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Avaliação do risco nas perícias médico-legais de inimputáveis

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Resumo

A avaliação do risco é parte integrante necessária da perícia médico-legal para determinação de (in)imputabilidade, e influencia não só a decisão do julgador como o melhor tratamento da pessoa. Esta avaliação deve basear-se em medidas objectivas. O presente trabalho procurou determinar a percentagem de perícias que continha alguma destas medidas, referentes a indivíduos internados ou à espera de internamento num serviço de internamento de inimputáveis (*n*=124). Concluiu-se que a utilização de instrumentos de avaliação de risco específicos é ainda muito baixa no nosso país (2.4% para a avaliação de risco global e psicopatia, 1.6% no que concerne à impulsividade, e 0.8% relativamente à agressão ou reacção à frustração). As implicações destes achados são analisadas à luz da evidência mais recente nesta matéria.

Palavras-chave: Perícia; violência; risco; psicopatia; instrumentos

Introdução

A relação entre criminalidade e doença mental grave tem ocupado um lugar central na investigação nas mais variadas disciplinas. Ainda que a ligação entre doença mental e violência ou criminalidade esteja empolada pela comunicação social sensacionalista, existe uma correlação, embora baixa, entre psicose e criminalidade, nomeadamente violenta (Wehring & Carpenter, 2011). Também se sabe que uma elevada percentagem de doentes mentais exibe nalgum momento comportamentos agressivos (até 20% de admissões ao serviço de urgência psiquiátrica são motivados por agressividade – Siever, 2008). Assim, é importante compreender esta relação, no sentido de optimizar as intervenções terapêuticas, tanto do ponto de vista do doente como da sociedade.

No momento actual, reconhece-se que, mais do que propriamente a psicopatologia aguda, são os traços psicopáticos de personalidade que condicionam a existência de comportamentos criminosos, e nomeadamente violentos (Wallinius et al., 2012). Neste contexto, são frequentes as histórias pregressas marcadas por privação socio-económica e um distúrbio da conduta presente desde a adolescência (Fazel, 2012), tal como se verifica em relação aos criminosos sem doença mental (Aebi ei al., 2014).

Assim sendo, não surpreende que as diferentes metodologias para avaliação de risco de indivíduos considerados inimputáveis perigosos reflictam de forma preponderante estas variáveis (Lourenço & Vieira, 2017), no sentido de auxiliar a avaliação jurídica de perigosidade, já que é a existência desta que, em princípio, determina a necessidade de cumprimento de medida de segurança privativa da liberdade (tendo em conta que, por princípio, um inimputável, isento de culpa, não poderá cumprir "pena", e só se justifica a sua privação de liberdade se houver perigo para bens de valor jurídico).

Num sistema judicial como o português, em que a prova pericial se presume "subtraída à livre apreciação do julgador", segundo o artigo 163º do Código de Processo Penal, a

correcta avaliação do risco de violência ou reincidência torna-se ainda mais relevante, sendo que, segundo alguns estudos (Melamed, 2010), a tendência é para sobre-estimar este mesmo risco, com as implicações negativas do ponto de vista ético que tais práticas acarretam. Por outro lado, o tipo de regime mais adequado a cada inimputável e medidas tendentes à sua reabilitação e reinserção social vai depender do perfil do mesmo, nomeadamente quanto aos factores de risco estáticos e dinâmicos que apresentam (Melamed, 2010), que devem ser desejavelmente conhecidos o mais precocemente possível, tendo em conta que o seu internamento apenas dura, em princípio, salvo as excepções previstas na lei, o tempo que perdurar a perigosidade.

Assim, para minimizar a subjectividade inerente a uma avaliação deste tipo, optimizando a probabilidade de uma prognose correcta, têm sido desenvolvidos, nas últimas décadas, modelos e protocolos de actuação para avaliação do risco de violência (Nicholls et al., 2004). Estão actualmente vigentes as avaliações segundo o modelo do juízo profissional estruturado, o qual procura integrar factores de risco estáticos e dinâmicos, e, assim, ser mais útil de um ponto de vista clínico e reabilitativo (Lourenço & Vieira, 2017). Exceptuando situações mais específicas, com métodos de avaliação próprios (crimes sexuais, violência doméstica, etc. – Lourenço & Vieira, 2017), o instrumento mais frequentemente utilizado, cuja utilidade foi extensamente apreciada em muitos estudos (Völlm et al., 2018a) é o *Historical Clinical Risk 20*: HCR-20 (Webster et al., 1997). Trata-se de uma *checklist* composta por todas estas variáveis, para utilizar com doentes psiquiátricos, que permite de forma sistemática percorrer todos os principais campos da análise do risco de comportamento inconforme às normas sociais, e assim melhor auxiliar na avaliação jurídica de perigosidade. Novamente, e de acordo com a investigação de Bo et al. (2013), mais do que a doença mental, são factores da personalidade a ter preponderância, fazendo inclusivamente parte

deste instrumento uma avaliação formal da psicopatia (*Psychopathy Checklist – Revised*: PCL-R – Hare, 2003).

A este propósito, um estudo recente (Krakowski & Czobor, 2018) propõe uma metodologia interessante para ilustrar esta realidade, estudando o contributo da psicopatologia versus traços psicopáticos em relação a comportamentos criminais (apenas violentos): compara os níveis de psicopatia (e outros traços facilitadores de violência) entre quatro grupos – i) indivíduos com história de agressão física, sem esquizofrenia; ii) esquizofrénicos com história de agressão física; iii) esquizofrénicos sem história de agressão física; iv) indivíduos sem história de agressão física nem doença mental. Conclui que os traços psicopáticos (medidos pela versão curta da PCL-R) se distribuem num contínuo ao longo dos quatro grupos, mais altos no primeiro e mais baixos no último, apontando para a probabilidade de a doença mental, de facto, poder baixar o limiar para a violência, em níveis mais baixos de psicopatia, mas sendo esta um factor determinante na sua génese.

Por outro lado, a própria psicopatia é ainda um conceito algo controverso. Define-se habitualmente como um construto que engloba características como a procura de dominância, crueldade, manipulação, violência predatória, comportamento impulsivo e inconsequente, falta de reactividade emocional e indiferença afectiva (Soderstrom et al., 2005). Não é, todavia, reconhecida como uma entidade diagnóstica, ao contrário do que acontece com a Perturbação de Personalidade Antissocial - PPAS (American Psychiatric Association, 2013), com a qual partilha numerosas características. A PPAS existe sempre num indivíduo psicopata, e, segundo alguns (Coid & Ulrich, 2010), a psicopatia corresponde a um extremo de gravidade da PPAS. Contudo, noutra perspectiva, mais comummente aceite (Ogloff, 2006) a psicopatia difere da PPAS por conter mais informação sobre o funcionamento psicológico do indivíduo, ao basear-se não essencialmente em aspectos comportamentais, mas também interpessoais/afectivos, no que concerne aos défices ao nível da empatia cognitiva (Jones et

al., 2010). Desta forma, uma avaliação da personalidade que conclua pela existência de uma PPAS não garante a presença de psicopatia. Nas últimas décadas, a investigação científica em torno da psicopatia tem sido abundante, sobretudo após a operacionalização do constructo na PCL-R (Gonçalves, 2017). Os resultados dos diferentes trabalhos demonstram a preponderância dos traços psicopáticos na génese de comportamentos criminosos em doentes mentais, incluindo esquizofrénicos, os quais constituem uma fatia importante dos indivíduos considerados inimputáveis perigosos.

Apesar das recomendações no sentido desta avaliação estruturada, a literatura referente à metodologia de avaliação utilizada nas perícias médico-legais para determinação de risco de violência dos inimputáveis mostra uma realidade bem diferente: numa amostra de 60 perícias médico-legais de homicidas inimputáveis de três países da Escandinávia, apenas 4 (6.7%) reportavam resultados da HCR-20, e 8 (13.3%) da PCL-R (Grøndal, 2005). Em Portugal, tanto quanto os autores têm conhecimento, não existem dados sobre esta realidade.

Objectivos

No sentido de melhor ilustrar a realidade portuguesa quanto à avaliação psicométrica do risco de comportamentos criminosos no momento da perícia médico-legal com vista à determinação da (in)imputabilidade, os autores propuseram-se analisar as perícias médico-legais dos indivíduos a cumprir medida de segurança no Serviço de Internamento de Inimputáveis da Unidade de Psiquiatria Forense (SII-UPF) do Centro Hospitalar e Universitário de Coimbra (CHUC), bem como aquelas referentes aos que se encontravam a aguardar vaga de internamento e estavam disponíveis no secretariado deste mesmo serviço.

Método

Foram analisadas todas as perícias disponíveis no SII-UPF do CHUC, referentes a todos os indivíduos aí internados e todos os processos de doentes a aguardar vaga que se encontravam no serviço entre os dias 9 e 17 de Agosto de 2018. Foram anotados: i) o género do indivíduo; ii) a idade à data da perícia; iii) o ano em que a perícia foi realizada; iv) a delegação do Instituto Nacional de Medicina Legal e Ciências Forenses (INMLCF) a que pertencia o instituto onde foi realizada; v) o diagnóstico enunciado na perícia; vi) os instrumentos de avaliação neuropsicológica utilizados. Não foram definidas, à partida, as classes dentro de cada variável, sendo a base de dados inicialmente preenchida com os nomes das escalas encontradas na análise das perícias. Nos casos em que não foi possível encontrar a perícia médico-legal, procurou-se esclarecer a razão da inexistência da mesma no serviço, no sentido de minimizar vieses, e esta foi igualmente descrita, quando encontrada.

Os dados foram posteriormente coligidos e tratados estatisticamente em Excel e apresentam-se em valores absolutos e percentuais, tratando-se de um estudo descritivo sem colocação de hipóteses a priori de comparação entre grupos.

Resultados

De um total de 150 processos analisados, obtivemos uma amostra de 124 perícias médico-legais - 26 processos (17.3% do total) não continham o relatório pericial, conforme se encontra detalhado no esquema da Figura 1.

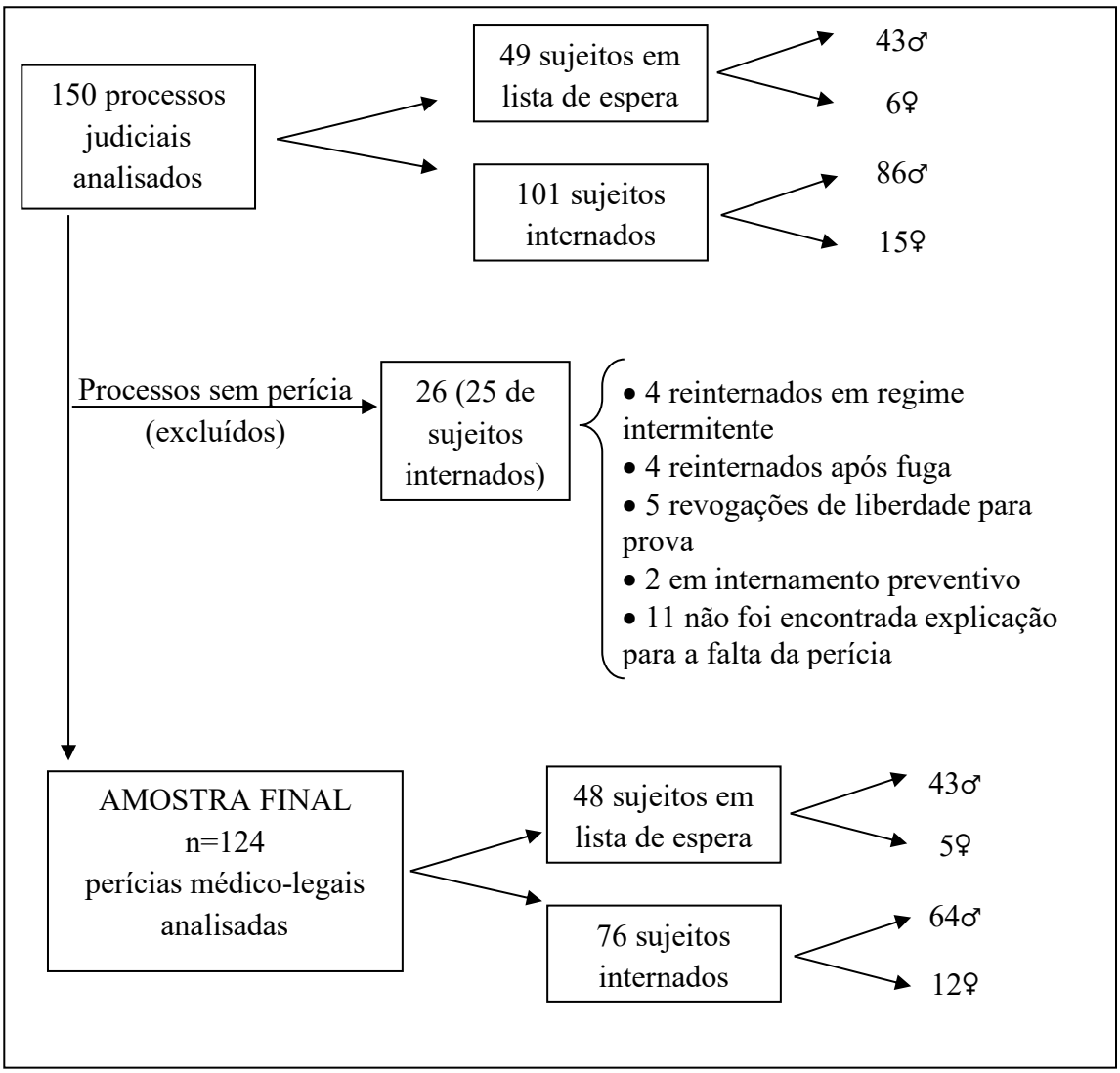

Figura 1: Representação esquemática da obtenção da amostra final a partir da análise dos processos judiciais de todos os sujeitos internados e em lista de espera para internamento na UPF do CHUC, à data da realização do estudo.

Relativamente às perícias analisadas, correspondentes a 76 sujeitos internados e 48 em lista de espera, obteve-se uma média de idades (à data em que foi feita a perícia) de 40.7±13.8 anos (com idades compreendidas entre os 17 e 81 anos), com uma predominância de homens (86.3%). Os diagnósticos principais preponderantes eram os de esquizofrenia (36.3%) e défice intelectual (35.5%), com ou sem abuso de substâncias associado. A maioria (89.5%) dos exames periciais realizou-se após 2009, e a distribuição entre delegações do INMLCF foi bastante equitativa, como pode comprovar-se pela análise da Tabela 1.

Tabela 1

Características selecionadas referentes às 124 perícias médico-legais analisadas. Siglas: PHDA – Perturbação de Hiperactividade e Défice de Atenção; TCE – Traumatismo Craneo-Encefálico.

Características da amostra			
Variável	Classe	*n*	%
Ano da perícia	<2000	1	0.8
	2000-2009	11	8.9
	2010-2014	41	33.1
	≥2015	70	57.2
Delegação INMLCF	Norte	40	32.3
	Centro	50	40.3
	Sul	34	27.4
Diagnóstico (na perícia)	Défice intelectual	24	19.3
	Défice intelectual + Abuso de substâncias	20	16.1
	Depressão	2	1.6
	Demência	6	4.8
	Esquizofrenia	25	20.2
	Esquizofrenia + Abuso de substâncias	20	16.1
	Perturbação bipolar	3	2.4
	Perturbação delirante	12	9.7
	Perturbação esquizoafectiva	3	2.4
	Perturbação de personalidade pós-TCE	3	2.4
	PHDA	1	0.8
	Psicose não especificada	2	1.6
	Psicose tóxica	3	2.4

Relativamente ao objectivo do estudo, verificou-se que em apenas três das perícias (2.4% da amostra) foi possível encontrar uma avaliação formal da psicopatia (preenchimento da PCL-R), no contexto da avaliação mais abrangente do risco (com a HCR-20). Duas realizaram-se na zona sul, e uma na zona centro, e todas são posteriores a 2015. Dessas perícias, uma corresponde a um indivíduo com uma perturbação delirante, e as outras duas a esquizofrénicos (um com abuso concomitante de substâncias).

Dois outros exames periciais foram efectuados recorrendo a medidas de impulsividade (Escala de Impulsividade de Barratt - EIB) e um utilizou o Questionário de Agressão Buss Perry (QABP). Por outro lado, verificou-se que a avaliação global da personalidade foi significativamente mais comum, totalizando 33 ocorrências. Note-se que, frequentemente,

mais do que um instrumento era utilizado no mesmo indivíduo, sendo a personalidade avaliada psicometricamente apenas num total de 21 perícias (16.9% da amostra).

Os testes mais frequentemente incluídos nas perícias foram os de avaliação das capacidades cognitivas, em 40 casos (32.2%), perfazendo um total de 44 testes. Na Tabela 2 pode consultar-se a informação relativa aos testes psicométricos identificados.

Tabela 2
Instrumentos de avaliação utilizados nas 124 perícias médico-legais analisadas.

Instrumentos de avaliação utilizados nas perícias			
Domínio	Teste	*n*	%
Cognição	WAIS-III	28	22.6
	MPR	12	9.7
	MoCA	2	1.6
	ACE-R	2	1.6
Personalidade	MMPI	15	12.1
	MCMI-II ou III	9	7.2
	Teste de Rorschach	5	4.0
	TAT	2	1.6
	IPE	5	4.0
	IAP	1	0.8
Psicopatologia	SCL90-R	6	4.8
	BSI	4	3.2
	ZungSAS	3	2.4
Específicos de risco	HCR-20 (inc. PCL-R)	3	2.4
	EIB	2	1.6
	QABP	1	0.8
	TFR	1	0.8
Outro	23QVS	1	0.8

Nota: MoCA – Montreal Cognitive Assessment; ACE-R – Addenbrook Cognitive Examination – Revised; TAT – Teste de Apercepção Temática; IPE – Inventário de Personalidade de Eysenck; IAP – Inventário de Avaliação da Personalidade; SCL90-R – Symptom Checklist 90 – Revised; BSI – Brief Symptom Inventory; ZungSAS – Zung Self-Rating Anxiety Scale; TFR – Teste de Frustração de Rosenzweig; 23QVS – Questionário de Vulnerabilidade ao Stress.

Discussão

A análise efectuada incidiu sobretudo em perícias médico-legais elaboradas recentemente, com mais de metade realizada no ano de 2015 ou subsequentemente, efectuadas em todo o território português. A amostra obtida correspondeu ao esperado num internamento forense, com predomínio dos diagnósticos de défice intelectual e psicose (Völlm et al., 2018b). Apesar das recomendações, já com cerca de três décadas (Lourenço &

Vieira, 2017), para conduzir uma avaliação estruturada do risco segundo o modelo do juízo profissional estruturado, com o auxílio de testes padronizados, como o HCR-20, esta apenas foi conduzida em 2.4% da amostra, valor ainda inferior ao do estudo escandinavo (6.7%), o qual era referente a perícias anteriores a 2001 (Grøndal, 2005).

Por outro lado, a utilização de outros instrumentos específicos de avaliação de risco não foi propriamente mais abundante: apenas em 1.6% dos casos foi utilizada uma medida de impulsividade (EIB), factor reconhecido como fortemente vulnerabilizador para manifestações agressivas (Tonnaer et al., 2016). Dois doentes foram avaliados com outros instrumentos: um com o QABP, específico para a agressividade, e outro com o Teste de Frustração de Rosenzweig (TFR), desenhado para definir o padrão de reacção à frustração, aplicável na população criminal (Ferreira & Capitão, 2013). Acresce que, tanto quanto os autores tenham conhecimento, nenhum destes instrumentos possui versão portuguesa validada, ao contrário da PCL-R (Gonçalves, 2007) e da HCR-20 (Neves & Gonçalves, 2006).

