need emergency shelter are sent to a homeless shelter, while emergency accommodation for the homeless is not suitable for women victims of violence [DEU]. **Barrier 3**: Social Services offers might interfere with welfare offers in some federal states. Victims living in shelters might lose their right to other welfare services, such as welfare payments. This forces some victims to decide between shelter-services or welfare payments. (Amesberger & Haller 2016). [AUT] **Barrier 4**: Funding for support services for some victims is lacking. Especially, migrants in precarious living conditions are often barred from accessing follow-up or additional support. Here, private donations partially help bridge funding gaps should state funds not cover support for these victim survivors. (Homberger & Güntner 2022). [AUT]
All vulnerable victims	**Barrier 1**: Staff's perception of DV is imbued with various stereotypes regarding gender roles and ethnicity (Löbmann & Herbers 2004; Schröttle & Khelaifat 2008; Hackenberg et al. 2021; Briones-Vozmediano et al. 2014a; Darley & Gauthier 2014). [DEU, FIN, ESP, FRA] **Barrier 2**: Lack of in-depth training of first line responders on how to deal with each of the different vulnerable groups, and on how to deal with victims of intersectional discrimination, with the exception of NGOs. [DEU] **Barrier 3**: Lack of strategy, standard procedure, and protocols in support services to deal with each of the different vulnerable groups (Sénat 2019). [FRA] **Barrier 4**: Lack of inclusion of victim support NGOs oriented towards supporting a particular vulnerable group in inter-agency cooperations. [DEU] **Barrier 5**: The organisation has no specific services adapted to the needs of the various vulnerable groups (Nägele et al. 2009; Schröttle et al. 2011; Rasch et al. 2020; Brzank 2022; Nublat & Karzabi 2017). [DEU, FRA] **Barrier 6**: Not enough space, infrastructural conditions, and adapted services in shelters for victims from vulnerable groups with special needs (Nägele et al. 2009; FHK 2021). [DEU] **Barrier 7**: There are not enough counsellors who are aware of the specific needs of the various vulnerable groups. [DEU] **Barrier 8**: Their staff lack respect and empathy with such victims (Schröttle et al. 2011; Schouler-Ocak et al. 2017). [DEU] **Barrier 9**: Shelters' lack of resources to deal with trauma of traumatized women (and their children) (BMFSFJ 2022). [DEU]
Older victims	**Barrier 1**: Services are primarily oriented towards the younger and middle-aged victims [DEU]

	Barrier 2: Specialised services for the elderly have not enough concern for combating DV and do not have sufficient skills and capacities (Nägele et al. 2009; Salminen-Tuomaala et al. 2022). [DEU, FIN] **Barrier 3**: Service professionals find it difficult to understand that the victim prefers to continue to live with her abusive partner, who is at the same time her long-term caregiver (Nägele et al. 2009). [DEU]
	Police **Barrier 1**: In rural areas, police officers are more likely to dismiss reports of DV as mere marital issues (Amesberger & Haller 2012). [AUT]
	Courts **Barrier 1**: Reluctance to separate a victim from a perpetrator who is at the same time the victim's permanent caregiver. Reluctance to issue restraining orders. (Nägele et al. 2009.) [DEU] **Barrier 2**: Criminal justice system tends not to prosecute violence in domestic care relationships very often [DEU]
	Hospital emergencies & Health care **Barrier 1**: Home care and home nursing services prefer not to intervene when they detect a DV situation. This is the case especially when the abusive partner is at the same time the main caregiver. Situations of concern are not systematically reported to proper stakeholders. (Salminen-Tuomaala et al. 2022.) [FIN] **Barrier 2**: Staff finds it difficult to distinguish between the consequences of DV and the illnesses / disability of the victim (Löbmann & Herbers 2004). [DEU]
	Shelters **Barrier 1**: Accommodation is not suitable for the specific needs of the elderly, particularly those with health and functional limitations [DEU]
Victims with children	**Courts** **Barrier 1**: The custody of children and visiting rights may jeopardize the safety of children (Berthier and Karzabi 2021; Assemblée Nationale 2019). [FRA] **Social services** **Barrier 1**: Child protection services are reluctant to cooperate with DV stakeholders. [FIN, AUT] **Shelters** **Barrier 1**: Not enough shelters equipped for comprehensive childcare (social workers, play corner, technical equipment, etc. (Berthier & Karzabi 2021). [DEU, FRA] Women with older (teenage) sons cannot enter the shelter (BMFSFJ 2022). [DEU] **Barrier 1**: Support services do not have enough resources to offer children qualified and gender-specific activities during their stay (BMFSFJ 2022). [DEU]
Victims with disability or impairment	**Barrier 1**: Many services do not have sign language interpreters (Schröttle et al. 2011). [DEU, AUT] **Barrier 2**: Many services do not have adequate infrastructural conditions for disabled. [DEU, AUT]

