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ATHENA BEGIN

NEEDS ANALYSIS REPORT

ATHENA BEGIN: 856613 - EUROPEAN CORPORATIONS AGAINST DOMESTIC
VIOLENCE TOWARDS PEOPLE WITH INTELLECTUAL DISABILITIES

WP2: DATA COLLECTION ON PROFESSIONALS NEEDS AND DEVELOPMENT OF
MATERIAL FOR IMPROVEMENT OF COMPETENCES



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Needs Analysis Report

The present document is one of the outputs of the “ATHENA BEGIN” project. The project aims to offer resources and tools to professionals who assist people with intellectual disabilities victims of gender-based violence against women (hereafter named as GBVAW) and empower the victims themselves to improve their quality of life by developing their skills and personal abilities. The document summarizes the main results of the data-collection process in each partner country (Portugal, Spain and Greece) concerning their needs according to their own perceptions. Both results and data analysis will be presented jointly, integrating information from all countries. This analysis intends to identify the main challenges in terms of knowledge and skills raised by professionals and informal caregivers of people with intellectual disabilities to effectively support this vulnerable group. The purpose of this report is to serve as a basis for the development of specific materials for workshops and training who may overcome the limitations identified by professionals, caregivers and people with intellectual disabilities who are/were victims of gender-based violence.

We will begin with a short bibliographic outlook concerning gender-based violence against women with ID. Then, we will describe the method of both quantitative and qualitative studies: instruments, sample, and procedure of data collection and analysis. Results of both studies will be presented: Regarding the quantitative study, results will be presented concerning four major topics: main motives to choose the job/career, most and least satisfying job features, perception of support, satisfaction with the job and impact of pandemic Covid-19, and Burnout. Analysis of the answers to open questions regarding the main needs identified as professionals and future professionals allowed the identification of three major themes: support for victims, professional’s aspirations and risk factors (e.g., workload, lack of specific training, lack of available resources, infrastructure and bureaucracies, pandemic effects). Finally, regarding the data collected through focus groups with professionals, future professionals and caregivers, they allow the identification of major themes regarding needs of knowledge and skills in the field of ID (e.g., degrees of disability, sexuality), victimisation (e.g., risk assessment, signs identification), ethical considerations, and training. A concluding discussion highlights the most important results and its implications for further steps in the project.

Introduction

I) Gender-based violence against women with ID

Gender-based violence against women (GBVAW) is an umbrella term that encompasses several forms of abuse which affect women and girls disproportionately such as rape, sexual exploitation, sexual harassment, genital mutilation and domestic violence. GBVAW is a pervasive form of human rights violation, affecting 1 in 3 women

worldwide (WHO, 2013). The everyday risk is especially experienced by women with disabilities, since evidence shows that abuse is more frequent against this vulnerable group (FRA, 2014; Dunkle, Van Der Heijden, Stern, & Chirwa, 2018).

As a form of GBVAW, domestic violence is one of the most prevalent forms of violence against women around the world (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Alhabib, Nur, & Jones, 2010). Its roots are profoundly related to inequality between genders and male dominance over the women (Dobash & Dobash, 1979; Yodanis, 2004). Although domestic violence is not restricted just to that violence perpetrated *behind the closed doors*, throughout the History, women have been abused by men inside their homes because of remaining myths such as “ideal families” and the “safe, intimate private world” (as refereed by Saraga, 2001). Some authors nominate the systematic abuse suffered by women as a form of terrorism (Pain, 2014) or patriarchal terrorism (Johnson, 1995; Bosch, Ferrer & Alzamora, 2006). Domestic violence can be defined as

“(…) the threat or exercise of physical, psychological, and/or emotional violence; i.e., any type of force against another person with the intent of inflicting harm or exercising power and control over them. The perpetrator belongs to the victim’s “domestic environment”: an intimate partner, husband, former intimate partner, family member, friend or acquaintance.” (Flury & Nyberg, 2010, p. 02)

In many cases, forms of abuse overlap, and it is common for a victim of GBV to experience more than one form of victimisation at the same time insofar the consequences can be even more pervasive for victims (WHO, 2012). The abuse may impact victims’ physical and mental health severely, and due to its prevalence and consequences, domestic violence is also considered as a public health problem (Flury & Nyberg, 2010). Despite the various manifestations and dynamics of this form of abuse, GBVAW will be used to refer only to the violence perpetrated against women, and also men, with intellectual disabilities. In this regard, It is essential to mention that women with ID are equally exposed to the same forms of violence than women without identified disabilities. However, the “additional vulnerability factor” (as referred by Nosek, Foley, Hughes, & Howland, 2001, p. 186) creates some particular forms of

violence which only affect women with disabilities, since that is intrinsically related to their limitations and healthcare needs (Walter-Brice, Cox, Priest, & Thompson, 2012).

