

Childhood, Disability & Violence Project

Empowering disability
organisations to develop
prevention strategies

Full report

Final draft version
September 2004



DG Justice
DAPHNE



**AIAS BOLOGNA onlus
& partners:
FENACERCI
DISABILITY NOW
DISMINUIDOS FÍSICOS DE ARAGÓN**

Childhood, Disability & Violence project

Full report

Published with financial support from the European Commission under the Daphne Programme.

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AIAS BOLOGNA ONLUS, Via Ferrara 32, 40139 Bologna, Italy. info@aiasbo.it.
www.aiasbo.it

FENACERCI, Rua Augusto Macedo 2º, 1600-794 Lisboa, Portugal.
fenacerci@fenacerci.pt. www.fenacerci.pt

DISMINUIDOS FÍSICOS DE ARAGÓN, José Luis Pomarón 9, 50008 Zaragoza, Spain. dfa@dfa-org.com. www.dfa-org.com

DISABILITY NOW, 3rd Septevriou 30, 54636 Thessaloniki, Greece. info@disabled.gr.
www.disabled.gr

Project team responsible for the text of this publication:

Chapter 2

Melissa Filippini (AIAS)

All other chapters

Melissa Filippini, Rita Serra, Nadia Vincenzi & Evert-Jan Hoogerwerf (AIAS)

Susana Lució & Ana Rodrigues (Fenacerci)

Cristina Diaz, Carmen Untoria, Carmen Sanz, Beatriz Vinuales, Eva Gracia & Ana Royo Salas (DFA)

Georgia Fyca (Disability Now)

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1. Introduction

1.1. Why is this project promoted?

Domestic violence is a worldwide problem that involves every section of the population. It can be found in all socio-economic, religious, cultural and ethnic groups. It is acknowledged as a significant social problem and fortunately in recent years greater attention has been devoted to the victims of domestic violence, in particular where it affects children. Nevertheless little is known about violence against children with disabilities. Maltreatment of children with disabilities can be considered as a taboo within a taboo, probably because the association between disability and violence is emotionally difficult to cope with.

Violence in families of children with disabilities is difficult to trace and to prevent. Too little accurate epidemiological data is available for us to have a clear idea of the incidence of domestic maltreatment involving these children, although what is available indicates a higher risk for certain groups.

In addition to the damage caused to the victims, the problem of child maltreatment has important social implications. Society as a whole must consider itself responsible for preventing it at all different levels, from an individual and family level to communities and institutions. If this is true for all children, it is

especially true for children with disabilities, who generally speaking are even more vulnerable. To achieve this shared responsibility, the weight and the nature of the problem have to be acknowledged, recognised and understood.

The aim of this project is to raise awareness levels regarding the importance of the issue of domestic violence against children with disabilities. It further aims to correctly inform the target audience on the complexity of the issues at stake, while avoiding branding the families as criminals. It does so by presenting important concepts and knowledge about violence against children with disabilities, in the form of definitions, explanatory models and indicators of violence. Finally the report intends to promote prevention, by providing “cornerstones” for the development of prevention strategies.

Project aims

The Childhood, Disability & Violence project aims at preventing violence in families of children with complex physical and multiple disabilities, involving and empowering local associations, social cooperatives and NGO's in the field of disability.

More specifically the project aims are:

to raise awareness among local disability organisations about the issue of violence against children with disability; about its incidence and complexity, providing them corner stones to develop prevention policies

to evaluate the appropriateness of existing explicative models and definitions of violence considering specifically the situation of children with disabilities.

to underpin multi professional and multi agency prevention strategies, coordinated interventions with the fundamental involvement of the family.

1.2. What is the target audience of the project?

Although the issue of maltreatment of children with disabilities regards the whole of society, and public institutions have specific responsibility in the matter, the authors believe that local associations representing families or people with disabilities, social co-operatives and other NGOs in the field of disability have an important and specific role in defining, understanding,

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analysing and preventing violence against children with disabilities. This report, therefore, has been written principally, though not exclusively, for them.

These organisations can claim to make a specific contribution in the fight against child maltreatment through the direct and daily contacts they have with families and children, which allow them to closely observe the family structure, the internal and external network surrounding the child, the psychological and emotional background, the quality of care and assistance and the implementation of supportive and protective laws and regulations. Many of these organisations have first hand knowledge of examples of maltreatment, but few have developed a systematic approach to prevention and intervention.

Their ability to “listen”, to identify situations at risk and to prevent maltreatment must expand, naturally in close collaboration with the institutional network supporting the families. In fact the report affirms that only co-ordinated and integrated networks sharing a common language and objectives can hope to be successful in prevention.

1.3. How can the outcomes be used?

The report aims to place the issue of violence against children with disabilities high on the agenda of organisations in the field of disability. It should motivate and support people within those organisations to raise the issues internally and externally. The report can be a valuable tool to start and guide the discussion.

In addition the report provides cornerstones for developing prevention strategies. Knowing the “whys” and the “hows” of the prevention of violence against children with disabilities means creating the basis for proper interventions to prevent dramatic situations from erupting into violent acts.

The report has been written by organisations working in differing social and cultural contexts across Europe. Nevertheless the authors believe the content to be universally valid, although any actions undertaken will require mediation with the local social, institutional and cultural context.

The main issues discussed in this report are summarised in a booklet which has been published in five language versions (English, Italian, Spanish, Portuguese, Greek). The booklets can be obtained by contacting the project promoting organisations, or by downloading them from the web site: www.aiasbo.it/daphne.

Note to the reader

The text of the report is the result of a collective writing process and not the sum of individual contributions.

The writing was preceded by a period of research during which the partner organisations collected literature, cases of violence against children with disabilities and good practices in prevention. Various experts, representatives of institutions and persons representing the target audience were consulted and the themes discussed within the organisations.

The cases reported are based on real stories, but names, places and situations have been altered to protect the privacy of the individuals involved. The examples of good practice have been chosen to be functional in the text and do not exclude the existence of other high quality prevention initiatives.

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2. Domestic violence and disability – literature review

2.1. Definitions and classifications of violence

In this section we will be given a brief overview of:

Definitions from literature

Classifications and different forms of violence

Domestic or family violence refers to deliberate harm, intimidation or coercion in the domestic context of a close relationship. Domestic violence is a form of interpersonal violence and refers to everyday violence of everyday life. Child maltreatment is harm (or risk of harm) caused to a child by a parent, caregiver, or any other person responsible for the child's safety. It might involve all family members, men, women and children, both as perpetrators and as victims. Domestic violence against children also includes violence inflicted on them by external family caregivers such as baby sitters and educators, and in addition includes violence inflicted on children living permanently in institutes.

For the authors the concept of “domestic” not only has a physical significance (home, family), but also an emotional significance, referring to the most intimate and safest sphere of life a child can expect to find. For this reason domestic violence is more difficult to cope with than violence experienced in other spheres of life, or at least it is for a child.

2.1.1. World Health Organisation

According to the **World Health Organization (WHO)** violence is defined as the “intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group that either results in (or has a high likelihood of resulting in) injury, death, psychological harm, maldevelopment, or deprivation”.

Child abuse and neglect, sometimes also referred to as child maltreatment, is defined in the World Report on Violence and Health as: “All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust, or power” (2002).

Within the broad definition of child maltreatment, five subtypes are distinguished – these are *physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse and exploitation*. These sub-categories of child maltreatment, and their definitions as given below, were arrived at following an extensive review of different countries' definitions of child maltreatment and a 1999 *WHO Consultation on Child Abuse Prevention*.

Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power, or trust. There may be single or repeated incidents.

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may included but not is limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials.

Among the numerous types of sexual violence, the most common are:

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- ▶ Abusive sexual contact: such as sex fondling K Forced sexual initiation (particularly with virgin girls)
- ▶ Rape and sodomy
- ▶ Sexual harassment
- ▶ Sexual trafficking, which is on the increase
- ▶ All forms of genital mutilation

Neglect and negligent treatment is the inattention or omission on the part of the caregiver to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes, or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.

Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potential, and in the context of the society in which the child dwells. There may also be acts toward the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, scape-goating, threatening, scaring, discriminating, ridiculing, or other non-physical forms of hostile or rejecting treatment.

Commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, moral or social-emotional development.

Sexual violence is a form of violence, which is common, but often deeply concealed. This hidden epidemic is a big problem. It happens in all societies, all strata are at risk, and it attracts media attention.

2.1.2. CISMAI (Coordinamento Italiano dei Servizi contro il maltrattamento e l'abuso all'infanzia)

CISMAI is an Italian coordination of services against maltreatment and abuse in children. It defines *sexual abuse* as the involvement of a child below the age of 18 years in sexual activities, also without an explicit aspect of violence. It always determines confusion and destabilization in the child, compromising his development. The intensity and the quality of the consequent damages depend both on the characteristics of the event (precocity, frequency, duration, gravity, relationship with the maltreating person) and on protective factors (individual resources of the maltreated person, of his environment and family, of the sanitary and psycho-social interventions).

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2.1.3. Child Abuse and Prevention Treatment Act (CAPTA)¹.

Child maltreatment is harm (or risk of harm) caused to a child by a parent, caretaker, or another person responsible for the child's safety.

There are four major types of child maltreatment: *neglect, physical abuse, sexual abuse, and emotional abuse*. Although any of the forms may be found separately, they often occur together. Each State is responsible for providing its own definitions of child abuse and neglect that meet Federal minimum standards found in the Child Abuse and Prevention Treatment Act (CAPTA). Most include the following:

Neglect is failure to provide for a child's basic needs. Neglect may be:

Physical (e.g., lack of appropriate supervision or failure to provide necessary food, shelter, or medical care).

Educational (e.g., failure to educate a child or attend to special education needs).

Emotional (e.g., inattention to a child's emotional needs or exposure to domestic violence).

These situations do not always mean that a child is neglected. Sometimes cultural values, the standards of care in the community, and poverty may be contributing factors, indicating that the family is in need of information or assistance. When a family fails to use information and resources, and the child's needs continue to be unmet, then further child welfare professional intervention may be required.

Physical Abuse is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child.

Physical abuse includes:

acts with a high potential for harming the child and including such behaviours as punches, bites, choking, beatings, shootings, stabbings, as well attempts to shoot or stab (Gelles, 1997)

creation, development, or active promotion of behaviours, events or situations under the parents' or caretakers' control that result in the intentional physical injury of a child

physical neglect: failure to provide food, clothing, supervision, medical care etc.

Sexual Abuse includes activities by a parent or caretaker such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and commercial exploitation through prostitution or the production of pornographic materials. There is a distinction between contact abuse involving physical contact between victim and perpetrator (such as touch or penetration of the body) and non-contact abuse (such as exhibitionism, voyeurism, or use of pornography).

Psychological maltreatment:

the ensemble of abusive psychological acts committed by the parents and also encompasses all acts of omission that result in emotional, cognitive or educational neglect (Fortin and Chamberland, 1995). It can take a variety of forms: rejecting, degrading, terrorising, isolating, mis-socialising, exploiting, ignoring the child, restricting the child's physical movements (Barnett et al., 1997).

¹ The US Federal legislation that provides definitions is included in the Child Abuse and Prevention Treatment Act (CAPTA) reauthorization of 1996 (P.L. 104-235).

A PDF version is available at:

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=104_cong_bills&docid=f:s919enr.pdf.

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Emotional abuse: acts that result in the impairment of a child's emotional or mental health, such as verbal abuse, belittlement, symbolic acts designed to terrorise a child, lack of maturity or emotional availability by caregivers (Mattaini et al., 1996). It includes the sustained, repetitive, inappropriate emotional response to child's experience of emotion, and its accompanying expressive behaviour. Emotional Abuse is any pattern of behaviour that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance.

2.1.4. CDC2

Violence is divided into four categories:

- Physical Violence
- Sexual Violence
- Threat of Physical or Sexual Violence
- Psychological/Emotional Abuse (including coercive tactics) when there has also been prior physical or sexual violence, or prior threat of physical or sexual violence.

Physical Violence

The intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair-pulling, slapping, punching, hitting, burning, use of a weapon (gun, knife, or other object), and use of restraints or one's body, size, or strength against another person. Physical violence also includes coercing other people to commit any of the above acts.

Sexual Violence

Sexual violence is divided into three categories:

Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed. A sex act (or sexual act) refers to the contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object. It is an attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).

Abusive sexual contact: intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (e.g., because of illness, disability, or the influence of alcohol or other drugs, or due to intimidation or pressure).

Threat of Physical or Sexual Violence

The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. Also the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent.

Examples: "I'll kill you"; "I'll beat you up if you don't have sex with me"; brandishing a weapon; firing a gun into the air; making hand gestures; reaching toward a person's breasts or genitalia.

Psychological/Emotional Abuse

Trauma to the victim caused by acts, threats of acts, or coercive tactics, such as those on the following list. This list is not exhaustive. Other behaviors may be considered emotionally abusive if they are perceived as such by the victim. Some of the behaviors on the list may not be

² CDC (Atlanta, Georgia, USA) is an agency of the Department of Health and Human Services.

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perceived as psychologically or emotionally abusive by all victims. Operationalization of data elements related to psychological/ emotional abuse will need to incorporate victim perception or a proxy for it. Although any psychological/emotional *abuse* can be measured by the IPV surveillance system, the expert panel recommended that it only be considered a type of *violence* when there has also been prior physical or sexual violence, or the prior threat of physical or sexual violence.* Thus by this criterion, the number of women experiencing acts, threats of acts, or coercive tactics that constitute psychological/emotional *abuse* may be greater than the number of women experiencing psychological/emotional abuse that can also be considered psychological/emotional *violence*.

Psychological/emotional abuse can include, but is not limited to:

- Humiliating the victim
- Controlling what the victim can and cannot do
- Withholding information from the victim
- Getting annoyed if the victim disagrees
- Deliberately doing something to make the victim feel diminished (e.g., less smart, less attractive)
- Deliberately doing something that makes the victim feel embarrassed
- Using money that is the victim's
- Taking advantage of the victim
- Disregarding what the victim wants
- Isolating the victim from friends or family
- Prohibiting access to transportation or telephone
- Getting the victim to engage in illegal activities
- Using the victim's children to control victim's behavior
- Threatening loss of custody of children
- Smashing objects or destroying property
- Denying the victim access to money or other basic resources
- Disclosing information that would tarnish the victim's reputation

Psychological maltreatment of children occurs when a person conveys to a child that he or she is worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs.⁵ The perpetrator may spurn, terrorize, isolate, or ignore or impair the child's socialization. If severe and/or repetitious, the following behaviours may constitute psychological maltreatment:

1. Spurning (belittling, degrading, shaming, or ridiculing a child; singling out a child to criticize or punish; and humiliating a child in public).
2. Terrorizing (committing life-threatening acts; making a child feel unsafe; setting unrealistic expectations with threat of loss, harm, or danger if they are not met; and threatening or perpetrating violence against a child or child's loved ones or objects).
3. Exploiting or corrupting that encourages a child to develop inappropriate behaviours (modelling, permitting, or encouraging antisocial or developmentally inappropriate behaviour; encouraging or coercing abandonment of developmentally appropriate autonomy; restricting or interfering with cognitive development).
4. Denying emotional responsiveness (ignoring a child or failing to express affection, caring, and love for a child).
5. Rejecting (avoiding or pushing away).
6. Isolating (confining, placing unreasonable limitations on freedom of movement or social interactions).
7. Unreliable or inconsistent parenting (contradictory and ambivalent demands).

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8. Neglecting mental health, medical, and educational needs (ignoring, preventing, or failing to provide treatments or services for emotional, behavioural, physical, or educational needs or problems).
9. Witnessing intimate partner violence (domestic violence).

The psychological maltreatment of children-technical report

Steven W. Kairys, MD, MPH; Charles F. Johnson, MD; and the Committee on Child Abuse and Neglect (2002)

2.1.5. DSM IV

The Diagnostic and Statistical Manual of Mental Disorders 4th ed. (American Psychiatric Association, 1994) considers the ***Munchausen Syndrome by proxy*** as a form of child abuse or neglect (MSBP). This is a psychiatric disorder which causes an individual, typically a mother, to intentionally induce real or apparent symptoms of a disease in her child. The disorder most commonly affects children from birth to the age of eight. Parents with MSBP may simply exaggerate or invent their child's symptoms, or they may deliberately induce symptoms through various methods, including poisoning, suffocation, starvation, or infecting the child's blood. Children are frequently made to suffer with unnecessary tests, surgery, or other invasive procedures. Some of them die at the hands of their mothers. This form of maltreatment differs from other forms in several ways: the perpetrator is almost always female and usually presents as a model parent, there is little or no indication of family discord, and the abusive behaviour is clearly premeditated, not impulsive or in reaction to the child's behaviour.

My mother caused my illness: the story of a survivor of Munchausen by Proxy Syndrome ***Mary Bryk and Patricia T. Siegel (2004)***

The first page of my 400-page medical record begins when I was 2 years old. My parents reported that I had fallen down a flight of stairs and twisted my right ankle. An initial diagnosis of cellulites was made. After several weeks of not responding to antibiotics, an incision and drainage procedure and biopsy were done of the area. The physicians who were treating me did not know the cause- repeated blows with a hammer by my mother...when neighbours asked about the cries coming from our house it was explained that I was being difficult during dressing changes. Because my mother was a nurse I was often released early from hospital and continued having intravenous therapy at home. My mother was allowed to provide total care for me during my hospitalizations...I turned 3 years old when my ninth hospitalization occurred...when the abuse ended for me I was 8 years old and I was filled with guilt because my little brother became my mother's next victim and began to manifest similar symptoms. For 2 years he had problems with "osteomyelitis" in his knee. In the beginning, I thought my father was unaware of what my mother did to me, otherwise he would have stopped her. However, I learned differently when I told him what my mother was doing and he didn't believe me.

2.1.6. Conclusions

Violence is a broad term which includes many different types of non verbal and verbal acts and thoughts.

The definition of an act or a thought as violent may depend on the cultural, social and historical context. This may be true for coercive disciplinary practices, that have been associated with abuse. Although there is considerable cultural and historical variation in disciplinary practices, some forms of discipline are inappropriate by any cultural norms: the right perspective for any

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understanding of the issue is to consider violence above all as a negation of the child's rights. The *UN Convention on the Rights of the Child*, which entered into force in 1990, states in article 19 that all countries "shall take appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and identification, reporting, referral, investigation, treatment and follow-up instances of child maltreatment". Consequently, violence can be any action that violates human rights. Committing violence is an offence in the eyes of the law.

2.2. Understanding the problem

In this section we will be given a brief overview of:

Risk/protective factors: definitions and classifications considering child, family, environmental factors

Explicative models

2.2.1. Explicative models and risk factors

Many causal theories have been elaborated to explain the phenomenon of maltreatment of children. First explanatory models suggested a direct cause-effect relationship between individual psychological characteristics or socio-economic factors and the occurrence of violence (for example, the psychiatric model). Over the years, the debate has evolved into models which recognise the interdependence or interaction of **multiple causal agents**. Maltreatment of children with disabilities is **a complex problem**. There is no single known cause of child maltreatment, nor is there any single description that covers all those families in which children are victims. Child maltreatment may occur across all socio-economic, religious, cultural, racial, and ethnic groups.

2.2.1.1. *The ecological model*

An ecological model (Garbarino, 1980; Browne, 1988) may be useful in helping to understand the causes and the development of violence, discussing the factors that contribute to maltreatment including socio-cultural factors, parent and/or child characteristics and triggering situations that serve as catalyst for maltreatment events. The ecological model considers predisposing factors (individual, familiar, social, cultural); mediating factors (social support networks); breaking out factors (life cycle's events, events' perceptions and interpretations and stressing power of these events on parents and family).

The ecological model acknowledge that certain child characteristics can play a role in maltreatment, particularly in already at risk families and environments (Ammermann, 1991). As many children with disabilities exhibit some of these characteristics (e.g. vulnerability, difficulty to manage behaviour problems), they provide an opportunity to examine and elucidate the contribution of child characteristics in maltreatment in general, and physical abuse in particular.

Multivariate and multi-factorial models, in which the aggregation and the interaction of contributory factors are considered, offers the most promising direction for uncovering the mechanism by which children with disabilities become at risk of maltreatment. Ammermann (1998) moves away from considering disability per se as a risk factor for maltreatment, and toward an understanding of those conditions under which characteristics associated with

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disability increase risk. Through his studies, he noted that the link between negative child characteristics and increased child abuse potential was significantly magnified when mothers reported low levels of social support. Considering the different factors that can intervene in a familiar situation at risk of violence allows the comprehension of the phenomenon in all its complexity, increasing the possibility to find ways and channels of preventive action and reducing the danger of useless judgements and critics against families.

2.2.1.2. Risk factors

Since no single causes have been definitively identified that lead a parent or other caregiver to abuse or neglect a child, research has recognized a number of **risk factors** or attributes commonly associated with maltreatment. Children within families and environments in which these factors exist have a *higher probability* of experiencing maltreatment. It must be emphasized, however, that while certain factors often are present among families where maltreatment occurs, this does not mean that the presence of these factors will *always* result in child abuse and neglect. The factors that may contribute to maltreatment in one family may not result in child abuse and neglect in another family. For example, several researchers note the relation between poverty and maltreatment, yet it must be noted that most people living in poverty do not harm their children. The *World Report on violence and health* (WHO, 2002) offers an ecological model to help understand the root causes and risk factors of violence that need to be identified and addressed by prevention strategies. It identifies risk factors at four levels: individual, relationship, community, and societal. The four levels and their interaction are represented in the following way (fig.1):



Fig.1. Ecological model for understanding risk factors for violence

At the individual level, personal history and biological factors influence how individuals behave and increase their likelihood of becoming a victim or a perpetrator of violence.

Personal relationships such as family, friends, intimate partners and peers may influence the risks of becoming a victim or a perpetrator of violence, for example according to transgenerational transmitted dysfunctional ways of interaction.

Community contexts in which social relationships occur, such as schools, neighbourhoods and workplaces, also influence violence.

Societal factors influence whether violence is encouraged or inhibited. These include social and economic policies that contribute to maintain and justify socio-economic inequalities between people, social norms such as parental dominance over children and cultural norms that endorse violence as a normal method to resolve conflicts.

Risk factors associated with child maltreatment can be grouped in four domains (Table 1):

- Parent or caregiver factors
- Family factors
- Child factors
- Environmental factors

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Risk factors			
Parent or caregiver factors	Family factors	Child factors	Environmental factors
Mental illness, personality disorders, suicide attempts and psychological suffering Lack of parental skills Low stress coping skills, self-esteem and self-expectancy Authoritative parental style History of maltreatment during childhood Substance abuse Inaccurate knowledge about child development needs and processes Unrealistic and unmet expectations History of behaviour disorders and aggressiveness Adolescents without family support High stress levels Social isolation Lower economic status Single parenthood Unwanted pregnancy Inadequate prenatal care Low family adaptation to disability Refusal of offered support and resources	Difficult and chaotic household (family size and density) Unsafe housing and inadequate day care Marital conflicts and domestic violence Stressful life events, parental stress and emotional distress Unemployment and financial discomfort Low cultural level Social isolation Greater tolerance for harsh discipline strategies and verbal aggression (e.g., hitting)	Physical, cognitive, emotional disabilities Premature birth and low birth-weight Special needs, frequent hospitalisations Behavioural disorders (e.g., aggressiveness, hyperactivity, sleep disorders etc.) or high demands for caring Inability to understand, report the abuse and escape from it	Non-existent, un-enforced child protection laws Decreased value of children (minority, disabled, gender) Poverty and unemployment Social isolation Less material and emotional support Dangerous neighbourhoods High social acceptability of violence Promotion of violence in cultural norms Media violence

Table 1.

Parent or Caregiver Factors (individual factors)

Parent or caregiver factors potentially contributing to maltreatment relate to:

1. Personality characteristics and psychological well-being
2. History of maltreatment
3. Substance abuse
4. Attitudes and knowledge
5. Age

1. Personality Characteristics and Psychological Well-Being

No consistent set of characteristics or personality traits has been associated with maltreating parents or caregivers. Some characteristics frequently identified in those who are physically abusive or neglectful include low self-esteem, an external locus of control (i.e., belief that events are determined by chance or outside forces beyond one's personal control), poor impulse control, depression, anxiety, and antisocial behavior.²¹ While some maltreating parents or caregivers experience behavioural and emotional difficulties, severe mental disorders are not common.²²

2. Parental Histories and the Cycle of Abuse

A parent's childhood history plays a large part in how he or she may behave as a parent. Individuals with poor parental role models or those who did not have their own needs met may find it very difficult to meet the needs of their children.

Violence is considered as a intergenerational phenomenon. While the estimated number varies, child maltreatment literature commonly supports the finding that some maltreating parents or caregivers were victims of abuse and neglect themselves as children.²³ One review of the relevant

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research suggested that about one-third of all individuals who were maltreated will subject their children to maltreatment. Children who either experienced maltreatment or witnessed violence between their parents or caregivers may learn violent behavior and may also learn to justify violent behavior as appropriate.

An incorrect conclusion from this finding, however, is that a maltreated child will always grow up to become a maltreating parent. There are individuals who have not been abused as children who become abusive, as well as individuals who have been abused as children and do not subsequently abuse their own children. In the research review noted above, approximately two-thirds of all individuals who were maltreated did not subject their children to abuse or neglect.

In conclusion, it is not completely understood why some parents or caregivers who were maltreated as children abuse or neglect their own children and others with a similar history do not. While every individual is responsible for his or her actions, research suggests the presence of emotionally supportive relationships may help lessen the risk of the intergenerational cycle of abuse.

3. Substance Abuse

Parental substance abuse is reported to be a contributing factor for between one- and two-thirds of maltreated children in the child welfare system. Research supports the association between substance abuse and child maltreatment. Substance abuse can interfere with a parent's mental functioning, judgment, inhibitions, and protective capacity. Parents significantly affected by the use of drugs and alcohol may neglect the needs of their children, spend money on drugs instead of household expenses, or get involved in criminal activities that jeopardize their children's health or safety.