Um instrumento utilizado que se encontra validado na população portuguesa e potencialmente interessante, ainda que não haja de momento dados empíricos a suportar a sua utilidade na estimativa do risco em contexto forense, é o Questionário de Vulnerabilidade ao Stress (23QVS - Vaz-Serra, 2000), que procura elucidar acerca da propensão para reacções negativas perante o stresse, dados os factores predisponentes do sujeito.

De forma previsível, verificou-se que a maior fatia de testes neuropsicológicos realizados visava as capacidades cognitivas, no caso de 32.2% dos indivíduos periciados. Ainda que a sua utilidade seja óbvia em termos do auxílio na decisão sobre eventual inimputabilidade, a inteligência é também um factor a ter em conta no que respeita à avaliação do risco de violência e incumprimento das normas legais, sendo que um nível de funcionamento intelectual mais baixo apresenta uma correlação, ainda que fraca, com a

violência (Lourenço & Vieira, 2017), e condiciona de forma muito evidente o tipo de intervenções que pode ser efectuado no sentido de diminuir a perigosidade ao longo do internamento.

Já a avaliação da personalidade, aparentemente mais próxima da possibilidade de avaliar os traços psicopáticos, como se viu fulcrais para estimar a probabilidade de recidiva (Douglas et al., 2007), é analisada com muito menos frequência, em 16.9% da amostra. Os autores hipotetizam que tal possa dever-se ao facto de a amostra ser constituída essencialmente por indivíduos com défice intelectual e psicóticos, cuja inimputabilidade não terá sido colocada em questão, e daí não terem sido considerados necessários mais meios complementares. A ser assim, mais uma vez preocupa a apreciação pouco estruturada do risco, e o entendimento que vigora acerca da utilização de testes padronizados sobretudo para verificação da (in)imputabilidade.

Não obstante, os testes de personalidade não foram especificamente desenhados para avaliação de risco de violência, não podendo substituí-los. Mais até, podem colocar importantes problemas éticos, se a sua utilização não for criteriosa e bem fundamentada. Do ponto de vista da utilidade para a determinação da perigosidade, apenas alguns aspectos são, como se viu, importantes, sendo a maioria das dimensões de personalidade avaliadas por estes testes não dirigidos irrelevante neste contexto. Recordando que a sujeição a perícia médico-legal psiquiátrica é compulsória, segundo o nº 3 do artigo 6º da Lei nº 45/2004, não necessitando o indivíduo de dar o seu consentimento, e não sendo o resultado da perícia confidencial, mais importa limitar ao máximo indispensável a obtenção de informação passível de violar a privacidade da pessoa (Austin et al., 2009). Aliás, está salvaguardado o direito à privacidade do examinado quanto aos dados irrelevantes para o objecto da perícia (Coentre et al., 2017), o que, no entender dos autores, torna uma avaliação global da personalidade inadequada se o propósito for a avaliação do risco de violência ou

cometimento de ilegalidade, já que há instrumentos específicos testados para o fazer (Völlm et al., 2018a).

Da análise dos dados recolhidos, salienta-se, assim, a escassez de dados objectivos a fundamentar o parecer do perito, obrigatório (Vieira & Trancas, 2017), acerca da perigosidade, o que, além do já aludido risco de aumento de falsos positivos, pode comprometer a tomada de decisão acerca da melhor forma de tratamento e reabilitação de cada pessoa (Völlm et al., 2018ª), e assim aumentar o tempo de duração da medida de segurança em internamento, já que a implementação de estratégias específicas tendentes à correcção de factores de risco elencados na HCR-20, por exemplo, parece estar relacionada com uma maior probabilidade de libertação aquando da revisão da medida, segundo um estudo recente (Jewell et al., 2017).

Todavia, uma possível explicação para a baixa utilização de instrumentos de avaliação de risco, e nomeadamente da PCL-R, pode prender-se com a percentagem elevada de indivíduos com limitações cognitivas (40.3%, entre os diagnosticados com Défice Intelectual e aqueles com Demência), para os quais a validade deste teste é questionável (Völlm et al., 2018a). Também a escassez de recursos em termos de tempo e de profissionais creditados para a administração de alguns testes pode condicionar os baixos resultados encontrados. Neste ponto, e, mais uma vez, especificamente em relação à HCR-20, refira-se que a 3ª versão deste instrumento não obriga ao preenchimento da PCL-R, podendo ser completada por outras pessoas com experiência no trabalho com esta população (Lourenço & Vieira, 2017). Naturalmente, tal não exclui a pertinência da avaliação da psicopatia, contudo, foi desenvolvido mais recentemente um questionário de auto-relato (Triarchic Psychopathy Measure - TriPM – Patrick, 2010) significativamente correlacionado com a PCL-R, já validada para a população forense (Dongen et al., 2017), e que possui uma versão portuguesa

(Vieira et al., 2014), que pode constituir-se como uma ferramenta de aplicação generalizada custo-efectiva como auxiliar na determinação da perigosidade.

Numa nota positiva, é de realçar o facto de a qualidade da avaliação do risco ter vindo aparentemente a melhorar, já que a procura da sua quantificação psicométrica aconteceu sempre em perícias conduzidas nos últimos quatro anos, o que pode revelar uma crescente sensibilização para esta questão, e vir-se a assistir a uma alteração na prática pericial nos próximos anos.

O presente estudo poderá ter sido prejudicado pela impossibilidade de localizar algumas perícias (quase 20% da totalidade dos processos analisados), apesar de a maioria corresponderem a doentes periciados antes de 2015, data da primeira perícia em que surgem resultados específicos de escalas de avaliação de risco. Ainda assim, considera-se a amostra representativa da prática pericial ao longo do território português nos últimos anos, no que se refere a doentes considerados inimputáveis perigosos. Naturalmente, a principal limitação do estudo resulta do facto de não terem sido analisadas perícias médico-legais de indivíduos considerados inimputáveis, mas sem perigosidade, e que, portanto, não se encontravam a cumprir medida de segurança privativa da liberdade (ou a aguardar a mesma). Coloca-se a hipótese de a avaliação de risco ter sido preferencialmente conduzida em situações duvidosas, e resultado num desfecho diferente por ter sido considerado um risco baixo. Neste sentido, poderia ser pertinente uma análise das perícias a partir da fonte, que permitiria controlar este viés.

Adicionalmente, o facto de a literatura ser omissa neste capítulo, exceptuando o já referido artigo escandinavo (Grøndal, 2005), a comparação com outras realidades fica impossibilitada – apesar de haver múltiplos estudos acerca de avaliação de risco, nomeadamente com a PCL-R e a HCR-20 (Ramesh et al., 2018), não existem estudos que avaliem a prevalência da sua utilização em exames periciais.

Conclusão

Pesem embora as limitações metodológicas já enunciadas, o presente estudo aponta para uma não utilização de medidas psicométricas na avaliação do risco de criminalidade. Ainda que a pronúncia sobre a perigosidade possa ser acertada em todos os casos, a fundamentação mais rigorosa desta atribuição serve não só o sujeito e o julgador, como o próprio perito, até do ponto de vista da possibilidade de o indivíduo contestar a decisão, salvaguardando-se assim melhor o médico subscritor da perícia.

A aparente tendência atual para a avaliação psicométrica do risco de criminalidade era quase inexistente até ao ano de 2015. É de admitir que, não obstante a existência de factores paralelos a contribuir para esta realidade, seja a maior visibilidade e formação em psiquiatria forense dos peritos, não só com a criação da sub-especialidade, em 2015, mas com a integração desta área de formação no plano obrigatório do internato, a contribuir para este incremento na qualidade das mesmas (Santos & Saraiva, 2017).

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Risk evaluation in expert evidence reports of Not Guilty by Reason of Insanity individuals

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Abstract

Risk evaluation is an integrant part of psychiatric expert evidence to determine Not Guilty by Reason of Insanity (NGRI) status and influences not only the judge decision, but also the therapeutic and rehabilitation measures applied. This evaluation should be based in objective measures. The present study aimed to determine the percentage of expert evidence reports that used any of the tools, by analysing the reports of individuals committed or waiting admission in a forensic inpatient unit for those considered NGRI (n=124). The authors concluded that the application of specific instrument tools for risk evaluation is still very low in our country (2.4% had a global risk or psychopathic measure instrument applied, 1.6% an impulsivity tool applied and 0.8% a measure of agressivity or reaction to frustration). The implications of these results are analyzed in the light of recent evidence regarding the subject.

Key-words: Expert evidence; violence; risk; psychopathy; instruments.

Introduction

The association of criminality and severe mental illness has been the focus of several investigation projects, in multiple areas of research. Although the link between mental ilness and violence or criminality is buzzed by sensationalist media, there is a correlation, even though small, between psychosis and criminality, namely violent (Wehring & Carpenter, 2011). It is also known that a high proportion of mental patients shows, at some point, agressive behaviors (up to 20% of psychiatric emergency service admissions are caused by agressiviness – Siever, 2008). As so, it is important to understand this association, in order to optimize therapeutic interventions, to provide the best outcomes to the patient and society.

Currently, it is recognised that, more than just acute psychopathology, psychopathic traits of personality determine criminal behavior, especially violent (Wallinius et al., 2012). In this context, past personal histories of socio-economic adversity and conduct disorder in adolescence are frequent (Fazel, 2012), as also seen between criminal populations without mental illness (Aebi ei al., 2014).

As so, it is not surprising that different methodologies of risk evaluation for individuals considered Not Guilty by Reason of Insanity (NGRI) predominantly reflect these variables (Lourenço & Vieira, 2017), in order to help legal evaluation of dangerousness, as intended by the probability to repeat the same ilegal acts. It is this probability of reincidence that determines the need of a security detention measure (as, by principle, a person considered NGRI only needs to be detained if there is threat to legal interests). In the portuguese legal system, psychiatric expert evidence is presumed "subtracted to the free apreciation of the judge", as stated in the Article 163º of the portuguese Code of Criminal Procedure. Therefore, the proper evaluation of the violence risk or reincidence of criminal behavior becomes highly relevant, and some

studies point to an overestimation bias of this risk (Melamed, 2010), with the negative ethical implications that such practices entail. On the other hand, the most suitable scheme for each person considered NGRI and consequent measures for their rehabilitation and social reintegration will depend on the individual profile, namely static and dynamic risk factors of violence (Melamed, 2010), that should hopefully be defined as soon as possible, as the detention of NGRI should only take place for as long as their dangerousness endure, with the exceptions legally prevised.

Thereby, to minimize the inherent subjectivity of this type of evaluation, optimizing the probability of a correct prognosis, in the last decades there have been developed different models and acting protocols to evaluate the risk of violence (Nicholls et al., 2004). Evaluations in accordance with the professional structured judgement, that try to integrate static and dynamic risk factors and, therefore, be more useful from a clinic and rehabilitative point of view, are currently in force (Lourenço & Vieira, 2017). With the exception of very specific situations, which rely on proper methods of evaluation (sexual crimes, domestic violence, etc., Lourenço & Vieira, 2017), the most frequently utilized instrument, whose utility was extensively appreciated in several studies (Völlm et al., 2018a) is the *Historical Clinical Risk 20*: HCR-20 (Webster et al., 1997). This is a *checklist* composed with all these risk variables, to use in psychiatric patients, that allows a systematic check of all fields of antisocial behavior, to help in the expert evaluation of dangerousness. As Bo et al. (2013) noticed, personality factors are at the core of this evaluation, that thus includes a formal evaluation of psychopathy (*Psychopathy Checklist – Revised*: PCL-R – Hare, 2003).

A recent study of Krakowski & Czobor (2018) proposes an interesting methodology to illustrate this reality, investigating the contribute of psychopathology

versus psychopathic traits to violent criminal behaviors: the authors compare psychopathic levels (and other violence facilitator traits) between four groups – i) probands with previous story of physical aggression, without schizophrenia; ii) schizophrenic patients with previous story of physical aggression; iii) schizophrenic patients without previous story of physical aggression; iv) proband without previous story of physical aggression or mental disorder. They concluded that psychopathic traits (measured by the short version of PCL-R) are distributed in a continuum among the four groups, being higher in the first group and lower in the last, suggesting that psychiatric disturbances can, indeed, reduce violence threshold, although psychopathic traits are determinant for violence foundation.

Nevertheless, psychopathy is still a controversial concept. I tis commonly defined as a construct built by traits as dominance seeking, cruelty, manipulation, predatory violence, impulsive and inconsequent behavior, lack of emotional reactivity and callous unemotional traits (Soderstrom et al., 2005). However, it is not recognised as a nosological psychiatric category, as Antisocial Personality Disorder - ASPD (American Psychiatric Association, 2013), with which it shares numerous characteristics. ASPD is always present in a psychopath and, according to some authors (Coid & Ulrich, 2010), psychopathy is an extreme of ASPD severity. Notwithstanding, other authors consider psychopathy a distinct category from ASPD (Ogloff, 2006), which englobes more information about the psychological functioning of the individual, based on interpersonal and affective facets related to cognitive empathic deficits and not only in behavioral facets (Jones et al., 2010). Therefore, a personality evaluation that conclude for the existence of an ASPD, does not conclude for the presence of psychopathy. In the last decades, scientific investigation concerning psychopathy has been abundant, especially after the operationalization of the construct in the PCL-R (Gonçalves, 2017).

Results of various reports show a predominance of psychopathic traits in the origin of criminal behaviors in psychiatric patients, including schizophrenic patients, an important part of those considered NGRI and dangerous.

While in theory most authors point to the need of a structured evaluation of violence risk, the published literature concerning evaluation methods used in psychiatric expert evidence to determine dangerousness risk of individuals considered NGRI shows a different scenario: in a sample of 60 psychiatric expert evidence of murderers considered NGRI in Scandinavia, only 4 (6.7%) reported results from the HCR-20 and 8 (13.3%) from the PCL-R (Grøndal, 2005). In Portugal, as far as the authors knowledge, there is no data on this reality.

Objectives

To better illustrate Portuguese reality concerning psychometric evaluation of the risk of criminal behaviors in the moment of the psychiatric expert evaluation to determine NGRI status, the authors proposed to analyze expert evidence from individuals committed to a psychiatric forensic unit in Centro Hospitalar e Universitário de Coimbra (CHUC) and from those waiting admission to the unit.

Method

All expert evidence available in the forensic unit in CHUC was analyzed, referring to individuals committed to the psychiatric inpatient forensic unit in CHUC and those waiting admission to the unit, between 9-17 August 2018. Data was collected regarding: i) gender; ii) age at the time of the psychiatric evaluation; iii) year of performance of psychiatric expert evidence; iv) delegation of the *Instituto Nacional de Medicina Legal e Ciências Forenses* (INMLCF); v) psychiatric diagnosis; vi) tools of neuropsychological

evaluation utilized. Classes within each variable were not defined *a priori*. When expert evidence report was not available, the authors tried to clarify the reason for it, to minimize bias.

Data was then collected and statistically analyzed using Excel. As a descriptive study without a priori hypothesis of comparisons between groups, only absolute and percentage values are shown.

Results

From the total 150 analyzed files, we obtained a sample of 124 expert forensic reports - 26 files (17.3% of the total) did not contain the expert report, as illustrated in

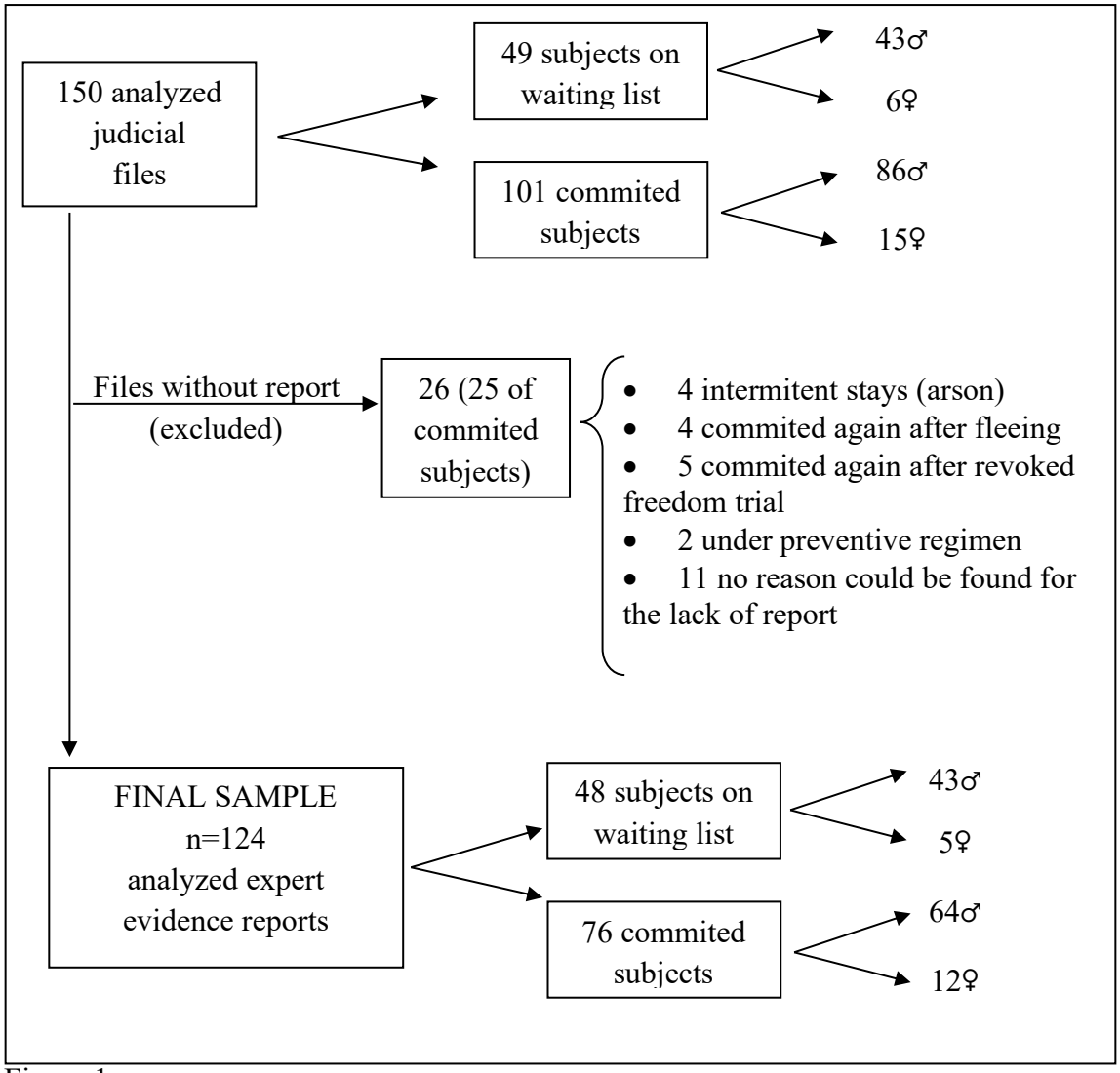

Figure 1.

Figure 1: Schematic representation of the final sample obtention from the analysis of all medical and judicial files of all patients admitted or waiting admission to the FPU of the CHUC under the study protocol.

Regarding the analyzed expert reports, concerning 76 committed subjects and 48 waiting for admission, we obtained a mean age (at the time of the expert forensic evaluation) of 40.7±13.8 years (ages varied between 17 and 81 years old), with a strong male preponderance (86.3%). Most of the diagnosis corresponded to schizophrenia (36.3%) or intellectual deficit (35.5%), with or without concomitant substance abuse. Most (89.5%) expert forensic evaluations were conducted after 2009, and the distribution between INMLCF delegations was fairly even, as can be seen in Table 1.