This being said, the ATHENA project addresses the vulnerability of people with disabilities to become victims of GBVAW abuse, including domestic violence. It seeks to offer resources and tools to professionals who assist victims with intellectual disabilities, and empower them to improve their quality of life by developing their skills and abilities. This arises the need to identify hidden realities, to tackle them professionally and effectively, and to minimise any secondary victimisation that victims/survivors may suffer during the process.

To achieve these goals, there has been a commitment to develop content to train professionals involved in the care of victims of GBVAW, to develop training programme(s) for prevention and guidelines for different actions. The implementation of a new training method for professionals and for prevention workshops addressing people with disabilities who may be at risk of suffering GDVAW has also been foreseen. Women and men with intellectual disabilities (ID), professionals (healthcare, psychologists, social workers, jurists, police agents, caregivers) and others (policy makers and general public) are the direct and indirect beneficiaries from the project.

It is expected that training materials may improve the competences of professionals for the protection and support of people with intellectual disabilities are developed. Additionally, capacity building for professionals and creating a handbook on preventing and building awareness of GBVAW, for professionals who work with people with ID is another objective of this project. It is also expected that several workshops for people with ID are organized, while a guideline with recommendations in attention to women with disabilities, victims of GBVAW, to include within the action protocols already established by the pertinent authorities will also be developed.

The results so far collected have contributed to the construction of two deliverables: the State of Art document (fully completed and uploaded) and the current document: the Needs Analysis Report (NAR).

The NAR is the product of the results obtained from both quantitative and qualitative data collected in the framework of this project (survey and a series of focus groups, respectively) implemented with caregivers, professionals and future professionals. Furthermore, it also results from the joint reflection of the professionals

who work in different fields of expertise that also integrate the project's research teams.

1. Methods

The NAR combines a methodological triangulation where quantitative and qualitative techniques were applied, hopefully allowing more solid outputs. The instruments, the procedure of data collection and analysis, and the sample of qualitative and quantitative data are described.

2. Instruments

Specifically in regards to the **quantitative** methodology, a twenty question survey on needs assessment of professionals who work with vulnerable populations was used to collect data amongst professionals and future professionals. This survey was composed by four groups: the first group with one question concerning the informed consent; afterwards, a set of sixteen affirmations related to the individual's personal and professional situation, the most and least valued features of the work, perceived support, and satisfaction; followed by the Maslach Burnout Inventory (MBI); and lastly, one question about the impact of COVID-19's and further comments/suggestions that the participant could be interested in sharing. In regard to the MBI, this instrument was sought to better assess the needs that professionals who work with vulnerable populations face in their daily professional activities. It is a self-assessment instrument built by Maslach and Jackson in 1981 and its current version is constituted by 22 likert type questions, with seven levels, ranging from 0 (never) to 6 (every day). The 22 items are states of feelings reported at work. These items are divided into three subscales: Exhaustion or Emotional Tiredness (EE), Depersonalization (DE), and reduced Professional Achievement or Professional Achievement (rRP). The EE consists of nine items (1; 2; 3; 6; 8; 13; 14; 16; 20) and refers to both physical and mental exhaustion, the feeling of having reached the limit of possibilities, while the DE corresponds to five items (5; 10; 11; 15; 22) and consists

of changes in the attitudes of individuals when coming into contact with the users of their services, starting to demonstrate cold and impersonal contact with suffering. Finally, the RRR at eight items (4; 7; 9; 12; 17; 18; 19; 21), measuring the perception of the influence of others, well-being with work, as well as the professional's relationship with their problems, showing the feeling of dissatisfaction (Maslach et al., 1996).

As regards to the **qualitative** study, all project partners committed themselves to carry out focus groups, following the guidelines elaborated and agreed by the teams. Focus groups were accomplished with members of different groups, identified as important informants on the topic, in order to give them voice and to triangulate information collected. Two focus groups were carried out in each partner country with current professionals and future interdisciplinary professionals, such as psychologists, educational scientists, criminologists, involved in the field of domestic violence and victim's assistance.