Also, studies suggest that substance abuse can influence parental discipline choices and child-rearing styles. Often, the number and complexity of co-occurring family problems often makes it difficult to understand the full impact of substance abuse on child maltreatment. Substance abuse and child maltreatment often co-occur with other problems, including mental illness, HIV/AIDS or other health problems, domestic violence, poverty, and prior child maltreatment. These co-occurring problems produce extremely complex situations that can be difficult to resolve. Because many of the problems may be important and urgent, it can be difficult to prioritize what services to provide. Additionally, identifying and obtaining appropriate resources to address these needs is a challenge in many communities.

4. Attitudes and Knowledge

Negative attitudes and attributions about a child's behaviour and inaccurate knowledge and expectations about child development may play a contributing role in child maltreatment. For example, some studies have found that mothers who physically abuse their children have both more negative and higher than normal expectations of their children, as well as less understanding of appropriate developmental norms. A parent's lack of knowledge about normal child development may result in unrealistic expectations. Unmet expectations can culminate in inappropriate punishment. Other parents may become frustrated with not knowing how to manage a child's behaviour and may lash out at the child. Still others may have attitudes that devalue children or view them as property. Not all research, however, has found differences in parental expectations.

5. Age

Caretaker age may be a risk factor for some forms of maltreatment, although research findings are inconsistent. Some studies of physical abuse, in particular, have found that mothers who were younger at the birth of their child exhibited higher rates of child abuse than did older mothers. Other contributing factors, such as lower economic status, lack of social support, and high stress levels may influence the link between younger childbirth—particularly teenage parenthood—and child abuse.

Family Factors

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Specific life situations of some families—such as marital conflict, domestic violence, single parenthood, unemployment, financial stress, and social isolation—may increase the likelihood of maltreatment. While these factors by themselves may not cause maltreatment, they frequently contribute to negative patterns of family functioning.

1. Family Structure

There seems to be a significant association between the familial status of the perpetrators and type of maltreatment. Immediately family members account for the vast majority of neglect, physical abuse and emotional abuse, while extrafamilial perpetrators were significantly more often the perpetrators of sexual abuse.

Children living with single parents may be at higher risk of experiencing physical and sexual abuse and neglect than children living with two biological parents. Single parent households are substantially more likely to have incomes below the poverty line. Lower income, the increased stress associated with the sole burden of family responsibilities, and fewer supports are thought to contribute to the risk of single parents maltreating their children.

In addition, studies have found that compared to similar non-neglecting families, neglectful families tend to have more children or greater numbers of people living in the household. Chronically neglecting families often are characterized by a chaotic household with changing constellations of adult and child figures (e.g., a mother and her children who live on and off with various others, such as the mother's mother, the mother's sister, or a boyfriend).

2. Marital Conflict and Domestic Violence

According to published studies, in 30 to 60 percent of families where spouse abuse takes place, child maltreatment also occurs. Children in violent homes may witness parental violence, may be victims of physical abuse themselves, and may be neglected by parents who are focused on their partners or unresponsive to their children due to their own fears. A child who witnesses parental violence is at risk for also being maltreated, but, even if the child is not maltreated, he or she may experience harmful emotional consequences from witnessing the parental violence.

3. Stress

Stress is also thought to play a significant role in family functioning, although its exact relationship with maltreatment is not fully understood. Physical abuse has been associated with stressful life events, parenting stress, and emotional distress in various studies. Similarly, some studies have found that neglectful families report more day-to-day stress than non-neglectful families.

In families of children with disabilities, there may be extra demands for physical care, more medical appointments, increased financial burdens, unsupported single parent household, inadequate support from families and friends, and disappointment about the lack of child's improvement over time (Martinson, 1990). In addition, parents may lack information about the disability, how it can be managed and what kind of progress to expect. Children with disabilities are more dependent on their parents than are other children, and this increased dependency may increase their vulnerability to maltreatment (Tharinger et al., 1990).

In general, it is not clear whether maltreating parents actually *experience* more life stress or, rather, *perceive* more events and life experiences as being stressful. In addition, specific stressful situations (e.g., losing a job, physical illness, marital problems, or the death of a family member) may exacerbate certain characteristics of the family members affected, such as hostility, anxiety, or depression, and that may also aggravate the level of family conflict and maltreatment. In a sample of 51 maltreated children with mental retardation, investigators found that 35% of their parents had psychological disorders, 31% had substance abuse problems and 25% had mental retardation. Among the parents, 77% did not cooperate with help provided by professionals, 41% had unrealistic expectations for their children, 66% did not understand their children's developmental needs, and 56% complained about the excessive time required to care for their child (Verdugo et al., 1995). Sullivan and Knutson (2000) found that children who were

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neglected or who experienced neglect with other forms of maltreatment experienced the largest number of additional familial stress factor.

4. Parent-Child Interaction

Families involved in child maltreatment seldom recognize or reward their child's positive behaviors, while having strong responses to their child's negative behaviours. Maltreating parents have been found to be less supportive, affectionate, playful, and responsive with their children than parents who do not abuse their children.

Research on maltreating parents, particularly physically abusive mothers, found that these parents were more likely to use harsh discipline strategies (e.g., hitting, prolonged isolation) and verbal aggression and less likely to use positive parenting strategies (e.g., using time outs, reasoning, and recognizing and encouraging the child's successes).

Child Factors

Children are not responsible for being victims of maltreatment. Certain factors, however, can make some children more vulnerable to maltreating behavior. The child's age and development—physical, mental, emotional, and social—may increase the child's vulnerability to maltreatment, depending on the interactions of these characteristics with the parental factors previously discussed.

1. Age

The relationship between a child's age and maltreatment is not clear cut and may differ by type of maltreatment. Infants and young children, due to their small physical size, early developmental status, and need for constant care, can be particularly vulnerable to child maltreatment. Very young children are more likely to experience certain forms of maltreatment, such as shaken baby syndrome and non organic failure to thrive. Teenagers, on the other hand, are at greater risk for sexual abuse.

Sullivan and Knutson (2000) have found that age at first incident of maltreatment was significantly related to disability group. Children with disability comprise around one-third of the maltreated children between the ages of birth to 9 years, almost one-fourth in the middle school years, and only one around one-sixth in the high school years. Children with Health/orthopedic disability and communication disabilities have a preponderance of the first incidents from birth to 5 years of age suggesting these disabilities are risks for maltreatment. In contrast, children with behaviour and mental disabilities appear to incur maltreatment across the age ranges suggesting these disabilities are both risks and consequences of maltreatment. In conclusion, children with disabilities tend to be maltreated at younger ages. Early intervention and support services are critically needed for families with young children with disability, the period of maximum risk can be targeted.

2. Sex

Researchers have suggested that gender and disability status may interact resulting in a greater proportion of boys among abuse victims with disabilities than might be expected from the proportion of boys among children without disability (Sullivan et al., 1991). However, Sobsey et al. (1997) support the hypothesis that when all categories of abuse are combined, boys and girls are equally likely to experience child abuse. The overrepresentation of boys would simply reflect the larger proportion of boys who have disabilities in the larger population. It is also supported that girls are more likely to be victims of sexual abuse than boys.

3. Disabilities

Children with physical, cognitive, and emotional disabilities appear to experience **higher rates of maltreatment than do other children**. The risk of child abuse is increased by the presence of disability and may be in part iatrogenic. In a research (Gonzalvo, 2002), considering a longitudinal study (1991-2001) and including 62 children with different types of disability, results have demonstrated that in the most cases of maltreatment of disabled children from our environment, the etiopathogenesis was unrelated to the presence of an isolated individual risk

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factor (disability). Instead, maltreatment was related to the existence of familial, social and environmental risk factors. The greater the number of risk factors associated with a disabled child, the greater will be the possibility of maltreatment.

Sullivan and Knutson (2000) study's results show that children with disabilities are 3.4 times more likely to be maltreated than non disabled peers. Neglect is the clearly the most prevalent form of maltreatment. 63% of the children with disability experienced multiple forms of maltreatment, that could occur in a single or in multiple episodes. There were no significant associations between type of disability and type of maltreatment. For each of the disability group, neglect was clearly the predominant form of maltreatment, followed by physical abuse, emotional abuse, sexual abuse, in descending order of prevalence for all disability groups.

Other studies, on the contrary, have showed that the incidence of maltreatment can be associated with the **type of disability**. Children with developmental disabilities are 1.7 times at higher risk than normal children (Jaudes and Shapiro, 1999). Premature birth, chronic illness and congenital abnormalities also increase vulnerability to maltreatment. In the 10-year review of National Pediatric Trauma Registry records, children who were abused were 7 times more likely to have a history of prematurity than children who were unintentionally injured (DiScala et al., 2000). The relationship between prematurity, low birth-weight and maltreatment may be attributable to higher maternal stress heightened by high caregiver demands, but it also may be related to poor parental education about low birth-weight, lack of accessible prenatal care, and other factors, such as substance abuse or domestic violence. In a study of 86 children with cerebral palsy, aged 6 months to 18 years, abuse was thought to be a causal factor for eight of the children; another eight children were abused after the diagnosis had been made (Diamond and Jaudes, 1983). For this group of children, maltreatment was both a cause and a consequence of disability. Children with mild disability may be at greater risk for maltreatment than those with more severe disabilities (Benedict et al., 1990). In a large sample of 482 children and adolescents both with disabilities and a history of sexual abuse, 53% of those with hearing impairment and 55% of those with speech language impairment experienced sexual abuse, while 39% of those with mental retardation experienced sexual abuse (Sullivan et al., 1991). A study of 445 children and adolescents with mental retardation showed that individuals with more severe functional impairment in walking, eating, or dressing experienced less maltreatment than those with more mild impairment (Verdugo et al., 1995). It has been suggested that children with more mild problems may be more frustrating for families because of their uncertain outcome. Families of children with more severe impairment may be more reconciled to their condition and may have more realistic expectation for progress (Benedict et al., 1990). Children with more severe disabilities may receive more or earlier services. It has also been suggested that mild disabilities are not readily detected and that undesirable behaviour related to a mild disability may be mistakenly attributed too child's character. Undesirable behaviour in children with more serious and obvious disabilities is appropriately attributed to the disability.

In general, children who are perceived by their parents as **“different” or who have special needs**—including children with disabilities, as well as children with chronic illnesses or children with difficult temperaments—may be at greater risk of maltreatment. **The demands of caring** for these children may overwhelm their parents. Disruptions may occur very early in the **bonding or attachment processes**, particularly if children are unresponsive to affection or if children are separated by frequent hospitalizations. The first intimation or diagnosis that something is wrong with the child represents for parents a shocking experience. Essential medical intervention may interfere with opportunities for interaction and contact between parents and their disabled children. Other threats to attachment and bonding, however, may result from professional intervention. Professionals may actively discourage parents of children with disabilities from becoming too attached to their children and by doing so increase the risk of abuse for these children (Sobsey, 1994).

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Some researchers and advocates have suggested that some **societal attitudes, practices, behaviours and beliefs** that devalue and dehumanize children with disabilities⁶⁸ Depersonalisation of potential victims is a key to dishinibiting violence against them (Sobsey, 1997). For example, neonatal care staff may use the term BABY to discuss healthy newborns to parents but the less personalized term INFANT to discuss newborns with disabilities with their parents (Bogdan et al., 1992). Similarly, the notion that children with severe disabilities are not entitled to the same rights and protections as other children has been commonly expressed in the medical community. Singer (1994), specifically argues that children with severe disabilities do not meet the basic requirements for “personhood” and therefore are not entitled to basic human protections.

4. Other Child Characteristics

Child factors such as aggression, attention deficits, difficult temperaments, and behaviour problems—or the parental perceptions of such problems—have been associated with increased risk for all types of child maltreatment. These factors may contribute indirectly to child maltreatment when interacting with certain parental characteristics, such as poor coping skills, poor ability to empathize with the child, or difficulty controlling emotions. In addition, these same child characteristics may be reinforced by the maltreatment (e.g., a physically abused child may develop aggressive behaviors that elicit harsh reactions from others) and create conditions that can lead to recurring maltreatment.

Environmental Factors (social and cultural factors)

Environmental factors are often found in combination with parent, family, and child factors. Environmental factors include poverty and unemployment, social isolation, and community characteristics. It is important to reiterate that most parents or caregivers who live in these types of environments are not abusive.

1. Poverty and Unemployment

Poverty and unemployment show strong associations with child maltreatment, particularly neglect. It is important to underscore that most poor people do not maltreat their children. However, poverty—particularly when interacting with other risk factors such as depression, substance abuse, and social isolation—can increase the likelihood of maltreatment.

Plotnik (2000) describes several theories related to the association between poverty and maltreatment. One theory is that low income creates greater family stress, which, in turn, leads to higher chances of maltreatment. A second theory is that parents with low incomes, despite good intentions, may be unable to provide adequate care while raising children in high-risk neighborhoods with unsafe or crowded housing and inadequate daycare. A third theory is that some other characteristics may make parents more likely to be both poor and abusive. For example, a parent may have a substance abuse problem that impedes the parent’s ability to obtain and maintain a job, which also may contribute to abusive behavior. A final theory is that poor families may experience maltreatment at rates similar to other families, but that maltreatment in poor families is reported more frequently, in part because they have more contact with and are under greater scrutiny from individuals who are legally mandated to report suspected child maltreatment.

2. Social Isolation and Social Support

Some studies indicate that compared to other parents, parents who maltreat their children report experiencing greater isolation, more loneliness, and less social support. Social isolation may contribute to maltreatment because parents have less material and emotional support, do not have positive parenting role models, and feel less pressure to conform to conventional standards of parenting behaviors. It is not clear, however, whether social isolation in some cases precedes and serves as a contributing factor to maltreatment or whether it is a consequence of the behavioral dynamics of maltreatment.

3. Violent Communities

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Children living in dangerous neighborhoods have been found to be at higher risk than children from safer neighborhoods for severe neglect and physical abuse, as well as child sexual victimization. Some risk may be associated with the poverty found in dangerous neighborhoods, however, concerns remain that violence may seem an acceptable response or behavior to individuals who witness it more frequently.

4. Media and attitudes

Societal attitudes and the promotion of violence in cultural norms and the media have been suggested as risk factors for maltreatment. Attitudes encompass three distinct components: the cognitive, the affective and the connotative.

The majority of programs, documents and films portray people with disabilities in a stereotypical way: misinformation and unrealistic negative impressions have strong consequences, increasing also the risk for maltreatment acceptance. Past research (Elliott and Byrd, 1983) concerning the impact of various types of programs upon attitudes toward persons with disabilities has indicated that greater positive attitude change was found in individuals exposed to documentary as opposed to dramatic and comedy presentations. This result has been confirmed by a more recent research (Hall and Minnes, 1999). They have also evidenced a number of factors which may contribute to the promotion of positive attitudes: demonstrating that people with disabilities have equal status with the rest of “normal” society, showing co-operative interdependence between two parties, having them actively engage together in informal situations and providing opportunities to disprove stereotypes.

While the research is controversial, some studies show a positive relationship between televised violence and aggressive behaviours, particularly for individuals who watch substantial amounts of television.

2.2.1.3. Protective factors

In the assessment and analysis of a situation both risk factors and **protective factors** have to be considered: they refer to the strengths and resources that appear to mediate or serve as a “buffer” against risk factors that contribute to vulnerability to maltreatment or against the negative effects of maltreatment experiences. Just as there are factors that place families at risk for maltreating their children, there are other factors that may protect them from vulnerabilities—factors that promote **resilience**. The concept of resilience usually include the ability to withstand and rebound from crisis and distress. A systemic view of resilience within ecological and developmental contexts is helpful to identify elements that enable families to cope more effectively and emerge hardier from crisis or persistent stresses (Walsh, 1996).

In general, research has found that supportive, emotionally satisfying relationships with a network of relatives or friends can help minimize the risk of parents maltreating children, especially during stressful life events (Quinton and Rutter, 1988). Parents who were abused as children are less likely to abuse their own children if they have resolved internal conflicts and pain related to their history of abuse and if they have an intact, stable, supportive, and nonabusive relationship with their partner (Egeland et al., 1988). Additionally, programs on marriage education and enhancement may provide a roadmap of expected challenges such as the birth of the first child, parenting adolescents, and common gender differences which may act as a protective factor by strengthening families (Stanley et al., 2002).

Also protective factors can be divided in four groups (Table 2)

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Protective factors			
Parent or caregiver factors	Family factors	Child factors	Environmental factors
Psychological well-being High stress coping skills, self-esteem and self-expectancy Acceptation of disability, recognition of both limits and potentialities of child Accurate knowledge about child development needs and processes Social and family support Adequate maternal and parental health care During childhood, positive relationship with at least one adult	Safe, ordered housing and adequate day-care Stable and supportive relationship with partner Ability to cope with the challenges and adapt to the changes which naturally characterise family life cycles Job and financial comfort Social support Positive educational strategies (e.g., positive feedback etc.)	Ability to interact with others and express his/her feelings Sex education during adolescence Integration in social contexts (e.g. school) Behaviour and attention stability	Child rights can not be disregarded Enforced child protection laws Increased value of children Welfare and employment Social support network Interagency and multi-professional social network Safe neighbourhoods Social unacceptability of violence Cultural norms and media promotion against violence

Table 2.

2.2.2. How to detect child maltreatment

Recognising the signs and the symptoms of child maltreatment is difficult, and is even more so in children with disabilities. They are often unable to express in words that they have been abused or they can not understand that what has happened to them was wrong. Signal symptoms of maltreatment in children with disabilities are often misunderstood, misinterpreted or ignored.

Diagnosing maltreatment requires a high level of suspicion and a number of definite signals which have to be collected from the different child and family contexts. In addition, the observation has to be longitudinal in time, in order to evidence possible changes in the type or the nature of indicators.

There are:

- child physical indicators which refer to physical lesions, hygiene, nutrition and appearance;
- child behavioural indicators which refer to behavioural characteristics and child personality traits;
- parental indicators which refer to behaviour, language and attitudes.

Indicators of child maltreatment

Child physical indicators: refer to physical lesions, health, nutrition and appearance

- Injuries or marks on the skin
- Burns
- Bites
- Fractures
- Signs of trauma
- Psychomotor delay
- Neglected aspect
- Low weight
- Neglected infections
- Dirtiness
- Apathy and lack of vitality
- Clinical signs of intoxication

Child behavioural indicators: refer to behavioural characteristics and child personality traits

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- Child is wary of adults and interacts with suspiciousness
- Child seems to be afraid of his/her parents
- Tendency to isolation and retirement
- Lack of participation in play and group activities
- Lack of differentiated reactions towards unknown people
- Aggressiveness, antisocial behaviour
- Destructiveness
- Hypervigilance
- Unexpected sexual behaviour
- Need to call attention
- Psychological disturbances (anorexia, insomnia, enuresis, irritability, somatisations, bullying)
- Failure at school

Parent indicators: refer to behaviour, language and attitudes

- Implausible explanation of what has happened
- Discrepancy of symptoms referred by the mother, clinical history and clinical evaluation evidence
- Family history of child maltreatment
- Dysfunctional family relationships
- Delay in obtaining medical assistance for the child
- Absence of worry about the child, his/her appearance, physical and emotional needs
- Overprotectiveness
- Jealousy
- Negative ideas and attitudes towards the child (devaluation, disdain)
- Severe discipline strategies

2.2.3. Conclusions

Disability is associated with an increased risk for maltreatment. However, disability per se does not cause maltreatment. The effect of the disability on family life has been reported also as positive: many parents perceive that the disability of their child has strengthened their relations, communication and complicity. Many families find the internal or/and external support to rebound crisis that can occur at different times of life, mobilizing into effective action and reorganizing their lives toward positive adaptation. These data sustain strongly the necessity to intervene as early as possible in helping families of children with disabilities, in order to guarantee a high quality of life for them.

Violence against children is a complex phenomenon, considering both the quantity and the quality of intervening factors and their connections. The analysis of situations in cases of children with disabilities is also more complex, considering the additional weight of disability. The different types of violence share a number of risk factors, at various levels, whose interactions can be both intra-level and inter-level. Single risk factors and their connections form a chain, in which each of them is affected by the other, so that it may be difficult to establish which is the “first” ring of the chain which breaks down determining the explosion of violent act: the challenge is preventing the explosion inside this chain, maintaining during time an equilibrium among the different bonds involved, acting from the external social levels.

The systemic and ecological model helps to clarify the causes of violence and their complex interactions. It is a multi-level and multi-factorial model, useful both in comprehending and in

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preventing violence. It suggests that to prevent violence it is necessary to develop interventions at the different levels, considering both risk and protective factors.

2.3. Prevention policies

In this section we will be given a brief overview of:

Definitions of prevention, considering three levels: first, secondary and tertiary prevention.

Forms of prevention: the operative application of the theoretic background

2.3.1. Introduction

The goal of child abuse prevention is to stop child abuse and neglect from happening in the first place, sparing children and families emotional and physical trauma and decreasing the need for costly intervention and treatment services. The best way to prevent child abuse and neglect is to support families and provide parents with the skills and resources they need. As a prerequisite to specific child abuse and neglect interventions, basic needs of families and communities must be met.

Effective prevention must involve a multidimensional strategic approach that challenges societal beliefs and attitudes about children, educates and improves awareness of children's rights, their vulnerabilities and their abilities, and improves policy, legal and services responses to children in general, and high risk family specifically (Tucci et al., 2001). In order to prevent child maltreatment, strategies are required that focus on both reducing risk factors and strengthening protective factors that foster resiliency (Tomison and Wise, 1993). Child maltreatment prevention services operating in communities today generally fall within a typology that may include several major approaches or methodologies: public awareness activities, skill-based curricula for children, parent education programs and support groups, home visitation programs, respite and crisis care programs, and family resource centers.

Just as there are factors that place families at risk for maltreating their children, there are other factors that may protect them from vulnerabilities—factors that promote resilience. In general, research has found that supportive, emotionally satisfying relationships with a network of relatives or friends can help minimize the risk of parents maltreating children, especially during stressful life events. For example, parents who were abused as children are less likely to abuse their own children if they have resolved internal conflicts and pain related to their history of abuse and if they have an intact, stable, supportive, and non abusive relationship with their partner. Additionally, programs on marriage education and enhancement may provide a roadmap of expected challenges such as the birth of the first child, parenting adolescents, and common gender differences which may act as a protective factor by strengthening families.

The basic contents of violence prevention are:

- personal safety skills training
- individual rights education
- assertiveness and self-esteem training
- communication skills training
- social skills training
- sex education
- self-defence training

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2.3.2. Levels of prevention

Interventions can be at three levels:

primary level: primary prevention attempts to stop the occurrence of abuse in the population by addressing issues which affect whole populations, for example pre-natal, perinatal and early childhood health care that improves pregnancy outcomes and strengthen early attachment

promoting good parenting practices: preparation for “parenthood”, providing parents with information about child development and behaviour

public awareness activities

community education programmes on Convention of the Rights of the Children (CRC). CRC represents a powerful instrument and forms the basis for the primary prevention. Through knowledge of CRC and active participation by all sectors of society.

availability and accessibility of social services, supports and networks

school based activities toward non violence

secondary level: prevention efforts that include interventions with those at risk, for example:

perinatal and ongoing identification of at risk children and families

family support such as home visiting

clearly established referral system of support services

substance abuse treatment programs

community based and family centred support, assistance and networks

information available about community resources and safety planning

schools based social services for high stress environment

tertiary level: tertiary prevention takes place after a problem has occurred to remediate the effects so that it will not occur again, for example:

early diagnosis

proper inter-disciplinary services to ensure medical treatment, care, counselling, management and support of victims /families

reintegration in a child friendly community/school

adequate child protection laws and child-friendly courts

2.3.3. Forms of prevention

Drawing upon the country experience of Brazil, Canada, China, Dominican Republic, France, Germany, Greece, Hungary, Israel, Italy, Japan, Jordan, Kenya, Malaysia, Senegal, Singapore, Switzerland, Thailand, UK, USA and Zimbabwe good practices were developed into specific areas that are inter-related:

- clear policy, protocols and programmes: CRC and active participation by all sectors of society
- data collection, monitoring, evaluation, in order to provide accurate and consistent data on child abuse
- comprehensive services and equity. Comprehensive services include for child victims prevention and protection, treatment and care and physical psychosocial rehabilitation
- working with children: reinforcing the child and family protective factors and the promotion of positive interactions between child and parents. Child resiliency must be identified, understood and strengthened
- working with families, parents and caretakers: parents and caretakers must have access to reliable information on the physical and emotional development needs of children. Parents need to be helped to develop feelings of self-worth
- community involvement

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- interdisciplinary and multi-sectoral approaches: all personnel and agencies dealing with child – related issues should form a network for rapid intervention and integrated services
- involving policy makers
- international collaboration and partnership.

2.3.3.1. Public Awareness Activities

Public awareness activities are an important part of an overall approach to address child abuse and neglect. Such activities have the potential to reach diverse community audiences, including parents and prospective parents, children, and community members. In designing prevention education and public information activities, national, State, and local organizations use a variety of media to promote these activities, including:

Public service announcements

Press releases

Posters

Information kits and brochures

Television or video documentaries and dramas

Through these media, communities are able to promote healthy parenting practices, child safety skills, and protocols for reporting suspected maltreatment.

2.3.3.2. Skills-Based Curricula for Children

Many schools and social service organizations in local communities offer skills-based curricula to teach children safety and protection skills. Most of these programs focus efforts on preventing child sexual abuse and teaching children to distinguish appropriate touching from inappropriate touching. Other programs focus on preparing young people to function successfully in society, while still others teach or enhance protective behaviours in children. Curricula may have a parent education component as well to give parents and other caregivers the knowledge and skills necessary to recognize and discuss sexual abuse with their children. Curricula may use various methods to teach children skills, including:

Workshops and school lessons

Puppet shows and role-playing activities

Films and videos

Workbooks, storybooks, and comics

2.3.3.3. Parent Education Programs and Parent Support Groups

Perhaps the most prominent prevention activity is parent education. Typically, these programs focus on decreasing parenting practices and behaviors associated with child abuse and neglect. Though parent education programs may serve the general community, many are directed at populations determined to be at risk for child maltreatment. These programs address issues such as:

Developing and practicing positive discipline techniques

Learning age-appropriate child development skills and milestones

Promoting positive play and interaction between parents and children

Locating and accessing community services and supports

In addition to parent education programs, parent support groups also can work to strengthen families and prevent child maltreatment.