Table 1
Selected characteristics from the 124 forensic expert reports analyzed.

Sample characteristics			
Variable	Class	*n*	%
Year of the forensic evaluation	<2000	1	0.8
	2000-2009	11	8.9
	2010-2014	41	33.1
	≥2015	70	57.2
INMLCF delegation	North	40	32.3
	Center	50	40.3
	South	34	27.4
Diagnosis (in the report)	Intelectual disability	24	19.3
	Intelectual disability + Substance abuse	20	16.1
	Depression	2	1.6
	Dementia	6	4.8
	Schizophrenia	25	20.2
	Schizophrenia + Substance abuse	20	16.1
	Bipolar disorder	3	2.4
	Delusional disorder	12	9.7
	Schizoaffective disorder	3	2.4
	Post-concussional personality disorder	3	2.4
	ADHD	1	0.8
	Psychosis - unspecified	2	1.6
	Substance-induced psychosis	3	2.4

ADHD – Attention Deficit and Hyperactivity Disorder.

Concerning the study objective, we verified that a formal evaluation of psychopathy (using the PCL-R) was only present in three of the reports (2.4% of the sample), in the context of a wider risk assessment (with the HCR-20). Two of them were carried out in the south delegation, and one in the center, and all of them are from 2015 or beyond. Of these reports, one is from an individual with a delusional disorder,

and the other from two schizophrenics (one with co-occurring substance abuse disorder).

Two other expert examinations contained measures of impulsivity (Barratt Impulsivity Scale - BIS) and one employed the Buss Perry Aggression Questionnaire (BPAQ). On the other hand, a more general personality evaluation was far more frequent, amounting to 33 occurrences. It should be noted that, frequently, more than one instrument was utilized in the same individual, resulting in a total of only 21 reports containing psychometrically evaluated personality information (16.9% of the sample).

The tests that were more frequently included in the reports were those evaluating cognitive abilities, in 40 cases (32.2%), totalizing 44 tests. Table 2 shows the information regarding the psychometric tests identified.

Table 2

Evaluation instruments used in 124 expert evidence reports analyzed.

Evaluation instruments used in expert evidence reports			
Domain	Test	*n*	%
Cognition	WAIS-III	28	22.6
	RPM	12	9.7
	MoCA	2	1.6
	ACE-R	2	1.6
Personality	MMPI	15	12.1
	MCMI-II or III	9	7.2
	Rorschach Test	5	4.0
	TAT	2	1.6
	EPI	5	4.0
	PEI	1	0.8
Psychopathology	SCL90-R	6	4.8
	BSI	4	3.2
	ZungSAS	3	2.4
Risk specific	HCR-20 (includes PCL-R)	3	2.4
	BIS	2	1.6
	BPAQ	1	0.8
	RFT	1	0.8
Other	23QVS	1	0.8

WAIS-3 – *Wechsler Adult Intelligence Scales* – 3; RPM – *Raven Progressive Matrices;* MoCA – *Montreal Cognitive Assessment*; ACE-R – *Addenbrook Cognitive Examination – Revised*; MMPI – *Minnesota Multiphasic Personality Inventory;* MCMI – II or III – *Millon Clinical Multiaxial Inventory – II or III;* TAT – *Thematic Aperception Test*; EPI – *Eysenck Personality Inventory*; PEI – *Personality Evaluation Inventory*; SCL90-R – *Symptom Checklist 90 – Revised*; BSI – *Brief Symptom Inventory*; ZungSAS – *Zung Self-Rating Anxiety Scale*; RFT – *Rosenzweig Frustration Test*; 23QVS – *Stress Vulnerability Questionnaire*

Discussion

Our analysis focused mainly on recent reports of medical faculties, with over half of them carried out in the year 2015 or after, conducted across all the portuguese territory. We obtained a sample typical of a forensic psychiatric unit, with most diagnosis being intelectual disability and psychosis (Völlm et al., 2018b). Despite the three decades old recommendation (Lourenço & Vieira, 2017) to conduct a structured risk evaluation according to the structured professional judgment model, based on standardized tests, such as the HCR-20, this was only performed for 2.4% of the sample. This is an even lower figure than the Scandinavian study (6.7%), which only included evaluations undertaken before 2001 (Grøndal, 2005).

On the other hand, the utilization of other risk-specific evaluation tools was not more common, too: a measure of impulsivity (BIS), which is a well-known vulnerability factor for aggressive conduct, was employed in only 1.6% of cases (Tonnaer et al., 2016). Two patients were evaluated with other tools: one with the BPAQ, specific for aggression, and another with the Rosenzweig Frustration Test (RFT), which was designed to define the persons's reaction to frustration pattern, and can be applied to the criminal population (Ferreira & Capitão, 2013). Furthermore, to the authors knowledge, none of these tools has a validated Portuguese version, unlike the PCL-R (Gonçalves, 2007) and the HCR-20 (Neves & Gonçalves, 2006).

There is, nevertheless, a potentially interesting instrument that is validated for the Portuguese population, although currently there is no empirical data to support its utility for risk assessment in the forensic context: the Vulnerability to Stress Questionnaire (23QVS; Vaz-Serra, 2000), which aims to define the propensity for negative reactions to stress according to the subject predisposing factors.

Somewhat predictably, we verified that the majority of the neuropsychological tests that were conducted was intended to assess cognitive abilities, as happened for 32.2% of the evaluated individuals. Apart from its utility as regards the decision to consider a person NGRI, intelligence is also a factor to consider when it comes to the evaluation of risk for violent and unlawful behaviour, as a lower intelectual functioning is correlated, albeit weakly, with violence (Lourenço & Vieira, 2017), and strongly conditions the type of intervention that can be designed to help reduce dangerousness throughout the patient's stay.

Personality, which is apparently closer to the psychopathic traits that are central to estimate the probability of recidivism (Douglas et al., 2007), is analyzed far less frequently, in only 16.9% of the sample. The authors hypothesize that this may be due to the fact that the sample is mostly comprised of psychotic and intellectually disabled individuals, whose NGRI status was not probably questioned, and thus no further evaluations were deemed necessary. In such a scenario, one should worry about the underinvestment in a structured risk assessment, and the general understanding of standardized tests as a tool to determine NGRI status only.

Notwithstanding, personality tests were not specifically designed to evaluate the risk for violence, and thus cannot replace these latter instruments. Furthermore, they can pose serious ethical issues, if their utilization is not criterious and adequately substantiated. From a strict dangerousness assessment standpoint, only a few aspects are important, and the majority of personality dimensions that these instruments analyze are irrelevant in this context. Taking into account that the subjection to a legal psychiatric examination is compulsory, according to the portuguese law (nr. 45/2004, article 6th, nr. 3), the individual does not have to consent to it. Moreover, its results are not confidential, which further stresses the importance of limiting the amount of

information obtained to the strictly necessary, in order to minimize the violation to the person's privacy (Austin et al., 2009). In fact, the examinee's privacy as regards irrelevant data is consecrated (Coentre et al., 2017), which, in the author's understanding, makes a global personality assessment inadequate when the purpose is solely the evaluation of risk for violence or reoffending, as there are specifically designed and validated tools to do that (Völlm et al., 2018a).

The analysis of the obtained data highlights the scarcity of objective information to substantiate the mandatory expert's advice concerning the person's dangerousness (Vieira & Trancas, 2017), which, besides the aforementioned risk of false positives, may also negatively affect decision making about the best course of treatment and rehabilitation for the individual (Völlm et al., 2018[a]), and thus lengthen the time spent commited. In fact, according to a recent study (Jewell et al., 2017), it seems that the likelihood of early discharge is increased by the implementation of specific strategies to correct the risk factors summarized by, for instance, the HCR-20.

However, one possible explanation for the low utilization of risk-specific assessment tools, and namely the PCL-R, is the high percentage of individuals with cognitive disabilities (40.3%, the sum of those diagnosed with Intelectual Disability and Dementia), for whom the validity of this test is questionable (Völlm et al., 2018a). The paucity of credited professionals and time constraints might also have contributed to the low values that we found. In this regard, and specifically concerning the HCR-20, it should be noted that its 3rd version does not include necessarily the PCL-R, and so it may be completed by anyone with experience working with this population (Lourenço & Vieira, 2017). Naturally, that does not exclude the relevance of a psychopathy assessment. However, there are alternatives to the PCL-R. One recently developed instrument is a self-report questionnaire (Triarchic Psychopathy Measure - TriPM –

Patrick, 2010) which is significantly correlated with the PCL-R, has already been validated for the forensic population (Dongen et al., 2017), and also has a portuguese version (Vieira et al., 2014). This may prove to be a cost-effective tool for widespread application as an aid to determine dangerousness.

On a positive note, it should be stressed that the quality of risk assessments seems to be improving, as its psychometric quantification has invariably occurred for expert evaluations from the past four years, which may be a sign of the growing concern for this issue, and harbour a switch in expert forensic evaluations in the years to come.

The current study may have been limited by the lack of expert evidence reports in almost 20% of the medical files analyzed, even though most of these concerned patients examined prior to 2015, which is the year when the first results from specific risk-assessment tools are available. Even so, one can consider this sample representative of the expert forensic activity along the Portuguese territory in the past few years, as regards patients who were considered dangerous and NGRI. Naturally, the main limitation of this study stems from the fact that we did not include expert reports of medical faculties from individuals considered NGRI, but not dangerous, as these would not have been admitted (or awaiting admission) to the forensic psychiatric unit, so we did not have access to their files. This raises the hypothesis that risk assessment was predominantly performed under dubious circumstances, resulting in low-risk individuals being diverted from the custodial setting. In that sense, it would be interesting to analyze expert evidence reports from the source, which would allow to overcome this bias.

Aditionally, the fact that the literature on this subject is so scarce, apart from the already mentioned scandinavian article (Grøndal, 2005), limits the comparison of our results with different realities – despite a multiplicity of studies about risk evaluation,

namely with the PCL-R and the HCR-20 (Ramesh et al., 2018), there are no studies that assess the prevalence of their utilization in forensic expert evidence reports.

Conclusion

Despite the aforementioned methodological limitations, the current study points to the non-utilization of psychometrically measures to assess criminal risk. Even though the expert opinion regarding dangerousness may be accurate in all cases, a more rigorous substantiation of the final opinion would better serve the interests of not only the judge and the individual under trial, but also of the expert, which would stand from a more solid ground, should his opinion be contested.

The seemingly new-found tendency to psychometrically assess the risk for criminal behaviour was almost non-existent up until 2015. One can admit that, notwithstanding the existence of parallel events concurring to this change, it is the greater visibility and academic formation of the experts in forensic psychiatric, with the creation of a separate sub-specialty in 2015, and its inclusion as a mandatory part of the psychiatry residence plan, that mostly contributes to the increasing quality of expert evidence reports (Santos & Saraiva, 2017).

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Critérios de manutenção em tratamento compulsivo ambulatório numa amostra de doentes mentais graves do Centro Hospitalar de Leiria

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Resumo

As doenças mentais graves podem afetar severamente a vida dos doentes e suas famílias. Nestas doenças, pode não existir *insight* para a patologia ou necessidade de tratamento e a não adesão terapêutica pode ter consequências graves. Em casos específicos, é necessário recorrer a internamento e tratamento compulsivos. Com este estudo retrospetivo descritivo, pretende-se analisar os critérios presentes na avaliação psiquiátrica que contribuíram para a manutenção do tratamento compulsivo ambulatório (TCA) numa amostra aleatória de doentes em TCA, utilizando como grupo de controlo doentes que passaram a tratamento voluntário (TV). Verificou-se que o diagnóstico mais prevalente, em ambas as amostras, foi o de esquizofrenia. Adicionalmente, verificou-se que existiam diferenças estatisticamente significativas em termos do *insight* para a doença, adesão ao tratamento e sintomatologia positiva, entre doentes que permanecem em TCA e que passam a TV. Os critérios para a manutenção do TCA regeram-se pela perceção de doença psíquica grave, em pessoa com ausência de *insight* para doença ou necessidade de terapêutica. Deverão ser efetuados mais estudos neste âmbito de forma a demonstrar a aplicação devida destas medidas e o seu sucesso terapêutico, justificando e validando a sua utilização.

Palavras-chave: tratamento involuntário; hospitalização involuntária; admissão involuntária; tratamento ambulatório; psiquiátrico.

Introdução

As doenças mentais graves podem cercear a funcionalidade do doente, assim como da sua rede de relações sociais e familiares (Yesufu-Udechuku *et al.* 2015). Estas doenças podem englobar uma mudança do pensamento, dos afetos e do sentido da própria individualidade (Keyes e Ryff, 2000). Visando uma intervenção mais rápida e eficaz, mas também um maior respeito pelos direitos humanos, assiste-se atualmente à substituição da institucionalização de indivíduos portadores de perturbações mentais por uma abordagem baseada nos cuidados psiquiátricos comunitários (Fennell, 2008). Em Portugal, essa tendência encontra-se explícita na Lei de Saúde Mental (LSM), Lei n.º36/98, de 24 de julho, que contempla a regulamentação do tratamento compulsivo, com a possibilidade de este ocorrer na comunidade através do tratamento compulsivo ambulatório (TCA) (Almeida e Molodynski, 2016).

A adesão à medicação é dos aspetos mais importantes no que concerne à eficácia psicoterapêutica. Porém, um dos aspetos integrantes da doença mental grave tem a ver com incapacidade de reconhecer a presença de doença ou para a necessidade de cumprir um tratamento adequado (Swartz, Swanson, Wagner, Burns, e Hiday, 2001). A não adesão terapêutica tem associadas consequências nefastas para a evolução da doença, a nível da sua sintomatologia e, consequentemente, da vida social e familiar dos doentes. Deste modo, surgiu a necessidade de efetuar tratamentos compulsivos em doentes com patologia mental grave. O TCA tem sido alvo de discussão em relação à sua eficácia e questões éticas relacionadas, muitas vezes centradas no seu grau de coerção (Craw e Compton, 2006; Muirhead, Harvey, e Ingram, 2006; Zanni e Stavis, 2007). Assim, torna-se basilar que para a análise da utilização de medidas restritivas da liberdade haja estudos, baseados em dados estatísticos, sobre os critérios que são utilizados para submeter os doentes a tais medidas.

Com este estudo, pretende-se analisar os critérios presentes na avaliação psiquiátrica que contribuem para a manutenção do tratamento em regime compulsivo ambulatório, numa amostra de doentes com antecedentes de internamento compulsivo e tratamento compulsivo ambulatório, acompanhados no Serviço de Psiquiatria e Saúde Mental (SPSM) do Centro Hospitalar de Leiria (CHL).

Material e Método

Trata-se de um estudo observacional transversal, tendo como população alvo uma amostra aleatória de doentes com historial de tratamento em regime compulsivo ambulatório, que decorreu entre 2011 e 2016. Através da análise dos processos clínicos, além de variáveis sociodemográficas, foram avaliadas e comparadas variáveis clínicas entre doentes em tratamento compulsivo ambulatório e doentes que passaram a tratamento voluntário (TV). De entre os critérios avaliados foram incluídos, nomeadamente, o diagnóstico do doente, a quantidade de internamentos compulsivos prévios, o seu *insight* para a doença, a adesão ao tratamento e a presença de sintomatologia positiva. A avaliação da probabilidade de adesão ao tratamento baseia-se na perspetiva do psiquiatra sobre a atitude do doente face a esta questão. Esta perspetiva tem em conta o historial de cumprimento/incumprimento de antipsicótico *depot* e os níveis sanguíneos de estabilizador do humor no momento da avaliação clínico-psiquiátrica e no passado, independentemente de estar em TCA ou TV tendo, ainda, em conta a verbalização do doente de adesão ou não adesão à medicação no momento da avaliação.

Sendo a população-alvo doentes em regime de tratamento ambulatório compulsivo, acompanhados no Serviço de Psiquiatria e Saúde Mental do Centro Hospitalar de Leiria, foram selecionados aleatoriamente 45 doentes em TCA e para a amostra controlo foram

selecionados 25 doentes que tiveram o seu regime de tratamento alterado de compulsivo para voluntário.

Os dados recolhidos foram analisados estatisticamente utilizando o programa SPSS, versão 23.0. Foram efetuadas estatísticas descritivas na análise das variáveis. Foi utilizado o teste Qui-quadrado (χ^2) para avaliar as diferenças entre grupos, admitindo-se significância estatística para valores de $p < .05$.

Resultados

Na amostra de doentes em TCA, a amostra compunha-se por 45 doentes, sendo 35 homens; dos 25 doentes em TV analisados, 16 eram mulheres. Relativamente à média de idades, verifica-se que esta é inferior nos doentes que passaram a tratamento voluntário (25 *vs*. 43 anos).

Verifica-se uma maior percentagem de doentes que atingiram o ensino superior em TV (24%) do que em TCA (20%). Quanto ao estado civil, 80% dos doentes em TCA e 64% dos doentes em TV são solteiros ou divorciados. Porém, quanto ao suporte sociofamiliar, na grande maioria dos doentes foi possível identificar pelo menos um membro de suporte/de referência como suporte sociofamiliar (91% dos doentes em TCA *vs*. 88% dos doentes em TV).

O diagnóstico mais prevalente é, em ambas as amostras, o de esquizofrenia (40%; n = 18 nos doentes em TCA e n = 10 nos doentes em TV). Seguidamente os diagnósticos mais prevalentes nos doentes em TCA são de psicose não-orgânica não especificada (n = 14) e de perturbação afetiva bipolar (PAB) (n = 5) e nos doentes em TV foram o diagnóstico de PAB (n = 8) e de psicose não-orgânica não especificada (n = 4). Os restantes diagnósticos englobavam sempre sintomatologia psicótica, sendo eles, por ordem decrescente de

prevalência, o de perturbação delirante, perturbação esquizoafetiva, psicose tóxica e incapacidade intelectual com sintomas psicóticos.

Dos doentes que se mantinham em TCA, 38% tinham mais do que um internamento compulsivo no SPSM do CHL comparativamente a 12% dos doentes em TV.

Sendo que vários doentes se encontravam a cumprir mais do que um psicofármaco, a maioria estava medicada com antipsicótico injetável – 80% dos doentes em TV e 84% dos doentes em TCA.

Os resultados demonstram que a perceção do psiquiatra assistente sobre o *insight* do paciente para a sua doença não era independente de este se encontrar em regime de tratamento compulsivo ($\chi^2 = 21.12$ [2], $p < .001$). Assim, a ausência de *insight* foi mais evidente em pacientes em TCA [79.5% vs. 20.5%]. Da mesma forma, a presença de sintomatologia positiva era mais prevalente em pacientes em tratamento compulsivo [95.0% vs. 5.0%] ($\chi^2 = 11.51$ [1], $p = .001$).

Relativamente à probabilidade percebida de não adesão ao tratamento, era mais provável em pacientes em TCA [91.4% vs. 8.6%] ($\chi^2 = 43.46$ [2], $p < .001$).

Discussão

O Artigo 33.º da LSM prevê a possibilidade da substituição do internamento por tratamento compulsivo, mantendo a obrigatoriedade do tratamento. Verifica-se que os doentes em TCA apresentam uma maior percentagem de internamentos compulsivos no SPSM do CHL (38% vs. 12% nos doentes em TV). Os valores encontrados podem estar relacionados com o facto de os doentes em TCA terem uma patologia com sintomas mais graves, com mais recaídas, que necessitem, muitas vezes, de reinternamentos. Além disso, o facto de o critério de não adesão à medicação ser basilar na opção pelo TCA, pode também

explicar que estes doentes não cumpram o tratamento, mesmo que teoricamente obrigados a tal e, por isso, tenham mais agudizações da doença com internamento associado. Este será, aliás, o principal fator explicativo de internamento de um doente em regime de TCA.