During these focus groups, several topics were explored comprised on a common guideline based upon a fictional story: i) reasons for working in the field; ii) common practices; iii) perceived or anticipated strengths and weaknesses of their initial qualifications and lifelong learning; iv) the perceived or anticipated strengths and weaknesses to their interventions, v) coping strategies used to deal with challenges; vi) risk of burnout, and vii) suggestions and recommendations for improvements. Other focus groups were also held with relatives, caregivers and observers of people with ID, two in each partner country. During the discussion, relevant topics were explored, such as: i) expectations and experiences of care-giving, challenges and risks; ii) perceived personal and institutional support; iii) suggestions and recommendations for improvements of the available services.

The informed consent was requested to each confirmed participant, prior to the respective focus group session and all sessions were recorded, whereas data protection was also covered. In each focus group session, a three-phase story was read, and a set of questions was presented respectively (please consult the story and respective guidelines in the attachments 1 and 2).

2.1 Quantitative data collection

2.1.1. Participants

311 professionals chose to participate in the quantitative survey: 119 from Greece (N=88 current professionals and N=31 future professionals) 112 from Portugal (N=71 current professionals and N=41 future professionals), and 80 from Spain (N=50 current professionals and N=30 future professionals).

In the Greek sample, most of the participants were female (66.4%), aged between 25 and 34 years old (44.5%), single (56.3%) and without children (66.4%). Most of them have a master degree (47.1%) mostly in Psychology, Education, Humanities and Social Sciences. 18.5% of the Greek participants work with people with ID, 8.4% with victims/survivors of domestic/gender-based violence and 4.2% with both. The others work with other vulnerable groups (e.g. dementia) or preferred not to answer. Most of them have a full-time work schedule (44.5%) for less than 1 year (30.3%).

In the Portuguese sample, most of the participants were also female (72.5%), aged between 35 and 55 years old (39.7%) or between 18 and 24 (19.7%), married or living with a partner (46%) and without children (49.2%). Most of them have a Master degree (60.4%) mostly in Education, Psychology and Social Sciences. 35.8% of the Portuguese participants work with people with ID, 25.3% with victims/survivors of domestic/gender-based violence and 16.2% with both, the others work with other vulnerable groups (e.g. addiction) or preferred not to answer. Most of them have a full-time work schedule (88.9%) for more than 20 years (29.8%).

In the Spanish sample, participants were not asked to identify themselves with a gender. Most of the participants were aged between 35 and 55 years old (47.5%), were single (52.5%) and had no children (58.8%). Most of them have a Bachelor (47.5%) or Master degree (31.3%) mostly in Education, Psychology, Disabilities and Social Sciences. 31.3% of the Spanish participants work with people with ID, 3.8%

with victims/survivors of domestic/gender-based violence and 23.8% with both, the others work with other vulnerable groups or prefer not to answer. Most of them have a full-time work schedule (52.5%) for a period of 1 to 10 years (40%).

2.1.2. Procedure of data collection

Data was collected online, using Limesurvey and GoogleDocs platforms during the second semester of 2020. The survey was disseminated through the personal contacts and social media of the researchers involved in this project, mostly working with people with ID and/or victims/survivors of gender-based violence. Participation in the study was anonymous and voluntary and preceded by a consent form.

2.1.3 Procedure of data analysis

Descriptive Statistics procedures were used to explore demographic and career related features of the sample, and also other variables associated with the occupation such as the motives, likes and dislikes, perceived social support, satisfaction and the impact of Covid 19 pandemic. Finally, concerning the Burnout dimensions, one sample T test was used to compare the scores of the samples with the reference cut off points for the instrument, repeated measures ANOVA was used to compare the levels of burnout in different dimensions among the same participants, and one way ANOVA or non-parametric Kruskal-Wallis (when groups were very small and/or asymmetrical) was used to explore differences according occupational features of the participants. IBM SPSS Statistics 24 was the software used to run the analysis.

Also, an analysis sheet was developed to integrate the main dimensions referred by the participants when filling out the open questions included in the questionnaires.

2.2. Qualitative data collection

2.2.1. Participants

In total, 21 professionals, 10 young professionals and 24 formal and informal caregivers participated in the focus groups. With regard to professionals, efforts were made to ensure diversity and representation from different areas, thus, psychologists, criminologists, police officers, and technicians participated in the focus groups.

2.2.2. Procedure of data collection

Due to the constraints of the pandemic, the qualitative data was collected through online focus groups. The participants were recruited from the research team's networks in each country and the participation was voluntary. All participants were contacted by phone or by email and a consent form was signed by each one. These focus groups lasted between 1h30 and 2h30.