2.3.3.4. Home Visitation Programs

Home visitation programs have existed in the United States since the late 19th century. Rather than a specific program or activity, home visitation is a strategy for service delivery.

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They are described as programs that include visitation of parents and child (en) in their home by trained personnel who convey information, and or offer support, and or provide training. visit must occur during at least part of the child's first two years of life, but may have been initiated during pregnancy and may continue after the child's second birthday. Programs may include one or more of the following components: training of parent (s) on prenatal and infant care, training on parenting, child abuse and neglect prevention, developmental interaction with infants/toddlers, development of problem solving and life skills for parents, assistance with educational and work opportunities, and linkage with community services. programs may be accompanied by the provision of day care, parent group meetings for support and /or instruction, transportation and other services. Longer duration programs produce large effects, programs of less than 2 years duration did not appear to be affective.

Activities offered through home visitation programs may include structured visits in the family's home, informal visits, and telephone calls that focus on topics such as:

Positive parenting practices and nonviolent discipline techniques

Child development

Availability and accessibility of social services

Establishment of social supports and networks

Advocacy for the parent, child, and family

Maternal and child health issues

Prevention of accidental childhood injuries through the development of safe home environments

2.3.3.5. Respite and Crisis Care Programs

Respite care services provide short-term care to children who have disabilities or chronic or terminal illnesses, who are in danger of abuse or neglect, or who have experienced abuse or neglect. For caregivers in stressful situations (they may be parents, foster or adoptive parents, or other relatives or guardians), respite care services provide temporary relief from the ongoing responsibilities of caring for children in the home. Crisis care is a unique form of respite. It is provided to children, with or without a disability, when the family is in crisis. Crisis care services may be referred to as crisis respite, emergency respite, crisis nursery, crisis stabilization, or shelter care (ARCH National Resource Center, 1998).

When family caregivers are not able to take a break from constantly providing care and supervision for their children, stress builds. This elevated stress can lead to increased incidences of abuse, divorce, and out-of-home placement of the dependent family member. Respite services are provided in a variety of settings, within or outside of the family home. Services are generally short term (ranging from a few hours to a few weeks), and are provided on either a planned or an emergency basis. Both respite and crisis care services can be provided by other family members, friends, neighbours, community recreation programs, child or dependent care providers or centers, home health aides, family resource centers, community human service providers and respite or crisis care agencies. In addition to care and supervision, many respite and crisis care providers also offer a variety of support services to families, including referrals to other programs, counseling, case management, meals, transportation, social activities, lodging, medications, personal care, and assistance with activities of daily living (ARCH National Resource Center, 1998).

2.3.3.6. Family Resource Center

Family resource centres are sometimes called family support centres, family centres, parent-child resource centres, family resource schools, or parent education centres. Each family resource center works with community members to develop specific services that meet the needs of the people who use the centre and the community that surrounds it. This is accomplished by involving community members in design, implementation, and evaluation. Many centres require

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that advisory boards oversee the day-to-day operation of the centres, and that more than one-half of the board members be parents. Family resource centres may include parent skill training, drop-in centres, home visiting, job training, substance abuse prevention, violence prevention, services for children with special needs, mental health or family counselling, child care, literacy, respite and crisis care services, assistance with basic economic needs, and housing.

2.3.3.7. Other examples of promising practice approaches

- Co-locating domestic violence advocates in child welfare offices for case consultation and supportive services.
- Developing cross-system protocols and partnerships to ensure coordinated services and responses to families.
- Instituting family court models that address overlapping domestic violence and child abuse cases.
- Cross training domestic violence and child welfare advocates.
- Creating domestic violence units in child welfare agencies.

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3 Exploring the complexity of the field (Project field research)

3.1. Introduction

Content development in the project has not only been focussing on literature studies (2), but also on original (field) research and data collection. This has led to a case history collection (3.2.), the collecting of viewpoints of experts, target audience members and professionals working for public institutions with formal responsibilities (3.3.), the collection of good practice in intervention and prevention (3.4.). Each case collected has been analysed, discussed in the international research team and key issues for the content development has been defined. This has led to a data collection which is represented in this full report, while key notions have informed the writing of the booklet. Further specific actions have been undertaken by the various partners to empower their own organisation or to collect additional data (3.5.). Either by raising awareness among their members or staff members, either by discussing the issues internally and with staff members.

3.2. Case histories

The passage from theory to practice, the operative application of literature results is possible considering case histories, collected and reported through a grid in order to have as many information as possible. Case histories will serve us to reach a better understanding of specific forms of violence typically related to disability. Their understanding is a key to the development of the corner stones at the basis of good quality prevention policies. The cases are presented here in their full form.

For most cases, key issues are be listed: these are the results of reflections and discussion about the case.

3.2.1. Abel

Abel was born in 1985. He has a left hemi-paresis, limited intellect, personality disorder and epilepsy. He has a disability degree of 82% certified by the Social Services Aragón Institute.

Abel has not had the paternal figure because his father never recognized him, so he has his mother's surname. His family has always told him that his father is in prison because of drugs problems; Abel does not even know his father's name . He has always been taken care of by his mother, Antonia and the family of hers.

Antonia was 21 years old when Abel was born. She was the youngest of two siblings, her mother was a housewife and her father worked for a packing firm. They could be regarded as a low-middle class family. Antonia showed signs of extreme rebellious behaviour during her puberty and left her studies at an early age because she wanted to earn money and, following her brother's example, become independent as soon as possible. She soon found a job as a domestic collaborator in different households. The money she gathered little by little was spent in fun and at nightspots.

She met a young man, but older than her, who worked in a disco. She went to live with him and was also pregnant. Antonia quarrelled with her parents, although her mother continued to support her. Her father did not accept that she lived with a man being a single woman. When she was pregnant her boy friend did not want to face the new situation and abandoned her.

Antonia had to move back to her parent's place and she was taken care of by them. Together with her parents lived also Antonia's brother, who had just split up with his girl fiend. He had problems with alcohol and drugs.

The pregnancy was not good, she had some miscarriage threats. When she was pregnant for 8 months and a half, Abel was born. Problems during the birth produced a cerebral anoxia, reason for Abel's disability.

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To give a better attention to the child, Antonia went back to work, and left the child at the care of his grandparents and uncle. She began to absent herself from home, she did not come back at nights, she did not call to ask about her son, she was out for days and weeks without giving any explanation to her family. The figure of Antonia was disappearing little by little. She said to her family that it was very difficult to find a job in the town where they were living and that she had to go to other cities to find a job. She hardly ever phoned or wrote to her family. From time to time she sent presents to Abel.

Abel had big difficulties at the school. He soon showed aggressive and antisocial behaviour and changed schools very often. He became a very spoilt brat who did not accept any refusal to his demands.

Before being five years old, he suffered an accident at home. He injured one of his arms, and was taken to the first aid service. Doctors informed police and minors protection service of the injury, who concluded that Abel had been maltreated, because of cigarettes burns. They thought that the perpetrator was the child's uncle.

Minors protection service took the child away from the family and gave Abel to another family. He was with them until he was 13 years old. The child saw his grandparents during the weekends. He missed her mother very much, he wanted to live with her and his grandparents again. He never adapted to the new family, so he told lies and said that he was psychologically abused by his new parents. While the situation was being investigated he went back with her mother, because she had found a job nearby and lived in the city again.

Soon after being together again, Antonia met a foreign man to whom she got married a few months later. They had a baby and named her Ana, who is 4 years old now. She is gentle and friendly and goes to school. Abel is jealous of his sister and thinks that all their mother's love is for her, so he is aggressive to her.

The family has opened a hotel business but without much success and now they are trying to sell it. The economic problems affected the couple's relationship and they have started divorce proceedings. His stepfather went back to his country and since then he does not give any money to his family, so Antonia, Abel and Ana had to move to the grandmother's house (the grandfather died when Abel was with the other family). The three of them depend economically on the grandmother.

The relation between Antonia and Abel has never been good and it has become a pathologic one. Antonia has always hurt Abel psychologically, telling him that he was completely useless, that he was lame but he has always asked for her love, mainly trying to attract her attention. He has recently tried to commit suicide and now is in hospital because of medicine consumption.

To look after Abel has been too much work for Antonia, she has never known how to attend him and because of this she is very stressed. She has suffered phobia episodes and has felt the necessity of escape from her reality.

She is currently in an emotional and anguished state of mind and is thinking about leaving their children with the grandmother and thus be able to find a job in another country and start from zero. She is working in black economy and receives a little amount from the Social Services every month.

She has asked for help to local organisations in order to take care of her son, she is thinking of a residence for disabled people, but as Abel is of age and for the law autonomous, it is him who must take the decision.

The grandmother is already very old, she has health problems (diabetes, arthrosis, high blood pressure, etc.). His uncle is in prison for drug traffic, he must spend three years more there.

Due to his behaviour disorder, Abel has no friends, spending most of his time at the games arcade and at home. He did not graduate from secondary school. He has met a girl with psychological disability some years older than him which he says to be his girlfriend. The girl is expecting a baby from a previous relationship.

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Abel is not aware of his psychical limitation, he is not able to live independently because he has not acquired the necessary personal autonomy abilities.

There is evidence that he has been and is still being physically abused, beside being abandoned and neglected..

Key issues

Intervention should focus both on the mother and Abel. Firstly it would be necessary to work with Antonia, because she has not been given neither support nor information to raise her son. She still has not accepted his son's disability. She needs psychological treatment in order for her to face her reality. This support could be co-ordinated among the health centre, women institute and town social services. It is also essential to offer her not only job training but a job. There should be a co-ordination among the Employment Institute, Women's House and temporary job companies. She should receive economical support until her situation restores to normal.

Abel should be attended by the health services with the support of a hospital or a day centre in order to help him structuring his time. It would be good for him to have social relations and he must be informed and supported in improving his bio-psycho-social development. Having an intellectual disability, his autonomy perspectives should be evaluated in order to process or not a legal incapacity and to establish intervention.

Prevention should be done at an individual and a familiar level.

Antonia should receive psychological support in order to develop knowledge about her son (recognition and anticipation of his signals and desires in order to satisfy them), parenting skills, abilities to cope with daily difficulties in caring her child, awareness about Abel's both difficulties and potentialities. Maybe, Antonia felt unable to take care of her child: telling him he was unless she projected her low self esteem feelings on her child. She should be helped to develop self-confidence (self-esteem training) in order to feel as a competent mother and make more likely that she receives positive feedbacks by Abel.

At a familiar level, Antonia and her family has to be helped (familiar therapy) to develop and establish positive relationships patterns. The development of affectionate bonds among Antonia, her parents and Abel is an important objective to reach in order to do prevention (above all, secondary prevention), since Abel has expressed the desire to stay with his family.

Factors of risk present in this case: unmarried woman at her first pregnancy, low-income, financial difficulties, social isolation.

The relationship between violence and disability is bi-directional: miscarriage threats during pregnancy may have contributed to problems during Abel's birth and peri-natal cerebral anoxia. Literature refers that adverse maternal health-related behaviours during pregnancy are associated with neurological and neuropsychological deficits of child. dysfunctional care giving contributes to developmental difficulties and emotional/behavioural dysfunction. Home visitations during Antonia pregnancy may have allowed the prevention of these problems

Prevention should be done at an individual and a familiar level.

Antonia should receive psychological support in order to develop knowledge about her son (recognition and anticipation of his signals and desires in order to satisfy them), parenting skills, abilities to cope with daily difficulties in caring her child, awareness about Abel's both difficulties and potentialities. Maybe, Antonia felt unable to take care of her child: telling him he was unless she projected her low self esteem feelings on her child. She should be helped to develop self-confidence (self-esteem training) in order to feel as a competent mother and make more likely that she receives positive feedbacks by Abel.

At a familiar level, Antonia and her family has to be helped (familiar therapy) to develop and establish positive relationships patterns. The development of affectionate bonds among Antonia, her parents and Abel is an important objective to reach in order to do prevention (above all, secondary prevention), since Abel has expressed the desire to stay with his family.

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Abel is not aware neither of his limits nor his potentialities because his family has never recognised him as a complete person, accepting him. Learning and social difficulties may have contributed to Abel aggressiveness and behavioural problems.

3.2.2. Andreas

Andreas was born in 1990. He was born with icterus and as a result he has spastic quadriplegia. He was hospitalized for several months and had several surgical operations. Doctors advised the family about the complications which might follow and the rehabilitation that Andreas needed to do.

His parents had their first child abroad where they used to work as waiters for several years. One year before Andrea's birth they decided to return back to Greece to start their own business. Coming back home things were not as the family expected. The family didn't manage to integrate into their new community and develop new friendships. They were living almost isolated as all of their friends and family members were living abroad. Two years after Andreas's birth his younger sister was born.

Andreas's mother according to a professional testimony was facing psychological problems deriving from her father death which was expressed with behavioral abnormalities.

After 15 years of marriage the couple decided to divorce. The three children were under their mother custody and the father did not have any communication with his children except from the financial support which he was obliged to give according to law.

Andreas and his sisters were always facing problems regarding the support they were receiving from their parents. Events like, not being properly feed or dressed or having the proper medical support or attend school were very common.

But the situation for Andreas was even worst. He is not self-managed and he needs assistance to perform every day tasks such as getting a bath, eating and so on. He did not go to school either had attended a rehabilitation program. Even though the doctors had informed his parents that Andreas will need professional help and probably more surgical operations, his parents were constantly neglecting his needs.

Due to the lack of medical intervention his health was weaken very much. At the age of five he was transferred urgently to the hospital where he stayed for a month. That time the doctors realized that Andreas was not having the appropriate support and assistance from his family and they reported to the social service of the hospital. Andreas revealed to the social worker how the situation at home was. His mother was never taking care of him and the situation became worst since she divorced with his father. The assistance he was receiving was coming only from his sisters. In comparison with his sisters, Andreas situation was even worst. Not only because the neglect he was facing had worst and more direct implications to him but also because his parents were always treating to him as someone who should not live. Usually his parents was talking to him on terms of disparagement and calling him names when he wanted to take part for example in a family chat.

When he returned home from hospital the social service of the hospital informed the local authorities. A social worker was visiting Andreas and his sisters at home but his mother was keeping avoiding these meetings. Except from the psychological support that the children were receiving from the social worker, they were also attending courses and were taking part in activities in a local organization for children. According to testimonies, children' participation in such programs aimed at reducing the time that children spend in their homes.

As the situation was not improving at all, the social worker reported the situation to a procurator. After several attempts to support the family and the mother, the court decided to take the custody of the three children from the mother and to place them in an institution.

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Now Andreas and his sisters live in different institutions. They could not stay together as Andreas needed to live in an institution with other children with disabilities in order to have better assistance.

Key issues

Standard institutional intervention often has limits and might have unexpected results. It is therefore important that agencies before intervening are aware about different options and analyse for each options the expected benefits and the risks. Staff has to be trained to monitor their intervention and be flexible, if necessary to change their expectations and strategies depending upon the expectations and reactions of the families. People can only be effectively helped if there are specific and shared aims. This is a process that might require time, resources and human effort. Target audience representing organizations might have a role in interpreting families expectations and needs and dialogue at various levels with services.

External intervention without the collaboration of the family is riskful. Why did the mother not accept the help offered by the social assistant? Did she saw the social assistant as a threat or as a possible help? Was she aware of the fact that her refusing help might have led to the taking away of the children.

Ideally the programming of intervention has to be based on an analysis of risk factors and not on an emergency. Well timed intervention is intervention that arrives at the right moment and continues as an ongoing process. This probably will save precious public money.

Siblings often pay a high price as well. Intervention should take into account their needs as well.

3.2.3. Carlos

Carlos is a 14 year old child, who suffers of cerebral palsy, affecting his language more than his motion skills. He has lived with his maternal grandmother since he was 4. His mother is believed to be a prostitute.

Carlos was also living with a 4-year-old cousin and his drug addicted father. The house was decrepit, with little hygiene, crawling with parasites, such as mice. The house had no toilet. Water was warmed and poured in a tub for the children to have their bath. The house was practically destroyed by a fire caused by a short-circuit. The grandmother received both a good retirement pension and a widow's pension, but her drug-addicted son, who used to inject himself in front of everyone in the house, stole most of this money.

In the meantime, the father moved to Spain and whenever he came to visit Carlos (once or twice a year) he was affectionate with the child, bringing him lots of gifts.

On one occasion, the child appeared bruised and complaining about it. In the meantime, an anonymous complaint was made regarding the lack of hygiene and the children's general living conditions. After an inspection by the social worker, the case of Carlos and his cousin was signalled as urgently needing a solution.

The children were taken from their grandmother's house due to the hygienic conditions in which they lived, despite the general opinion according to which the grandmother took good care of them with her meagre possibilities and was very loving. Carlos was, at this time, found to have lots of parasites.

The children were taken to a foster centre. The uncle and aunt were contacted and the girl was placed in their care, but nobody would have Carlos. The child was therefore left in a day-care institution for disabled people, and returned to the foster centre at night. One of the centre's employees accepted to take Carlos in her home for the weekends and holidays. She was a divorced mother, and her children accepted the idea of having Carlos with them. This family received a benefit for acting as a foster family. The employee was known to have had alcoholism

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problems, but was always considered to have an exemplary professional record. She is somewhat unstable emotionally.

About a year after being in this foster family, Carlos appeared with a bruised nose and eye. His behaviour had changed; he was quieter and calmer. Nothing was mentioned until the employee was enquired about what had happened. This was justified by Carlos' refusal to take a bath and attack to the employee. He was taken to hospital, where he showed signs of mishandling.

On another occasion, he arrived at the institution with a swollen ear, which had to be drained twice, and finally undergo surgery. As a justification it was said that a car door had hit Carlos.

After this, the child was taken away from this family, and his custody was given to the institution.

The employee kept her job at the institution, and was not subject to any disciplinary measure.

Carlos is a very affectionate child, who sometimes gets to be visited by his father, his new wife and their baby son. Carlos enjoys his father's visits, even though he does not stay long. He sometimes speaks of his father and grandmother.

His grandmother suffered a health problem and is now living with Carlos' mother who steals all her pension.

3.2.4. Elisa

Elisa was born in 1951. She is affected by the Syndrome of Down. The family, at that time, is composed of five persons: father, mother, two brothers and Elisa, the youngest of the three children. For what concerns the pregnancy and the moment of birth no particular problems are reported. Elisa has never used specific medicines over a longer period, neither has she been hospitalised for operations.

When Maria, an educator of the Social Services, gets in contact with Elisa she is 44 years old. Her mother at that moment is affected by a form of Alzheimer, while the father is old and retired from work but still in good health. The brothers are both married and live in apartments nearby, properties bought for them by their father.

The family in which Elisa is born was a typical upper middle class family. It seems as if both parents have had important difficulties in accepting the child, in particular the father. According to a neighbour, especially after the birth of Elisa his work took him fully and brought him often to stay away from home for long periods of time. Elisa's mother instead was a house wife and took care of Elisa and her brothers. Although victim of the aggressive attitude and behaviour of her husband and her sons, she was the "driving force" of the family. The relationship between the parents has always been difficult and full of tension. Also the relationship between the father and the brothers of Elisa has not been without conflicts: it is reported that one of the sons has left home for ever after a furious quarrel with his father.

Elisa has spent most time of her childhood, youth and adult life in the family, but when she meets Maria it is to accompany her entrance in a day care centre for adults with disabilities. To assist her better in this transition, Maria collects information on the family history of Elisa, her habits and her everyday activities. She gets the picture of Elisa as a well known figure in the community, wondering often round in the quarter, collecting newspapers and letters even from other people's mail boxes, bringing them home and hiding them under her bed in the room that she shares with her brother. Nevertheless Elisa is well accepted and beloved by most people in the area and the family is accepted and socially non isolated.

Elisa has developed good basic skills and has reached a high level of independence in personal care. Anyway her look was not always appropriate. She often dressed in male or worn-out clothes and a brace, necessary for correcting her teeth, has never been bought.

At the time of meeting Maria is struck by Elisa's introvert character and shy personality. Towards her father instead she is excessively uninhibited, embracing and kissing him with strength. The

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father reacts passively to these demonstrations of affection. Elisa's mood is described as alternatively euphoric and depressed.

A year after the death of her mother, during an open air social group activity, Elisa states to have had sex with her father when she was a teen. "Incest" she calls it, an appropriate but not everyday word that Elisa probably has heard from someone else. In the following days, during different individual dialogues between Elisa and Maria, more details are revealed. Maria doesn't insist to hear all the truth at once, to leave time for Elisa and herself to elaborate the emotions caused by the reconstruction of this part of Elisa's youth memories. Elisa states that Maria is the first person to know about the abuse.

In the period that Maria comes to know her Elisa doesn't sleep very well. She often remains awake smoking in bed. It is not clear since when Elisa has sleep disturbances, anyway, successively she tells Maria that she fears the night as it was during night time that her father did abuse her.

Apparently no physical violence has been inflicted on her by her father as Elisa doesn't show anger, regret or disgust. Nevertheless she is convinced to have done something not "allowed". It is possible that the local priest has heard her "confessions", which would explain why Elisa knows the word "incest". Apparently the mother and the brothers were not aware of what was going on.

Maria, the educator, doesn't know very well how to react. She contacts her direct superior of the service she works for. Together they decide to consult a psychologist, to assist both Elisa and Maria.

In a very reserved way more information is collected and finally the few people informed on the case decide not to proceed legally, although the father is still alive. Principally for two reasons. Firstly because a lot of time has passed since the abuse. Secondly because the episodes refer to a specific period and has not been repeated over a longer period. Anyway professional psychological support is delivered to Elisa. The father dies some years later and Elisa is transferred to a residential home, where she still lives now.

Key issues

The "secret" of Elisa is revealed only after 30 years and after the death of the mother. It is Elisa to talk about it. With appropriate information, training and support, maybe Elisa would have talked before.

In case of sexual abuse young victims may feel "guilty" for compliance which makes the revealing more difficult. It seems important to educate the person with difficulties and the families in distinct sessions to the acceptance of the sexual instincts, teaching the right ways to expressing them and controlling them. Sexual instincts have not to be a taboo in the education of a person with a disability; it is a right the person with disability has to be helped to realize. Also in this sense, an appropriate training for professionals is important.

Maria declares that she was not sufficiently prepared to handle this case. A strong plea for appropriate training for professionals working with children and support in handling the own emotions.

It is decided not to prosecute legally the "aggressor", but the considerations underlying this decision seem to be rather "improvised". Probably the decision is as well based on the fact that the expected damage caused by a case in court is bigger than the benefits. Often there is no sufficient guarantee that the court will recognise a person with a mental disability as a fully credible testimony.

Sometimes, the belonging to a good social-economic background and the idea by others of a "good and respectable" family, reduce the state of alertness and attention towards the care of the child with disability. Hence, social stereotypes may reduce the objectivity of the evaluation and observation.

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The decisions about what is wrong or right for a child with disability, first of all must be dependent on the emotional, physical and psychological status of the child. The welfare of the child and his rights have to maintain the priority in the evaluation of a situation.

3.2.5. George

George was born in 1964. Three days after his birth he caught the polio. Since then he has physical disability and uses exclusively a wheelchair for his transfers. After many difficulties, he succeeded in completing his studies as a civil engineer and at the moment, he works in one of the biggest constructional companies in Greece.

George was born and grew up in one of the most undeveloped districts of Athens. His parents came from a provincial town. They had moved to Athens few years before his birth to live a more comfortable life with the hope to improve their economical situation. While they were living in the province George's father was a farmer, but as the harvest was poor, he decided to sell some fields and buy a small house in Athens. George's mother was a housewife. His father was coming from a very strict family where the women are not allowed to work and they have to stay at home raising the children.

Now, George is fully self-managed, as he can manage his needs on his own, without any help. However, during his childhood, the situation was very difficult, as he needed the family support like every child does, and, extra support to manage his disability and his personal needs.

In these frames, George revealed that he met violence in his family, especially psychological violence and neglect particularly from his father. He believes that his disability had a major impact on his father's behaviour. However the main reason he feels that made his father to express such a behaviour is the lack of national social provision from the Greek state, which obligates the family to fully undertake the support of the disabled member and to shoulder the total responsibility (economical, social, psychological) for this support.

According to George's words, this fact led his father, for example, to leave him alone at school after the end of the class, while he knew very well that George could not return home without assistance or to abandon him at bed for hours, forbidding also the mother to help her child. Furthermore, many times his father was insulting and swearing at George, blaming him for all the evils and his disasters of his life. Words as "useless" and "cripple" were very often used by his father. George does not remember going out with his parents for a walk as his father was ashamed of him due to his disability.

George supports that his mother was always very affectionate and very protective to her son but rather passive as she could not do otherwise. His father was very imperious and he always had to have the first and the last word in everything. Moreover, she was also suffering from many sorts of humiliations from her husband. He was beating her, he did not allow her to go out without his permission and he was often accusing her because their son was born disabled. In fact, several times, George was watching his father beating his mother, while he could do nothing to help her, fact which was hurting him very much. Additionally, all of their relatives were living in another city miles away and his parents did not have many close friends in Athens. George was all alone and there was none who could perhaps intervene and save him from his torture.

George also suffered physical violence, but, as he claims, the psychological and verbal abuse was so strong for him that many times he thought to suicide. An illustrative example of physical violence that George still remembers very clearly was a night when his parents had gone out to pay a visit to some friends and his father returned back home drunk. George asked for a glass of water from his mother and the father got furious. He rushed into his room and beat him up so badly, that, the next day he was in great pain and full of bruises. In fact, that was the only time that the physical violence was so intense, as George's father had never been so drunk before.