A aplicação de medidas compulsivas é de elevada importância em alguns doentes, nomeadamente com o diagnóstico de esquizofrenia, uma vez que os dados da literatura indicam que cerca de 90% destes pacientes apenas aderem parcialmente ao tratamento (cumprem o plano entre 50 e 80% do tempo) (Bellack et al., 2009). Na nossa amostra, o diagnóstico de esquizofrenia foi predominante. O abandono da medicação é o principal motivo para a descompensação psicótica: ao curto período de não adesão terapêutica entre 1 e 10 dias foi associado um risco duas vezes superior de internamento devido a recaída (Weiden, Kozma, Grogg, & Locklear, 2004). Estas recaídas têm como consequência um período mais longo de remissão da sintomatologia, cerca de 47 dias após o primeiro episódio e cerca de 130 dias após o terceiro (Lieberman et al., 1996). A não adesão ou adesão parcial ao tratamento está associada a um maior número de recaídas, reinternamentos e a pior prognóstico, acarretando maiores custos monetários e uma diminuição na qualidade de vida dos doentes (Chen et al., 2005). Segundo Muirhead, Harvey e Ingram (2006) uma solução para esta falta de adesão será a aplicação do regime de TCA, já que se verificou uma diminuição significativa no número de internamentos, assim como da sua duração, em doentes com esquizofrenia submetidos a um ano de TCA. Em contrapartida, para Preston, Xiao e Kisely (2004), as ordens para TCA, por si só, não reduzem as taxas de admissão hospitalar. Segundo estes autores, não existem provas de custo-efetividade, não se verificando melhorias significativas a nível de função social e qualidade de vida dos doentes (Kisely, Campbell, & Preston, 2011).

Verifica-se ainda que a maioria dos doentes estava medicada com antipsicótico *depot* – 80% dos doentes em TV e 84% dos doentes em TCA. Vaughan, McConaghy, Wolf, Myhr e Black (2000) sugerem que o TCA diminui as taxas de reinternamento precisamente devido à utilização deste tipo medicação injetável. O facto de a grande maioria dos doentes analisados cumprir este tipo de terapêutica pode justificar tanto o facto de haver uma grande percentagem de doentes que puderam passar a TV pelo facto de terem níveis sanguíneos regulares e adequados de medicação antipsicótica (pelo facto de cumprirem antipsicótico *depot*), como o facto de ser uma opção terapêutica frequente em doentes em TCA (para garantir a adesão à medicação). Desta forma, a adesão ao tratamento é facilitada pela toma do injetável, podendo ser controlada: se o doente não comparecer à toma do injetável, rapidamente é possível a equipa perceber a falha na toma, permitindo uma intervenção mais eficaz. Neste caso, o doente deve ser contactado para se perceber o incumprimento e, no caso de ser por recusa na toma, é comunicado ao Tribunal para que, pelos pressupostos da LSM, o doente possa ser avaliado e, eventualmente, internado compulsivamente para ser submetido ao tratamento adequado.

Os opositores do tratamento compulsivo encaram a compulsividade como uma coercividade, encarando-a como uma restrição excessiva à autonomia e liberdade individual e um mecanismo de controlo social, que pode aumentar o preconceito e incitar ao abandono dos serviços por parte do doente (Link, Castille, & Stuber, 2008; Swanson et al., 2009). Para Prinsen e Van Delden (2009), o respeito pela autonomia e pelos direitos humanos são aspetos fulcrais, não sendo, no entanto, motivos suficientes para suprimir as medidas de obrigatoriedade de tratamento. Não obstante a bondade da intervenção, um indivíduo psicótico acaba por não ser um homem livre, pois ver coartada a sua autodeterminação, em concreto, a capacidade de exigir um tratamento.

Conclusão

No cuidado psiquiátrico, o tratamento compulsivo prova ser um assunto relevante, uma vez que a patologia mental se pode acompanhar de uma ausência de juízo crítico ou de incapacidade para tomar decisões, o que se traduz na LSM por "anomalia psíquica grave". Na psicose, nomeadamente na esquizofrenia, o doente em fase de agudização da sua doença pode não ter qualquer *insight* sobre o seu estado clínico ou ações que executa. Torna-se, assim, essencial existir um conjunto de normas e regras claras que especifiquem o modo de atuar nestas situações. Com este trabalho pretende-se aumentar o conhecimento sobre a forma como a LSM tem sido aplicada, apresentando os critérios presentes, numa amostra de avaliações clinico-psiquiátricas do CHL, que contribuem para a manutenção do tratamento em regime compulsivo ambulatório. Verifica-se que existem diferenças estatisticamente significativas em termos do *insight* para a doença, adesão ao tratamento e sintomatologia positiva, entre doentes que permanecem em TCA e os que passam a TV. Desta forma, percebe-se que os critérios utilizados para a manutenção do tratamento compulsivo se regem pela perceção de doença psíquica grave, em pessoa com ausência de *insight* para a doença ou necessidade de terapêutica e que, na ausência desta, condicionam um agravamento do estado clínico. Considera-se que mais estudos deverão ser efetuados neste âmbito de forma a demonstrar a aplicação devida destas medidas e o seu sucesso terapêutico, justificando e validando a sua utilização.

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Criteria for Maintenance in Involuntary Outpatient Treatment in a Sample of Severe Mental Patients of the Hospital Center of Leiria

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Abstract

Severe mental illness may gravely affect the lives of patients and their families. When it come to these illnesses, there may not be insight for the pathology or the need for treatment, and non-adherence to treatment may have severe consequences. In specific cases, it is necessary to resort to involuntary admission and treatment. This descriptive retrospective study intends to analyze the criteria present in psychiatric evaluation that contribute to the maintenance of involuntary outpatient treatment (IOT) in a random sample of patients in IOT, using, as a control group, patients who moved on to voluntary treatment (VT). It was found that the most prevalent diagnosis, in both samples, was schizophrenia. In addition, statistically significant differences were found in terms of insight regarding the illness, adherence to treatment and positive symptoms, between patients who remained in IOT and those who moved on to VT. The criteria for maintenance in IOT are guided by the perception of severe mental illness, in people with lack of insight for the illness or the need for treatment. More studies in this area are necessary in order to demonstrate the proper application of these measures and their therapeutic success, justifying and validating their use.

Keywords: involuntary treatment; involuntary hospitalization; involuntary admission, outpatient treatment; psychiatric

Introduction

Severe mental illness may limit the functioning of patients, as well as their network of social and family relationships (Yesufu-Udechuku et al. 2015). These illnesses may include changes in thinking, affect or the sense of one's own individuality (Keyes & Ryff, 2000). Aiming towards a quicker and more effective intervention, but also greater respect for human rights, there is currently a substitution of the institutionalization of individuals with mental disorders for an approach based on community psychiatric care (Fennell, 2008). In Portugal, this trend is explicit in the Mental Health Law (MHL), Law n.º36/98, of July 24, which contemplates the regulation of involuntary treatment, with the possibility of it occurring in the community through involuntary outpatient treatment (IOT) (Almeida & Molodynski, 2016).

Adherence to medication is one of the most important aspects for psychotherapeutic efficacy. However, one of the integral aspects of severe mental illness is related to the inability to recognize the presence of the illness or the need to undergo appropriate treatment (Swartz, Swanson, Wagner, Burns, & Hiday, 2001). Non-adherence to treatment is associated with adverse consequences for the evolution of the illness, in terms of its symptomology and, consequently, the social and family lives of patients. Therefore, there has emerged a need to conduct involuntary treatment in patients with severe mental pathology. IOT has been the subject of discussion regarding its efficacy and related ethical questions, often centered on its degree of coercion (Craw & Compton, 2006; Muirhead, Harvey, & Ingram, 2006; Zanni & Stavis, 2007). It is therefore essential that, to analyze the use of these measures restricting freedom, there be studies based on statistical data, regarding the criteria that are used to submit patients to such measures.

This study intends to analyze the criteria present in psychiatric evaluation that contribute to maintenance in involuntary outpatient treatment, in a sample of patients with a

history of involuntary admission and involuntary outpatient treatment, who are being followed at the Psychiatry and Mental Health Department (PMHD) of the Hospital Center of Leiria (HCL).

Material and Methods

This is a cross-sectional observational study, which has, as a target population, a random sample of patients with a history of involuntary outpatient treatment, which occurred between 2011 and 2016. Through the analysis of clinical reports, in addition to sociodemographic variables, we also analyzed and compared clinical variables between patients undergoing involuntary outpatient treatment and patients who moved on to voluntary treatment (VT). Among the evaluated criteria were the diagnosis of the patient, the amount of previous involuntary admissions, their insight regarding the illness, adherence to treatment and the presence of positive symptoms. The evaluation of the likelihood of adherence to treatment is based on the perspective of the psychiatrist regarding the attitude of the patient towards this issue. This perspective takes into account the history of compliance/non-compliance with the depot antipsychotic, as well as the blood levels of mood stabilizers at the moment of the clinical-psychiatric evaluation, and in the past, regardless of undergoing IOT or VT, also taking into consideration the patients' verbalizations of adherence or non-adherence to medication at the moment of evaluation.

Since the target population were patients undergoing involuntary outpatient treatment, who were being followed at the Psychiatry and Mental Health Department of the Hospital Center of Leiria, we randomly selected 45 patients in IOT and, for the control sample, we selected 25 patients who had their treatment regimens changed from involuntary to voluntary.

The data collected were statistically analyzed using the software SPSS, version 23.0. Descriptive statistics were performed in the analysis of the variables. The Chi square (χ^2) test

was used to evaluate the differences between groups, with statistical significance set for values of $p < .05$.

Results

The sample of patients in IOT comprised 45 patients, of which 35 were men; of the 25 patients in VT, 16 were women. Regarding mean age, it was lower for patients who moved on to voluntary treatment (25 *vs*. 43 years).

There is a greater percentage of patients who reached higher education in VT (24%) than in IOT (20%). As for marital status, 80% of patients in IOT and 64% of patients in VT are single or divorced. However, as for socio-familial support, in most patients it was possible to identify at least one support/reference member as socio-familial support (91% of patients in IOT *vs*. 88% of patients in VT).

The most prevalent diagnosis is, in both samples, schizophrenia (40%; $n = 18$ for patients in IOT and $n = 10$ for patients in VT). Moreover, the most prevalent diagnoses for patients in IOT were unspecified nonorganic psychosis ($n = 14$) and bipolar affective disorder ($n = 5$) and for patients in VT were bipolar affective disorder ($n = 8$) and unspecified nonorganic psychosis ($n = 4$). The remaining diagnoses, which always included psychotic symptoms, were, in a descending order of prevalence, delusional disorder, schizoaffective disorder, substance-induced psychosis and intellectual disability with psychotic symptoms.

Of the patients who remained in IOT, 38% had more than one involuntary admission to the PMHD of the HCL compared to 12% of patients in VT.

Since most patients were taking more than one psychotropic drug, most were medicated with an injectable antipsychotic – 80% of patients in VT and 84% of patients in IOT.

The results show that the perception of the assistant psychiatrist about the insight of the patients towards their illness was not independent of the patient going through an involuntary treatment regimen ($\chi^2 = 21.12$ [2], $p < .001$). Thus, the absence of insight was more evident for patients in IOT [79.5% vs. 20.5%]. Similarly, the presence of positive symptoms was more prevalent in patients under involuntary treatment [95.0% vs. 5.0%] ($\chi^2 = 11.51$ [1], $p = .001$).

Regarding the perceived probability of non-adherence to treatment, it was more probable for patients in IOT [91.4% vs. 8.6%] ($\chi^2 = 43.46$ [2], $p < .001$).

Discussion

Article 33 of the MHL predicts the possibility of replacing hospitalization with involuntary treatment, maintaining the mandatory nature of the treatment. It is found that patients in IOT exhibit greater rates of involuntary admissions in the PMHD of the HCL (38% vs. 12% in patients in VT). The results found may be related to the fact that patients undergoing IOT have a pathology with more severe symptoms, with more relapses, who often need readmission. In addition, the fact that the criterion of non-adherence to medication is fundamental to opting for IOT may also explain why these patients do not follow treatment, even when theoretically obliged to do so and, thus, experience greater aggravation of the illness with an associated hospitalization. In fact, this may be the main explanatory factor for the admission of a patient in an IOT regimen.

The application of involuntary measures is of paramount importance for some patients, namely those with a diagnosis of schizophrenia, since data from literature indicates that approximately 90% of these patients only partially adhere to treatment (they comply with the treatment plan between 50 and 80% of the time) (Bellack et al., 2009). In our sample, the diagnosis of schizophrenia was predominant. Abandonment of medication is the main reason

for psychotic decompensation: the short period of non-adherence to therapy, between 1 and 10 days, was associated with double the risk for hospitalization due to relapse (Weiden, Kozma, Grogg, & Locklear, 2004). These relapses have, as a consequence, a longer period of symptom remission, about 47 days after the first episode and approximately 130 after the third (Lieberman et al., 1996). Non-adherence or partial adherence to treatment is associated with a greater number of relapses, readmissions and a worse prognosis, resulting in higher monetary costs and a reduction in the life quality of the patients (Chen et al., 2005). According to Muirhead, Harvey and Ingram (2006), a solution for this lack of aderence would be the application of an IOT regimen, since there was a significant reduction in the number of admissions, as well as in their duration, in patients with schizophrenia submitted to one year of IOT. Conversely, for Preston, Xiao and Kisely (2004), the order for IOT, by itself, does not reduce the rates of hospital admissions. According to these authors, there is no proof of cost-effectiveness, and there are no significant improvements in terms of the social functioning and life quality of the patients (Kisely, Campbell, & Preston, 2011).

It was also found that most patients were medicated with depot antipsychotic – 80% of patients in VT and 84% of patients in IOT. Vaughan, McConaghy, Wolf, Myhr and Black (2000) suggest that IOT reduced the readmission rates precisely due to the use of this type of injectable medication. The fact that the vast majority of patients analyzed were undergoing this type of therapy may justify both the fact that there is a large percentage of patients who were able to move on to VT since they had regular and adequate blood levels of antipsychotic medication (as they complied with the depot antipsychotic), as well as the fact that it is a frequent treatment option for patients in IOT (to guarantee adherence to medication). Therefore, adherence to treatment is facilitated by the taking of the injectable, which can be controlled: if the patient does not show up to take the injectable, it is possible for the team to quickly understand the reason behind this failure to take the injectable, allowing for a more

effective intervention. In this case, the patient must be contacted in order for the non-compliance to be understood and, in the case it is due to refusing to take the medication, this is communicated to the court so that, according to the provisions of the MHL, the patient can be evaluated and, eventually, involuntarily admitted, so as to be submitted to the appropriate treatment.

Opponents of involuntary treatment view its mandatory nature as coercion, regarding it as an excessive restriction to individual autonomy and freedom and a mechanism of social control, which can increase prejudice and incite the patient to abandon the service (Link, Castille, & Stuber, 2008; Swanson et al., 2009). For Prinsen and Van Delden (2009), respect for autonomy and human rights are fundamental aspects, however, they are not sufficient reasons to suppress mandatory treatment measures. Notwithstanding the goodness of the intervention, a psychotic individual is not a free person, as their self-determination is restricted, specifically, their ability to demand treatment.

Conclusion

In psychiatric care, involuntary treatment proves to be a relevant topic, since the mental pathology may be accompanied by a lack of critical judgement or inability to make decisions, which is reflected in the MHL as “severe mental anomaly”. In psychosis, namely in schizophrenia, patients experiencing an aggravation of their illness may have no insight regarding their clinical state or the actions they take. Therefore, it is pivotal to have a set of norms and rules that specify the course of action in these situations. This work intends to increase the knowledge about the way the MHL has been applied, by presenting the current criteria, in a sample of clinical-psychiatric evaluations of the HCL, which contribute to maintaining treatment in an involuntary outpatient regimen. Statistically significant differences were found in terms of insight towards the illness, adherence to treatment, and

positive symptoms, among patients who remain in IOT and those who move on to VT. Thus, it is understood that the criteria used for maintenance in involuntary treatment are guided by the perception of severe mental illness, in individuals with lack of insight regarding the illness or the need for therapy and, in the absence of the latter, condition an aggravation of an individual's clinical state. It is believed that more studies must be conducted in this field, so as to demonstrate the proper application of these measures and their therapeutic success, thus justifying and validating their use.

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Medo do crime e femicídio na intimidade: considerações teóricas

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Resumo

A insegurança e o medo do crime têm sido cada vez mais objeto de atenção da Criminologia. A literatura neste domínio converge no sentido de afirmar que as mulheres são as que apresentam níveis mais elevados de medo do crime, muito embora sejam menos vitimadas pela criminalidade. Entretanto, quando olhamos para os crimes que são cometidos nos espaços das relações de intimidade as mulheres são, desproporcionalmente, mais vitimadas do que os homens. Importa, assim, considerar que o medo do crime reportado pelas mulheres se relaciona diretamente com a insegurança vivida tanto nos espaços públicos, quanto nos espaços da vida privada. Neste sentido, o femicídio na intimidade, enquanto manifestação última e mais grave da violência contra a mulher nas relações de intimidade, é uma realidade transversal que não pode ser ignorada. Após uma breve revisão teórica da relação entre o medo do crime sentido pelas mulheres e o femicídio na intimidade, percebe-se que estes dois conceitos raramente são analisados conjuntamente. Neste sentido, e tentando colmatar esta lacuna, o presente artigo o presente artigo propõe uma integração teórica destes construtos até agora não explorada pela Criminologia.

Palavras-chave: medo do crime; femicídio; violência na intimidade

"*O femicídio rouba tragicamente a vida de uma rapariga ou mulher.*
Para além deste trágico e intencional ato, muitas raparigas e mulheres
experienciam múltiplas formas de violência, degradação, isolamento psicológico
e físico, medo e terror nas horas, meses ou anos antes de serem mortas.
A sua experiência é de profundo sofrimento;
e são eternamente silenciadas e para sempre perdidas"[1]

Medo do crime

O crime e o desvio são objetos de estudo de particular interesse para a Criminologia. Na verdade, segundo a metáfora bem conseguida de Kuhn e Agra (2010), a Criminologia está para o crime assim como a meteorologia está para o clima. Se por um lado a meteorologia é muito mais do que saber concretamente se irá chover ou estar sol, também a Criminologia é muito mais do que perceber se determinado crime ocorreu. A Criminologia encarrega-se da investigação e da produção de saber científico sobre este fenómeno complexo que é o crime, seus correlatos e quais as implicações que terá na vida social, indo mais além do leigo debate público na matéria.