	Barrier 3: Weak protection measures against violence in institutions housing persons with disabilities, while women living in such institutions are particularly at risk. [DEU] **Barrier 4**: Group leaders and contact persons in care institutions often have insufficient qualifications in dealing with violence. Obstacles to report are insufficient seriousness and dependence on the workshop management or group leaders. (Schröttle et al. 2021.) [DEU]
Migrant and refugee victims	**Barrier 1**: Lack of services that are adapted to the cultural needs of the victim. Lack of intercultural skills in the organisation's staff. (Briones-Vozmediano 2014a.) [ESP] **Barrier 2**: Lack of resources for professional language mediation and trained translators (Pozo-Triviño & Toledano-Buendía 2017). [DEU, ESP] Victim's right of information cannot be not guaranteed when there is a language barrier (Antón García 2014). [ESP] **Barrier 3**: Supporting migrant victims is not a priority for stakeholders and public policies, although this type of victim is on average more likely at risk and needs more assistance to be protected from DV (Briones-Vozmediano et al. 2014a, 2014b). [ESP] **Barrier 4**: Public officials dealing with asylum procedures are not sufficiently trained to detect DV and to refer victims to appropriate support service. [DEU] **Barrier 5**: Women have to leave their assigned place of residence for security or capacity reasons. This is associated with lengthy redistribution applications that can take several weeks or months. During this period, it remains unclear who is responsible for the financing of services, whether the women are allowed to resettle and where social benefits can be applied for. (BMFSFJ 2022.) [DEU] **Barrier 6**: Necessary to make formal services more accessible to immigrant women, since this group has a higher prevalence of IPV and probably suffers from more severe cases, given that their probability of being killed due to IPV is five times greater than that of Spanish women (Sanz-Barbero et al. 2014). [ESP]
Victims in remote or rural areas	**Barrier 1**: Stakeholders tend to regard DVs as a normal thing in many rural communities, to see DV as mere family dispute, or to minimise the seriousness of DV. [AUT, FIN] **Barrier 2**: Due to limited resources in FLR organisations, it is difficult to control implementation of protective measures (restraining orders, etc.) [DEU] **Barrier 3**: It is difficult to reach services in rural areas. There is a lack of counselling on DV. Often women have to travel far away to receive specialized counselling. Yet, while many women do not own a car, public transportation in rural areas is not easily available. Although some violence counselling centres offer decentralized counselling, fixed counselling hours are an exception. In rural areas, seeking counselling is therefore only possible with an effort by the victims. (BMFSFJ 2022.) [DEU]
Homeless victims	**Barrier 1**: Access for homeless women affected by violence is often difficult, since women without a registered address often cannot be admitted to services due to financing rules (BMFSFJ 2022). [DEU]

Victims with substance abuse issues	**Barrier 1**: Training gap on the double burden of violence and a problematic use of addictive substances. [DEU] **Barrier 2**: Support services are not adapted to the needs of victims with addiction. [DEU] **Barrier 3**: Not enough coordination between first line responders and youth welfare services, so that mothers with addiction fear losing the custody of their children or children's safety is jeopardized. [DEU] **Barrier 4**: Mentally ill and addicted women often cannot be admitted to women's shelters if they cannot manage their daily lives independently and/or if safety cannot be guaranteed (BMFSFJ 2022). [DEU]