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Most of the cases of physical violence was performed by kicking at George's feet or at the head but never so strong as that time.

We asked George when had all started and if there was any particular reason which was driving his father to behave like this. He answered that, he always remembers his father insulting him and calling him "names". Concerning the physical abuse, it started when George started school and needed someone to assist him in that. Probably the more assistance George needed the more his father was seen him as a bigger "burden". As George said, his father had never had a permanent job and their economical situation was very bad, so probably this fact influenced him to attitude like that. George characteristically refers that the periods that his father was unemployed were the worst for him, as then his father was showing his anger against him more strongly.

While George was growing up and he could cover his needs by his own, the above incidents were not so often. At the age of 20 George left his home and went to live alone in a region miles away from his parent's home. He had never asked for a professional help as he was afraid that in case his father found out something like that would make things worst and also because he did not have the possibility to contact with someone since he was unable to be transferred by his own at that age. The only person that could ask for help was his mother. Unfortunately she was always under the father's supervision and unable to take any responsibility and any decision. George's family was very patriarchal, a model of family which still stands in some parts of Greece.

Concerning the possible problems that this whole situation may caused to George's life, he claims that when he remembers these moments it is like he relives them. So he avoids such thoughts and tries to do many things in order to leave behind all these that broke his heart. Luckily, as he says, the independence that he gained when he grew up allows him to forget the past, how all these happened and why. At this moment, he has a busy personal life and he has "many and good friends". He works too much, as his job demands it, but he always finds time for himself and for his friends.

George's mother passed away about six years ago. His father lives alone in their house, but George does not visit him very often, only once or twice per year. When his father complains about that then George in order to excuse himself he tells him that "I am disabled and I can't be transferred easily". This is something that he says only to his father. He does not believe that his disability actually prevents him from anything, but he feels that this particular excuse is more acceptable by his father than anything else.

Key issues

Restricted views about the role of the father as the sole responsible member of the family might lead to a high stress on the father and at the same time might obstruct the search for solutions internally and externally of the family. In some European countries a patriarchal family model is still surviving stronger than in other countries.

There is a relationship between helplessness (impotenza) and aggressiveness. Maybe the behavior of George's father is the result of his sense of incapacity to solve the problems of his son? Maybe it is the result of his perception not to be able to handle his emotions towards George and his disability. The more a person will feel unable to control a situation, the more that situation will be perceived as a burden. If the father would have felt to be useful for George, probably he would have reacted differently.

Worldviews and social cultural backgrounds can play a role in determining violence. In this case George's father's ideas about manhood and work may have contributed to defining his son "useless".

The lack of a parental network can contribute to feeling of loneliness.

Children with disabilities are at risk of becoming "scapegoats" for all the difficulties in the family life, even those related to the parent frustrations concerning their own capacities to handle situations.

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In some traditional families the gender of the child may influence the expectations about the future of the family. In case these expectations are not met frustration will rise. It could be a reason why male children are more at risk of experiencing violence.

Children assisting to domestic violence without the possibility to intervene will feel guilty. The more the child will have the feeling of being unable, also in the future, to intervene, the more seriously the effects will be on the development of his/her self esteem.

There is a risk that multiple risk factors leading to violence in the view of the aggressor are related to one single cause, which in the perception of the aggressor will be the most obvious cause (disability).

The closer the dependency relation, the more a victim will try to find excuses for his/her aggressor.

3.2.6. Leonor

Leonor was born in 1988 and was diagnosed as suffering from Global Development Delay and Epilepsy. Her father is a tinsmith with a criminal record. As far as it is known, her mother is a prostitute. She had 9 children, 3 of them having died as a result of extreme negligence. The father had a drinking habit and often hit all the members of the family. When Leonor was 5 the mother left the house taking some of the children with her, but leaving her behind. Hospital records indicate that Leonor showed signs of physical violence and sexual abuse. Leonor lived for some periods with her paternal uncle and aunt. Here too showing signs of physical violence and sexual abuse. The child basic needs were also neglected.

Leonor was taken away from her family and put in a home, and registered into a primary school. The child showed many difficulties in keeping up with the lessons and ended up going to an institution during the day and back to home to sleep at night. During this period, it is said that Leonor often missed the institution's bus because she was not ready when it came to pick her up. It is referred that Leonor was always poorly dressed and lacking care in terms of hygiene. She frequently had lice. The home was eventually closed, and Leonor transferred to a Foster Centre. At this time the institution where she is currently is contacted.

Leonor was admitted into the institution when she was 10. When she arrived she sought isolation, rejecting contact with others. She adapted to life in the institution, despite showing a somewhat inconstant behaviour. Adoption was tried a few times, but they could only find a foster family for weekends and holidays. This relationship was interrupted after a while.

Leonor has never had visits by her family since she is at the institution. Her father died and her mother's whereabouts are unknown. Leonor is very affectionate and seeks the love of people in the institution. She never mentions her family. She does not control her sphincters during the night. She has a boyfriend in the institution, which seems to have contributed to a more stable behaviour.

3.3.7. Maria

Maria was born in 1969. She was two years old when she was diagnosed with cerebral palsy. As a result she is quadriplegic and she needs 24 hours support. Her parents were the only ones who provided support to her as there were not any organizations in Greece which could support her. As a child she used to live with her parents but now she lives with her aunt, one of her father's sisters.

Her dream had always been to study psychology but she didn't manage to fulfill it, because she had never attended even the primary school. Also, her psychological and her physical state never allowed her to do things that she wanted. Consequently, Maria has never worked either she has

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looked for a job because she believes that she is not qualified and she is unable to work due to her impairment.

Maria was the only child in the family. She was born and raised in Athens, like her parents did, in a very rich region. Both her parents were coming from prosperous families and they had inherited a significant fortune by their parents. They invested the money from the inheritance and they started a knitwear factory which rapidly became one of the most famous in Athens.

She said that before her father's death, her family was a normal family, without problems and quarrels. Their life was rolling harmonically. Her father was a busy businessman working almost all day and her mother was a housewife, taking care of her but they always trying to find time to spend all together. Unfortunately, when she was six years old her father died by heart attack and the situation in her home became unbearable. Her mother's behavior completely changed, especially over Maria and she was accusing her for her husband's death. She was also saying to Maria that he died because he could not afford the pain he was feeling for his disabled daughter. In parallel, she started drinking very much, staying out and neglecting Maria on a such degree which was dangerous for her life.

Many times, when Maria was still very young, her mother was disappearing for three- four days, while Maria could not get out of bed. She remembers that she was leaving some food to a table beside Maria's bed, but she knew that Maria could not reach it, as her impairment is so restrictive that she can't use neither her wrists nor her legs. When her mother was coming back and sees that Maria had not eaten, she was arguing with her, saying that Maria was causing her problems on her own and that her health would become worst with the things she was doing. She was also adding that "Even that I don't believe that there is anything worst than your situation right now".

Maria, as she claims, has never suffered from physical violence, in the sense of walloping, but her mother's behavior was enough to make her lose her self-respect and her dignity leading her in many cases to desperation. She was insulting and swearing at Maria very often but things were becoming worst when she was drunk. Some times when she was out of control, totally drunk, she was sitting on Maria's bed threatening her with a knife to cut her neck. Maria characteristically referred that at those moments, while her mother was watching the fear in her eyes she seemed to enjoy it as she was laughing and making fun of Maria's weakness and fear.

Gradually, the drinking problem was becoming worst and worst. One night Maria's mother ended up to the hospital and doctors announced to their relatives that Maria's mother is alcoholic. Maria was 15 years old and since then none of her relatives had realized what was really happening in her home. Her mother had arranged to hire reliable people to manage their factory and she didn't have to undertake any professional responsibility. So, everyone had assumed that she was just staying at home taking care of her daughter.

After that their relatives and especially her parents' brothers and sisters took care of Maria, while her mother was transferred to an institution out of Athens for rehabilitation. Apparently, as the doctors said, she was not willing to rehabilitate, so after 2 years in the institution she committed suicide.

In the meantime, Maria had already moved to her aunt's house who was living alone. She had never been married and she did not have children, so she decided to take care of Maria and to offer her the love and the affection that her mother never showed to her. Maria has been also visiting a psychologist since she was 15 years old, as what she went through during her childhood had caused to her many psychological problems, with long periods of depression and bad mood. As she claims, since today, she has not managed to sleep calmly, because she still has nightmares and feels intensively that someone is coming after her, especially while she sleeps.

Maria gets out of the house rarely. She does not have any friends or a social life. Her only company is her computer, while through the internet she says that she had met interesting people, but never at close. In fact, as she told us, internet was proven a very useful tool and she wishes to had it especially when she was leaving with her mother.

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Even though that living with her aunt has actually improved her situation in many areas, her greatest fear is what is going to happen after her aunt's death. Of course, she has thought of the possibility to hire personal assistants. The money she inherited from her family, while her relatives haven't intervene to this, allow her to do so. However, she is afraid, as she says that she won't have the psychological strength to look for and find the appropriate assistants.

Key issues

Social economic well being is not always a factor of protection. On the contrary, well to do families might have more difficulties in accepting the disability of the child, "hiding" or denying it, as it disturbs the image of successfulness of the family. In case public support is income related, their lack of buying additional support might be a reason of alert.

Shocking events in the lives of people are factors of risk that are not necessarily absorbed better by families living in apparent harmony. Situations that change drastically require a reorientation on life expectations and tasks and a reorganization of internal and external relationships is required.

Apparently harmonious situations might lower the level of attention and alertness of external observers including friends, relatives and social services.

The type of disability and how it is acquired will influence the type and quality of the relationship within the families and expose those held responsible to various forms of violence. In this case Maria is held responsible both for her disability and the death of her father. As an effect she feels guilty which impedicts her to build up sufficient self esteem to be confident about her future. Therefore any risk analysis should include these variables.

Sleep disturbances as indicators and effects.

The presence of relatives is not necessarily a protective factor. The programming of intervention should keep this in mind.

3.2.8. Miguel

Miguel was born in 2000 and he is an only child. His mother, Josefina, had a normal pregnancy and a Caesarean birth due to insufficient dilatation. Miguel's psychomotor development has a certain deficiency as he began to walk when he was 19 months old. Miguel now controls the sphincters during the days but not during the nights, that is why he wears nappies. He can scarcely communicate, he speaks his own jargon but even his mother does not understand him very often. During his first three years of life he didn't go to a nursery, being exclusively taken care of by Josefina. When he was 3 years old he went to a school, where has emerged a personal and learning retardation in his development. Staff must constantly keep an eye on him. He does not pay attention when instructed, neither does he copies examples. All those tasks that require attention, accuracy and active listening are made deficiently. He rejects social relationships with other children, causing them injures, an attitude that he shows against her mother too. He hits his mother, shake his fists at her, does not obey any order at home, paint the walls of the rooms, etc.

Miguel's case has been evaluated by the Social Services Aragón Institute in order to start an Early Attention Programme and has been diagnosed with retardation in his global mature development (psychomotor, conduct and language). He receives in our association a personal treatment on psychotherapy, speech therapy and psychomotor activity. His request for determining the disability degree is in procedure.

Miguel is considered a social risk child because of the socio-familiar situation in which he lives. His mother, Josefina, comes from a totally rootless situation. She is the youngest of five siblings. Her father was alcoholic and abusive with his wife and sons. Josefina has always been more rebellious than her siblings, so the confrontations with his father were continual. When she was 17 years old she left home and move to another part of the country, she came to Aragón. To earn a living she worked as a prostitute. Due to her childhood problems she defines herself as a very

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nervous person, who is distressed at anything and who needs affection. She says that has stomach problems since she was five years old, which generate bad digests, vomits and faints. She is receiving medical treatment, but all these pathologies are psychosomatic due to psychological problems derived from her personal experience. She receives sedative medication for anxiety.

Josefina got pregnant during the period she worked as a prostitute and she doesn't know who Miguel's natural father is. She had the choice to abort, but she decided to carry on the pregnancy and to be a "single mother". She continued seeing clients until the pregnancy was far advanced. When Miguel was about six months old, one of her clients offered her help, giving her a flat and maintenance. Josefina, thinking of his son, accepted.

Josefina and Miguel live in a house and lead a more or less regular life. Josefina does not know how to deal with Miguel's attitude and behaviour problems. She tries not to be upset and not to shout at him, but due to her anxiety, she gets irritated very often and shouts at him or punishing him. She adores her son, telling that he is the only good thing in all her live. She brings him every day to the school, always clean and well-fed. Nevertheless she feels his son' situation is too much for her and that's why she has asked for institutional support.

Recently, the man who supported them, moved in the flat and the mother-son relationship is worsening, as well as the Miguel's conduct development. The couple's cohabitation is not good, and Josefina, who knows that her partner has another woman, is afraid of him leaving her and throwing her and her son out on the street.

Josefina has no formal training qualifications, she has neither work experience nor economic resources, so her insertion in labour market is difficult. She has been living in Zaragoza for while now, but her social relationships are the ones she established when she worked as a prostitute. She has neither contact with her family nor a social network to support her. She is afraid of institutions taking her son away from her.

Key issues

This is not a case of maltreatment but it is expected that an important change in the social and familiar situation might occur. It would be necessary to continue and to increase intervention in order to prevent a greater uprooting which might imply a possible abuse against Miguel.

First of all, it would be necessary an intervention with Josefina in all aspects (training, social abilities, psychological support, etc.) in order to help her to face the new situation. If she loses this man' support, she will be in the street with no resources.

The first step is to act together with the Social Services Council Centres. We emphasise the importance of working together because it is easy to wash one's hands of cases once we have given it to public institutions. All organizations, public services, institutions, etc, must work hand-in-hand in order to get the full integration of Josefina and Miguel.

It would be necessary to process a public economic help in order to defray the costs of primary needs (food, clothes, etc.) and that this economical support would last until she has a job and the situation stabilizes and return to normal.

Josefina has only worked as a prostitute and this is the only way she knows to earn money. It is necessary to insert her in a training and labour integration programme To do this it would be essential to work with INAEM (Aragón Employment Institute), employment agencies, labour insertion centres, etc. As she is not qualified to access to the labour market on an equal basis than others, it would be good she takes part in one of the programmes for acquiring social abilities, a job, etc.

It is also necessary the joint work to support Josefina in the search of a house. As the objective of looking for a house will be a long term one, it would be necessary to help her to look for any alternative place (institutional centre).

But we must not forget to pay attention to Miguel. To do this the co-ordination with the school and the psycho-pedagogical team is essential and thus to improve his bio-psycho-social development.

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It would be very positive for mother and son to have the support of a familiar educator who guides both of them. If it is necessary on the basis of achieving the objectives, it would be appropriate they were temporally and institutionally housed until the social and labour situation improves.

Factors of risk present in this situation may be considered at different levels:

level of Miguel's mother: family history of child maltreatment, low socio-economic status, mother's psychological disturbances, anxiety, unmarried woman, unwanted pregnancy;

level of Miguel: global developmental delay, behavioural disorders, lack of communication and interaction skills;

level of society: social isolation, lack of a formal support

There appears to be a dysfunctional relationship between mother and child, apparently since the establishment of an early good attachment, even if she declares to love him. The dysfunctional relationship may be due to a lack of parenting skills, that makes Miguel's mother unable to define a positive interaction with her son. A parenting-skills training may be useful to avoid some form of maltreatment.

3.2.9. Pedro

Pedro is now 6 years old. When he was born, his father was 24 and his mother 22, and both worked in a factory. The mother had syphilis during pregnancy. Pedro went to live with his paternal grandmother from a very early age since his parents had economic problems. The father's behaviour was always rather immature, according to the professionals in charge of this case.

Pedro was sent by the Paediatrician of the Health Care Centre to the Early Intervention Service of an institution for the disabled, for showing a quite severe Pervasive Developmental Disorder. It was arranged that Pedro would attend Occupational Therapy sessions at the Health Care Centre, under the guidance of the institution, but Pedro did not show up. No justification was given to this fact. It is referred that Pedro also missed the routine visits to the Paediatrician. When he went to these visits, he showed signs of neglect in his hygiene and nutrition.

This situation was considered as not appropriate to the child's well being and development, and the CEACF (Centro de Estudos a Apoio à Criança e à Família) was contacted in order to obtain that Pedro went to kindergarten. A visit was arranged with the parents who did not attend.

According to the Social Worker dealing with the case, Pedro was, at this time, almost 2 years old and had an irrational behaviour, screaming and crying whenever he wanted something. He was still unable to walk, but could sit. Apparently, he could understand very simple orders.

As far as we know, Pedro only ate baby food, never having soup, meat or fish for his meals. At this time, he was fatter than usual for his age. The Social Worker tried to share the child's parents and grandmother in her concern about his development and education. Despite the family assurance that this situation would change they still would not attend the scheduled meetings and therapy sessions.

Since this situation was not to the child's advantage, his maternal grandmother is contacted. She mentions her grandson is always dirty, smells badly and his nails are never clipped. She says her daughter is "crazy". At this time, Pedro's mother is identified as suffering from a psychosis and self-mutilating crisis.

When Pedro was about 2 years old, a neighbour filed a complaint for lack of hygiene and the child's living conditions. The Social Worker visited the house and found the child was very dirty, with very long nails and unable to stand up. There were no toys and he did not interact with children, being kept in the house all day long. He slept in his grandparents' bed, apparently because he had the habit to uncovering himself during the night. The grandparents are stimulated to prepare a room for the child, but, although there is enough space in the house, fail to do so.

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The parents are contacted and informed that if they miss the appointment with the Social Worker, the case will be sent to the Minor's Commission.

It is arranged for the child to go to kindergarten and the parents commit to pay the fees until a social benefit is assigned. The parents met this decision.

The parents got separated and the mother moved in with an alcoholic man. She became pregnant soon after that.

The family failed to send to the Social Security the documents which would enable them to receive social benefit for the child.

Pedro's grandmother died when he was 4 and he was put in the care of his father and aunt, spending the weekends with his mother. She suffered a self-mutilating crisis cutting her arms with a x-cutter. She was admitted into a Psychiatric Hospital. After leaving the hospital, the mother did not pick Pedro up, forcing the father to miss work to stay with the boy.

Later, the institution ask for the parents to sign a statement in which they committed to pick the child up at weekends at the maternal grandmother's house, where he stayed during the week. A week later, the grandmother refused to keep him, with allegations that she could not handle him.

>From then on, Pedro stayed alternate weeks with each parent, attending kindergarten during the day. He started to show signs of abuse. His parents are contacted. They say it would be beneficial if Pedro was sent to a boarding school. This decision was left to the parents. The parents select a school and contacts are made. Pedro's application is accepted, and the child stayed at his mother's while he waited for the new school year. Again, he showed signs of abuse. The mother attacks her companion throwing boiling water at him.

They moved to another house and Pedro is still staying at the institution. Both parents are now unemployed.

3.2.10. Teresa

Teresa was born in 1962, she is the youngest of three siblings. Only few months after her birth she caught the polio and after a long convalescence period, with the support of her family, she recovered from the illness but with some consequences in her legs and her spinal column and she has important limb problems and must use crutches.

In spite of these lesions, her child life was normal. She was loved by her parents and sisters. She went to the school, but as years passed, a great sadness was taking possession of her. Her family thought that this could be due to her disability but she seemed to make fun of it and she even joked about her physical situation.

Teresa's family was not a well-off one but they did not suffer dearth. Their relationship with the maternal grandmother and her aunt (her mother's sister) and uncle was very close. Teresa spent some times with them.

Teresa's father fall ill so her aunt and uncle took care of her more often. After a few years he died, the economical situation worsened and the mother had to work hard to go ahead. Teresa's two sisters had to start working at an early age. As Teresa was a very good student she went on with her studies. She became very introverted but as she was very responsible nobody suspected that an anomalous situation could take place.

When she was 14 years old, she began aggressive treatments to control her growing abnormal curvature of the spin, and because of this she had to spend long periods of time with her body in plaster. When this medical process finished, Teresa, who was 19 years old, took an irrevocable decision: she left home. Although all were surprised they accepted her decision. She moved to Madrid where she found a job. She studied (an arts degree) and worked offering private tuition. She moved very often to different cities, she even travelled to South-America as a volunteer for a humanitarian organization. She seemed to flee someone or something.

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This situation lasted ten years, then she decided to go back Zaragoza, her town, and to her home, and she thought about a new life. She only met her family and thought of going to a disability association in order to make new relationships and look for a new job. And it was here where she met people to whom she told what had happened in her childhood. Teresa had suffered sexual abuse by her uncle since she was 4 years old to 14. This event has affected her profoundly. This sexual abuse stopped when she was in plaster but when the treatments finished she was sexually harassed again and it was then that she decided to leave home. The sorrow, anxiety, introversion and the rest of the symptomatic shows that her family though to be due to her disability were the result of the sexual abuse, but nobody suspected anything. The disability disguised the causes of her behaviour, signs that in any other cases, might be evident.

When she dared to tell what had happened, she was already broken inside and outside. Six psychological treatment years were necessary to keep going, but fortunately today she is a person who has rebuilt her life, she has a steady job, an active social life and finally she has been able to tell her family what happened in her childhood. She is free from all the ghosts that had threatened her during all those years.

At first sight, this case did not present any relevant risk factor which made think of Teresa was being maltreated. Although her behaviour changed and she was overwhelmed by sorrow, everybody attributed it to the fact that she did not accept her own disability. They regarded her behaviour as something “normal” implicit in her disability.

Maybe the medical attention she received did not act properly when they did not recognise the signs derived from the abuse she was suffering. It is true that 40 years ago the medical processes were not the same as now, but the signs or indicators of a rape are always the same.

There was a lack of information and assessment as for Teresa’s parents as for herself. A four-year-old girl does not how to explain what is happening, that is why the familiar intervention is so important in the prevention of abuse in families.

The signs Teresa showed should be detected in the school.

And what about the sisters? Did not they know anything? Did they suffer abuse as well?

Today, 40 years after, there are sexual abuses too, and although it is easier to detect them, unfortunately they continue taking place. At the present time, as at a medical level as at educational and social levels, there are detection processes of possible abuse, although there is also a lack of general information about it.

Probably now this girl, when having structural changes, should have been leaded to the IASS Centre in order to follow an early attention treatment. So the abuse should have been detected. The psycho-pedagogical team should have also taken part.

There are many resources to attend children with or without disabilities and disability is being accepted in our society. But the fight for the social promotion and defence of disabled people’s rights, disability prevention and social prejudice removal of social prejudices which cause the social alienation of this group.

It is necessary that all the institutions, organizations, services and population in general, support, help and understand people with disability, and over all the bi-directional collaboration among all of them.

Key issues

This story sustains the literature data that often familial people are perpetrators of violence and maltreatment;

There is an evident lack of knowledge on precise characteristics and consequences of Teresa’s disability, affecting both her parents and her;

Teresa reveals what happened to professional figures working inside the association: this underlies the important role that staff have in detecting violence and maltreatment, since they work directly and daily in contact with disabled people;

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Maybe, Teresa's self-esteem was too low to think that what happened her was wrong, as if she deserved abuse, feeling guilty for her disability and not accepting it. She could reveal what was happened only after a period of self maturation and personal gratification in Madrid and getting in contact with the context of disabled association that she felt as protective and sure. Empowering people with disability, allowing them to realise their potentialities and to develop a positive self-image, makes them aware of what happens them, finding the strength to denounce situations of maltreatment

3.2.11. Tommaso

Tommaso is a 13 years old boy. He is affected by a severe cerebral palsy, with severe mental retardation and grave hypo-vision, caused by a pre-natal intrauterine haemorrhage. Tommaso does not speak, he expresses his feelings through cry and smile. He can not walk or move his body. He does recognize people by the voice and the touch. He is described as lovely and very sweet. At school he is supported by a remedial teacher. Tommaso needs pharmacological treatment and is epileptic but he is not followed by a physiotherapists because the father doesn't agree.

The assistance at home has been required at the age of 10, to help the parents to handle and sustain the wellbeing of Tommaso, and in order to be able to satisfy their other sons' necessities.

Tommaso's family is composed by the mother, the father and two brothers. His mother and his father work as nurses at the hospital. Both parents reject the traditional medicine, and in the past they have experimented alternative therapies with Tommaso. The mother has lost her mother when she was young. She has a mother- and two sisters- in law, but she does not have good relationships with them, because she feels they don't have helped her. Her father, Tommaso's grandfather, was a paediatrician, he has died since some years: the relationship with him was good, he has always suggested her to divorce from her husband. The mother is described as emotionally and psychically disturbed. She seems too weak to decide about her sons and herself, and depends entirely on her husband in the housekeeping. She has a personality disorder and has menaced suicide. She does not divorce because she is convinced that her husband would forbid her to see her sons and take them away from her. Sometimes she affirms she wants to kill her husband. She didn't want to have children and it seems that she feels guilty for this, especially when she speaks about Tommaso's disability. When her husband discovered she was pregnant, he affirmed he was not the father. She would have liked a daughter: now, she says that also this son is "his" and not "hers". She does not have many social relationships and feels alone.

Tommaso's father has lost his father when he was young and since then he had to manage the family. His mother lives in the south of Italy: a couple of times a year she comes to visit them. He is described as a rude and impolite person, who insults the operators of the educational home assistance service. He is authoritative and presumptuous. He has not accepted the chronic and severe condition of his son and seems to be very strict and rigorous in the use of a specific rehabilitation method with Tommaso, appearing as bitter and dogged. He has unrealistic expectations about Tommaso's possibilities of improvement. He imposes the method on the home care assistants as well, teaching them how to apply it, in the same rigorous way. The method exists in frequent (many times a day) visual, auditory, tactile stimulations imposed on Tommaso, using a machine in order to favour the breathing. Tommaso is fixed to a machine with belts that impose a certain breathing rhythm. The operators and the mother have to do these stimulations and exercises, keeping a register of how many times and for how long they have been doing them. Every night the father checks what have been done: if the exercises have not been realized in the "proper" way, he gets angry and shouts. The mother does the exercises even if she does not agree just for escaping the anger of the husband. Other exercises consist in keeping a plastic mask on the mouth, making Tommaso breath through it for some minutes,

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repeating it for all the morning. The father has rent a small gymnasium for some afternoons in the week where Tommaso has to crawl on a mattress: Tommaso can't move, so actually he has abrasions at the basis of the neck. In addition, in a slinging hanging on the wall, Tommaso has to move from one part of the room to the other: his efforts to do that are often accompanied by his mothers shouting. On some occasions, during all these stimulations the child has been seen crying and some epileptic seizures have occurred. Once Tommaso had an epileptic seizure with head version: the father turned his head to the middle line with strength, shouting him. The father wants the operators to behave with Tommaso as he were a "man" and not a little child to cuddle. When Tommaso sees the father he becomes rigid, while with the mother his posture appears more relaxed.