Neste sentido, um dos temas que mais tem atraído a atenção dos estudos científicos na Criminologia nos últimos 40-50 anos, na sequência da formulação de 'pânico moral' teorizada na década de 1970 por Stanley Cohen (2011), é o chamado sentimento de insegurança ou medo do crime. A teorização de Cohen está estreitamente ligada às reações e ansiedades sociais frente à emergência das chamadas subculturas delinquentes e, mais detidamente, na forma como os *mass media* exploram as notícias dos crimes. Esta análise do

[1] Tradução livre das autoras. No original: "Femicide tragically robs a girl or woman of life. In addition to the finality of this cruel and intentional act, many girls and women experience multiple acts of violence, degradation, psychological and physical isolation, fear, and terror in the hours, months or years before they are killed. Their experience is one of profound suffering; then they are forever silenced and forever lost." (Baker, Etherington, Pietsch, Straatman, Ansems, Barreto & Campbell, 2015: 1)

crime pelos media decorre muitas vezes com alguma seletividade e exagero, transformando-as em material útil à reação social, permeando debates culturais, influenciando as práticas da imprensa e encontrando também eco no discurso político (Garland, 2008). No entanto, é preciso considerar que a extrema atenção capturada pelos episódios desencadeadores do pânico moral, em certa medida, "obscurece o quadro mais amplo, afastando a atenção de um exame das estruturas gerais de sentimento e preocupação em torno do risco, do crime e da vitimização"[2] (Godfrey, 2017, p. 11). Assim, novas nuances concetuais emergiram no âmbito da Criminologia com a finalidade de melhor compreender as perceções e preocupações públicas relativamente ao crime. Neste contexto, os discursos quanto à insegurança e o medo do crime começam a ser explorados principalmente no que diz respeito a crimes que ocorrem em espaços públicos - ou chamados crimes de rua - que se evidenciaram diante das novas conjunturas dos grandes centros urbanos. O medo do crime tornou-se, assim, objeto de pesquisa científica e também de intervenções políticas (Garofalo, 1979; Simon, 2017). Neste sentido, as chamadas pesquisas de vitimação começaram a ser difundidas com o principal objetivo de conhecer a real extensão da vitimação e também de captar a perceção dos/as cidadãos/ãs a respeito da sua própria segurança e também da segurança das cidades e áreas de residência (Van Dijk, 2007; Gray, Jackson & Farrall, 2012).

Os primeiros estudos sobre o sentimento de insegurança foram desenvolvidos nos Estados Unidos da América, tendo sido posteriormente disseminados por todo mundo. Em regra, para a aferição do sentimento de insegurança, estes estudos utilizam questões tais como "*quão seguro/a se sente ao andar sozinho nesta área durante a noite*?" ou ainda "*quão seguro/a se sente em estar sozinho/a no seu bairro durante a noite*?" (veja-se Hale, 1996, p. 85). Embora úteis para propósitos do estudo da insegurança de uma forma mais genérica,

[2] Tradução livre das autoras. No original: "...obscures the broader picture, directing attention away from an examination of the general structures of feeling and concern around risk, crime, and victimisation."

estas medidas globais parecem não ser suficientes[3] para abarcar as complexidades subjacentes ao medo do crime (Hale, 1996; Hardyns & Pauwels, 2010). Neste sentido, algumas das críticas quanto às formas tradicionais de medição do medo do crime foram enumeradas por Gray, Jackson e Farrall (2012), dentre as quais se podem destacar: i) o fato de não se fazer uma referência clara ao crime; ii) o facto de, em geral, se referirem a áreas geográficas vagas; iii) alguma confusão entre o que é, propriamente, medo e o que são conceções quanto ao risco[4]. Esta insuficiência parece ser ainda mais evidente quanto o objetivo é estudar o medo reportado pelas mulheres, pois, além das críticas já apontadas pela literatura, estas questões tradicionais parecem ignorar o sentimento de insegurança experienciado nos ambientes privados e semi-privados (Broll, 2014; Madriz, 1997a; Pain, 2012).

Tal como ocorre em relação às formas de medição do medo do crime, a sua definição também não é teoricamente unânime (Hale, 1996; Hinkle, 2015). A literatura indica que este é um fenómeno multifacetado, multidimensional e que pode ser resumido numa categorização tripartida, segundo a qual o medo do crime compreende uma dimensão cognitiva, uma dimensão comportamental e outra dimensão afetiva (Gouseti, 2017; Guedes, 2012, 2016; Hardyns & Pauwels, 2010). A primeira dimensão, a cognitiva, prende-se com a (auto)avaliação do risco ou da probabilidade de uma pessoa se tornar vítima de um crime. A segunda dimensão refere-se aos comportamentos adotados pela pessoa com o fim de prevenir e/ou evitar o risco de vitimação. Por fim, a terceira dimensão, que se associa à afetividade, faz referência à reação emocional desencadeada na pessoa pela vitimação ou pela ameaça dela (Gouseti, 2017).

[3] "Nevertheless, the complexity of a concept such as fear of crime demands further studies on the different components of fear, before one moves on to an explanation of fear based on survey data." (Hardyns & Pauwels, 2010, p. 4).

[4] Para uma visão mais completa quanto às críticas sugeridas pelos autores, veja-se o quadro de referência da p. 5 em Gray, Jackson & Farrall (2012).

No presente artigo, a reflexão que se pretende mais aprofundada é, justamente, sobre a componente afetiva do medo do crime, ou seja, o medo do crime experienciado enquanto emoção. Neste sentido, importa destacar a definição de Ferraro (1994), segundo a qual o medo do crime é uma "resposta emocional de pavor ou ansiedade quanto ao crime ou quanto aos símbolos que uma pessoa associa ao crime" (p. 4)[5].

As mulheres e o medo do crime

Ainda que diante de algumas divergências terminológicas, há um dado que surge de forma transversal nas pesquisas desenvolvidas neste campo de estudo: a consistência do variável género enquanto preditora do medo do crime. A literatura tem apontado que são as mulheres que reportam os níveis mais elevados de medo do crime, ainda que, de um modo paradoxal, sejam os homens os mais vitimizados pela chamada "criminalidade comum" (Hale, 1996; Madriz, 1997b; Stanko, 1992; Warr, 1984).

A desproporção entre o elevado medo do crime reportado pelas mulheres e a baixa probabilidade de uma mulher se tornar vítima de um crime no espaço público, foi nomeada pela literatura como 'paradoxo medo-vitimação', um conceito que se mantém sustentado na atualidade (Hale, 1996; Bilsky, 2017). Em razão deste paradoxo, inicialmente o medo das mulheres foi considerado não apenas desproporcional, mas também irracional (Young, 1987). Na tentativa de encontrar explicações para este paradoxo, várias teorias foram sendo exploradas para compreender, afinal, do que é que as mulheres têm medo. Assim, quando se estuda o medo por parte das mulheres, ou medo feminino, é importante considerar qual é a real extensão das vitimações a que as mulheres mais frequentemente se encontram expostas (Hale, 1996). Analisando as formas de vitimação feminina ao redor do mundo, torna-se

[5] Tradução livre das autoras. No original: "'an emotional response of dread or anxiety to crime or symbols that a person associates with crime".

evidente que os crimes que atingem desproporcionalmente mais mulheres têm na sua base questões estruturais relacionadas com o género. Para Esther Madriz a diferença entre os géneros nos níveis de medo do crime pode, em certa medida, ser explicada por imagens dominantes, reflexo de uma visão dualista que situa as mulheres como frágeis e passivas e, por outro lado, concebe os homens como fortes e ativos (Madriz, 1997a; Lane, 2013). A manutenção destas desigualdades, por sua vez, dá azo à perpetração de diversas formas de violência que, pela sua natureza socialmente instituída, estão intimamente relacionadas com as sociedades de forma transversal. Assim, importa explorar, ainda que brevemente, estas formas de violência mais comumente praticadas contra mulheres.

A violência contra as mulheres baseada no género é definida pela Convenção de Istambul[6] como "toda a violência dirigida contra uma mulher por ela ser mulher ou que afete desproporcionalmente as mulheres" (Conselho da Europa, 2011, p. 4). Esta disparidade, como o próprio documento identifica, encontra-se enraizada nas desigualdades de géneros e em estereótipos de género relativos aos papéis socialmente atribuídos ao longo do tempo a mulheres e homens[7]. Assim, importa relembrar a necessidade de um enfoque de género na compreensão e leitura das questões de insegurança[8], o que implica o reconhecimento de que o medo do crime não é um conceito neutro do ponto de vista do género. Mais do que isso, é um fenómeno que se situa no curso da vida quotidiana e que não se mantém limitado a barreiras do experienciado no espaço público ou privado (Fitz-Gibbon & Walklate, 2018).

[6] Convenção do Conselho da Europa para a Prevenção e o Combate à Violência Contra as Mulheres e a Violência Doméstica.

[7] Não cabendo neste artigo uma explicação detalhada sobre as desigualdades existentes, de género e não só, recomendam-se outras leituras para uma compreensão mais abrangente do impacto que estas desigualdades têm no quotidiano de mulheres e meninas, nomeadamente na sustentação da violência de género (ver, por exemplo, Lombard, 2017; Neves & Costa, 2017; Renzetti, Miller, & Gover, 2018).

[8] E não só relativamente às questões de insegurança, como bem pontuado por Fitz-Gibbon e Walklate, "there is still a great deal of work to be done in understanding the place of gender in much criminological endeavour and the fear of crime debate is no exception to this" (2018, pp. 87-88).

Violência por parceiro íntimo e medo do crime

Muito embora a Convenção de Istambul enumere outras formas de violência contra as mulheres[9], o foco do presente trabalho recai sobre aquela que é considerada como potencialmente mais grave: o homicídio, e especificamente o homicídio na intimidade[10]. No entanto, antes desta análise, é indispensável contextualizar a imagem de fundo mais abrangente que muitas vezes caracteriza estas mortes: a violência doméstica. Em razão das dinâmicas relacionais subjacentes, a violência doméstica e, mais concretamente, a violência doméstica na intimidade, é um crime cuja manifestação é marcada por ciclos de violência, conforme proposto por Lenore Walker (1979), é composto por três fases: a fase da tensão, a fase da explosão (onde decorre a violência propriamente dita) e a fase de lua-de-mel (em que o agressor manipula e convence a vítima de que tal não irá voltar a acontecer). Sendo um ciclo, verifica-se que estas fases têm um caráter de repetição, sendo cada vez mais rápida a transição entre fases, e mais grave a violência usada. A fase da lua-de-mel tem um papel fundamental na manutenção da relação da violência, uma vez que é nesta fase que o agressor usa algumas das estratégias de poder e controlo para manter a vítima na díade relacional. Os dados estatísticos sobre a incidência da violência doméstica confirmam a existência desse ciclo uma vez que estas vítimas têm em comum a experiência repetida deste tipo de vitimação ao longo da vida (veja-se FRA, 2014).

Em Portugal, segundo o Relatório Anual de Segurança Interna, no ano de 2018, 78,6% das vítimas de violência doméstica eram do sexo feminino, sendo 83,5% dos denunciados do sexo masculino (SSI, 2019). A este respeito importa mencionar que o crime de violência doméstica em Portugal, previsto no artigo 152º do Código Penal, contempla,

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[9] "...entendida como uma violação dos direitos humanos e como uma forma de discriminação contra as mulheres e significa todos os actos de violência baseada no género que resultem, ou sejam passíveis de resultar, em danos ou sofrimento de natureza física, sexual, psicológica ou económica para as mulheres, incluindo a ameaça do cometimento de tais actos, a coerção ou a privação arbitrária da liberdade, quer na vida pública quer na vida privada." (Conselho da Europa, 2011, p. 4).

[10] Veja-se mais em UNWOMEN (2019).

além das relações de intimidade propriamente ditas, outro tipo de relações, nomeadamente progenitor de descendente comum em 1.º grau (alínea c, do referido artigo) e pessoa particularmente indefesa (alínea d). Este relatório anual contempla ainda, e bem, como violência doméstica, o artigo 152.º-A, relativo a maus tratos, que inclui como vítimas qualquer pessoa que seja menor ou particularmente indefesa em razão de idade, deficiência, doença ou gravidez. Ora, estas diversas inclusões na categoria criminal, e por sua vez, a não especificação dos diferentes tipos de violência doméstica registadas pelas forças policiais, leva a que não se possam retirar conclusões diretas sobre a percentagem de vítimas mulheres nos crimes de violência doméstica em contexto de intimidade. Não obstante, apesar desta limitação, é possível verificar que, no ano 2018, 69,8% dos/as denunciados/as tinham, ou haviam tido, uma relação de intimidade com a vítima, sendo que 53,1% correspondia a uma relação atual e 16,7% a uma relação anterior (SSI, 2019).

Diante desta caracterização, a consideração da vitimação feminina nas relações de intimidade mostra-se de especial importância para uma melhor compreensão do medo do crime reportado pelas mulheres. Este medo resultante da violência na intimidade, tem sido referido pela literatura como uma forma de "terrorismo privado" ou "terrorismo na intimidade, pela sua natureza, dinâmica e intensidade" (Caputi & Russell, 1992; Fitz-Gibbon, Walklate, McCulloch, & Maher, 2018; Pain, 2012, 2014). Ainda assim, a Criminologia não tem aprofundado reflexões sobre a relação entre medo do crime e violência (Broll, 2014; Madriz, 1997a). A escassa literatura que foca o medo do crime e violência na intimidade demonstra que a vitimação prévia por parceiro íntimo se associa positiva e significativamente ao medo do crime (veja-se em Broll, 2014; Carcach & Mukherjee, 1999; Iglesias, 2019).

Ademais, a literatura tem identificado alguns fatores de risco que estão associados às manifestações do poder e do controlo na violência na intimidade. Alguns desses fatores merecem um especial destaque por se relacionarem especialmente com o medo do crime para

as mulheres, nomeadamente: a perseguição (McFarlane, Campbell, Wilt, Sachs, Ulrich & Xu,1999), a tentativa ou efetiva separação (Femicide Census, 2018; Stark, 2007; Polk, 1994) e a denúncia da violência doméstica vivenciada (Campbell, Glass, Sharps, Laughon & Bloom, 2007). De forma semelhante, estes fatores também surgem como importantes fatores de risco do homicídio na intimidade (Campbell et al., 2003; Dobash, Dobash, Cavanagh & Medina-Ariza, 2007; Femicide Census, 2018; McFarlane et al., 1999).

Homicídio em contexto de intimidade e femicídio

O caminho teórico construído até aqui, desde a conceptualização do medo do crime, passando pelas formas de violência contra as mulheres mais prevalentes, nomeadamente a violência na intimidade, foi um percurso necessário para introduzir de forma contextualizada a relação que será objeto de reflexão no presente artigo: o medo do crime e o homicídio na intimidade ou femicídio na intimidade.

O homicídio em contexto de intimidade é a manifestação última do exercício de poder e controlo de uma das partes da relação sobre o/a parceiro/a íntimo/a e, não raras vezes, o ponto final numa relação pautada pela existência de violência física, psicológica e/ou sexual (Brennan, 2016; Campbell, Glass, Sharps, Laughon, & Bloom, 2007).

O homicídio, numa visão mais global, tem geralmente como principais vítimas os homens (Almeida, 1999; Daly & Wilson, 1988; UNODC, 2013). No entanto, existe aqui um paradoxo quando a questão da intimidade é introduzida: a maior parte das vítimas de homicídio em contexto da intimidade é do sexo feminino (SSI, 2019; Stöckl et al., 2013). Sem menosprezar a importância do todos os homicídios, o presente artigo, pelas razões já expostas, terá como foco a morte de mulheres no contexto das relações de intimidade.

Segundo dados das Nações Unidas, mais de um terço das mulheres que foram mortas, em 2017, foram vitimadas por um parceiro íntimo, atual ou passado - alguém que, como o

relatório identifica, estas vítimas "esperariam à partida poder confiar"[11] (UNODC, 2018, p. 10). O mesmo relatório destaca que, na Europa, a percentagem de mulheres mortas por (ex)companheiros íntimos corresponde a 28% (UNODC, 2018).

Como já abordado, os dados de Portugal sobre o homicídio estão reunidos no Relatório Anual de Segurança Interna (RASI). Segundo este documento, pode afirmar-se que do total de homicídios cometidos em Portugal, 13,6% são homicídios cometidos na conjugalidade ou situação análoga. Deste total, 68,2% das vítimas eram mulheres.

Uma outra fonte de informação nacional sobre morte de mulheres por homicídio é o OMA - Observatório de Mulheres Assassinadas desenvolvido pela UMAR - União de Mulheres Alternativa e Resposta. Segundo os dados do OMA foram assassinadas, entre 1 de janeiro e 31 de dezembro de 2018, 28 mulheres. Segundo este Observatório, que tem como fonte as notícias sobre homicídios publicadas diariamente num jornal nacional, 68% das mortes de mulheres decorreram em contexto de intimidade (OMA-UMAR, 2019).

As mortes de mulheres em contexto de relação de intimidade têm particularidades e características que são diferenciadas dos outros contextos. Alguns estudos apontam para uma análise mais genérica das diferenças entre homicídios em contexto de intimidade e outros contextos (Avakame, 1998; Caman, Howner, Kristiansson, & Sturup, 2016; Polk & Ranson, 1991; Pontedeira, Sousa, Cruz, Almeida, & Grangeia, 2017), outros estudos, por sua vez, exploram claramente as especificidades dos homicídios de mulheres em contexto de intimidade (Moracco, Runyan, & Butts, 2003; Violence Policy Center, 2017; Waiselfisz, 2015). De modo geral, os resultados apontam para diferenças substanciais entre os homicídios cometidos em contexto de intimidade e homicídios cometidos noutros contextos, nomeadamente no que diz respeito à existência de premeditação e outras formas de violência

[11] Tradução livre das autoras. No original: "someone they would normally expect to trust".

- especialmente física e sexual - envolvidas no cometimento do crime (Pontedeira et al., 2017). Quando se colocam em foco os crimes de homicídio na intimidade cometidos contra mulheres algumas diferenças tornam-se particularmente relevantes, especialmente o facto de que, na maioria dos casos, se identificam relações de violência prévia. Christina Nicolaidis e colegas (2003), num estudo que envolveu entrevistas profundas a 30 mulheres vítimas de tentativa de homicídio e concluíram que 67% destas tinham historial de violência física ou sexual repetida. A grande maioria destas vítimas tinha perceção do risco que corriam, especialmente quando já existiam ameaças de morte e escalada de violência.

A necessidade de poder e controlo por parte do homem na relação está também frequentemente associada à existência de relações violentas e não igualitárias (Nicolaidis et al., 2003; Polk, 1994). Na verdade, muitas das vezes, os homicídios acontecem quando o homem se apercebe que poderá estar a perder o controlo da vítima, por exemplo através da tentativa de separação por parte desta (Campbell, 1995; Campbell et al., 2003; Daly & Wilson, 1988; Nicolaidis et al., 2003). A não aceitação do término das relações e os ciúmes têm sido apontadas como as principais razões que motivam os homicídios de mulheres por parte de ofensores do sexo masculino (Vatnar, Friestad, & Bjørkly, 2018; Polk 1994). De forma contraditória, quando se exploram as razões pelas quais as mulheres matam companheiros íntimos do sexo masculino, surge uma motivação inexistente no sexo oposto: o medo. No estudo de Vatnar, Friestad e Bjørkly (2018) 3 das 20 mulheres mataram o companheiro por medo, enquanto que em nenhum dos 157 casos de ofensores masculinos esta motivação foi sugerida. Esta teoria é também suportada por Eriksson e Mazerolle (2013) e por Carline (2005) nos seus trabalhos que também associam o medo como uma das motivações mais frequentes.

Reconhecendo as especificidades dos homicídios de mulheres, anteriormente focadas, Sofia Neves (2016) aponta que “muitos países falham a adoção de uma lente de género na

compreensão do crime de homicídio contra as mulheres, deixando de lado os fatores estruturais que o enquadram" (p. 10). Alguns/mas autores/as apelam, portanto, à necessidade de nomear claramente este crime específico para que possam existir desenvolvimentos académicos, políticos, judiciais direcionados e adequados ao fenómeno (Diniz, Costa & Gumieri, 2015). A partir desta necessidade de nomeação, surge a proposta do uso do termo de 'femicídio'. A literatura aponta que o termo 'femicídio' surge pela primeira vez numa sátira sobre a cidade de Londres de John Corry (1801) ainda que de forma pouco contextualizada. Mais tarde o termo é associado a uma antologia da autoria de Carol Orlock (Radford & Russell, 1992). No entanto esta antologia nunca chegou a ser publicada e por isso não é possível ter uma visão compreensiva do que esta autora entendia como femicídio. Diana Russell é a autora mais associada ao termo 'femicídio' uma vez que reavivou e desenvolveu o conceito, não só academicamente como na prática. Russell terá usado pela primeira vez o termo 'femicídio' no Tribunal Internacional sobre os Crimes contra as Mulheres, em 1976, numa chamada de atenção para a morte de mulheres motivada por questões de honra.