2.2.3 Procedure of data analysis

The focus groups were recorded and partially transcribed. A model template was designed to orient and standardized data analysis in all partner countries. One template was filled per each focus group, and the document summarizes the main quotes and topics discussed during the focus groups. The document also highlights notes that the research team deemed necessary in each situation (attachment number 3).

3. Results

3.1 Quantitative results:

3.1.1 Results of the questionnaires

l) Main motives to choose the job/career, most and least satisfying job features

To make the difference on people's lives was the most selected motives for Portuguese (Figure 1) and Greek (Figure 2) professionals (68.8% and 37.8% respectively); this was the second motive among Spanish professionals (Figure 3) (17.5%) who chose as the first one *To help people with intellectual disabilities and/or victims/survivors of gender based/domestic violence* (40%), the second most selected one among Portuguese professionals (28.2%). Greek participants chose as thesecond main motives *income and career opportunities* (16.8%) which were the least chosen by Portuguese professionals (8.5%) along with schedule and social benefits (4.2%).

Figure 1 – Motives to choose the job/Portuguese sample

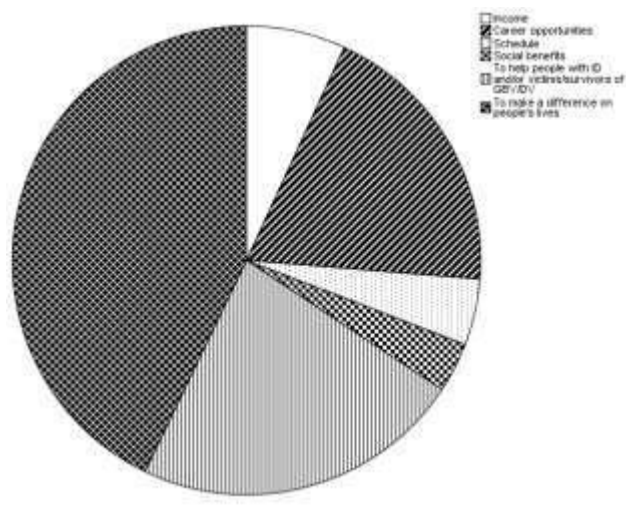
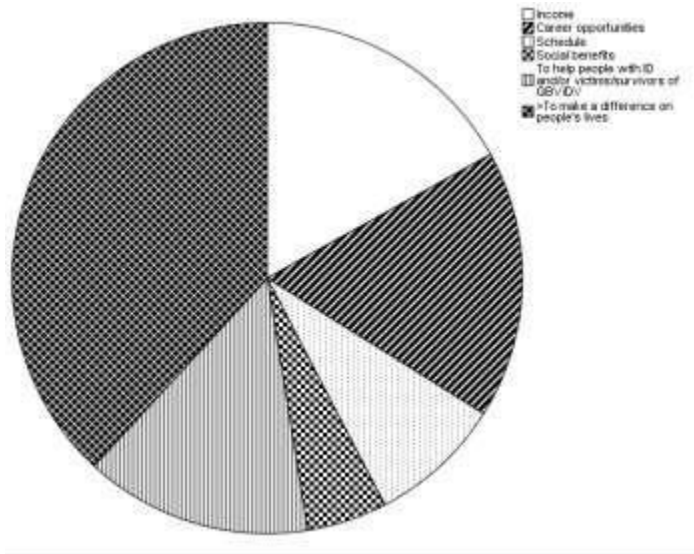


Figure 2 – Motives to choose the job/Greek sample



For Spanish (figure 3) and Portuguese (figure 4) professionals, *To make the difference on people's lives* is the most valued feature of their work (48.8% and 68.5%, respectively). Other very satisfying features were *The opportunity to use knowledge and skills* (27.5% and 64%), *The opportunity to acquire more knowledge and skills* (28.8% and 61.8%), which were the most valued features for Greek (figure 5) professionals (50.6% and 64.7%).