The father beats the other son because he didn't do his homework. The other son seems to have relation difficulties, assisting frequently to the mother complaining about the father. There's no parental network of help and support of this family, they are alone. The father has been quarrelling with all the professionals around Tommaso, such as teachers and doctors.

Key issues

Excessive expectations about the child's potential can lead to situations where therapy turns into inflicted suffering. Primary prevention should include correct information about the situation and the possibilities of improvement of the child.

Even if the child is not able to speak, there are different and various non verbal signals that can be useful to detect grief and suffering. Staff has to be trained to identify these signals.

In a multiple factor model where various factors are interrelated, results can be obtained through intervention on indirect factors. For example supporting or empowering the mother role, who often is the principle care giver.

The absence of a formal network which plays an active role in the care of the child collaborating with the family, increases the risk that parents are not able by themselves to handle and control the situation in the right way. This does not necessarily mean that where a formal network exists that delivers supporting services, these services correspond to the expectations of the client.

3.2.12. Conclusions

There are specific forms of violence that typically see children with disabilities as victims but that are hard to detect or to recognise as such.

At a family level the non acceptance of the disability or the unrealistic expectations that parents have concerning rehabilitation can cause therapeutic obstinacy inflicted on children. The improper use of pharmacological treatment or the denial of appropriate health assistance (for instance dental care) can also be considered forms of violence. Maternal risk behaviour during pregnancy, for example drug or alcohol abuse, is a form of prenatal violence that may cause severe disabilities

There are specific forms of violence related to disability caused by complex individual social and cultural convictions, which are strictly inter related and worked out at different levels. They are the expression of attitudes which are particularly difficult to detect and change as they are culturally determined and widely accepted. Some examples are the lack of early intervention aiming at autonomy and independence, including access to assistive technology, the denial of a sexual identity to children with disabilities, the lack of self determination and decision making power, the lack of communication opportunities and the lack of privacy for adolescents and adults with disabilities.

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Negative attitudes towards diversity and disability are expressed by many people through open discrimination. Humiliation, fear of physical contact and disdain, are forms of violence that often see children with disabilities as victims.

Many people with disabilities will argue that the lack of equal opportunities in all realms of life has violent effects on their lives. The barriers that obstruct people with disabilities from having access to opportunities are both physical and mental.

Disability per se does not cause violence, but undoubtedly increases the risk.

According to the ecological model, risk and protective factors represent data which is non static, but which enters a dynamic process with breaking out factors (i.e. a sudden life event that demands a high level of adaptation) and which may act as a catalyst for maltreatment. It is as if a delicate balance is suddenly disrupted.

Children with disabilities are children with special needs. Feeling full responsibility for responding to these needs on a daily basis may lead to stressful situations and too much stress may lead to violence.

Being the parents of a child with disabilities requires immense coping skills and abilities to be able to adapt to countless new and adverse situations. The birth of a child with a disability causes a trauma which demands profound reorganisation of both expectations and future perspectives. Parents immediately have to find the strength both to react to the shock and to arrange a new life. Taking care of the child, the rest of the family and having to go to work in many cases turns out to be incompatible. Therefore many main care givers, who in the majority of cases are women, leave their jobs, which leads to the family becoming impoverished and the couple splitting up into two distinctly separate specialist roles. One is home centred and concentrates on the provision of care while the other involves being out of the house and is fundamentally concerned with providing income. Both roles demand different types of priorities and develop different types of stress which are not always easy to mediate.

Another important change is that represented by the activation of a formal network comprising social and health services, and an informal network made up of relatives and friends. The more solid these networks, the better protected the child will be. Adequate networks will guarantee the family both material and psychological resources and thus the opportunity to achieve and maintain a good quality of care and life. In these cases, both the parents' abilities to cope with situations and also their positive expectations will be reinforced. When support is offered late and there is poor communication with the parents, intervention will be less successful (Andreas).

A family member's disability is a risk factor which interacts with others. The weight of risk factors on a situation is not absolute, but is counterbalanced by that of protective factors. The result is a complex pattern of factors, the characteristics, internal mechanisms and processes of which are not always simple to detect and to understand. Mapping them can be of help to identify high risk situations, but should never lead to simple and linear conclusions.

The different types of maltreatment indicators can make the detection of violence against children more precise and objective, although some indicators of maltreatment are also symptoms of specific pathologies and disabilities (i.e. hyperactivity, behaviour disorders and so on).

Maltreatment detection is often a process which requires time, particularly in cases of disability. The observation of the child with disability has to be prolonged and carried out both in family and non family environments. Only by analysing data collected at different moments and in different contexts, can it be assumed that maltreatment has occurred or is occurring.

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3.3. The point of view of the target audience and professionals

The discussion about literature results and outcomes of the ongoing research has to be opened to the different professional figures that are involved in the network of the child care, such as social and health services, other associations and organisations. The networking developed within the framework of this project will be based on information exchange and feedback on the role disability organisations can have in developing or supporting prevention programmes. After a short introduction this chapter will be informed by a report of each single partner regarding the activities undertaken under action lines B.1. and B.2.

3.3.1. Interviews with target audience representing professionals

The **target audience** of the project is formed by people with responsibilities in non profit oriented organisations in the field of disability, in particular those who represent families or people with disabilities. Some will provide services with public or private money (for example from private insurance companies), others won't and will limit themselves to voluntary work, political representation, advocacy, campaigning.

For the scope of the project it is important to collect feedback from some of these target audience representing organisations. The following grid has been used to structure interviews:

Please introduce your organisation and the project. Explain that it is a European project and what the project is about.

The aim of the interview is double:

- A. to collect information and viewpoints of institutions
- B. to understand how to collaborate in networks aiming at prevention..

Collect information on the interviewed (role, professional background, years of post holding):

Questions

The organisation's perception of the issue

What are the main activities of your organisation?

Is the issue "domestic violence" a theme that concerns or worries your organisation?

Has your organisation been involved in a debate or in actions concerning this theme? If the answer is affirmative, check whether those actions have been promoted by the organisation or promoted by other institutions and whether these were preventive actions or not.

The institution has been involved in domestic violence prevention actions?

Are you aware of situations of violence against children with disabilities? Was the organisations directly involved? What was the role of the organisation and what resources have been used to tackle to problem?

Have you ever detected within the organisation differences regarding the interpretation of the concept of "violence"?

Inside your service delivery and organisation policy, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members) and what has been done?

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

Considering your general knowledge about the disability issue, do you consider that violence against children with disabilities requires a specific institutional approach?

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

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Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

Prevention strategies

What does it mean preventing violence against children with disability?

Which are the conditions necessary to develop a prevention strategy?

What would you consider fundamental characteristics of any prevention strategy?

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Who should co-ordinate inter agency intervention and prevention?

Resources

Regarding the available resources in you organisation (staff and money), which of these resources are already geared towards prevention?

Do you believe that your organisation is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

If we would organize a round table to discuss this topic, would you be interested in joining it?

Juan Carlos Castro, Secretary general of DFA

The organization's perception of the issue:

What are the main activities of your organisation?

To support people with disabilities through social and labour insertion.

Is the issue "domestic violence" a theme that concerns or worries your organisation?

We are interested in and worried about this issue.

Has your organisation been involved in a debate or in actions concerning this theme? If the answer is affirmative, check whether those actions have been promoted by the organisation or promoted by other institutions and whether these were preventive actions or not.

We've carried out isolated actions related to concrete cases. The preventive job involves attention and familiar assessment programmes and the intervention of the multi-disciplinary teams with the families.

The institution has been involved in domestic violence prevention actions?

No specifically, but the familiar support and assessment reduce the risks that can lead abuse situations.

Are you aware of situations of violence against children with disabilities? Was the organisations directly involved? What was the role of the organisation and what resources have been used to tackle to problem?

Yes, I am. My organisation hasn't taken part in concrete abuse situations but it is involved with these problems through prevention

Have you ever detected within the organisation differences regarding the interpretation of the concept of "violence"?

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No, I haven't.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, I think it isn't sufficiently highlighted.

Inside your service delivery and organisation policy, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members) and what has been done?

No, I've never tackled this problem.

Considering your general knowledge about the disability issue, do you consider that violence against children with disabilities requires a specific institutional approach?

Yes, I think that institutions dedicated to children should take into account the disability circumstance.

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

No, abuse is the same in children with or without disabilities.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Knowing all the extent of the abuse and the concrete environment in which it takes place.

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

I consider that the social-cultural background can influence the perception and the definition of violence against children with disability but it isn't determinant.

Prevention strategies

What does it mean preventing violence against children with disability?

To be able to establish procedures with these children families.

Which are the conditions necessary to develop a prevention strategy?

First of all, the identification of the abuse cases and detection of risk situations.

What would you consider fundamental characteristics of any prevention strategy?

Continual work on the families.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Initially, preventing interventions.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

When we speak about a prevention intervention we refer a action before the abuse situation appears. Intervention with the child and the family is information and daily work with a bi-directional implication.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

In some cases, financing research programmes and in other cases, delivering attention or prevention services .

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Yes, I consider that they should be included on the basis of their experience and the cases they know.

Who should co-ordinate inter agency intervention and prevention?

The public institutions should co-ordinate this.

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Resources

Regarding the available resources in your organisation (staff and money), which of these resources are already geared towards prevention?

Specialised staff.

Do you believe that your organisation is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

Not yet.

If we would organize a round table to discuss this topic, would you be interested in joining it?

Yes, of course, I'd be very interested.

Pedro Cano - Fundación Instituto para la Integración Social

The organization's perception of the issue

What are the main activities of your organisation?

Fundación Instituto para la Integración Social is a non profit making association whose aim is the social integration of disadvantaged people through programmes that make easier their social and cultural development as a way of abolishing the discrimination. The services we offer are the following: social services (guidance-information, training- employment, job training) and welfare work (Day Centre, occupational centres, speech therapy, leisure centre, residential home, technical and personal autonomy helps).

Is the issue "domestic violence" a theme that concerns or worries your organisation?

We are mainly worried about it while working on its prevention. We work with mentally children. This disability may be a possible maltreatment handicap.

Has your organisation been involved in a debate or in actions concerning this theme? If the answer is affirmative, check whether those actions have been promoted by the organisation or promoted by other institutions and whether these were preventive actions or not.

As well as all the activities I told before, recently we have set in motion a Parents School in order to work directly with them in the care, attention and above all the acceptance of their children disability and offer them all the support they could need.

The institution has been involved in domestic violence prevention actions?

We consider that prevention in general is one of the goals of all the activities the Foundation set in motion.

Are you aware of situations of violence against children with disabilities? Was the organisations directly involved? What was the role of the organisation and what resources have been used to tackle to problem?

Our foundation doesn't know any direct case of an abused child, but we work daily on the prevention.

Have you ever detected within the organisation differences regarding the interpretation of the concept of "violence"?

The concept of violence has different understandings, that's way information is very important.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, this topic isn't sufficiently highlighted. That's is due to the lack of information and the social and mental barriers in the own families when they have to face to their children disability.

Inside your service delivery and organisation policy, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members) and what has been done?

As I said before, we haven't directly know any case of children maltreatment.

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Considering your general knowledge about the disability issue, do you consider that violence against children with disabilities requires a specific institutional approach?

Yes, I do. I think that there would be administration channels and/or lead the cases to the ONG's.

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

There isn't any difference when we face to children maltreatment, whether the child has disability or not. We must condemn the same both cases.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

The necessary actuation would be to inform not only professionals who work with these children but population in general, in order they accept the child's disability.

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

Yes, I do. It mainly depends on the person's culture and on the type of disability. It's not the same the abuse perception we have of a physically disabled child or of a child with plural-deficiency.

Prevention strategies

What does it mean preventing violence against children with disability?

It means to give total information on the disability in order to accept it as a natural thing in order to eradicate the risk factor it implies.

Which are the conditions necessary to develop a prevention strategy?

To be able to develop a prevention strategy it is necessary to identify the real situations and the risk factors that can contribute to the violence. We will be able to take part by analysing the reality.

What would you consider fundamental characteristics of any prevention strategy?

It's essential for a proper prevention that all the society involves and not only the institutions and specialised professionals.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

As I've told before the most useful thing is the information and the general support to the parents of children with disabilities, without forgetting population in general.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Preventing is to intervene before the abuse develops and support the family once it has taken place. We must support and listen to the family and the disabled child.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Collaboration is necessary for a proper prevention, it should be bi-directional among services, associations and institutions.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

The role of parents organizations is important to work against the violence against children with disability and in all the aspects related to their integration. Parents are who care their children and they are the main intervention focus.

Who should co-ordinate inter agency intervention and prevention?

It could be created an inter-institutional committee so that all the intervention groups are represented and all of them work together in order to get the same objective.

Resources

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Regarding the available resources in your organisation (staff and money), which of these resources are already geared towards prevention?

We always use staff and money. Grants are used to contract qualified staff.

Do you believe that your organisation is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

I think that we are positively working but everything can be improved. It's necessary to go on growing in order to have a greater intervention with our group and get their full psycho-physical-social development.

If we would organize a round table to discuss this topic, would you be interested in joining it?

Naturally, as personally as a member of the Foundation.

President of Greek Association of disability organisations.

The organisation's perception of the issue

What are the main activities of your organisation?

We are an umbrella organisation we provide information to our members and safeguard our rights, one could add that our activities are mainly syndicalistic.

Is the issue "domestic violence" a theme that concerns or worries your organisation?

Violence not only domestic is an important issue, of course it worries us but we have not taken any actions.

Has your organisation been involved in a debate or in actions concerning this theme? If the answer is affirmative, check whether those actions have been promoted by the organisation or promoted by other institutions and whether these were preventive actions or not.

No we have never done anything officially.

The institution has been involved in domestic violence prevention actions?

No we have never done anything officially.

Are you aware of situations of violence against children with disabilities? Was the organisation directly involved? What was the role of the organisation and what resources have been used to tackle the problem?

We do not know anything officially and as an organisation we have not been involved directly

Have you ever detected within the organisation differences regarding the interpretation of the concept of "violence"?

There is no official statement or definition on violence, but there is a common understanding of the physical and psychological aspects

Inside your service delivery and organisation policy, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members) and what has been done?

There was a case of a disabled child that showed signs of suffering domestic violence, which we dealt with unofficially. We took the initiative to intervene and talk to the mother, who stopped the abuse after warnings that we would take the case to court. If there had been an organised approach, more help and support would have been given.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

There is a lack of expertise on violence against children with disability and it tends to be homogenized with other groups of children suffering violence.

Considering your general knowledge about the disability issue, do you consider that violence against children with disabilities requires a specific institutional approach?

I think we need to pay specific attention to the conditions surrounding disability that may lead to violence against children, so as to develop a complete approach to solutions and prevention.

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Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered “violent”, that in situations where disability doesn’t play a role wouldn’t be recognised as such?

There may be more feelings of overprotection in the cases of disability, but generally violence is perceived to be a sensitive issue anyway.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

It is useful to think of violence and disability within the environments they occur, looking at family situations, community context as well as general societal norms, in order to understand the general trends of this problem.

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

Definitely, in different times and different places, disability itself, as well as violence against children with disability, can be treated as a shame, or as a common experience, or with overprotection.

Prevention strategies

What does it mean preventing violence against children with disability?

In the short-run, understanding the factors that lead to it, and intervening to provide support to families. In the long-run, it means having positive attitudes to disability, enabling environments and policies.

Which are the conditions necessary to develop a prevention strategy?

Thorough research, cooperation and coordination of organisations with different expertise for exchange of knowledge, and commitment to implementation

What would you consider fundamental characteristics of any prevention strategy?

A strategy that is preventive should have a clear idea about who it is targeting, how widespread is the problem, and set clear objectives and methods to be met.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Interventions must aim to support ideally the whole family, transfer knowledge to the parents, create an enabling environment for the child.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Prevention support might be more targeted, and needs more the cooperation of parents. To the child, it may provide more information and consultation regarding the problems of violence and disability.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Collaboration among different organisations should be kept at all times, including prevention strategies. It should be about sharing knowledge and information, and communication for discussing problems and improving solutions.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Yes, they should be involved on the basis that preventing violence against children means having a holistic approach to the situation, considering parental and family conditions. The associations representing these will thus provide useful insight.

Who should co-ordinate inter agency intervention and prevention?

Agencies that may have more expertise and experience, and interest in this issue should take the initiative to co-ordinate.

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Resources

Regarding the available resources in your organisation (staff and money), which of these resources are already geared towards prevention?

As I mentioned before we have not got any resources available for this purpose.

Do you believe that your organisation is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

No, of course not.

If we would organize a round table to discuss this topic, would you be interested in joining it?

Yes, it is time that violence against children with disability is given more attention in Greece.

A psychologist in a Greek Protective work centre

The organisation's perception of the issue

What are the main activities of your organisation?

It is a protective work centre for people with learning difficulties. The ages vary between 15-40

Is the issue "domestic violence" a theme that concerns or worries your organisation?

Yes it is. We are also aware if something like that happens.

Has your organisation been involved in a debate or in actions concerning this theme? If the answer is affirmative, check whether those actions have been promoted by the organisation or promoted by other institutions and whether these were preventive actions or not.

No, we have never taken any actions concerning the theme.

The institution has been involved in domestic violence prevention actions?

No we have never done anything for prevention. However, many of the parents see the time that disabled people spend in our centre very useful for them as they find time to rest as they say or time to have other activities.

Are you aware of situations of violence against children with disabilities? Was the organisation directly involved? What was the role of the organisation and what resources have been used to tackle the problem?

I am not aware of violence in physical form at any of the people who are working at the centre but if we notice that something might go wrong with them people we contact the family asking about what has happened. What we can only do is make them notice that there are people who care about their children and make them understand that we will do our best to safeguard their rights. This is something that we are doing voluntarily not that it is an official activity of our organisation.

Have you ever detected within the organisation differences regarding the interpretation of the concept of "violence"?

No, because there has not been a need for further action than the communication with the parents and we have not faced any difficult issues.

Inside your service delivery and organisation policy, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members) and what has been done?

No.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, not at all. Generally I have not seen many activities happening about the issue of violence against children. Personally, if I had to face such a case I would first contact the police as I do not know any specialised organisation.

Considering your general knowledge about the disability issue, do you consider that violence against children with disabilities requires a specific institutional approach?

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No, I don't think that we should distinguish children with disabilities from non-disabled children. However, children with disabilities might be less capable of defending themselves so there should be specialised staff within an organisation.

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

No I don't think that these kinds of separations should have part in disability issues

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

If you are talking about the family's background it is an issue of question because even if the family has a high social and cultural background this doesn't mean that they will not harm their child and vice versa . On the other hand, if we are talking generally of course it does. There is not any information and there is prejudice against disabled people. People are not informed about the disabled people's needs, disabled people are always seen as children and as people who will always be dependent on others. Especially with people with learning difficulties even if they are 45 years old people continue to call them 'kids' and treat them in such way.

Prevention strategies

What does it mean preventing violence against children with disability? Which are the conditions necessary to develop a prevention strategy?

First find the risks that disabled children might be in and then create those mechanisms which can support and safe guard them. It is necessary to find people who will be trustworthy to work on such strategy as it is a very delicate issue.

What would you consider fundamental characteristics of any prevention strategy?

Information and sensitize people about this issue.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Education and information of all the people who are dealing with children with disabilities. Also children should learn what violence is and understand when their rights are violated. It is important for parents to know which are the needs of their child, how to fulfil them and where they can turn to when they face difficulties.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

I cannot say exactly but when an incidence violence occurs you have to protect the child from a future incident like that and make the family realise what they have done and what has driven them to such action and work specifically on that. In prevention we give general information, you are never sure that violence will occur in the family even if you see some signs that might lead your thought that they could abuse their child. Generally on intervention there is more counselling and on prevention there is more information

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Definitely but it could be a good idea if there was a centre office which was managing and coordinating all the services

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

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They should certainly be included. They could distribute information about disability related issues and also they could work supportively between parents. There could be a place where parents could talk with people who face similar problems. something like psychological support.

Who should co-ordinate inter agency intervention and prevention?

A group of very specialised people both on the field of violence and disability.

Resources

Regarding the available resources in you organisation (staff and money), which of these resources are already geared towards prevention?

There are not any resources available for that purpose

Do you believe that your organisation is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

We do not have any program to do on that. We try to have a close relationship with the disabled people and their families. We try to understand if everything is fine at their places.

If we would organize a round table to discuss this topic, would you be interested in joining it?

Yes, of course.

Francesco Spoto, Cooperativa Attività Sociali

The Cooperative works with children, adolescents and parents, giving assistance, support, training. It works in the field of intellectual and behavioural deficits in different contexts: family, school, free time spaces. It organises researches and training meetings in the social and pedagogic field.

The perception of the issue

The definition of violence includes different forms, such as phisycal aggressiveness and psychological violence. Violence can be defined as personal freedom deprivation and rights negation, it is a form of child overwhelming. There is not a causal relationship between disability and violence.

Concepts such as depressive anguish, loneliness, perceived impotence by parents, social isolation have to be taken in account to understand the phenomenon of violence against children with disabilities. In cases of family isolation, parents are not able to educate their children to be autonomous and independent, a symbiotic relationship may develop between them.

Violence can be the result of too much stress: children with disabilities require more care and have more specific demands and needs which parents have to satisfy daily.

The economic and social background influences the perception and the definition of violence against children with disabilities, although not completely: risk factors such as multi-problematic families, alcohol abuse, low cultural level can be found also in families characterised by an high economic level.

Prevention strategies

Prevention has to be centred first of all on families, which have to be supported since the birth of the child. Anyway, preventive strategies have to be developed involving the network of professionals and services. Preventive actions have to be visible by the entire community: violence is a social problem.

Associations like AIAS have to support families through home assistance: useful interventions can be guaranteed through trained staff. Prevention has to be integrated and multi-professional: public institutions are responsible of the main coordination.

Silvia Stefani, Blind children Association

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The national Association is made by parents and its aim is that of exchanging information, knowledge, experiences to sustain, educate, train parents to the parenthood.

The perception of the issue

Violence is an hidden phenomenon and it is very difficult to establish its incidence since it develops mostly inside the family. Parents who get violent often live isolated, they have difficulties to go out and take moments of respite for themselves. Parents' stress is an important factor which may determine violence.

Since the birth, if the parent is not aware of both limits and potentialities of the child there can be problems in the attachment bond establishment. Social background may represent a risk factor, even if violence is diffused also among high social level families.

Prevention strategies

Prevention has to be centred on families, training them to parenthood and giving them educational strategies. Marital support represents an other important prevention strategy.

Institutions, associations like AIAS and social services have to define a standardised and formal protocol of information and training for parents. Home visiting is an useful prevention instrument.

Some prevention cornerstones in cases of disabilities can be defined in the following manner:

- correct and professional diagnosis;
- early home assistance;
- give to parents the necessary competences to handle difficult situations;
- avoid social isolation;
- consider the negative impact of media exalting a violent culture.

3.3.2. Interviews with experts

Across Europe there are a number of people that can be considered experts on the issue of maltreatment of children. Some of them might have developed a particular expertise in the field of disability. Typically they will work for Universities as researchers or for NGO's particularly active in the defence of children's rights. Some might be independent professionals working as psychologists or lawyers. Finally some of them will work for public institutions as magistrates, policy makers or service deliverers. In that quality they might be interviewed using the "*grid for the collection of feedback from public institutions*". Target audience representing experts will have to be interviewed using the "*grid for the collection of feedback from target audience representing organisations*".

Please introduce your organisation and the project. Explain that it is a European project and what the project is about.

The aim of the interview is to collect information and viewpoints of experts

Collect information on the interviewed (job, professional background, experience with the issue):

Questions

The perception of the issue

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

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Which forms of violence you believe are the most harmful for children with disabilities, and why?

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Which are the aspects of the issue that, according to you, require more research?

Prevention strategies

What does it mean preventing violence against children with disability?

Which are the conditions necessary to develop a prevention strategy?

What would you consider fundamental characteristics of any prevention strategy?

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Who should co-ordinate inter agency intervention and prevention?

How can a public service act in order to be perceived as a support to the family?

Which risk factors and protective factors you believe should be ?

Desirée Garrido

Psicologa del programa de Atencion Temprana y de DFA

The perception of the issue

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, I don't. Violence against children is a problem that is not taken into account while establishing preventing measures in the childhood field. People only act when the problem is detected and it is then when preventing actions are implemented.

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

No, I don't think so. The respect to the other, whatever his/her circumstances are, is a universal thing.

Which forms of violence you believe are the most harmful for children with disabilities, and why?

Maltreatment in itself is harmful to the bio-psycho-social development of the child and any person.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

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Understanding the abuse means to analyse it in an integral way (social, physical, biological, etc.) in the family in general and not as pathologic action by the parents or as a consequence of particular characteristics of the children.

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability?

It influences, but it is not determinant.

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Needing preventing programmes means to provide individual information on the disability and “relief programmes” which help to decrease the familiar strain.

Which are the aspects of the issue that, according to you, require more research?

Mainly, to detect the abuse. Many times these situations are not detected due to the lack of information on the issue.

Prevention strategies

What does it mean preventing violence against children with disability?

To establish social mechanisms which reduce or eliminate the factors that lead to a violent situation.