Em 1992, surge a primeira publicação académica intitulada de: *Femicide: The Politics of Women Killing* (Radford & Russell, 1992). Na introdução deste livro fica claro que o "Femicídio, a morte misógina de mulheres por homens, é uma forma de violência sexual"[12] (Radford & Russell, 1992, p. 3). Segundo o entendimento das autoras, a violência sexual não se caracteriza apenas pela necessidade de obtenção de prazer com o corpo feminino, mas também pelo desejo masculino de deter poder, dominância e controlo (Radford & Russell, 1992). Alguns anos mais tarde, Diana Russell atualiza a sua definição de femicídio, focando-o como "a morte de mulheres por homens, porque elas serem mulheres"[13] (Russell, 2001: 3).

[12] Tradução livre das autoras. No original: "Femicide, the misogynous killing of women by men, is a form of sexual violence".
[13] Tradução livre das autoras. No original: "the killing of females by males because they are female"

Na América Latina, Marcela Lagarde y de los Ríos, que havia já traduzido para Espanhol o livro de Radford e Russell, ressignifica o conceito, propondo o uso do termo de 'feminicídio'. Segundo a autora é também importante acrescentar à definição de Russell a responsabilidade do Estado, nomeando a frequente passividade do Estado perante estas mortes (Lagarde, 2006).

Ao longo do tempo, vários/as autores/as propuseram categorizações de femicídio, incluindo diversos tipos de mortes de mulheres motivadas por questões de género. Em 2013, na primeira das publicações anuais do Academic Council on the United Nations System (ACUNS) Vienna Liaison Office, o femicídio é descrito como "a última forma de violência contra mulheres e raparigas e com múltiplas formas. As suas causas são várias e estão enraizadas nas relações de poder historicamente desiguais entre homens e mulheres e na sistemática discriminação baseada no género"[14] (ACUNS, 2013, Foreword). O encontro que precedeu esta publicação, foi o primeiro simpósio das Nações Unidas sobre o Femicídio realizado a 26 de novembro de 2012, em Viena. Deste simpósio resultou a Declaração de Viena sobre o Femicídio (2012) onde são classificados os vários tipos de femicídio[15] e se chama a atenção dos Estados para agir, no imediato, para proteção das mulheres e meninas quanto a estas formas de femicídio.

Atualmente, em resposta a este desafio de um melhor entendimento sobre o femicídio, tem-se assistido ao crescimento de observatórios e monitores do femicídio. A título exemplificativo, nomeiam-se o Femicide Watch, o Canadian Femicide Observatory for

[14] Tradução livre das autoras. No original: "Femicide is the ultimate form of violence against women and girls and takes multiple forms. Its many causes are rooted in the historically unequal power relations between men and women and in systemic gender-based discrimination." (p. Foreword)

[15] "the murder of women as a result of intimate partner violence; 2) the torture and misogynist slaying of women 3) killing of women and girls in the name of " honour"; 5) targeted killing of women and girls in the context of armed conflict; 5) dowryrelated killings of women; 6) killing of women and girls because of their sexual orientation and gender identity; 7) the killing of aboriginal and indigenous women and girls because of their gender; 8) female infanticide and gender-based sex selection foeticide; 9) genital mutilation related femicide; 10) accusations of witchcraft and 11) other femicides connected with gangs, organized crime, drug dealers, human trafficking, and the proliferation of small arms" (Vienna Declaration on Femicide, 2012: 1).

Justice and Accountability (ambos lançados em 2017) e o Observatório Europeu do Femicídio (que surge em março 2018). Estes progressos demonstram também que existe, cada vez mais, um foco político e social dirigido à importância de conhecer as especificidades do femicídio para melhor o prevenir.

Considerando as várias definições de femicídio apresentadas, importa finalmente mencionar que no presente artigo, o foco irá ser apenas nos femicídios que são cometidos em contexto de intimidade, ou seja, nas mortes de mulheres por parceiros íntimos atuais ou passados, a que chamaremos de femicídio na initmidade (tal como Dawson & Gartner, 1998; Johnson, Eriksson, Mazerolle, & Wortley, 2017; Kerry, 2001; Stout, 1992).

Medo e Femicídio na Intimidade

A primeira reflexão que urge focar é que, estranhamente, não há muitos estudos que relaciona explicitamente o medo do crime e o femicídio na intimidade. Na verdade, o medo é explorado na literatura como uma dimensão que permite a manutenção das relações de violência e o controlo coercivo na intimidade (ver, por exemplo, Health Quality and Safety Commision New Zealand, 2015). Esta fomentação do medo por parte do companheiro íntimo ao longo da relação, e que inclusivamente muitas vezes se manifesta em ameaças de morte, faz com que a vítima viva num constante clima de terror e medo. Estes sentimentos, muitas vezes não são devidamente valorizados pelas instâncias de apoio, formais e informais, que rodeiam a vítima, pois se o fossem, como já referido, talvez, algumas destas mortes pudessem ser evitadas.

A existência deste medo por parte das vítimas antes do homicídio ou da tentativa de homicídio está claramente identificada em vários estudos. Um estudo exploratório das razões pelas quais 23 vítimas de femicídio na intimidade, em Espanha, não denunciaram o ofensor anteriormente, aponta o medo como a terceira razão mais mencionada pelos profissionais,

familiares e amigos/as destas vítimas (Pérez & Fiol, 2016). A realidade portuguesa também não se revela muito diferente. Uma revisão de António Castanho (2015) relativa a 20 homicídios na intimidade cometidos em Portugal, indica, não só que em quase metade dos casos a vítima tinha medo de ser morta pelo ofensor, como conclui pela necessidade de considerar os vários fatores de risco, incluindo o sentimento de medo, não como eventos isolados, mas sim como padrões comportamentais (Castanho, 2015).

Algumas investigações que focam as mulheres como ofensoras deste tipo de crime também argumentam, em vários momentos e de diversas formas, que as mulheres matam pelo medo de morrer (Ballinger, 2005; Ferreira, Neves, & Gomes, 2018). No entanto, nenhum destes estudos explora expressamente a dimensão do medo do crime na determinação do homicídio. Uma das exceções será o estudo de Elicka Peterson (1999) que menciona o papel do medo e do uso da violência letal enquanto mecanismos de sobrevivência por parte das mulheres que sofrem violência doméstica.

O medo sentido pelas vítimas antes de serem mortas é, muitas vezes, como se fará ver, reportado e denunciado a outras pessoas. Este medo representa a manifestação emocional mais evidente do perigo que correm, e assenta na realidade da violência experienciada e por esse motivo não deve ser ignorado (Women's Aid, 2016). Uma breve análise da literatura permite concluir que em muitas das análises retrospectivas de homicídios na intimidade nacionais e internacionais apontam para a existência do medo das vítimas antes da consumação do crime (ver, por exemplo: EARHVD, 2017a, 2017b, 2017c, 2018, sobre Portugal; Cheltenham Strategic Leadership Group, 2016 sobre o Reino Unido; Family Violence Death Review Committee, 2014, sobre a Nova Zelândia). Para além disso, as principais recomendações elaboradas a partir destas análises retrospetivas em Ontário, destaca inclusivamente que a sensação intuitiva de medo por parte da vítima é um dos

maiores fatores de risco de homicídio e que, se a vítima revela este medo a outra pessoa, este é um definitivo indicador de risco de vida eminente (Dawson & Jaffe, 2016; Lucas, 2015).

Em contexto português, importa destacar que a Equipa de Análise Retrospetiva de Homicídio em Violência Doméstica[16] desenvolveu cinco análises retrospetivas entre outubro de 2017 e março de 2019 e que, em quatro delas, o medo do ofensor ou medo de serem mortas foi previamente identificado pelas vítimas. Esta Equipa não só consegue identificar retrospetivamente que este medo estava presente como, em muitos dos casos, conclui que este medo foi identificado também pelas próprias forças de segurança como um fator de risco (vejam-se os casos descritos nos relatórios: EARHVD, 2017a e 2017c). Em alguns casos foi ainda possível perceber alguns dos comportamentos adotados para prevenir a violência e evitar serem mortas. O medo é tão presente na vida destas mulheres que, como citado num dos casos, as obriga a "munir a sua habitação de armadilhas, como por exemplo, ligar o fio de corrente elétrica aos estores, colocar trancas de madeira nas janelas" (EARHVD, 2017b, p. 5) como meio de evitar a aproximação do agressor. Neste exemplo, os atos descritos ocorreram em consequência do medo sentido e são evidência clara do terrorismo íntimo pelo qual a vítima estava a passar e que pautou os seus últimos anos de vida.

A propósito destas equipas de análise retrospetiva de homicídios cabe ainda referir que em nenhum destes relatórios, quer nacionais, quer internacionais, se identificam conclusões concretas relativas ao medo manifestado pelas vítimas, nomeadamente à importância de o ter em consideração, e especialmente quando a vítima tem o ato de coragem de o verbalizar.

[16] Para informações mais detalhadas sobre a missão e objetivos desta equipa, visitar: https://earhvd.sg.mai.gov.pt/

Conclusões

O presente artigo propõe uma breve reflexão teórica com a finalidade de integrar os construtos do medo do crime e do femicídio na intimidade. Uma leitura mais abrangente acerca do medo do crime reportado pelas mulheres implica considerações não apenas relativas à sua operacionalização, mas também da necessidade de reflexões mais profundas acerca da própria natureza concetual da expressão (Walklate, 2004). Muito embora os primeiros desenvolvimentos em Criminologia sobre o tema sugeriram um conceito de medo do crime enquanto fruto das ameaças da vida urbana, é preciso reconhecer que, especialmente em relação às mulheres, tal conceção não se mostra suficientemente adequada. Neste sentido, é importante ajustar a lente de análise do medo do crime para reconhecer a importância dos crimes cometidos nos espaços de intimidade, nomeadamente quanto ao impacto que possam ter no medo do crime reportado pelas mulheres. O primeiro passo para esta leitura é, sem dúvida, a superação da ideia de que a experiência do medo (re)conhece as tradicionais barreiras entre o que é público e o que é privado. Por outras palavras, o medo do crime manifesta-se como resultado das experiências vividas - sejam elas na rua, com estranhos; sejam elas no âmbito das relações de afeto ou intimidade. Esta consideração aponta para uma viragem conceptual e interpretativa na forma de se estudar e conceber o medo do crime e especificamente, o medo do crime experienciado pelas mulheres. Dados internacionais mostram que, em todo o mundo, 1 em cada 3 mulheres foi vítima de violência na intimidade perpetrada por atual ou ex-parceiro íntimo (UNWOMEN, 2019). Dentre todas as formas de violência experienciada neste contexto, a mais grave é o femicídio na intimidade (que pode assumir forma tentada ou consumada). Conforme reflexão já explorada o femicídio, sendo o ‘último degrau’ da violência exercida contra a mulher manifesta-se após uma série de ciclos de violência, medo e terror experienciado pelas vítimas ao longo dos dias, meses ou anos da vida. Assim, se por um lado o medo das mulheres, segundo as pesquisas tradicionais de

vitimação, parece exagerado ou não demonstra uma concreta razão de ser; por outro lado, as estatísticas sugerem que, em muitas situações, "...a casa, ou a área mais 'privada' das mulheres, não é um escape para o medo"[17] (Walklate, 2004, p. 93).

Esta breve revisão teórica procurou operacionalizar este dois construtos conjuntamente e explorar a forma particular como se interrelacionam. Assim, é possível concluir sobre a essencialidade de que os estudos sobre o medo do crime passem a integrar outras dimensões específicas do crime (deslocando-se do estudo genérico de medo, referente quase exclusivamente à criminalidade de rua). Como segunda conclusão, aponta-se também a importância de se atentar quanto ao medo referido pelas vítimas, uma vez que ele se encontra evidenciado em momentos anteriores ao femicídio. Portanto, este medo funciona, muitas vezes, como um sinal de alerta quanto aos riscos efetivamente vivenciados, o qual deve ser identificado e validado pelas redes de apoio formais e informais com o fim de tornar o femicídio um desfecho evitável.

[17] Tradução livre das autoras. No original: "...the home, or 'private' area of a woman's life, is not an escape from fear".

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Fear of crime and intimate femicide: theoretical considerations

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Abstract

Insecurity and fear of crime have been increasingly studied by social sciences, including Criminology. Literature in this field converges towards the paradox that women report highest levels of fear of crime, despite the fact that they are less victimised by general crime than men. However, when analysing the crimes that are committed in the spaces of intimacy, women are, disproportionately, more victimized than men and this could explain their feeling of insecurity, given their experience both in public and in private spaces. Intimate femicide, as the last and most severe manifestation of violence against women in intimate relationships, is a transversal phenomenon that can not be ignored. This paper provides a brief theoretical review of the interconnections between women's fear of crime and intimate femicide. From this review, it is possible to conclude that these two concepts are rarely examined and explored together despite their close link. Aiming to fill this gap, this paper facilitates a theoretical integration between these themes hitherto not explored together by Criminology field.

Keywords: fear of crime; femicide; intimate partner violence

"Femicide tragically robs a girl or woman of life.
In addition to the finality of this cruel and intentional act,
many girls and women experience
multiple acts of violence, degradation, psychological and physical isolation, fear,
and terror in the hours, months or years before they are killed.
Their experience is one of profound suffering;
then they are forever silenced and forever lost."[18]

Fear of crime

Crime and deviance are subjects of particular interest in Criminology. According to the metaphor of Kuhn and Agra (2010), Criminology stands for the crime just as climatology stands for the climate. If it is agreed that the climatology involves much more knowledge than informing if it will rain or not on a specific day, also Criminology is more complex than to inform that a particular crime occurred. Criminology is the area responsible for the investigation and production of scientific knowledge about the complex phenomenon that is a crime, as well as its related factors and social life's implications, going beyond the lay public debate on the subject.

The feeling of insecurity or fear of crime is a theme that has drawn the attention of Criminological Studies over the past 40-50 years, following the formulation of 'moral panic' theorised in the 1970s by Stanley Cohen (2011). Cohen's theory is closely linked to social reactions and anxieties facing the emergence of delinquent subcultures and, more specifically, to the attention that the mass media give to crime news. The analysis of crimes by the media often happens with some selectivity and exaggeration, turning news into useful material for social reaction, permeating cultural debates, influencing press practices and also

[18] Baker, Etherington, Pietsch, Straatman, Ansems, Barreto & Campbell, 2015: 1

finding an echo in political discourse (Garland, 2008). However, the extreme attention captured by the triggering episodes of moral panic, to some extent, "obscures the broader picture, directing attention away from an examination of the general structures of feeling and concern around risk, crime, and victimization" (Godfrey, 2017, p. 11). New conceptual nuances emerged within Criminology to a better understanding of the public's perceptions and concerns about crime. In this context, the discourses about insecurity and fear of crime began to be explored mainly concerning crimes that occur in public spaces - or street crimes - that have become evident in the face of the new conjunctures of large urban centres. Fear of crime has become the subject of scientific research as well as political intervention (Garofalo, 1979; Simon, 2017). Victimisation surveys are then created and implemented with the primary objective of knowing the real extent of victimisation and also capturing the citizens' perception of their security and the safety of their cities and home areas (Van Dijk, 2007; Gray, Jackson & Farrall, 2012).

First studies on feelings of insecurity were carried out in the United States and were subsequently disseminated throughout the world. As a general practice, measures used are related to questions such as "*How safe do you feel being out alone after dark*?" or "*How safe do you feel being out alone in your neighbourhood after dark*?" (see also Hale, 1996, p. 85). Although these type of questions can be useful for the study on insecurity in a more broader way, these global measures do not seem to be sufficient[19] to address the complexities underlying fear of crime (Hale, 1996; Hardyns & Pauwels, 2010). Some criticisms relating to the ways of measuring fear of crime have been enumerated by Gray, Jackson and Farrall (2012), highlighting: i) absence of explicit reference to crime in questions; (ii) in general, these questions refer to vague geographical areas; iii) some confusion between what is fear

[19] "Nevertheless, the complexity of a concept such as fear of crime demands further studies on the different components of fear, before one moves on to an explanation of fear based on survey data." (Hardyns & Pauwels, 2010, p. 4).

and conceptions about risk[20]. This insufficiency seems to be more prominent when the study focuses on the fear reported by women, since, in addition to the criticisms already pointed out in the literature, these questions seem to ignore the fear experienced in private and semi-private spaces (Broll, 2014; Madriz, 1997a; Pain, 2012).

Similarly, with the measurements criticism, the definition of fear of crime is not theoretically unanimous (Hale, 1996, Hinkle, 2015). The literature indicates that fear of crime is a multifaceted, multidimensional phenomenon, and it has a threefold structure. According to these theories, fear of crime comprises cognitive, behavioural and affective dimensions (Gouseti, 2017; Guedes, 2012, 2016; Hardyns & Pauwels, 2010). The cognitive dimension refers to the (self) evaluation of the risk and the likelihood of a person becoming a victim of a crime. The second, behavioural dimension, refers to the behaviours adopted in order to prevent or avoid the risk. Finally, the third dimension, which is associated with affectivity, refers to the emotional reaction triggered by the person's victimisation experience or the threat of its possibility (Gouseti, 2017).

In this paper, the reflection will fall precisely on the affective component of the fear of crime; that is, the fear of crime experienced as emotion. Thus, it is crucial to emphasise Ferraro's definition (1994) of fear of crime as an "*emotional response of dread or anxiety to crime or symbols that a person associates with a crime*" (p. 4).

Women and fear of crime

Despite some terminological divergences, a collective agreement in most of the research within this field of study is that gender is often a predictor of fear of crime. Some authors realize that despite women are those who report the highest levels of fear of crime;

[20] A deeper analysis of the suggested criticism can be consulted in Gray, Jackson & Farrall (2012).

paradoxically, men are the most victimized by the so-called "street crime" (Hale, 1996; Madriz, 1997b; Stanko, 1992; Warr, 1984).

The disproportion between the high fear reported by women and their low probability of becoming a victim of crime in public spaces has been named as the 'fear-victimisation paradox', and this concept is still maintained in use today (Hale, 1996; Bilsky, 2017). Given this paradox, initially, the women's fear of crime was considered not only disproportionate but also, irrational (Young, 1987). Various theories have been raised in an attempt to find explanations for this paradox; and explain, after all, what women afraid of? Thus, when studying women's fear (or female fear), it is essential to consider the real extent of the victimisation to which women are often exposed (Hale, 1996). A detailed analysis of the female victimisation around the world leads to a concluded that crimes that disproportionately reach more women are based on structural gender-related issues. According to Esther Madriz, gender differences in levels of fear of crime can be explained, to some extent, by dominant images that reflects a dualistic view in which women are considered as fragile and passive and, on the other hand, men are strong and assertive (Madriz, 1997a; Lane, 2013). These inequalities, consequently allow space to the perpetration of various forms of violence socially established. It is, therefore, important to briefly discuss here these forms of violence most commonly perpetrated against women.