Which are the conditions necessary to develop a prevention strategy?

Identification of risk factors.

Detection of families with these factors.

Implantación de medidas preventivas

What would you consider fundamental characteristics of any prevention strategy?

It must be easy to be applied.

It must be disclosed in all social spheres (health, educational, etc.)

It must have efficient flow information channels.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

To provide information on the risk factors and where to address to the social elements; Proporcionar a los elementos sociales información a cerca de los factores de riesgo y de dónde dirigirse; lo que implica centralizar esta intervención en un elemento concreto

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

The intervention with the object of prevention is to act before abuse takes place.

the specific characteristics of a prevention intervention concerning the child must guarantee a healthful integral development in the child.

Intervening with the family in order to the family provides to the children all they need for his/her personal development.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

We think that it is essential the coordination among all of them. This collaboration must be clearly defined and articulated through communication channels.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

They are very important in the detection of risk factors.

Who should co-ordinate inter agency intervention and prevention?

Public institutions but with the collaboration of the associations.

How can a public service act in order to be perceived as a support to the family?

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Offering prevention programmes, measures and services to all the families with children with disabilities and/or to the families at risk of maltreating their children, so that identify the risk factors and offer the necessary measures individually for each family.

Which risk factors and protective factors you believe should be ?

Problems of domestic violence, drug-addictions, alcoholism, antisocial behaviour, poverty, isolation, disabilities, etc. Each person, each family presents different situations and different experiences, so the study and the intervention must be individual.

Dr. Gonzalo Oliván Gonzalvo

Head of Paediatrics and Adolescence Division

Social Services Aragón Institute

Government of Aragón, Zaragoza, Spain

The perception of the issue

1. *Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?*

From the socio-health point of view, no roundly no. If we analyse the biggest bibliographic database in the world (Medline) and we enter “Child abuse and Disabled / Handicapped children” there are only 23 studies. If we add to the search “Physically disabled / handicapped, Mentally disabled / handicapped” less than two hundreds studies appear. Most of these studies are from the USA European studies are only a few and most of them are from the northern countries. There are only two Spanish studies. In Spain, the Magazine of Work and Social Affairs Ministry (number 4, pages 205-209) recollects the bibliography publishing during 2000-2003, which regards interesting in the disability field. There is only one quotation relating to the maltreatment of children with disability.

2. *Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered “violent”, that in situations where disability doesn’t play a role wouldn’t be recognised as such?*

Of course. In our present-day society there are still individuals and social groups with some ideas, attitudes and behaviours which label, stigmatise, undervalue, depersonalise, segregate and push away children with disabilities. To those people or groups, violence against children with disabilities is more acceptable than in children without disabilities. Ideas, attitudes and behaviours such as “children with disabilities are different and, thus, they must not have the same social, health, educational or professional opportunities as children without disabilities”, “children with disability are asexual and therefore do not need to receive sexual education”, “children with disabilities are not able to manage their behaviours”, “children with mental disability don’t need to be respected, because they don’t understand”, “some children with disabilities don’t feel pain, sorrow or suffering”, place children with disabilities at a greater risk of suffering physical and emotional neglects, sexual abuse and physical maltreatment.

3. *Which forms of violence you believe are the most harmful for children with disabilities, and why?*

I think that any kind of violence or maltreatment against children is harmful for their correct physical, psycho-emotional and social development. Anyway, the intensity of the harm done to children will depend on the age of the child when the maltreatment is done or begins, the duration of maltreatment, severity of maltreatment, relationship with the perpetrator and children’s awareness of have been maltreated. Have been sexually abused with touching at the age of three by a caregiver for a month in a sporadic way does not leave the same consequences that have been sexually abused with penetration by the biologic father from 9 to 14 years old.

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4. *Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?*

I think that the most useful explicative models of the problem of violence and children maltreatment are the so-called “ecological models” or “ecosystemic models”. These models try to integrate the biologic, psychiatric, behavioural, psychosocial, socio-economic, political-structural, cultural and environmental factors, both individual and familiar, seeing the maltreatment phenomenon as the expression of a malfunction in the “parents-child-environment system”, and not as a mere result of pathological features of parental personality, of a high level of socio-environmental psychological stress or of particular features of the child.

5. *Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?*

Of course, as in the social globalisation scope as in the Spanish society. Each country, culture and race may have a different conception of what is violence, maltreatment and disability and, therefore perceive it in a different way. For instance, during the Nazism it was ordered to kill children with disabilities in order to achieve the supposed purity of race. In China the infanticide of children with disabilities was used to control the birth rate. In India it is worse seen to maltreat a cow than a child with disability. Some cultures perceive the children with disabilities as a “punishment of God” segregating and isolating them, while others regard them as “spiritual people, close to God”, giving them the most respect.

In Spanish society, certain socially discriminated groups and often with no cultural background, certain little and isolated rural population groups, wide gypsy ethnic groups, and the more and more greater immigrant population from The Maghreb and sub-Saharan Africa, Asia and Latin-America conceive violence, children maltreatment and the situation of the disables in a different way. They may expose disabled children in their charge to a greater risk of suffering physical and emotional neglects, sexual abuse and physical maltreatment.

6. *Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?*

Yes, an specific approach but it must be a parallel approach or an approach which is integrated in the existing generic programmes for the prevention and detection of child abuse and neglect made by the governmental institutions. If a non-governmental institution or an association of people with disabilities doesn't take into account these action programmes when it comes to make a prevention plans, it will be auto-segregating itself. I consider that competent governmental institutions in protection of childhood and adolescence should devote at least a 10% of their funds to finance the research and prevention of maltreatment of disabled children. Non-governmental institutions and associations of disabled people should also devote a percentage of their budgets to fund all the aspects of this problem.

7. *Which are the aspects of the issue that, according to you, require more research?*

In the USA, the country which has researched this issue more, the “Workshop on Children Exposed to Violence” from the National Institute of Child Health and Human Development, July 2002, concluded that more investigations focused on all the aspects concerning the problems of violence and child maltreatment were necessary. The United Nations Organization in July 2003, through the Committee which studies the violence against children, declared that it will pay attention to the impact and factors which influence the violence of vulnerable groups such as mentally and physically disabled people. In Spain, all the aspects related to the violence and maltreatment against children with disabilities need a greater investigation.

Studies carried out in our country are only a few. We cannot take as ours and base on data obtained in the United States of America and northern Europe countries, countries which are socio-culturally different to ours. It is necessary to develop research studies on all the aspects of the problem, and collaborate with other countries social-culturally similar to our country.

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Prevention strategies

8. *What does it mean preventing violence against children with disability?*

Preventing violence against children with disability means to avoid physical pains, emotional sufferings, difficulties of integration and added consequences to those they already have due to their disability, besides to avoid big costs to the community. Investing from society in preventing maltreatment and violence against children with disability may be more effective as for as the costs and give important and lasting profits .

9. *Which are the conditions necessary to develop a prevention strategy?*

Wherever a prevention strategy is planned to be developed, it is essential to know the context of the problem in order to adapt the intervention to the target population and concentrate the resources in the most vulnerable and risk groups.

10. *What would you consider fundamental characteristics of any prevention strategy?*

Violence against children with disability is a multifactor problem, in which biological, psychological, social, economic and environmental factors take part, and for which there is not a simple or sole solution. On the contrary, it is a problem that must be simultaneously tackled from several levels and in multiple sectors of society. We must be based on the perspective of the ecologic model of children maltreatment that prevails nowadays, provided that factors which can contribute to the maltreatment are diverse and interrelated. So, it is necessary that different prevention strategies against violence and maltreatment of children with disability are oriented in a multidisciplinary and multi-sectorial way, and co-ordinately applied.

11. *Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?*

To prevent domestic violence against children with disability, I consider useful those interventions directed to the community or society in general (“primary prevention strategies”), and those strategies called “secondary prevention strategies” directly aimed at the families with children with disability. The latter are regarded with risk of maltreatment to the disabled child and to his/her extra-familiar environment more close to them or not. The “tertiary prevention strategies” are only useful once the maltreatment has happened. They are also designed to try to reduce the traumas or disabilities associated to the violence and to avoid that the maltreatment against the child happens again. The primary and secondary strategies against violence and maltreatment of children with disability may be applied, in a integrated way, in the generic programmes of prevention of children maltreatment that are useful for all the children, or in a parallel way to these ones, carrying out specific programmes to disabled child population. Generally, the parallel strategies and prolonged in time interventions which have been undertaken during the childhood are more efficient that integral and isolated interventions undertaken during the adolescence.

12. *Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?*

What marks the difference between an intervention of normal support to the families with children with disability and an intervention that has as objective the prevention is that , in the first case there are not or we don't know the existence of risk factors in the family that predispose to the violence and children maltreatment. In these cases it is only necessary the application of support measures or socio-economic, socio-health and socio-educative help. In the second case, there are risk factors in the family that predispose to the violence and maltreatment or we suspect there are risk factors, such as show domestic violence problems, antisocial behaviour, drug-addiction, alcoholism, psychiatric disorders, disability, poverty, isolation or social alienation.

The specific characteristics of a violence or maltreatment prevention intervention aimed to the disabled child are those which guarantee that the measures to be applied are:

Appropriate and accessible to the children with disability.

Globally and specifically suitable to the intellectual capacity, to the culture and gender.

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Continual or frequently repeated during the childhood and the adolescence and not occasional. Accepted by parents and family, with the maximum concern in programmes and activities, and knowing and supporting the imparted teachings.

Family is the micro-system in which the child live. To increase the development potential of a child with disability depends, to a great extent, on that family provides appropriate cares and socio-emotional support. A low familiar adaptation to the disability will affect negatively to the development and psychosocial welfare of the child, and will reduce his/her capacity to live and work efficiently in the society. In fact, an effective integration along the vital cycle depends on the familiar support and care. Provided that most cases of violence and maltreatment of child with disability take place in the family, is in the family where a great part of the efforts and preventive services must be focused. So, the specific characteristics of a violence and maltreatment preventive intervention focused on a family with a child with disability are those which apply information, training and support measures to the parents and family and that increase the disabled child's development potential.

13. Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Undoubtedly, the collaboration among services, associations and institutions can be considered a prevention strategy. The community prevention strategies focus on the cultural, social and economic factors related to the violence and maltreatment against children with disabilities. They give especial attention to the legal, political and social environment modifications and to the promotion of healthy behaviour and attitudes in order to reduce maltreatment and violence rates in this specific society group. National and autonomous regional governments, regional and local administrations, justice system, institutional services specialised in minors protection, associations and confederations of disabled people, non-governmental organizations and associations interested in the issue, several knowledge fields professionals and services providers should work and collaborate in a coordinated way to support families with children with disabilities. And also to make sure that the efforts to develop prevention strategies in this specific group are multi-sectorial and multi-disciplinary, independently they are integral or parallel strategies.

14. How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

I consider that, up to now and generally the associations and social cooperatives representing the families in preventing violence against children with disabilities have very little involved in the issue and particularly in the violence and maltreatment against their children. I think that the members of those associations and the professionals who work there, are the people who can know and experiment first-hand the problem. Therefore, they are probably the most valid and important interlocutors when it comes to programming an inter-agency network, whose aim is violence and maltreatment of children with disability prevention.

15. Who should co-ordinate inter agency intervention and prevention?

I think that inter agency intervention of prevention strategies should be made by the legislatively competent in protection and welfare of children public institution. This, without detriment that certain prevention measures can be promoted and co-ordinated from the very organizations representing disabled people, informing the competent public institution about the development and results of the programme.

16. How can a public service act in order to be perceived as a support to the family?

In the scope of families with children with disabilities, the public services prevention strategies should focus on developing:

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Parents training programmes to increase the knowledge and understanding on the child development, giving information of the specific disability and the real expectations in the development.

Parents training programmes to consolidate skills to the correct child breeding and develop positive skills to bear the disability.

Measures to reduce the emotional stress.

Measures to reduce isolation, particularly in families who live in distant rural areas.

Measures to improve the knowledge and to make easy the access to early attention, healthy, legal, educational, leisure time and vocational training resources and services of the community.

Information and training programmes on the imprudent, improper or illicit use of medicines and therapeutic substances, and rehabilitation therapies for children with disabilities.

Extensive home-based support, including assistance with daily household tasks.

Respite care programmes and services, in order to avoid the *burnout* carer syndrome, and particularly if the carer has also a disability.

Home visitation programmes, by trained professionals, particularly to families that are at risk of maltreatment.

Parent-to-Parent programmes, so that families at risk of maltreatment against their children with disabilities are able to communicate and get information, help and resources from other families who are or had been in the same situation.

These prevention programmes, measures and services can be offered to all the families with children with disability or only to families at risk of maltreatment of children. In these last ones it is very important to identify the risk factors in order to prioritise the programmes and offer the necessary measures individually for each family. These programmes and services must be operative as long as families need them to avoid to take a risked situation again.

17. *Which risk factors and protective factors you believe should be ?*

In the scope of the family, I have commented before on the most important risk factors and the possible protection measures. Besides, I consider that it would be a significant prevention strategy to develop early prevention social programmes which act at the same moment a child with disability is born in a family that can be regarded a risky one for showing domestic violence problems, antisocial behaviour, drug-addiction, alcoholism, psychiatric disorders, disability, poverty, isolation or social alienation.

In the scope of the disabled child, I think that it would be very interesting to develop prevention strategies focused on:

Increase their self-esteem and improve their corporal auto-image

Inform them on and train them on physical abuse, how to identify it, how to face to it, how to communicate it to other people, what feelings can people have after an abuse or abuse attempt, and what rights they have.

Educate them on self-protection and defence against abuse, particularly against sexual abuse through sexual education courses specifically designed for them, so that they can learn how to behave in a proper sexual way and the protective personal skills.

In the scope of the community, I think that it is basic to set prevention strategies focused on develop:

Legislative and judicial measures that safeguard the rights and improve the children with disability protection.

Policies to obtain funds from governmental and non-governmental public or private institutions, to finance campaigns, programmes and projects devoted to violence and children with disabilities abuse investigation, spreading and prevention.

Campaigns to increase and improve information, to raise public awareness on the issue.

Campaigns to modify community negative attitudes and behaviours towards disabled children with the following goals for the community:

Share responsibilities in their care and welfare.

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Promote the inclusion of these children into diary activities.

Stimulate their appreciation.

See them as useful individuals to society.

Specific programmes, projects and protocols for the investigation and spreading of violence and abuse against children with disability or its suspicion.

Platforms which make easy the data recording and interchange and information on the results of:

Raising public awareness campaigns.

Specific programmes and projects.

Experts' contributions to this issue.

Lastly, we do not forget risk and protective factors focused on the close environment to the family and the disabled child. Although the percentage of violence against children with disability cases which have been produced by people near to the family, other relatives, friends, neighbours, caregivers, educational and health services providers are only a few, it does not mean that we must not strive to prevent abuse. Efforts to develop prevention strategies in the close to the family and children with disabilities environment should be focused on developing:

Information campaigns on the cares they need and on raising public awareness, addressed to the adults of the close environment to these children.

Campaigns at the school to inform, raise awareness and educate children with and without disabilities. They must be campaigns on the eradication of violence and on the understanding and the acceptance of disabled children and among peers.

Training programmes for professionals who are more frequently in contact with children with disabilities, particularly health and special education professionals so that they know, raise awareness and detect the problem and they understand their role on prevention.

Measures for the correct selection of caregivers and services providers by the families of children with disability.

Measures for the external supervision, by trained professionals, of the cares and services provided to disabled children.

Maria Chiara Risoldi

Psychologist, she has worked with children living in the war.

The perception of the issue

Defining violence, it is useful to distinguish between destructivity and aggressiveness: there is a qualitative difference and only destructivity can become violence against children. Aggressiveness and a certain measure of destructivity are instinctive: civilization and education teach us how to control them, mainly through intelligence, creativity and empathy with personal emotions and feelings. Maltreatment against children with disabilities is not sufficiently highlighted because of defense mechanisms which make it impossible to get aware of emotions and feelings raised by maltreatment and disability. Refusal of the phenomenon represents in many cases the result of this defense.

Violence against children with disabilities is particularly associated with parents' difficulties to accept limitations and difficulties of their children: on the other hand, they are not able to see their potentialities, to discover their abilities. Consequently, they do not allow them to express their needs and to realize their potentialities: that's a tremendous form of violence.

Prevention strategies

School represents a fundamental prevention instrument: teachers' training about forms and modalities of emotions' expression and awareness may represent an important form of prevention. School represents a point of meeting for parents and a space of development for children. Maltreatment can be detected early inside the school: early intervention should be aimed to educate and train to express conflicts, aggressiveness and

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destructivity in a non violent manner. In addition, school represents an important space for research, in the sense that information can be easily transmitted.

AIAS as an Association should cooperate with families, listening to parents in an empathic way.

Rita Bosi, social assistant

Social assistant, she works with children and his multi-problematic families especially maintaining the contact with Tribunals.

The perception of the issue

Violence against children is an important phenomenon, whose weight is the same both in children with disabilities and in children without disabilities. Indeed, in cases of disabilities there is more protection. In cases of children with disabilities, father usually spend more time working out of home, while mothers spend a lot of their time at home, taking care of the child and in certain cases can get hypertrophic and establish a symbiotic relationship with children. Brothers and sisters often pay for familiar difficulties. Anyway, symbiotic relationship between the child and his mother can represent also a protective factor: the risk lies in the passage through the phases of separation and individuation.

Violence can be explained through the theory of problematic families, in cases both with and without disability. Multi-problematic families represent the most important risk factor of violence.

Socio-cultural background influence the phenomenon of violence in the sense that violence can be considered as a transgenerational phenomenon.

Prevention strategies

Prevention has to focus on parents, in order to help them to accept and elaborate negative emotions and accept the as a natural aspect of human people. Self-help groups can be organised to give to the parents strategies to elaborate aggressiveness.

AIAS staff should be trained to listen to parents, starting from the awareness that families are different and unique.

Greek psychologists

The perception of the issue

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, not at all, but generally I don't think that the issue of violence against children is sufficiently notice.

Do you think that in situations of disability certain kinds of ideas, attitudes, and behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

In some case this may be possible, especially when the family does not know how to handle the child's impairment

Which forms of violence you believe are the most harmful for children with disabilities, and why?

Any humiliating or oppressive action which a person is submitted to. Most harmful might be cases where child life is in ranger. This is when justice is involved as well.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

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Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

It does. The way people perceive disabled people is very important. The stereotypical ideas about disability play an important role on how the family sees the disabled member.

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Probably yes because they have more needs. However I could be an organisation for violence against children which could have a specialized service.

Which are the aspects of the issue that, according to you, require more research?

What is defined as violence and the damages it can have to a person in order to be penalized.

Prevention strategies

What does it mean preventing violence against children with disability?

I believe that the problem is more general. A turn in mainstream ideas about disability should happen. If the existing negative meanings and ideas about disability and people with disabilities continue then they will face prejudice and negative attitudes. It is very important for community and people to be informed and sensitive about disability issues

Which are the conditions necessary to develop a prevention strategy?

To make know that there is a problem which must be solved and that we have to protect people who are in danger.

What would you consider fundamental characteristics of any prevention strategy?

Information about the issue in general and information about the existing services that someone could turn to.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

It will be good if self help groups for parents existed. Perceptions about disabled people should change and parents have to be the first to be carefully informed about the difference on their child's body and mind.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

I don't know if one can support a family individually before a violent issue occurs because it seems patronising. I mean a professional can not support a family or have a close contact with a family without them asking just because they have some of the indicators that bibliography supports.

After a violent issue occurs then specialised help should be given to the family and to the child.

Prevention probably targets a larger group or creates the structures in order to protect but I don't think that you can work individually because they might abuse their child. Intervention is different because in some cases they are obliged to cooperate, I mean the family, because it is proposed by the court.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

It could. Organisations could for example target a different group families, professionals, children, or other might work on planning the strategy and other could work on actualising it.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Of course they should. As they are responsible for domestic violence they should be informed. It is preventing when you include the population who is the possible 'abuser' to a strategy of prevention.

Who should co-ordinate inter agency intervention and prevention?

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It could be a public organisation or corporation with non governmental organizations

How can a public service act in order to be perceived as a support to the family?

By fulfilling their needs.

Which risk factors and protective factors you believe should be?

The relationships between parents is very important, the financial situation of the family, parents' ability to adjust their lives to the new circumstances that a newborn child with disability brings. However, those circumstances might not be risk factors on their own but in combination. Also, it is a risk factor the neglect of the psycho-emotional needs of the child which barriers his/her healthy development.

Greek social anthropologist

The perception of the issue

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No, I don't think so

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

No, because violence is the same regardless the presence of disability.

Which forms of violence you believe are the most harmful for children with disabilities, and why?

Every violent action is harmful. One cannot tell which form might have the worst consequences to a child. Violence is any action which can do harm to a child's dignity and physical well being.

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

The low self-esteem of the parents and the emotional well being are important factors. In case the parent is not emotionally and mental stable there is a bigger problem. It might be a issue if one or both parents had been abused during their childhood. The educational and the socio-economical status of the family. However, all these factors might not tell anything separately but when they are in combination the child may be in greater risk.

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

It is possible that disabled children might be more vulnerable in psychological abuse. Maybe they are not so vulnerable to physical abuse as they have more needs which have to be covered so the parents do not have an alternative other than take care of them. What I mean is the level of care that parents have to give to their disabled children is higher so this might tire them. This however might drive them to psychological abuse.

Which are the aspects of the issue that, according to you require more research?

I do not know any research about disabled children and violence so I could not answer this one. As, it is not a well known subject I suppose that research should focus on what drives parents to abuse their disabled children.

Prevention strategies

What does it mean preventing violence against children with disability?

Developing a mechanism which informs people about the issue of violence and the way they can protect themselves when it occurs.

Which are the conditions necessary to develop a prevention strategy?

Well specialised staff.

What would you consider fundamental characteristics of any prevention strategy?

Information and creation of specific laws

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Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

I think that families should be supported emotionally and financially if necessary.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Both of them are about support. In the first case, you can inform the general community about the issue of violence and create organisations where disabled children and their parents can find solution to all their problems, an organisation which can work as a benchmark and in the second case you have not only to support both parties but to provide counselling and to have the solution ready e.g. an organisation which can very quickly work or collaborate with others e.g. lawyers and protect the child if necessary.

As for the child, the child should know where to get help from.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

It can work as an intervention strategy as well and in one way it does. As for a prevention strategy, it might work if each service undertakes to support and inform different groups of people and have different activities.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

They can work on an equal basis as there are the ones who work and act under families' decisions and demands. As I said before they could be a benchmark for information and support for parents, for those who don't know how to deal with their child's disability and as a peer therapy group

Who should co-ordinate inter agency intervention and prevention?

An organisation specialised on violent issues which could be public or non-governmental

How can a public service act in order to be perceived as a support to the family?

Support groups, which can be coordinated by other parents or by psychologists if necessary can organise a program whose target will be to provide the opportunity for the parents to rest for some hours per day or week. Also, parents should be aware of the changes that might come to their child life regarding their disability, it will be good for them if they know what to expect as such as possible. Many times parents might have guilts that it is their fault that the child has a disability I think that support should be given in that area too.

Which risk factors and protective factors you believe should be?

If the child was wanted, if parents had been abuse in the past, if they have a disability or an illness, their self-esteem or their age.

Greek Lawyer

The perception of the issue

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

The issue of domestic violence is not highlighted at all.

Do you think that in situations of disability certain kinds of ideas, attitudes, and behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

That's for sure. What differentiates disabled children is the level of care that they need. As care must be higher than other children they are in bigger danger of facing violence.

Which forms of violence you believe are the most harmful for children with disabilities, and why?

Probably physical violence because their lives could be threatened.

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Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

The background influences the issue of violence in general. The stereotypes of disability play an important role on people's perception.

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Yes, because groups such as women, children, elderly people, disabled people are groups which are in bigger danger. If a person belongs in two of these groups then the risk is bigger.

Which are the aspects of the issue that, according to you, require more research?

The problem is that the issue of violence is not research. We do not have any details or formal accurate data to work on. The issue of violence against disabled children does not 'exist' I could not separate an aspect, as all it is not researched at all.

Prevention strategies

What does it mean preventing violence against children with disability?

Safeguard children's rights

Which are the conditions necessary to develop a prevention strategy?

Children should be informed and they should be educated about these issues at all levels of the educational system. It also very important to make the problem known to professionals such as doctors, they should have this in mind when they examine for example a patient. I mean that they should think if what they have been told by children e.g. that he fell down the stairs, is true or not.

What would you consider fundamental characteristics of any prevention strategy?

To make the issues known to the public.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

First to make the issue known. Then to inform professionals, to educate children about their rights and the services they can use, contact and refer to. Finally structures have to be created which can work after an incident has occurred.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

These two overlap. The difference is that when the issue occurs you need to have an organisation, an institution which will house a child if necessary.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Yes it could. I think the collaboration should be divided in two parts, in a scientific group and in a group which will put things in action.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Yes they should by supporting other families and informing them about what their child probably needs. Also they could work as keepers checking parents behaviours towards their children.

Who should co-ordinate inter agency intervention and prevention?

It is better if it is a non-profit organisation with specialised staff but if we want this action to have more prestige it has to be a governmental

How can a public service act in order to be perceived as a support to the family?

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It is too difficult for a public service to work sufficiently and it will take time to create a public organisation for violence against disabled children. I believe that most of the work should be by non-governmental organisation

Which risk factors and protective factors you believe should be?

The low social-educational level, immaturity of the parents and the most important one is the attitude of power that especially many men take over their children or wives.

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3.3.3. Interviews with public institutions

In European democracies there is a clear distinction between **the public** and **the private sector**. The principle difference is that the public sector is made up of institutions with formal responsibility to administrate the country on behalf of the citizens, who elect their representatives and a government to guide these institutions in determining their mandate and practice, while the private sector is made up of initiatives that are the expression of individual citizens, of course within limits of freedom set by the public sector.