The Istanbul Convention defines gender-based violence against women[21] as " *violence that is directed against a woman because she is a woman or that affects women disproportionately*" (Council of Europe, 2011, p. 4). This disparity identified by the document is rooted in gender inequalities and gender stereotypes based on socially assigned

[21] The Council of Europe Convention on preventing and combating violence against women and domestic violence.

roles to women and men[22]. It is essential a gender approach in understanding and reading issues of insecurity[23], which implies the recognition that fear of crime is not a gender-neutral concept. More than that, it is a phenomenon that is situated in the course of daily life and is not limited to the barriers between the public and private spaces (Fitz-Gibbon & Walklate, 2018).

Intimate partner violence and fear of crime

Although the Istanbul Convention lists other forms of violence against women[24], this paper focuses on that form of violence considered as potentially the most serious: homicide, or more specifically, intimate homicide[25]. Before the reflection about intimate partner homicide, it is essential to refer to the broader background that often characterises these deaths, which is domestic violence. Domestic violence and, more specifically, intimate partner domestic violence, is a crime which manifestation is characterised by cycles of violence. As proposed by Lenore Walker (1979) these cycles are composed by three main phases: phase 1 - tension; phase 2 - explosion (where violence takes place); phase 3 - honeymoon (in which the perpetrator manipulates and persuades the victim that the violence will not happen again). As a cycle, these phases are repeatable, and the transition between them is increasingly quick and more severe. The honeymoon phase plays a crucial role in maintaining violence since it is at this stage that the abuser uses some of the power and control strategies to keep the victim prisoner in the relationship. Statistical data on the

[22] It is not the aim of this article to not provide a detailed explanation of existing gender inequalities and other inequalities, so further reading for a broader understanding of the impact these inequalities have on the daily lives of women and girls, including its support for gender-based violence is recommended (see also Lombard, 2017; Neves & Costa, 2017; Renzetti, Miller, & Gover, 2018).

[23] Not only on issues of insecurity, as well referred to by Fitz-Gibbon and Walklate, "there is still a great deal of work to be done in understanding the place of gender in much criminological endeavour and the fear of crime debate is no exception to this" (2018, pp. 87-88).

[24] understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Council of Europe, 2011, p. 4).

[25] More information at: UNWOMEN (2019).

incidence of domestic violence confirm the existence of this cycle and that victims have in common the repetition of this victimisation process throughout life (see FRA, 2014).

According to the Annual Internal Security Report, in Portugal in 2018, 78.6% of the victims of domestic violence were women, and in 83.5% of the cases, the perpetrators were men (SSI, 2019). Domestic violence in Portugal, foreseen in article 152 of the Penal Code, includes violence within intimate relationships but also includes other relationships, namely violence towards a parent or a common first-degree descendant (152, c) and person particularly defenceless (d). This annual report also includes maltreatment as domestic violence, in which the victim may be any minor or particularly defenceless person on the grounds of age, disability, illness or pregnancy (Article 152a).

These inclusions in the criminal category and the failure of the report to specify the different types of domestic violence do not allow conclusions to be drawn about the prevalence of adult female victims in intimate partner domestic violence. Despite this limitation, it is possible to conclude that, in 2018, 69.8% of the perpetrators were intimately related with the victim - 53.1% corresponding to a current relationship and 16.7% to former relationships (SSI, 2019).

Given this characterisation, it is crucial to consider the extent of female victimisation in intimate relationships for a better understanding of the fear of crime reported by women. The constant fear of violence in intimacy has been referred to in the literature as a form of "private terrorism" or "intimate terrorism, by its nature, dynamics and intensity" (Caputi & Russell, 1992; Fitz-Gibbon, Walklate, McCulloch, & Maher, 2018; Pain, 2012, 2014). Nevertheless, Criminology has not deepened reflections that integrates fear of crime and intimate violence (Broll, 2014; Madriz, 1997a) and the scarce literature that focuses on these topics shows that prior victimisation by an intimate partner is positively and significantly

associated with fear of crime (see also in Broll, 2014; Carcach & Mukherjee, 1999; Iglesias, 2019).

Moreover, scientific production has identified some risk factors for violence that are associated with the manifestations of power and control. These factors are related to women's fear of crime, stalking (McFarlane, Campbell, Wilt, Sachs, Ulrich & Xu,1999), divorce or attempted separation (Femicide Census, 2018; Stark, 2007; Polk, 1994) and the domestic violence reported (Campbell, Glass, Sharps, Laughon & Bloom, 2007). Similarly, these risk factors also arise as associated with intimate homicide (Campbell et al., 2003; Dobash, Dobash, Cavanagh & Medina-Ariza, 2007; Femicide Census, 2018; McFarlane et al., 1999).

Intimate Partner Homicide and Femicide

The theoretical ground constructed from the fear of crime conceptualisation up to the violence against women, including intimate partner violence, was a necessary path to explore further the topic proposed in this paper: fear of crime and intimate partner homicide, or intimate femicide.

Intimate partner homicides are the last factual manifestation of the use of power and control above another person, in this case, an intimate partner. It is often the result of several years of physical, psychological and sexual violence (Brennan, 2016; Campbell, Glass, Sharps, Laughon, & Bloom, 2007).

Homicide, in its general perspective, has males as the primary victims (Almeida, 1999; Daly & Wilson, 1988; UNODC, 2013). However, there is a paradox when intimate homicides are analysed: most of the victims are female (SSI, 2019; Stöckl et al., 2013). Despite all crimes being equally important, this paper will focus the female victims.

According to the United Nations, more than a third of the intentional women's killing in 2017, were killed by their intimate partners, either current or estranged - "someone they

would normally expect to trust" (UNODC, 2018, p. 10). This report also emphasizes that in Europe, the percentage of women's killed by intimate partners in 2017 corresponds to 28% (UNODC, 2018).

As previously explored, official statistical data about Portuguese homicides can be explored in the Annual Report of Internal Security. According to this report, it is possible to recognise that from the total number of homicides, 13.6% are intimate partner homicide, being 68.2% of the victims of these killings female.

The Observatory of Murdered Women kept by Alternative and Response Women's Association (a non-governmental national organization), counts 28 women killed between 1 January and 31 December 2018. Having newspapers as data sourse, this Observatory estimates that 68% of the femicides in 2018 were in the intimate context (OMA-UMAR, 2019).

Female homicides in intimate contexts have particularities and characteristics that distinguish these killings from other types of killings. Whilst some studies focus on the general differences between intimate homicides and other homicide's contexts (Avakame, 1998; Caman, Howner, Kristiansson, & Sturup, 2016; Polk & Ranson, 1991; Pontedeira, Sousa, Cruz, Almeida, & Grangeia, 2017), other studies specify the particularities of the female killings (Moracco, Runyan, & Butts, 2003; Violence Policy Center, 2017; Waiselfisz, 2015). Generally, it can be said that results demonstrate that there are significant differences between intimate partner homicides and other contexts namely the higher degree of premedication and other forms of violence involved (Pontedeira et al., 2017). When intimate femicide is analysed, and therefore, the focus is on female victims, it is possible to conclude that in most of the crimes, there was a previous domestic violence history. Christina Nicolaidis and colleagues (2003), used in-depth interviews with women who survived intimate homicide attempts and concluded that 67% of these women had previously

experienced repeated physical or sexual violence. Most of these victims had a bright feeling of their risk, especially after the death threats and escalation of violence they suffered.

The need for power and control by the male figure in the intimate relationship is associated with violent and non-egalitarian relationships (Nicolaidis et al., 2003; Polk, 1994). Many of the killings happen when the murderer realises that he is losing control over the victim, for example when she attempts to separate from him (Campbell, 1995; Campbell et al., 2003; Daly & Wilson, 1988; Nicolaidis et al., 2003). The non-acceptation of the end of relationships and jealousy have been presented as two of the main reasons that motivate the intimate partner homicides perpetrated by male offenders (Vatnar, Friestad, & Bjørkly, 2018; Polk 1994). Female offenders have contrasting motivations to commit intimate partner homicides. There is a characteristic in female offenders history that is not present in male offenders: the fear of their partners. In a study conducted by Vatnar, Friestad and Bjørkly (2018), three of the 20 women who killed their intimate partner have indicated the fear as the motive for the crime. None of the 157 male offenders raised fear as motivation. This theory is also supported by Eriksson and Mazerolle (2013) and Carline (2005) in their researches in which they mention fear as associated with female intimate partner murderers.

Having in consideration the specificities of intimate femicide previously mentioned, Sofia Neves (2016) highlight that "many countries fail to adopt a gender lens in the comprehension of the female homicides, setting aside all the structural factors that frame them"[26] (p. 10). Some authors argue about the necessity of attribute clear labels to these specific crimes so that they can be easily understood and academic, politic and judicial developments are directed and adequate to this phenomenon (Diniz, Costa & Gumieri, 2015). Considering this necessity, some authors suggest the name of 'femicide'. Literature reference that the term 'femicide' was used for the first time despite devoid of its current context, in a

[26] Translated by the authors from the original version in Portuguese.

satire book about London, by John Corry (1801). Later the term is associated to an anthology of ‘femicide’ by Carol Orlock, but this was never published and therefore it is not possible to have comprehensive knowledge about what she meant by ‘feminicide’ (Radford & Russell, 1992). Diana Russell is the author most commonly cited as using and defining the term ‘femicide’. This author is responsible for the development and contextualization of the term, both in academia and in practice. Russell used ‘femicide’ for the first time in the first International Tribunal on Crimes Against Women, in Brussels, 1976, calling for attention for the killings of women motivated by honour (Radford & Russell, 1992).

In 1992, the first academic publication on femicide was released having as a title: *Femicide: The Politics of Women Killing* (Radford & Russell, 1992). In the introduction, this books defines ‘femicide’ as: “Femicide, the misogynous killing of women by men, is a form of sexual violence” (Radford & Russell, 1992, p. 3). According to these authors, sexual violence is not characterized by the necessity of having pleasure with the women’s body, but by the necessity ofholding power, dominance and control over women (Radford & Russell, 1992). Some years later, Diana Russell upgrades her definition on femicide, focusing it on “the killing of females by males because they are female” (Russell, 2001: 3).

In Latin America, Marcela Lagarde y de los Ríos, who was responsible for the translation of Radford and Russell’s book, gives another meaning to the term, suggesting the use of the ‘feminicide’ word. According to this author, it is crucial to add in Russell’s definition, the State responsibility and passivity regarding these killings (Lagarde, 2006).

Over the years, several authors proposed different categorisations of femicide, including and excluding different types of killings motivated by gender. In 2013, the Academic Council on the United Nations System (ACUNS) Vienna Liaison Office published the first edition several publications on Femicide. In this book, the definition used of femicide is the following: “Femicide is the ultimate form of violence against women and girls and

takes multiple forms. Its many causes are rooted in the historically unequal power relations between men and women and in systemic gender-based discrimination." (ACUNS, 2013, Foreword).

Before this set of publications, the first symposium on Femicide took place in Vienna on the 26th November 2012, where a Vienna Declaration on Femicide was signed as a result. This declaration classifies different types of femicide[27] and calls for immediate attention and action of State Members.

Currently, in response to the challenge of a better understanding of femicide, States and other institutions have been creating a set of different observatories and monitors of femicide. The Femicide Watch, the Canadian Femicide Observatory for Justice and Accountability (both launched in 2017) and the European Observatory on Femicide are examples of this growing of interest on understanding femicide. These also demonstrate that there is a political and social interest in knowing the phenomenon better to acknowledge what is possible to do in order to prevent it.

In this paper, the focus is only on femicide that is committed in intimacy, and therefore, the killings of women by their former or current partners. These will be named as intimate femicides (such as done by Dawson & Gartner, 1998; Johnson, Eriksson, Mazerolle, & Wortley, 2017; Kerry, 2001; Stout, 1992).

[27] "the murder of women as a result of intimate partner violence; 2) the torture and misogynist slaying of women 3) killing of women and girls in the name of " honour"; 5) targeted killing of women and girls in the context of armed conflict; 5) dowryrelated killings of women; 6) killing of women and girls because of their sexual orientation and gender identity; 7) the killing of aboriginal and indigenous women and girls because of their gender; 8) female infanticide and gender-based sex selection foeticide; 9) genital mutilation related femicide; 10) accusations of witchcraft and 11) other femicides connected with gangs, organized crime, drug dealers, human trafficking, and the proliferation of small arms" (Vienna Declaration on Femicide, 2012: 1).

Fear and Intimate Femicide

Strangely, there are not many studies that relate the fear of crime and intimate femicide. Fear is studied as a dimension that allows for the maintenance of relationships of violence and coercive control in intimacy (see, for example, Health Quality and Safety Commission New Zealand, 2015). This behaviour, fostered by the intimate partner during the relationship, and often manifested in death threats, leads the victim to live in a constant climate of terror and fear. These feelings are often not adequately valued by the formal and informal support instances surrounding the victim, and if they were perhaps some of these deaths could be avoided.

The fear felt by the victims before the homicide or attempted homicide is identified in several studies. An exploratory study of the reasons why 23 victims of intimate femicide in Spain did not previously denounce the offender, points to fear as the third most mentioned reason for professionals, relatives and friends of these victims (Pérez & Fiol, 2016). The Portuguese reality is not different. A review by António Castanho (2015) concerning 20 intimate homicides in Portugal indicates not only that in almost half of the cases the victim was afraid of being killed by the offender, but concludes that there is a need to consider the various risk factors, including feelings of fear, once this is not an isolated event, but a form of violence with behavioural patterns (Castanho, 2015).

Some research that focuses on women as offenders argue, at various times and in various ways, that women kill motivated by the fear of dying (Ballinger, 2005; Ferreira, Neves, & Gomes, 2018). However, none of these studies explicitly explores the extent of fear of crime in determining homicide. One of the exceptions is the study conducted by Elicka Peterson (1999) that mentions the role of fear and the use of lethal violence as a survival mechanism for women who experience domestic violence.

The fear felt by victims before being killed is often a fear reported by them to others. Fear is the clearest emotional manifestation of the danger that victim is facing; it is based on the reality of the violence experienced and hence should not be ignored (Women's Aid, 2016). Previous studies, including many of the retrospective national or international analyses of intimate homicides, suggests the existence of fear expressed by victims before the consummation of the homicide (e.g: EARHVD, 2017a, 2017b, 2017c, 2018, for Portugal; Cheltenham Strategic Leadership Group, 2016 for United Kingdom; Family Violence Death Review Committee, 2014, for New Zealand).

In addition, the main recommendations drawn from one of these retrospective analysis in Ontario highlight that the victim's intuitive sense of fear is one of the highest risk factors for homicide and that if the victim reveals this fear to another person, this is an indicator of an imminent risk to their lives (Dawson & Jaffe, 2016; Lucas, 2015).

In Portugal, it is essential to highlight that the Retrospective Homicide Review Team on Domestic Violence[28] developed five retrospective analyses between October 2017 and March 2019, and in four of them, the fear of the offender or fear of being killed was reported by the victims. In many cases, the team concluded that this fear was also perceived by the security forces as a risk factor for homicide (see the cases described in reports: EARHVD, 2017a e 2017c). In some cases, it was even possible to perceive how did fear shaped their behaviours to avoid both violence and homicide. As an example, in one of the cases, the fear is so powerful that obliges the victim to "*...provide their dwelling with traps, such as connecting the electric current to the blinds, putting wooden locks on the windows...*" (EARHVD, 2017b, p. 5) to avoid the aggressor approach. In this example, the acts described occurred as a consequence of the fear experienced and evidence the intimate terrorism suffered by the victim, which permeated her last years of life.

[28] For more information about this team, visit: https://earhvd.sg.mai.gov.pt/

Conclusions or recommendations regarding the importance of the victim's fear are not raised in none of the national or international domestic homicides reviews. Considering that victim's fear is often present, it would be important that these reports recommended both institutions and possible witness to have victim's descriptions of fear in consideration, especially if she has the act of courage or verbalising it.

Conclusions

This paper proposes a brief theoretical review to interconnect two topics: fear of crime and intimate femicide. A comprehensive reading of the fear of crime reported by women implicates a more in-depth analysis and understanding of its operationalisation, but also about its conceptual construction of this expression (Walklate, 2004). Despite the first studies in criminology about fear of crime raised conclusions about threats of urban life, it is fundamental ro recognize that this is not enough to understand completely the fear of crime reported by women. It is crucial to adjust our lens of analysis and recognize the importance of crimes committed in intimate spaces, namely domestic violence.

The first step is to overcome the idea that fear recognises the traditional barriers between what is public and what is private. The fear of crime manifests itself as a result of the lived experiences - both on the street, with strangers; and in the context of affection or intimacy, and this points to a conceptual and interpretive change in the way to research fear of crime and specifically the fear of crime experienced by women.

International data indicate that 1 in 3 women were victims of intimate violence perpetrated by current or former intimate partners around the world (UNWOMEN, 2019). In this context, among all forms of violence experienced, the most serious is the attempted or actual intimate femicide. According to the previous discussion, femicide, being the 'last step' of violence against women and manifests itself after a series of cycles of violence, fear and

terror experienced by the victims throughout their lives. Thus, while on the one hand, women's fear of crime seems exaggerated in the traditional surveys; on the other hand, data suggests that in many situations "*...the home, or 'private' area of a woman's life, is not an escape from fear*" (Walklate, 2004, p. 93).

This brief theoretical review sought to analyse these two topics together and to explore the particular way in which they interrelate. This article emphasises the need for fear of crime to be studied under the lens of other crimes, not restricted to street crimes. Besides, it is crucial to consider the fear referred by the victims since it is evidenced in moments before the femicide. This fear expressed by victims is often a warning sign about the risks experienced and must be identified and validated by formal and informal support networks to make femicide an avoidable outcome.

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Intimate Partner Violence among Immigrant Women:

Intersectional challenges in health services

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Abstract

In a world in progressive movement, with increasingly diverse societies, the number of women living in a multicultural and migration context is a recognized reality. Many immigrant women living in Portugal suffer intimate partner violence, however there are a lack of knowledge about these realities. This invisibility makes it difficult to understand their specific needs and difficulties. It is known that many cases of intimate partner violence remain unreported (FRA- European Union Agency for Fundamental Rights, 2014), which in the case of immigrant women may be more serious (WHO, 2014). Studies suggest that immigrant women face huge challenges related with the accessibility and use of the health services (Fonseca, Silva, McGarrigle & Esteves, 2007), namely victim support services. Considering this, this paper aims, through an intersectional lens, to create a conceptual and theoretical discussion about intimate partner violence among immigrant women as well as to explore the different barriers in the access and use of health support services.

Key-words: Migrations, Intimate Partner Violence, Intersectionality

Introduction

Migrations represent a complex and multifaceted phenomenon in contemporary societies. Portugal, a country that traditionally faced waves of emigration, has become in the last 25 years an attractive host country to immigrants from different parts of the world (Lages, Policarpo, Marques, Matos & António, 2006). Nowadays, international migration is an increasingly important reality in Portugal, involving human rights and transversely women human rights. To address the challenges implied by international increasing migration, Portugal drew different integration policies (e.g., health, education, social).

Of the foreign population (421.711), 215,837 are women and 205,874 are men (SEF, 2017). Resident immigrant women represent about 51,2% of the immigrant population (SEF, 2017), assuming and giving an unequivocal contribution to the Portuguese economy (Padilla & Ortiz, 2012), counterbalancing falling birth rates[1] and the growth of the elderly population as well as providing needed labour (Padilla & Miguel, 2009). As a country inserted in the model of immigration of the south of Europe, is characterized by the increasing feminization of migratory flows, for have a labor market segmented by ethnic/racial, sex, age and educational level (Castels & Miller, 2003; Padilla & Ortiz, 2012; Yamanaka & Piper, 2006). Foreign population shows a great concentration at the young and active ages, between the 20-49 years (62%) (Gomes, 2017). However, despite the enormous prevalence of immigrant women nationally, the study of migration has largely been indifferent to the gender perspective (Peixoto et al., 2006), since gender was not assumed as a fundamental pillar of

[1] In 2015 women of foreign nationality accounted for 8.4% of all live births of mothers residing in Portugal (Gomes, 2017).

characterization and analysis of migrations (Neves, Silva, Topa & Nogueira, 2016; Topa, Nogueira & Neves, 2018).