Through the institutions of the public sector European governments guarantee **collective benefits** to the citizens, such as security and protection, health, education, and a minimum level of welfare. Depending on the political orientation and the financial and organisational resources available, the level and quality of collective services can be restricted or amplified.

Clearly the models of service delivery by public institutions is different across Europe. Some countries have an expanded network of institutions, all state controlled, in all sectors, including Health, Social and Educational Services. Classical examples are Public Health Systems, State School, etc. Other countries have “lighter” models, in which the governments have delegated much to private initiatives, and have limited the role of the public institutions to defining standards, to monitoring service delivery and to distributing public money. Typical examples are private schools and privatised health services funded by public money.

The private sector is not only made up of profit oriented enterprises. Also associations, social cooperatives, foundations and other non profit oriented organisations belong to the private sector. Sometimes they are referred to as well as the *third sector* or the *social private sector*. In the social and educational sphere, many of these **non profit oriented organisations** will provide services to their members or target groups, some of them will do so with public money. Many governments believe that these organisations can provide better and cheaper services than public institutions. Instead of enlarging the state apparatus they prefer to contract non profit oriented organisations paying them for the services they deliver.

The **target audience** of our project is formed by people with responsibilities in non profit oriented organisations in the field of disability, in particular those who represent families or people with disabilities. Some will provide services with public or private money (for example from private insurance companies), others won't and will limit themselves to voluntary work, political representation, advocacy, campaigning.

However it is believed that prevention policies can only be effective if they are the expression a larger network of stake holding organisations. **Organisations in the public sector are very important stakeholders**, as the **formal responsibility** to provide security, child protection and social support is theirs. It is therefore important to understand how they see their role, to what extend they intervene or can intervene, and how they see the role of private non profit oriented organisations.

We therefore have invited the partners to detect important public institutions and have interviews with key people in those organisations. The following set of questions will be helpful in focussing on the project issues.

Please introduce your organisation and the project. Explain that it is a European project and what the project is about.

The aim of the interview is double:

- A. to collect information and viewpoints of institutions
- B. to understand how to collaborate in networks aiming at prevention..

Collect information on the interviewed (role, professional background, years of post holding):

Questions

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The institution's mandate and perception of the issue

May you describe the specific role or mandate of your institution/office/service in the field of violence against children?

How is violence defined inside your service? Have you ever detected misunderstandings with other services and/or families as regards the interpretation of the concept of "violence"?

Inside your service, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members, conferences/articles/literature) and what has been done?

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

Prevention strategies

What does it mean preventing violence against children with disability?

Which are the conditions necessary to develop a prevention strategy?

What would you consider fundamental characteristics of any prevention strategy?

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Who should co-ordinate inter agency intervention and prevention?

Resources

Regarding the available resources in you service (staff and money), which of these resources are already geared towards prevention?

Do you believe that your service is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

Service delivery

How can a public service act in order to be perceived as a support to the family?

Which risk factors and protective factors you believe to be able to influence with your service?

Which psychological and/or technical characteristics should a staff member develop and acquire to be effective in prevention?

If our association would organize a round table to discuss this topic, would you be interested in joining it?

Tragainidis – Probation officer

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The institution's mandate and perception of the issue

May you describe the specific role or mandate of your institution/office/service in the field of violence against children?

I am a probation officer, in charge of the service of children .

How is violence defined inside your service? Have you ever detected misunderstandings with other services and/or families as regards the interpretation of "violence"?

Violence is the physical and psychological abuse of a child. No there have never been such misunderstandings.

Inside your service, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members, conferences/articles/literature) and what has been done?

Our office works more with children who are law-breakers but in such families one can see some times that those children have been abused.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

It is a problem I don't think that it is highlighted. On the other hand, I think that, because those children are more vulnerable, parents pay more attention to them.

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Yes, because they have different and more needs.

Do you think that in situations of disability certain kinds of ideas, attitudes, and behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

No I don't think that disability plays a role. As I mentioned before I think that parents care more for disabled children as they have more needs.

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

I think that the social- educational- economical background that the family has plays a role. Especially if the educational level is low then it is more probable that the family abuses their child as they might not know ways to edify their child.

Prevention strategies

What does it mean preventing violence against children with disability?

Having the appropriate services which support the families with disabled children.

Which are the conditions necessary to develop a prevention strategy?

To write down the existing services which can support disabled people and their families.

What would you consider fundamental characteristics of any prevention strategy?

To sensitize people about the issue through seminars, conferences, leaflets.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

To develop such laws which safeguard disabled children rights.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

Prevention is to support generally the family and the child, also to educate the child. The difference also is that in prevention you have to inform the professional and the general public when you support the family. You have to work more one their specific needs.

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Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Collaboration by each self might work for prevention. It is important generally for the social services to have good communication and collaboration because every case is different and there are different needs.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

They should take part in both aspects prevention and intervention. They should have an important role as they are the ones who know the difficulties of raising a disabled child.

Who should co-ordinate inter agency intervention and prevention?

An organisation which could be created for this purpose.

Resources

Regarding the available resources in you service (staff and money), which of these resources are already geared towards prevention?

We have not made any resources available for prevention.

Do you believe that your service is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

No, because our role is not such, to do something like that has to be decided by the government. In a case of abuse the social workers are informed and do counselling with the family and the child but this is unofficial because our target group is children as criminals. If we notice that the child is in danger then we inform the attorney

Service delivery

How can a public service act in order to be perceived as a support to the family?

Government should create such an organisation. I think there should be a specialised institution giving advice and help on how to raise a disabled child. Also, there must be a place to house children who have to leave away from their families, As far as I know there is only one institution where disabled children stay.

Which psychological and/or technical characteristics should a staff member develop and acquire to be effective in prevention?

People who have education on the field of care and legislation.

If our association would organize a round table to discuss this topic, would you be interested in joining it?

Yes

Juan Manuel Casión

Aragón Autonomous Region

The Institution's mandate and perception of the issue

1.- May you describe the specific role or mandate of your institution/office/service in the field of violence against children?

The Aragón Autonomous Region has the exclusive competence in the issue of the Child Protection in all the whole region (Zaragoza, Huesca and Teruel provinces).

2.- How is violence defined inside your service? Have you ever detected misunderstandings with other services and/or families as regards the interpretation of "violence"?

In the field of our work we use the "child's maltreatment" and "child's vulnerability" terms. They are wider terms and not only include the physical maltreatment but the psychological maltreatment, physical and emotional neglect, abuses, etc.

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The terms that are used in this field are confused and arise differences in the interpretation of the situations. To solve these problems, a new programme is being developed since several years ago. It is a programme that tries to co-ordinate the concepts and determine definitions, indicators and action criteria in the whole autonomous region.

3.- Inside your service, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members, conferences/articles/literature) and what has been done?

Yes, I have. The Social Service Institute of Aragón is the competent institution in child's maltreatment situations. Usually, the citizens, services related to the childhood and professionals take the cases to us.

The action is similar in all the cases: verify the information, study the case, check different information resources, interviews with the minor and the family, diagnosis and assessment of the cases, legal measures and intervention proposals.

4.- Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

The violence against children issue is not known enough. Now, people speak a lot about domestic violence, but not enough about what domestic violence means to the children who suffer it. Children with disability are more vulnerable and their situation is unknown.

5.- Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

I think that if the normal procedures to solve the maltreatment problems work correctly there wouldn't be necessary any specific action to these population. It would be only enough to adapt some details.

6.- Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

I think that people with disability are more vulnerable and that makes that the necessities of the minors are different.

7.- Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

I think that the causes that start these problems are multiple. I would say that the studies for the general situations are useful to explain the ones of the children with disabilities. Adding all I have commented on their biggest vulnerability.

8.- Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

The social-cultural situation influences the perception of everything people have. The more resources, the more easiness to solve the problems. The more culture, the more ability to understand the necessities of the others.

Prevention strategies

9.- What does it mean preventing violence against children with disability?

To try to do actuations that reduce the probabilities of these kind of events.

10.- Which are the conditions necessary to develop a prevention strategy?

Political wish and economic budget.

11.- What would you consider fundamental characteristics of any prevention strategy?

Definition of the problems we wish to deal with. Definition of the target audience of the preventing actuation.

12.- Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

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Information, raising awareness, motivation and training of the population in general. Provide Public Services which detect early cases of disability. Early intervention in treatments. Training for the professionals.

Support resources (not only economic ones) for the families to cover the necessities derived from a bigger difficulty in treatment.

13.- Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

We aren't going now to speak about primary, secondary and tertiary prevention. Any intervention prevent deeper situations which will be able to take part later.

Promoting the rights and covering the necessities.

Early detection. Early treatment. General support to the families.

14.- Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

The collaboration and coordination among services, associations and institutions improves the working of the resources and optimise the efficiency.

15.- How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

The associations that defend the rights of their members invigorate the society and mobilize institutions in order to they hasten the bringing into operation new actuation programmes.

16.- Who should co-ordinate inter agency intervention and prevention?

The institutions with competence in this issue.

Maybe the proposal of starting this co-ordination should arise from the associations more directly affected by this problem.

Resources

17.- Regarding the available resources in you service (staff and money), which of these resources are already geared towards prevention?

Social Services Aragón Institute has many resources allocated to issues related to disability and early attention. I don't know the actuations in this field.

In the scope of protection of the family there are several preventing programmes directed to some of aspects we have commented above. Programmes directed to violence against children in general, not specifically disabled children.

18.- Do you believe that your service is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

No, I don't think so.

Service delivery

19.- How can a public service act in order to be perceived as a support to the family?

Institutions have the ability to legislate and this is the best system to implement preventing politics.

Promoting the rights of the family, of minors and of people with disabilities.

Universal access resources faced with certain situations of family and/or personal necessity.

20.- Which risk factors and protective factors you believe to be able to influence with your service?

From this Service we can influence in the inter-institutional co-ordination and with other organizations. To improve the definitions of concepts, indicators and actuation criteria. We can act in the arising of awareness and training of professionals who are in touch with childhood in general (schools, hospitals, leisure centres,...)

21.- Which psychological and/or technical characteristics should a staff member develop and acquire to be effective in prevention?

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Technical knowledge on the matter, motivation by the problem, empathy ability and tolerance to the frustration.

22.- *If our association would organize a round table to discuss this topic, would you be interested in joining it?*

Yes, of course.

Carlos Hue Garcia Jesus Gimeno Gomez

Aragon Regional public institution in charge of education

The Institution's mandate and perception of the issue

1.- *May you describe the specific role or mandate of your institution/office/service in the field of violence against children?*

It is a regional public institution in charge of education.

2.- *How is violence defined inside your service? Have you ever detected misunderstandings with other services and/or families as regards the interpretation of the concept of "violence"?*

We understand violence as all those actions which make an attempt on the fundamental rights of people. It is included in the violence definition the physical, psychological, social or educational violence, by action and omission.

3.- *Inside your service, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members, conferences/articles/literature) and what has been done?*

I have only once had to face violence against children with disability. The head of an specific educational centre for children with disability called me. One child got off the school bus with evident signs of physical violence (bruises and contusions) . Instructions were given to the school board of directors. They were told that if the event was repeated they should bring it to health and judicial authorities' attention, and on the other hand, we had an interview with the mother, who said that she thought that these bruises took place on the school bus.

4.- *Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?*

I do not think so. However, I think, on the basis of my experience, that although it is a serious problem, it is not very known.

5.- *Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?*

Yes, I do. It requires a constant vigilance by all the interested institutions and professionals, and besides, it would be opportune to set specific measures aimed at detecting possible cases of violence which might be concealed now.

6.- *Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?*

Any violent attitude or behaviour against a child should be recognised as maltreatment independently his/her ability.

7.- *Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?*

On my opinion they would be two explicative models to analyse the problem of violence against children with disability. On the one hand, the learning of violent behaviours by the ones who exert them, and on the other hand, the frustration that the disability may mean to the families in a social context that does not show solidarity.

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8.- *Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?*

It especially influences the learning of violent behaviours on the previous education of people.

Prevention strategies

9.- *What does it mean preventing violence against children with disability?*

To educate all the families with children with or without disabilities, on the necessities that each type of disability causes and the formula to give answers to these necessities.

10.- *Which are the conditions necessary to develop a prevention strategy?*

Violence prevention is only understood within the framework of tolerance, living together, respect and solidarity.

11.- *What would you consider fundamental characteristics of any prevention strategy?*

The above quoted values: development of the tolerance, living together, respect and solidarity.

12.- *Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?*

Social, psychological and educational support.

13.- *Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?*

Intervention aiming at prevention are directed to the population in general. The ordinary support intervention is an specific act for a specific family. Intervention aiming at prevention implies the knowledge of the specific necessities that the different disabilities can cause: dependence, cares, not suitable behaviours... by the

population in general. Prevention intervention concerning the families are determined by their specific characteristics.

14.- *Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?*

Yes, of course. The collaboration among services, associations and institutions is essential in the development of prevention programmes. This collaboration should be done taking into account the solution of problems of the people in this situations and not the institutional prominence.

15.- *How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?*

The leadership in the prevention plans falls to the institutions but a prevention programme will must always take into account the civil society, especially the associations and social cooperatives.

16.- *Who should co-ordinate inter agency intervention and prevention?*

The Minors Regional Service, which is the institution that acts by delegation of the fiscal ministry in relation to the minors or people in situations of incapacity.

Resources

17.- *Regarding the available resources in you service (staff and money), which of these resources are already geared towards prevention?*

The Department of Education, Culture and Sport is developing prevention actions as in the ordinary centres through the creation of values by means of the transversal issues in the curricula, as in the specific centres with special attention to the child's welfare.

18.- *Do you believe that your service is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?*

Yes, I do. Another thing is that sporadic violent acts towards children with disabilities occur and that they are unknown.

Service delivery

19.- *How can a public service act in order to be perceived as a support to the family?*

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Supports to the family, just as I have told before, are specific actions for the families. Thus, to be perceived as a support to the family, the service will have to comply with the conditions of individuality and adaptation to each case with the pertinent resources.

20.- *Which risk factors and protective factors you believe to be able to influence with your service?*

Cases of physical and emotional overload in the professionals can occur in the educational services. To avoid this, it is tried that the ratios, timetables and support mechanisms in the ordinary and specific educational centres that attend children with disabilities are enough.

21.- *Which psychological and/or technical characteristics should a staff member develop and acquire to be effective in prevention?*

An specific training on the characteristics of the different disabilities, as well as a balanced and tolerant personality who develops all the abilities of the children with disabilities.

22.- *If our association would organize a round table to discuss this topic, would you be interested in joining it?*

Yes, of course, we are interested in any collaboration.

Greek attorney of children

The institution's mandate and perception of the issue

May you describe the specific role or mandate of your institution/office/service in the field of violence against children?

I am an attorney. I do the job that an attorney has to do. Support the children when the case comes to justice and work towards their best interest,

How is violence defined inside your service? Have you ever detected misunderstandings with other services and/or families as regards the interpretation of the concept of "violence"?

As it is defined in Greek legislation. However, as every case is unique and the law does not specify actions, we work in a way that protects the children.

Inside your service, have you ever tackled specifically the problem of violence against children with disability? Why (direct experience, sudden awareness, input from staff members, conferences/articles/literature) and what has been done?

No we never had such case.

Violence against children is an important social problem. Generally speaking, do you consider the topic of violence against children with disabilities sufficiently highlighted?

No I don't think so according to my experience I have never heard a case about the specific issue of violence and disabled children

Considering your general knowledge about the issue of violence against children, do you consider that violence against children with disabilities requires a specific institutional approach?

Yes, because those children have more needs than non-disabled children and they need specialized support in every aspect of their lives.

Do you think that in situations of disability certain kinds of ideas, attitudes, behaviours may be considered "violent", that in situations where disability doesn't play a role wouldn't be recognised as such?

I do not think so. Violence is violence even if it is against disabled or non-disabled children

Different explicative models and hypothesis have been elaborated to analyse the problem of violence against children. Which do you think may be useful to understand the problem in situations of disability?

Do you consider that the social-cultural background influences the perception and the definition of violence against children with disability? If yes, in which way?

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It has effects because families with different background act differently in many cases. However, I could not say that a poor family or a family with low educational level might abuse their child more easily than a family with a high social educational background.

Prevention strategies

What does it mean preventing violence against children with disability?

Diminish those factors which has been proven that drive to violence

Which are the conditions necessary to develop a prevention strategy?

Specialized staff, funding,

What would you consider fundamental characteristics of any prevention strategy?

The establishment of structures who work on a specific field.

Generally speaking, which kinds of interventions do you consider useful to prevent domestic violence against children with disabilities?

Inform people that there is such danger through seminar and conferences. Generally tell people which are the services they could contact.

Which are the factors that make the difference between an intervention aiming at prevention and an ordinary support intervention for families? Which are the specific characteristics of a prevention intervention concerning the child? Concerning the family?

As for prevention, more information is needed after a case of violence occurs. Professionals such as psychologists and social workers should understand why the family acted in this way and support psychologically the child if it is necessary to take the child away of the family.

Can the collaboration among services, associations and institutions be considered a prevention strategy, and how should this collaboration look like?

Probably, but after a case of family abuse the family and the child should be turn to a service which has to know how to support them according to their specific needs e.g. according to child's disability or other services which can support the family.

How do you see the role of associations and social cooperatives representing the families in preventing violence against children with disabilities? Should they be included in any inter-agency network on this issue, and on which basis?

Of course there should be an organisation that parents can turn to for support depending on what they need.

Who should co-ordinate inter agency intervention and prevention?

I think that a non-governmental organisation should take such role.

Resources

Regarding the available resources in you service (staff and money), which of these resources are already geared towards prevention?

No one , I act after an incident has ocured and our job is to protect the child

Do you believe that your service is doing the maximum in order to prevent the occurrence of violence towards children with disabilities?

No because our role is not as such.

Service delivery

How can a public service act in order to be perceived as a support to the family?

By counselling but as I said before non-governmental organisations should develop the tools to do so.

Which risk factors and protective factors you believe to be able to influence with your service?

Which psychological and/or technical characteristics should a staff member develop and acquire to be effective in prevention?

They should be professional social workers, psychologists, psychiatrists, lawyers specialized people who know about violence and disability.

If our association would organize a round table to discuss this topic, would you be interested in joining it?

If I have the time I will be glad

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Luciana Nicoli (pediatric, Il Faro)

Il Faro is a provincial specialized centre against child maltreatment. It is involved in all phases: training of social assistants, teachers etc., counselling, diagnosis and psychotherapy.

The perception of the issue

Strasbourg Convention gives a definition of violence, which can be classified in different forms, including pathologies of care. Violence against children with disabilities is not sufficiently highlighted: anyway, disability can represent a precipitating risk factor. In cases of disabilities, there are forms of violence associated with therapeutic rehabilitation strategies, often in relationship with psychiatric pathologies of parents.

The explicative model useful to understand the phenomenon is that of protective and risk factors, whose relationship with violence is not linear, it depends also on the role of the context. Factors of risk give indications about areas which have to be analysed in order to find the problems; factors of protection are useful to define strategies of intervention.

Socio-cultural background may have an influence on the phenomenon, for example in cases of nomad children.

Prevention strategies

Familiar support has to be guaranteed by social institutions in order to prevent violence: home visiting since the birth of the child and until the age of 2 can represent good examples of primary intervention.

AIAS has an important role in prevention supporting and training staff who is going to work with families. Operators should be trained to recognise indicators of maltreatment (physical) and to accept negative emotions, in order not to activate defense mechanisms.

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3.4. Good practice intervention

Definition of good practice examples, characteristics and minimum information standards have been defined and a grid for the collection of good practice has been given. Documents and material collected will be discussed and analysed considering the grid, in order to have a common method of description and evaluation. Good practice allows prevention at the primary and secondary level: this distinction could be considered in examples' description. Good practice examples can be used to put in evidence those contents which will be included in the corner stones section. After a short introduction this chapter will be informed by

In the overall framework of the project the examples of good practice, just like the case histories, have a double function. On the one hand they serve *to illustrate prevention policies put into practice*, on the other hand they serve *to give us a better understanding of the cornerstones at the basis of good quality prevention policies*.

The examples of good practice thus inform the research report and the booklet in different ways. Methodologically speaking they should respond to certain characteristics and minimum information requirements.

Characteristics

Good practice examples are interventions, projects, services or initiatives (including editorial or Internet based), developed/implemented by institutions or organisations, that:

aim to reduce the factors leading to violence or aim to strengthen prevention factors

refer to one of the "cornerstones" so far identified

are not improvised but developed to prevent

respond to specific needs

have demonstrated effectiveness

are reproducible for other organisations

CISAP

Description of the source (article, presentation, interview, study visit, self experience, etc.)

Presentation of the project "Maltrattanti, maltrattati e rete sociale", CISAP (Consorzio intercomunale dei servizi alla persona), Grugliasco.

What is the target audience of the intervention?

Families of children (age 0-6 years)

Local social, law, assistance, health and educational services (pediatricians, social assistants, teachers, judges etc.)

Schools

Policies

Voluntary services

What is the situation the intervention tries to avoid?

the explosion of familiar situations at risk into violence (neglect, physical and/or psychological maltreatment, sexual abuse)

a fragmented and no-coordinated intervention when violence has occurred is likely unsuccessful in protecting both the child and the family

lacking sensibilization towards the problem of violence

What is done /proposed to avoid the situation to endure or to occur?

early detection of familiar situations at risk: psychopathological parents' behaviours evaluation, identification of pathological relationship patterns between parents and child, diagnosis and prognosis elaboration by professional figures (home visiting)

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support intervention to the family to modify the pathological relationship patterns which have contributed to the violence or to accept the departure of the son (legal action)
train the professionals to work in network, sharing projects and interventions
establishment of a permanent Observatory on protection of maltreated children
publication of an handbook for protection to be used by professionals
agreement protocol among local services related to modalities to define and realise evaluation and intervention actions

Why is the intervention effective, on the basis of which criteria and according to whose opinion?
the project develops and considers strategies of secondary and tertiary level
it underlines the fundamental concept of the necessity of an integrated and coordinated network project

the permanent Observatory allows the collection of data to quantify the phenomenon considering the incidence of different kinds of violence
results dissemination through an handbook and agreement protocols allows the diffusion of information, knowledge and strategies of prevention

Why do you consider this intervention/experience particularly relevant for this project?
(key issues)

early detection, integrated network intervention, results dissemination

Familiar meeting point in Zaragoza

The Familiar Meeting Point in Zaragoza is a neutral place and an ideal way to favour the paternal/maternal-filial relationship during crisis periods or to carry out the visits system which makes easy the proper integral development (personal and social) of a minor who lives separated from his/her parents (one or both), parents who are in the middle of a separation, divorce or nullity process.

This meeting point is co-ordinated by the city council and Aragón government (Aragón Employment Institute). Other organizations, such savings banks, Aragonian companies collaborate too.

Its aims are:

To make possible the meeting between the parents (whose children are not in their care) and family with the minor.

To take care of the minor's physical and psychical integrity during the regimen of visits.

To attend and/or intervene on the possible psycho-social needs which have been detected by the inter-agency team.

To provide guidelines for educational skills by the inter-agency team, which improve the paternal/maternal-filial relationship in cases where it is necessary.

To collect and register trustworthy information on the development of the visits regimes which help to guarantee the minor's welfare.

To reach these aims, the Meeting Point carries out several services for the minor defence:

Support for fulfilling the visits regimen.

Beginning and end of visits in the Familiar Meeting Point in Zaragoza.

Living together under and without vigilance (depending on the situation) in the Meeting Point.

Meetings in other places (for instance, in a park) under vigilance and without vigilance.

Psycho-social intervention on the minor needs and visits regimen.

Monitoring and assessment of the visits regimen.

Thus, this service is one of the suitable tools to attend those minors of families in crisis, families who are in the middle of a separation, divorce or nullity process, who are in risk of losing the paternal/maternal-filial relationship with both parents.

Children suffer more from divorce and separation and in many cases they are used as emotional blackmail by the parents. These situations can become a risk factor of abuse to the children, thus

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the necessity of detecting, assess and intervene as soon as possible to the integral welfare of the child.

80 families from Aragón and more than 100 children take part in this service weekly. In most cases, this measure is determined judicially and as a way to control the visits and children delivery. It is a multi-professional team who works together with the justice department, to whom they send reports on the fulfilment or not fulfilment of the custody turns and parents' visits periodically.

This service is regarded as a good practice for childhood benefit, it is not a question of supporting one of the parts but offering support to the children thanks to the work of the professionals team. The professionals also work with the parents who request or need them, they give them their professional advice in order to solve the possible problems which can occur (they join together in self-help groups). The final aim is to get that parents get over their lack of communication and make them to understand that the main benefit for their sons and daughters is to maintain a normal relationship, with the love, values and principles the children need to be brought up.

Early attention programme (DFA)

The Early Attention Programme is an intervention model carried up by Disminuidos Físicos de Aragón together with the Social Services Aragón Institute. It is aimed at children under six years old with any kind of impairment and impairment degree which implies a certified disability degree. This programme is also aimed at children with high risks of having a motor, cognitive and/or sensory deficiency in a near future in the case they do not receive an specific attention from the first moments of their life.

Early Attention Programmes are the interventions directed to children from 0 to 6 years old, to the family and to the environment, whose aim is to deal with the temporary or permanent needs of children with development disorders or being at risk of having them. These actions are carried up individually and take into account the totality of the child (biological, psychological and social aspects) and are planned by a multi-professional team.

The specific **aims** pursued by this actions are:

To reduce the effects of the disabilities on the total development of the child.

To optimise, as far as possible, the child's development.

To introduce the necessary compensatory mechanisms, removal barriers and adaptation to specific needs.

To avoid or reduce the appearance of secondary effects or deficits due to a disorder or high risk situation.

To deal with and meet the necessities and demands of the family and the child's environment

To consider the child as an active subject of the intervention.

Thus, this programme considers a three-dimensional approach, and regards the CHILD, the FAMILY and the ENVIRONMENT as objects of the intervention.

CHILD: To facilitate the adaptative competences acquisition, to strengthen the self-esteem, the self-control, the maximum degree of personal autonomy and to promote the recognition of the individuality.