It is clear that migrations can have many positive effects in women lifes but, on the other hand, it can cause risks for women. Their social and economic vulnerability can lead to situations of social, professional and family victimization (Neves, 2010a, 2010b, 2011).

On the positive side, women's migration often represents a way of acquiring economic security and a factor of reducing gender inequalities, leading to women autonomy, economic independence, higher social status and freedom, functioning migration as an empowerment factor (UNFPA, 2006).

Migration can also be a potentiating factor for considerable improvements in the quality of life of migrants and their families. Immigrant women are considered agents of change for countries of origin and receiving countries, thus contributing to the sending of remittances for the support of their families in the countries of origin, providing better studies for their children and better health care for their families (Bäckström, 2009 Cruz, 2010).

Migrant women are also agents of innovation and development for the receiving countries where they contribute their labor to support the autochthonous families whose women have decided to enter the professional world (Padilla & Ortiz, 2012). At the educational level, these women often have access to new educational opportunities in the host countries, which can improve their social status, build heritage and improve their quality of life in the country that received them (Dias et al., 2009; Miranda, 2009; UNFPA, 2006).

On the other hand, migration may expose women to situations of vulnerability resulting from job insecurity, exclusion, irregular status and isolation (Jolly & Reeves,

2005; Miranda, 2009). Not infrequently, these women have less access to information on migration opportunities and often have less preparation to deal with the conditions inherent in the migratory process (Omelaniuk, 2005).

Policies that restrict certain types of migration and hinder the process of legal migration may favor the involvement of migrant women in clandestine migration networks, placing them at risk of discrimination, exploitation, violence, abuse and trafficking (Rosário et al., 2011; UNFPA, 2006).

In contexts with extreme poverty levels and low access to education, health, financial resources and information networks on migration and employment, women may have weak autonomy and less decision-making capacity on their mobility (Dias et al., 2009; UNFPA, 2006), with limited opportunities for participation in social, political and cultural life in the host country. These difficulties in integration often translate into barriers to access to social services, health, education, skills development and the labor market. Many of these women are low skilled, low-paid, social unprotected in there jobs (Dias & Gonçalves, 2007), what can lead them to prostitution, or becoming victims of human trafficking (Neves, 2010a, 2010b, 2011). In fact, Castles and Miller (2003) point out that the primarily responsible for the absorption of women immigrant labor is the services sector, with emphasis on domestic work, care for the elderly and children and the sex industry (Neves, 2010a; Miranda, 2009; Padilla, 2007). In fact, some of the characteristics (social / economic) of the countries of South Europe enhance the insertion of immigrant women in these occupations, which are based on the expansion of the services sector in these countries, the existence of an informal labor market, the persistence of traditional gender roles, and population aging with low fertility rates (Anthias & Lazaridis, 2000).

At the same time, these women are more prone to unemployment, presenting in 2015 a higher rate of unemployment (54,8%) than foreign men living in Portugal (Gomes, 2017). There is still a feminization in migration, poverty and lack of jobs, which leads to the need to characterize and take into account their problems in the globalization process (Boyd, 2006; Oishi, 2002).

On the other hand, women, who depend financially and legally on their partners (because they depend on their administrative status), often face the non-recognition of their fundamental rights (UNFPA, 2006).

Another problem is that many immigrant women suffer gender violence and specifically intimate partner violence in the host countries. The research on intimate partner violence and gender violence among immigrant women is very limited in academic fields (El-Abani, Jacobs, Chadwick & Arun, 2018). This article aims to create a conceptual and theoretical discussion about the phenomenon of intimate partner violence in immigrant communities, using as a reference the theory of intersectionality and it's interface with health services.

Intimate Partner Violence

Intimate partner violence (IPV) is consider a type of interpersonal violence and one of the most common forms of gender violence and violence against women. It includes physical, sexual, and/or emotional abuse and controlling behaviors by an intimate partner, in a heterosexual or homosexual relationship (Cezario & Lourenço, 2013). IPV occurs in all settings and among all socioeconomic, religious and cultural groups (Garcia-Moreno et al. 2006). The overwhelming global burden of IPV is borne by women. The most common perpetrators of violence against women are male intimate partners or ex-partners (RASI, 2017; WHO, 2013).

Historically, the General Recommendation of the United Nations (UN) Committee on the Elimination of Discrimination against Women (CEDAW Committee)[2] recognized in 1992, that gender-based violence is *"violence that is directed against a woman because she is a woman or that affects women disproportionately"* (Article 6) and that it *"is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men"* (Article 1)[3].

The recognition of violence against women as a hindrance to women's full enjoyment of their human rights and fundamental freedoms was further strengthened at the Fourth World Conference on Women in Beijing in 1995[4], and in the resulting Beijing Declaration and Platform for Action[5].

The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)[6], adopted in 2011, largely follows these earlier definitions. The Istanbul Convention defines both terms 'violence against women' and 'domestic violence' (Article 3):

"(a) 'violence against women' is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or

[2] The CEDAW Committee is a body of 23 independent experts on women's rights around the world; it monitors the implementation of the Convention on the Elimination of All Forms of Discrimination. against Women (CEDAW), which entered into force on 3 September 1981. As at January 2014, 187 countries have ratified or acceded to the convention

[3] UN, CEDAW Committee (1992), General Recommendation No. 19 on Violence against women, adopted at the 11th session, 1992, A/47/38, 29 January 1992.

[4] The UN Commission on the Status of Women organised this conference 'Action for equality, development and peace' in Beijing (China) on 4–15 September 1995

[5] Fourth World Conference on Women in Beijing (1995), Beijing Declaration and Platform for Action, adopted at the 16th Plenary session, 15 September 1995.

[6] The Council of Europe Committee of Ministers adopted the convention on 7 April 2011. It opened for signature on 11 May 2011 on the occasion of the 121st Session of the Committee of Ministers in Istanbul, available at: www.conventions.coe.int/Treaty/ Commun/ChercheSig.asp?NT=210&CM=&DF=&CL=ENG.

economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life;

"(b) 'domestic violence' shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim."[7]

Despite this conceptual definition, UN Women estimates that at least 35% of women have suffered physical and/or sexual intimate partner violence or sexual violence by a non-partner, with some studies indicating rates of 70% (WHO, 2013, Watts & Zimmerman, 2002). The last report of European Union for Human Rights[8] revels that one in three women (33 %) has experienced physical and/or sexual violence since they were 15 years old and out of all women who have a (current or previous) partner, 22 % have experienced physical and/or sexual violence by a partner since the age of 15 (FRA, 2014).

This report also inlights some details of intimate partner violence. One third of victims (34 %) of physical violence by a previous partner experienced four or more different forms of physical violence. The most common forms of physical violence involve pushing or shoving, slapping or grabbing, or pulling a woman's hair and that in most cases violence by a previous partner occurred during the relationship, one in six women (16 %) who has been victimized by a previous partner experienced violence after the relationship had broken up. Another other relevant data points that of those women who experienced violence by a previous partner and were pregnant during this

[7] Council of Europe, Convention on preventing and combating violence against women and domestic violence, CETS No. 210, 2011, p. 8.
[8] This report is based on findings from FRA's survey of 42,000 women. It presents EU-wide data for the first time on the extent, nature and consequences of violence against women in all 28 Member States of the EU.

relationship, 42 % experienced violence by this previous partner while pregnant. In comparison, 20 %-experienced violence by their current partner while pregnant (FRA, 2014).

Intimate partner violence can take place over a long period and can involve various types of violent acts. IPV can have serious consequences to women, affects their health and reinforces other forms of violence and inequality throughout society (Costa, 2017). As is widely acknowledged, violence against women is not only a manifestation of sex inequality, but also serves also to maintain this unequal balance of power as well as maintain socio-economic and racialized hierarchies (Crenshaw, 1991; Sokoloff & Dupont, 2005; Watts & Zimmerman, 2002).

FRA report (2014) show that is clear that only one third of victims of partner violence (33 %) and one quarter of victims of non-partner violence (26 %) contacted either the police or some other organization, such as a victim support organization, following the most serious incident of violence. However, in total, victims reported the most serious incident of partner violence to the police in 14 % of cases and the most serious incident of non-partner violence in 13 % of cases. For about a quarter of victims, feeling ashamed or embarrassed about what had happened was the reason for not report the crime (FRA, 2014).

In Portugal, 26.713 cases of domestic violence were report to police in 2018, of which 22.423 of these cases were of intimate partner violence, where 79% of the victims are women and 84% of the reported men (RASI, 2018). However, according to Lourenço and Lisboa (1998), there are innumerable weaknesses in official statistics, since they do not represent real crime, but rather the crime that is report to the authorities.

Intimate Partner Violence among Immigrants

Immigrants are at risk of experiencing multiple types of violence (Kasturirangan, Krishnan & Riger, 2004) and different life events during the immigration process, both in the departure and host countries (Shah & Menon, 1997). Violence and discrimination in the public sphere is a concern since acts of violence may be perpetrated by employers or by members of the general population (Dias, Fraga & Barros, 2013).

Limited evidence is currently available, however it is clear that some immigrant women may be at greater risk to suffer IPV (El-Abani, Jacobs, Chadwick & Arun, 2018; Shetty & Kaguyutan, 2002). The stresses of culturization and changes in family or gender roles that often accompany migration can trigger or intensify IPV (Jampaklay, et al. 2009). Lack of social or family support, frequent difficulties dealing with administrative procedures, language and cultural barriers faced by women in their interactions with health systems all help to explain the special vulnerabilities of migrant women who suffer from IPV (Raj & Silverman 2003; Menjívar & Salcido, 2002).

For migrant women, this institutional discrimination, the lack of access to knowledge about services, and cultural perception of this phenomenon can prevent women experiencing IPV from seeking help (PACE, 2009). According to Duarte and Oliveira (2012), the fear of consequences, feelings of shame, economic dependence, administrative status, isolation, fear of losing their children, among others equally important aspects contribute to the fact that violence remains in the family space and is not denounced (Bauer, Rodriguez, Quiroga & Flores-Ortiz, 2000; Duarte & Oliveira, 2012; Raj & Silverman, 2005). When living under the constraints of their irregular immigration status, victims are particularly afraid of being sent back to their countries of origin (Dias, Fraga & Barros, 2013).

The report of Family Violence Prevention Fund (2009) and another authors (Dias, Fraga & Barros, 2013; El-Abani, Jacobs, Chadwick & Arun, 2018; Volpp, n.d.) inlight that the exercise of power and control underlies all IPV, but many immigrant women are especially vulnerable because of poverty and other factors such as:

a) Limited language proficiency- IPV perpetrators frequently rely on foreign-born women's limited language proficiency skills to control their behavior.
b) Disparities in economic and social resources- While IPV cuts across all social and economic classes, and economics can affect all women's experiences with violence, some types of marriages and relationships involve uneven social and economic resources that can make foreign-born women especially vulnerable to their partners' power and control (e.g., marriages to military personnel, marriages through international brokers or dating services, and international arranged marriages). Many of these marriages are based on stereotypical views of women as subservient and passive.
c) Social isolation-The isolation experienced by immigrant battered women can be severe because they may be isolated both within their communities and within the dominant culture. A number of factors affect isolation, including beliefs about the dominant roles of men, religious doctrines, shame and fear.
d) Immigration status- Immigration status can increase a woman's vulnerability to IPV and further reduce her options. Abusers use immigration status to threaten deportation and also to warn that the abuser could be deported if the violence were disclosed. For undocumented migrants, social stigmatization and fear of deportation can also serve as barriers to accessing health services (Larchanché, 2012).

e) Cultural Values- Divorce is such a stigma in some communities that a woman may never be able to remarry within her community once she has left her abuser. If she does leave she is often held responsible for the end of the marriage, even if she was the victim of violence. Her family of origin may or may not accept her back, because such an act may bring disgrace to the entire family (Supriya, 1996; Dasgupta & Warrier, 1996). In addition, the presence of relatives who witness the violence may not deter the batterer, as family members may ignore or condone the violence (Family Violence Prevention Fund, 2009).

However, few studies have addressed the intimate partner violence among immigrants (Guruge, Khanlou & Gastaldo, 2009; WHO, 2014). The study of Sónia Dias, Sílvia Fraga and Henrique Barros (2013) with 702 immigrants living in Portugal show that there are a marked gender difference in the intimate partner violence, with 7.1 % of women and only 0.9 % of men claiming to have been victims.

In Spain, a cross-sectional study of 10 202 women attending primary care centres showed an IPV prevalence of 27.9% in migrants, compared to 14.3% in Spanish women (Vives-Cases et. al. 2009). Prevalence rates may differ by country and by the characteristics of migrant status, such as country of origin, administrative status and length of stay in the host country (WHO, 2014).

Studies show that immigrant women's lives are often characterised by high levels of vulnerability because their lifes are between gender inequalities, structural inequalities, interpersonal power relations, norms of masculinity and men's perpetration of various types of violence has long been noted (El-Abani, Jacobs, Chadwick & Arun, 2018; Piper, Rosewarne, & Withers, 2017). Such gendered and racialised experiences deepen structural forms of precarious social relations, with insecure situations existing within homes, workplaces and wider society (Piper, Rosewarne, & Withers, 2017;

Premji & Shakya, 2017). Domestic immigrant household who suffer gender-based violence face particular challenges in accessing health services, social support and knowledge about and intimate violence (Dias, Fraga & Barros, 2013). It situates violence against women within a wider framework of male dominated gender relations and gender and racial regime (Collins, 2009; Crenshaw, 1991).

Intersectional challenges in accessing health services, social support and knowledge about IPV

Intimate partner violence is a public health problem that occur worldwide and can damage physical, sexual, reproductive, emotional, mental and social health of the victim and his/her family (WHO, 2013). Consequently, women affected by IPV may require more frequent use of health services, such as primary and specialist care, mental health care and inpatient services such as hospitalization (WHO, 2014).

Many immigrant women experience IPV in the context of language difficulties, confusion over their legal rights (e.g., social and heath support), and the overall stress of adaptation to new cultural and social structures (Family Violence Prevention Fund, 2009).

In migrations gender relations of power constitute the root causes of gender inequality what can determine whether people's health needs are acknowledged, whether they have voice or a modicum of control over their lives and health, whether they can realize their rights (Sen & Östlin, 2007).

Gender intersects with economic inequality, racial or ethnic hierarchy, caste domination, differences based on sexual orientation, and a number of other social markers (Topa, 2016). Many times health services display this gender, race, etnic, age regimes

that might inadvertently contribute to the discrimination of women, especially those belonging to certain groups (e.g., migrants, Roma, refugees) (Sen & Östlin, 2007).
So we can realize that immigration, and violent dynamics shapes how women understand, response to IPV and access to community resources.

Lack of awareness (knowledge about the existence of a health problem) and acknowledgement (recognition that something should and can be done about the health problem) are important barriers to women's access to and use of health services and victim support services (Sen & Östlin, 2007). For migrant women, gender and ethnicity may be barriers to access and use services (Kocze & Popa, 2009). Empirical research has shown that some people may be completely unaware of their entitlement to health care, where to look for them, and how to make an appointment (FRA, 2013; Topa, 2016).

When women started to be victim in their own country, the lack of habits of use of health or victim services in the origin country (because was nonexistent, scarce or had poor quality) is also a reality.

In addition to accessibility, underuse of health services on the part of migrant women experiencing IPV is related to lack of knowledge about women's rights, support programmes for those experiencing IPV and how to use them (illiteracy).
Many immigrants are also unaware of existing support institutions and services. This is a common problem among migrant women that have recently arrived in the host country and those who are not fluent in the language (WHO, 2014). Linguistic and cultural differences also contribute to misunderstanding between women and health care professionals and may generate confidentiality problems if women must communicate with health providers through a relative or a friend. It is not uncommon for some groups of immigrant women to require an interpreter when they go to health services (HCHC,

2003) without qualifications (Ganann et al., 2011). This not only raises ethical issues regarding confidentiality, informed consent, and privacy among patients and health professionals (UNFPA, 2006), but can also lead to other types of constraints, both for the patient and the interpreter, for the issues and power relations that are generally present, as well as the possibility of a poor interpretation of what has been transmitted to them ((Estrela, 2009; EWL, 2007). In fact, the language barrier is signaled as one of the major barriers to access to health care (Ponce et al., 2006).

Access to care is not always dependent on administrative or citizenship concerns alone; in some IPV cases, abusers retain control of all of the family finances and health insurance details (Wilson et al. 2007), resulting in restricted access.

Economic and social barriers can also create barriers for immigrant battered women. Health costs, the costs of public transport and the precarious working conditions can make difficult the acess health services.

All these factors, IPV can not be seen as a homogeneous problem, which means that diversity among migrants goes many times unnoticed (Padilla & Miguel, 2009). Battered women's oppression is often multiplied by their location at the intersections of particular race, ethnic, class, gender, sexual orientation, and immigrant systems of oppression and discrimination (Crenshaw, 1991). Kimberlé Crenshaw (1991) proposes an intersectional analysis to understand what is experienced at the intersection of two or more axes of domination, recognizing the multidimensional and relational nature of social positions (based on factors such as race, social class, gender, sexual orientation, sexual identity) and places lived experiences, social forces and systems of oppression (prejudice, stereotype, inequality, discrimination and heteronormative bias). This intersectional analysis is based on the assumption that power systems and oppression

systems and mechanisms do not operate alone, but they intersect and operate simultaneously with an impact on the production of inequalities (Costa, 2017).

To fully understand the experience of abused women, we must consider the total dimensions of their lives including socioeconomic status, age and other identity makers and that the intersection of gender, race, and ethnicity, as well as the cultural diferences experienced by immigrants, compound each other and lead to the social construction of identity and opression (Sokoloff & Dupont, 2005).

Conclusions

Preventing IPV is a challenge and a public health priority in Portugal. Multiple sectors have to be involved in order to address the issue appropriately. The role of health systems, services and professionals in responding to women affected by IPV, specifically migrants is clear. So far, policies responses to violence against women have not looked through an intersectional lens. They tend to focus on the common experiences of abused women (Sokoloff & Dupont, 2005). However, we are now in a turning point in Portugal. The National Strategy for Equality and Non-Discrimination - Portugal + Equal[9] in full articulation with other existing national strategies, plans and programs for migrants, such as the Strategic Plan for Migration and the European Commission's Strategic Commitment for Gender Equality 2016-2019, contemplates the perspective of intersetionality conceptualizing that the discrimination results from the intersection of multiple factors, including age, racial and ethnic origin, disability, nationality, sexual orientation, gender identity and expression, and sexual characteristics.

[9] http://cite.gov.pt/asstscite/downloads/legislacao/RCM_61_2018.pdf

Having into account that race, ethnicity, culture and immigration status play an important role in these women's intimate partner violence experiences, a more intersectional approach is conceptualized as necessary to address this women's specific needs. Portugal in the Plan of Action for the Prevention and Combating of Violence against Women and Domestic Violence 2018-2021 integrates simultaneously the need to support and protect these victims and to expand and consolidate the intervention, namely training professionals that works with victims of vulnerable groups (Diário da República, 2018). It is now perceived that only starting from an intersectional prism, as a primordial frame of reference, we can have clues to understand the reality of intimate partner violence, we can access the complex and intense range of possibilities, unfolding and challenges, both in the theoretical and practical spheres (Hankivsky et al., 2010; Topa, 2016).

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