FAMILY: To facilitate the family implication in all the intervention process, to promote the parents' cooperation, to encourage the active participation and to support the welfare.

ENVIRONMENT: To reach the maximum degree of social integration making easier the adaptation of the environments, from the familiar to the social medium in which the child develops; and at the same time to provide the strategies and resources which let him/her a positive integration and the future access to equal opportunities criteria.

This early attention programme is regarded a good practice because it considers the child's totality contributing to the prevention of the abuse and helping the professionals who work directly with the child and the family to detect it .

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Programme for the prevention and the detection of situations of vulnerability and abuse against children

The Social Services Aragón Institute has as a main objective to render services to the citizens in order to improve and guarantee their life quality.

So, it guarantees the minors and adolescents in a unfavourable situation an individual attention that ensures their basic needs, living together in their environment and a training which allows their autonomy and personal freedom, as well as their social and labour integration.

One of the services it carries out is the Detection and Assessment of minors at risk and abandoned situations. So, together with the Community Development Association in Aragon Areas, the University of Zaragoza and the Social Affairs Ministry, the Social Services Aragón Institute sets in motion the programme for the prevention and detection of situations of vulnerability and abuse against children, in order to know better the maltreatment against children in the autonomous region of Aragón and find efficient proposals to face it and carry out the interventions which allow a correct attention.

They have being working since 2000 and have published several actuation proposals to detect the abuse in different minor fields (education, leisure time, etc.).

The aims are:

To raise awareness and motivate the professionals on their roll in the prevention and detection of the children maltreatment.

To clarify and unify the basic concepts of abuse.

To make easier the detection and notification processes.

To promote actions coordinated among the different institutions interested in the attention to these people.

The case is of great importance, as the professionals of different actuation fields with the childhood (education, social centres, leisure centres, health, social services, etc.) as the population in general find difficulties when they face the children's maltreatment:

Difficulty to recognize and identify the different maltreatment situations.

The lack of information and orientation on how to act .

It is highly necessary to determine the definitions of maltreatment and its different types and the indicators to identify the abuse and know how to face this situation

The Greek Ombudsman

The Greek Ombudsman is an independent Authority which was found in 1998 and it is composed by five deputy Ombudsmen who cover different activities. These activities are:

Department of Human Rights

Department of Health and Social Welfare

Department of Quality of Life

Department of State-Citizen Relations

Department of Children's Rights

We found this organization on internet while searching for information regarding children rights. For further details and information about the Ombudsman we decided to contact them.

The department of Children rights was established by the law no 3094/2003 and started to work on April 2003. The target audience of this department is professionals, organizations, community and individuals.

It aims at safeguard and promote children' rights. They intercede after someone submits a report supporting that a service or an organization or an individual violates children' rights.

The reports have the full name of the accuser and all the necessary information of the accused as well all the available data about the case.

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People can submit their report either by mail, by fax to 2107289600 or personally to the Ombudsman's offices. The address is Xatzianni Mexi 5,11528 Athens.

There is also a telephone help line to which children can call to report violation of their rights to 80.111.42.000 or 2107289144. Except from the telephone line children can visit the offices of the department for Children Rights where they can talk with specialized professionals in a nice environment.

After a report, the deputy Ombudsman researches the case and intervenes in order to find a solution regardless if the abuser is a public service, an organization or an individual.

For that they cooperate with various organisations and services which are more specialized in particular issues for each case in order to support and safeguard children rights generally or if it has to do with an individual's child rights.

In frame of protecting children' rights the deputy Ombudsman for Children Rights informs children about their rights and the ways they can defend them and protect themselves, by visiting schools and distributing printed materials.

Their mission is the dissemination and the application of Greek legislation and International Conventions about Children Rights. In this frame they actualize researches in order to test the correct implementation and to compose reports when this is judged necessary proposing ways of solution or by making recommendations.

Due to the short time of its operation some of the activities that they have included in their program, are not implemented yet but they intend to operate them soon. Some of these activities are: meetings with children in their own environment in order their needs to be written down and their problems to be heard and programs to sensitize parents and professionals to avoid violation of children rights. Additionally, they plan to upload valuable information and articles on their website in order people to have direct and fast access to them on <http://www.synigoros.gr/index.html>

Institute of Child Health

Department of Family Relations

Fokidos 7 (4th floor)

115 26 Athens

ph. 01-7715.791 - Fax 01-7793.648

<http://www.ich.gr/>

The Institute of Child Health is a private right organization which was founded by Spyros Doxiadis on 1965. Its main activities involve prevention and public health, and it also develops research and educational tasks.

It is constituted by the following departments:

Department of Social Paediatrics

Department of Social Psychiatrics

Department of Family Relations

Department of Education and Enlightenment

Department of Genetics

Department of Endogenous Metabolic Diseases

Department of Biochemical Researches

Department of Biochemical Laboratories

Department of Enzymology and Cellular Operation

Specifically the Department of the Family Relations deals with issues which involve violence against children within the family. The staff members are professionals such as social workers, psychologists, paedo- psychologist, paedo- psychiatrics and lawyers.

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The target audience is professionals, organizations, community, families and children. The aim of the department is the prevention against the victimisation of the children and the protection of their rights.

Additionally the department carries out researches regarding the sexual maltreatment of the children, physical abuse and neglect for Greek children aiming to locate and understand the risk factors. Moreover, it researches the role that the physical abuse has as a tool for edification and education in Greek culture and the know how of the professionals regarding violence issues.

One of their activities is prevention. Regularly, the department organizes conferences and seminars for professionals and the community members aiming to inform and to protect children's rights in Greece. For example they visit schools and institutes in order to inform the children.

Furthermore, they have programs for counseling for professionals and organizations who works on the field of child care about the ways to deal with cases of abused children and to inform them about the other sources which could assist them in these kind of issues.

Additionally, the Institute of Child Health provides specialized diagnostic, therapeutic services for children who have been abused as well as legal advices for those who needed it.

Finally, it has a library with books related to child care and abuse for all the professionals who are interested.

Cerci Estremoz

Description of the source (article, presentation, interview, study visit, self experience, etc.)

CERCI ESTREMOZ is an institution from FENACERCI that is located in the South of Portugal (Alentejo).

Early Intervention Programme of the institution.

The person who respond to the Grid is an Educator. that works with disabled children for 18 years.

What is the target audience of the intervention?

Children from 0 to 6 years old and their families

What is the situation the intervention tries to avoid?

To give competencies to the families to deal with their problems. Empowering families, giving resources and provide networking services.

What is done /proposed to avoid the situation to endure or to occur?

Raise awareness of the situation within the family and with family members. Talk about precipitating factors with family members

Why is the intervention effective, on the basis of which criteria and according to whose opinion?

The intervention is effective because it starts within the family and because it is in the family that the solution should be found.

Why do you consider this intervention/experience particularly relevant for this project?

(key issues)

Working with the families; Trying to lead the families into to the solution for the problem, not giving them the solution. The solution may be found within the family. The belief that the family have some resources to deal with their own problems.

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3.5. Other research activities

Some of the partner organisations have conducted specific activities aiming at collecting more data or at empowering their organisations. .

3.5.1. AIAS Special interest group

AIAS has set up a special interest group within the organisation that has started a discussion on the issue of domestic violence. The group was composed of board members, staff members (psychologists and educators), parents and adult members with disabilities. View points have been collected and different forms of violence against people with disabilities have been discussed. The group has met 10 times in the spring of 2004 and has produced the following report.

Il gruppo di lavoro all'interno del Progetto Daphne, ha visto coinvolte 8 persone, ognuna con una professionalità diversa (1 Consulente familiare-Operatrice AIAS, 1 Medico-Laureanda in Psicologia, 1 genitore-Consigliere storico all'interno dell'AIAS, 1 Psicoterapeuta, 1 Consigliere AIAS persona disabile, 1 Educatrice professionale, 1 Psicologa, 1 Socio AIAS disabile) ma allo stesso tempo tutte collegate al discorso dei minori con handicap.

Il fine del gruppo (che si è ritrovato per una decina d'incontri) era:

lavorare sul concetto di violenza domestica su bambini disabili

Per la complessità e vastità dell'argomento, il gruppo dal primo incontro, ha definito di comune accordo una serie di obiettivi di lavoro:

lavorare sul concetto di violenza domestica (definizione del concetto e cosa ognuno di noi intendeva per violenza, rapportandosi alle proprie esperienze e professionalità);

rilevare casi e situazioni di rischio esistenti o/e note;

individuare situazioni di rischio che possono avere un'escalation di gravità;

ipotizzare alcune strategie di prevenzione da proporre.

Dopo questa prima fase di delimitazione di un confine di discussione, si è partiti dalla riflessione personale sull'argomento, aiutandoci attraverso la lettura della "carta sui diritti del fanciullo".

Dalla discussione e confronto sul concetto di violenza domestica, è emerso fin dall'inizio come siano molteplici le forme di violenza che si possono manifestare nei confronti dei bambini disabili. Oltre alle situazioni di violenza più estreme come l'abuso sessuale, maltrattamenti fisici (botte), emergono altre forme più sottili e nascoste come:

violenza, come mancanza di cure mediche, igieniche, affettive;

violenza come uso-abuso di farmaci con scopo sedativo;

violenza come negazione di altri bisogni personali come l'autonomia o l'intimità;

cure fisiche o terapie troppo forzate.

Durante gli incontri, sono venute ad evidenziarsi come le stesse situazioni, possono essere vissute in maniera diversa da diverse persone e conseguentemente una particolare azione può essere vissuta come violenza e per un'altra no! Nella definizione di violenza esistono diverse forme di interpretazione a seconda di come una persona le vive.

Oltre a queste considerazioni, emerge all'interno del gruppo un interrogativo, ossia se l'iperprotezione di un genitore nei confronti del proprio figlio disabile possa essere considerato una forma di violenza!

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Questo lavoro di discussione è stato arricchito da esperienze raccontate da educatori che hanno vissuto e visto situazioni a rischio in contesti familiari, e racconti personali di giovani adulti disabili.

Ha invece lasciato molta perplessità tra i membri del gruppo il resoconto sul Convegno sulla violenza sui minori svoltosi a Firenze “Il bambino che assiste alla violenza”, in cui si è riportato il fatto che anche in questo Convegno nessuno abbia accennato al discorso “di violenza sui minori con handicap”, e ad una domanda specifica sul tema sono seguiti 5 minuti di silenzio.

Negli incontri sono emersi come protagonisti 2 elementi fondamentali, se si parla di prevenzione:

L'operatore e la famiglia

Il ruolo importante dell'operatore nella rilevazione di situazioni a rischio: proprio per il fatto che lavora in contesti domiciliari è la persona che deve Osservare e Riferire a chi di dovere (necessità di avere una figura di supervisione e possibilità di confronto e scambio con altri colleghi che lavorano nelle stesse situazioni in orari diversi); da qui è emersa la necessità di sapere il parere di altri operatori che lavoravano in domiciliare e che ha portato alla formulazione di un questionario per rilevare come gli operatori che lavorano in domiciliare sentono o vivono questo problema o se qualcuno di loro ha conosciuto un'esperienza di questo tipo. Evidenziando come l'operatore sia una grossa risorsa di prevenzione!

Altro elemento, la famiglia, che deve sentirsi Protagonista.

E' emersa l'importanza dell'aiuto e del sostegno nei confronti di tutte le famiglie: sostegno non solo di tipo pratico-quotidiano, ma anche psicologico. A nostro parere, per prevenire le situazioni di criticità che possono portare alla violenza (perché la violenza è l'estremo di una situazione di disagio) occorre non abbandonare le famiglie nella solitudine, ma occorre sostenerle e saperle ascoltare.

In base a queste considerazioni il gruppo ha elaborato 2 proposte di prevenzione:

-una rivolta al ruolo dell'operatore: importanza di una Formazione adeguata (formazione non personale ma strutturata dall'Associazione), per sviluppare empatia sia rispetto alle famiglie sia al problema della violenza domestica;

-una rivolta alle famiglie: realizzare un luogo di ascolto dove i genitori possano parlare liberamente delle proprie difficoltà sentendosi ascoltato...l'Associazione può essere un luogo importante per offrire uno spazio di questo tipo con operatori qualificati. Ma ancora più importante, sarebbe realizzare un lavoro psicologico sulle aspettative dei genitori nel momento della rilevazione dell'handicap del proprio bambino rispetto a se come genitore e rispetto al bambino: occorre riflettere sul fatto importante che “le aspettative fatte nel periodo di attesa della nascita, il genitore le deve sostituire con altre”; c'è infatti un'elaborazione del dolore e del lutto (perdita delle aspettative) e molti genitori si sentono abbandonati e in solitudine fin dai primi momenti in ospedale. Questa solitudine, la carica degli aspetti negativi, il non essere compresi, portano alla rabbia che si può trasformare in violenza.

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3.5.2. AIAS Staff enquiry

Within the framework of the project AIAS has paid particular attention to its group of educators and home care assistants, working on a daily basis with children with disabilities and families. A questionnaire has been distributed among staff members. More than 25 educators and other staff people have responded, giving a good insight in their perception of the problem and their training needs. Further the theme has been discussed with the support of a professional supervisor (Dott. Laura Fregoli) during various sessions in the weekly meetings of the teams of the various care centres. These outcomes have informed the special interest group within AIAS and the project co-ordinator. Further case histories have been collected informed by the staff members.

The AIAS Staff Questionnaire

Eta': _____

Sesso: F/M

Profilo professionale:

Adb

Ep

Educatore

Psicologo

Pedagogista

Assistente sociale

Altro, _____

Anni di esperienza di lavoro con minori con disabilita': _____

1. Hai mai riflettuto sul tema della violenza contro minori disabili?
2. Come definiresti la violenza domestica?
3. Hai conoscenza di atti di incuria? Se si, per quale motivo li ritieni forme di violenza?
4. Hai conoscenza di atti di abbandono? Se si, di che tipo? Per quale motivo li ritieni forme di violenza?
5. Hai conoscenza di atti di maltrattamento psicologico? Se si, per quale motivo li ritieni forme di violenza?
6. Hai conoscenza di altri atti verbali o azioni che consideri forme di violenza ma generalmente non sono considerati come tali?
7. In base alla tua esperienza, quali fattori possono definirsi come indicatori di rischio di violenza?

(per indicatori di rischio si intendono fattori relativi ai genitori, al bambino, al contesto familiare e/o sociale che in relazione tra loro o isolatamente aumentano il rischio che una situazione difficile e stressante esploda in un atto di violenza)

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8. Ritieni che tra i fattori di rischio vadano considerate anche le lamentele ripetute che i genitori possono riferire
(ad esempio di rivendicazione rispetto ai servizi, di difficoltà nella cura quotidiana del bambino, di senso abbandono da parte della rete parentale e/o sociale)?

Si
No

In casi specifici, per esempio:

9. Il disagio familiare (ad esempio, per le aspettative disilluse) può diventare discriminazione del familiare con disabilità'?

Si
No

In situazioni specifici, per esempio:

10. Quali sono, in base alla tua esperienza, le caratteristiche specifiche associate alla disabilità' che possono aumentare il rischio di violenza?

11. La storia di ogni bambino e di ogni famiglia e' unica. Ad ogni modo, a partire dalla tua esperienza, in condizioni di armonia raggiunta all'interno della famiglia e della coppia, quale equilibrio e' piu' in pericolo quando nasce un bambino con disabilità'?

	Molto in pericolo	Abbastanza in pericolo	Poco in pericolo
Equilibrio di coppia			
Rapporti con il mondo esterno			
Equilibrio economico			
Capacità di relazione del genitore			
Identità personale			
Altro:			

12. In base alla tua esperienza, quali ritieni siano le emozioni che più facilmente un operatore può provare in situazioni di violenza?

Rispetto alle emozioni

Depressione

Rabbia

Angoscia

Disgusto

Altro: _____

Rispetto all'azione

Impulso ad agire

Inutilità

Senso di fallimento

Bisogno di reazione

Senso di impotenza

Frustrazione

Ricerca di aiuto

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Denuncia

Bisogno di distanza e distacco

Altro: _____

13. Ritieni che le emozioni dell'operatore in queste situazioni rappresentino una risorsa o un ostacolo rispetto alla realizzazione dell'intervento?

14. Hai avuto notizie di comportamenti o giudizi considerabili violenti da parte di operatori ?

Si

No

Se si, cosa potrebbe fare l'AIAS se questo si verificasse?

15. Quale ritieni potrebbe essere il modo piu' efficace attraverso il quale AIAS puo' favorire la prevenzione della violenza nelle famiglie con bambino con disabilita'?

Scrivi tutto quello che vuoi a proposito di questo tema, questo progetto o questo questionario. Ti saremo grati.

Grazie per la collaborazione!!

Le risposte saranno elaborate ed analizzate durante i prossimi mesi, cosicché la prossima primavera vi convocheremo per un incontro di confronto sulle tematiche emerse.

Outcomes

The questionnaire has been presented to 28 AIAS operators: 3 basic nurses, 21 educators, 2 psychologists, 1 social worker.

The majority (60%) of operators refers that has already reflected on the theme of violence. The definition of maltreatment given, first of all refers to the parents of the child: violence may be the consequence of the feeling of helplessness perceived by parents. In general, violence is considered an abuse of power by caregivers, which manifests through psychological and/or physical oppression.

Referring to the different types of violence presented, the ideas expressed by operators are the following:

neglect refers to inadequate care of child body, clothing, health; sometimes it is the consequence of ignorance and low cultural level;

the physical abandon of children is considered as the extreme manifestation of parents perceived impotence;

psychological maltreatment is considered more the consequence of parents physical and psychological tiredness rather than a primary form of violence. Anyway, it is perceived as a very severe type of maltreatment, because it represents a denial of the most basic human rights and causes negative long term consequences, which are often invisible in a short time. Among the forms of psychological maltreatment, operators indicate humiliating, indifference towards child actions and words;

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operators consider that there are forms of violence which remain more hidden and that generally may not be considered as violence: for example, discrimination, social isolation (often as a consequence of discrimination), architectural barriers, parents hyperprotective behaviours.

Factors of risk can be grouped at different levels and are represented by the following examples:

at the cultural level, ignorance and lack of knowledge;

at the social level, social isolation, sense of loneliness, lack of satisfying social relationships, absence of a supporting formal and/or informal network and difficulties in communication with professionals ;

at the familiar level, marital conflicts and incapacity to reorganize familiar lives and find resources;

at the parents level, stress and substance abuse.

Parental complaints (referring for example to a stressful period) have to be taken seriously in account according to the majority of operators (80%) in order to prevent the loss of control of delicate situations.

Disability per se is considered as the most significant factor increasing risk for maltreatment against children with disabilities. Parents stress, familial problems, social difficulties and the original family are the other aspects related with disability that can raise the risk of violence. The majority of operators consider child disability as a strong danger for parents couple stability.

Operators believe that in a violent setting caregivers feel in most cases emotions of anger, anguish, depression and disgust. Their consequent actions are search for help, impulse to action, but also need for denounce and frustration. Anyway, all operators consider their emotions as an useful instrument in revealing and intervening in situation of risk and/or maltreatment if they are accepted, elaborated, verbalised.

Most of the operators (55%) are aware of some type of maltreatment by other operators: many of them know example of maltreatment perpetrated by caregivers.

Prevention actions explained by operators can be grouped at different levels:

most of the intervention should be realised putting at the centre the family of children with disabilities: counselling services, professional forms of psychological help, programs of training on emotions. One of the pre-requisite seems to be the co-ordination of an efficient and supportive network around families. Respite care services have to be organised in order to guarantee the parents welfare, more time to spend for themselves and, eventually, for other children;

operators have to be trained in order to receive: information and knowledge about the theme of maltreatment, strategies of coping with personal emotions, with families and with children.

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3.5.3. Fenacerci survey among its members

Fenacerci has conducted a survey among its members with the following results:

81 questionnaires delivered to Non governmental institutions
78 responses

80,8 % of the institution say that they are concerned about domestic violence in families with disabled children;

41,0% say that they have been involved in activities concerned to domestic violence with families of disabled children and 57,7% say they have not;

56,7% of the institution that say they have been involved in activities of debate, say also that those activities have been organized by others., 20' % have been organized by themselves and 23,3% by both

87,3% say that they are interested in being involved in activities of debate about domestic violence.

88,9% say that they are concerned about prevention of domestic violence, but only 38,1% say that have already been involved.

About those who have been involved in prevention activities 33,3% say that those activities have been organized by themselves, 29,2% by others and 37,5% by both.

93,7% say that they are very interested in being involved in prevention activities.

85,7% say that they know cases of domestic violence in families of disabled children, and that those cases are from outside of the institution (83,3%) and 5,6% are in the institution. 11,1% are form both situations.

73% of the institutions say that they have already to deal directly with cases of domestic violence.

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4 Corner stones for the development of prevention policies

Corner stones define the fundamental principles of intervention. They represent the guidelines of the prevention action. They have to be clear and short, such as “slogans” of prevention. They have to be “pregnant” and coherent considering case histories and good practices examples reported in the previous sections. This section will be very much alike the booklet.

Cornerstones for prevention strategies

Developing prevention strategies means carefully defining the problem to be tackled, the aims to be achieved, the activities to be undertaken and the expected results. The following “cornerstones” will be helpful for any organisation that directly intends to address the issue of domestic violence against children with disabilities or that intends to encourage public services and institutions to do so.

Methodological issues

- To know and to understand the problem, its “whys” and “hows”, and its implications for children with disability is the first step towards and a prerequisite for choosing a prevention strategy. Accurate data, uniform definitions and a common view on child maltreatment represent the basis for the planning of interventions.
- As prevention is a process aiming at change, promoters should plan and monitor the process and the effects of their activities. Given the complexity of the issues and their emotional impact, these effects are not always easy to predict. Organisations planning an internal discussion should choose a careful strategy and guarantee professional support if necessary. Where prevention activities may lead to a higher demand for services, sufficient resources to cover these needs over a longer period must be available.
- Prevention is a process which includes different phases: detection, intervention and follow up. Some fundamental qualities of this process are: appropriate timing (prevention should be planned as early as possible), flexibility (prevention and intervention should change according to the needs of both child and family), objectiveness (intervention should be based on specific and detailed signals of risk and effectiveness and must be monitored and evaluated), contextualisation (prevention should take into account the context and its complexity in terms of the main players and their relationships).
- Prevention strategies should focus on both reducing risk factors and strengthening protective factors. Effectiveness can be increased if prevention embraces multi-level interventions that simultaneously address risk and protective factors from different domains.
- Prevention (as well as intervention) should refer to a clear strategy and ideally follow a multi-disciplinary, integrated and co-ordinated approach. Therefore professionals working in different areas, namely, health, justice, social work, education and special education, should work together sharing common goals and a common vision of prevention. It is essential that they should maintain good and rigorous communication with each other (!).

Issues related to the various stakeholders

- Associations and other private organisations wanting to prevent domestic violence must first of all work on themselves, discussing the issues internally, and be aware of their role during all phases of prevention: in collecting signals, in deciding an intervention strategy and in directing it. Spaces and moments for dialogue and the sharing of ideas, of evaluation and modification of the prevention/intervention projects must be formalised within the organisation. This will encourage establishing a common language and reduce the ambiguity of meanings and interpretations, which often cause non taking of responsibility and delegation. These spaces should be opened to families with the aim of involving them.
- As a priority in successful child maltreatment prevention, the needs of the family have to be met at different levels (individual/parental, physical/psychological and so on). Families must

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be put in the right condition to fulfil their fundamental role in the child's development. Prevention should build on family strength, exploiting their personal, parental and social resources. Families must be helped to discover and realise their abilities as parents and as individuals (!!).

- Co-operative and mutually supportive relationships between parents and agencies and institutions responsible for the physical and psychological well being of the child (e.g. schools, health services etc.) are to be encouraged, as they will increase the efficiency of any intervention aiming at prevention. Intervention should be carried out through active listening and understanding of the parents' situation and be as much as possible agreed upon in order for it to be perceived as concrete support (!!). Associations and social co-operatives should be aware that even professionals in the institutional network often do not know how to deal with the issue of domestic violence. Only very few assistance and care providing institutions have adopted a code of practice regarding the prevention of violence.

- Empowering children means recognising their right to explore their potentials/potentialities and providing them with the necessary skills to enhance them. Training and educational programmes must develop and reinforce communication, interaction and action abilities, both in family and non-family contexts. Children must be taught to become aware of their needs and feelings (e.g., sex education training) and of the proper way to express them. This will facilitate intervention aiming at physical, social and emotional support.

- Associations and other private organisations must encourage the development of a network of relevant stakeholders and decide a role in it which best suits their mission and competence. Such networks are typically made up of different public institutions holding formal responsibility for the child's well being and private non profit oriented organisations representing families' and children's interests. The network's aims and the roles and responsibilities of the participating institutions and organisations must be clear to all.

- Both public services and private organisations must promote an active prevention policy targeting their human resources, including selection, training and supervision procedures. There must be training especially for operators and volunteers working with children and families in order for them to acquire and consolidate technical and relational skills, covering cognitive, organisational and emotional contents. Valid methods of observation of child and family characteristics, interaction and behaviour need to be taught.

- Prevention strategy should include awareness raising activities. The general public needs to know the impact of the problem and to become aware of the context of maltreatment in which children with disabilities can find themselves. The raising of awareness concerning the risk of maltreatment of children with disability should be transversally integrated into normal education, professional training and institutional practice.

- Organisations should use their political power to defend the rights of children with disabilities and to obtain appropriate legislation, intervention and support for their members and others.

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Bibliography - web site

For further consultation

- http://www.who.int/violence_injury_prevention/violence/neglect/en/
- <http://www.unhchr.ch/html/menu2/6/crc/>
- <http://www.ualberta.ca/~jpdasddc/abuse/>
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- <http://www.securityworld.com/library/retirement/abuseofthedisabled.html>
- <http://nccanch.acf.hhs.gov/pubs/prevenres/focus.cfm>

- <http://www.aisbo.it/daphne> for the full project report and more web links.

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