Figure 3 – Motives to choose the job/Spanish sample

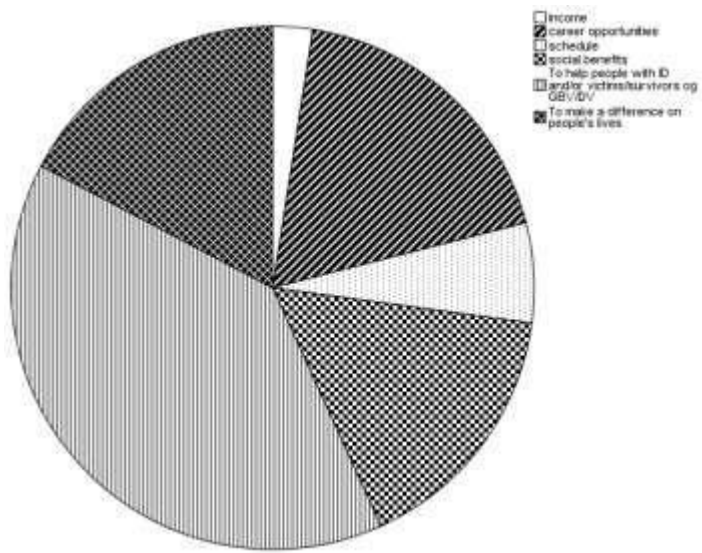


Figure 4 – Most satisfying features of the job - Portuguese Sample

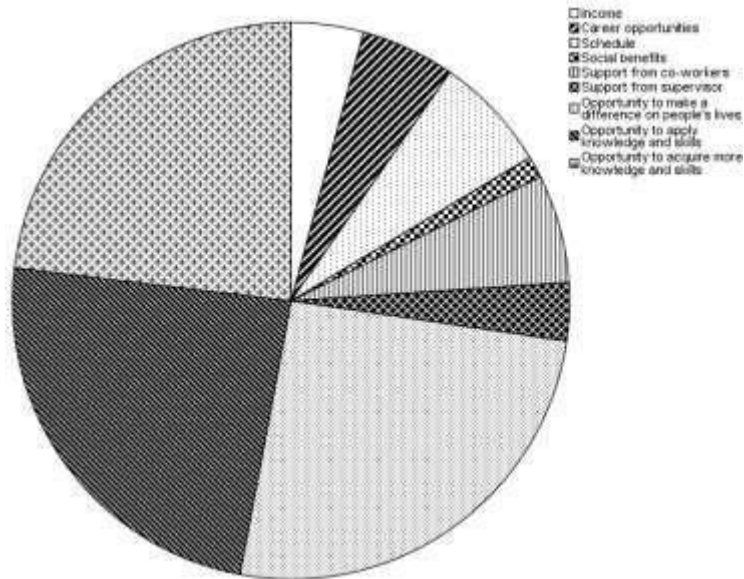
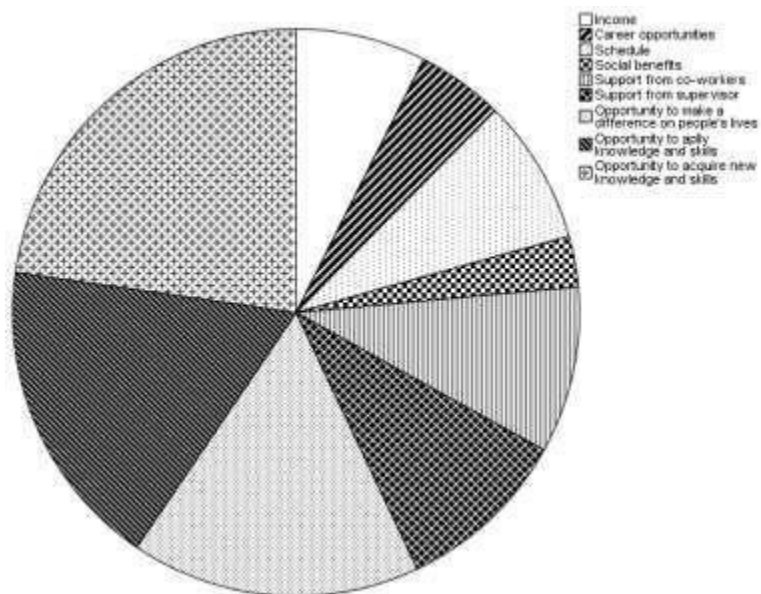


Figure 5- Most satisfying features of the job - Greek sample



Accordingly, *The lack of preparation* (PT6.8%/GR9.5%) or *The lack of opportunity to use* (4.5%/13.1%) and *acquire* (11.4%/8.3%) *more knowledge and skills* were among the least selected items concerning the less appealing features of the job from both, Greek (figure 8) and Portuguese (figure 7) participants. Also the *Support from co-workers* (9.1%/7.1%) are among the least selected disliked features in both samples. Spanish participants did not answer the questions regarding the least satisfying features, but seem to agree about the importance of the support of co-workers identified as an important satisfying feature by the 33.8% of the participants (figure 6).

Figure 6- Most satisfying features of the job – Spanish sample

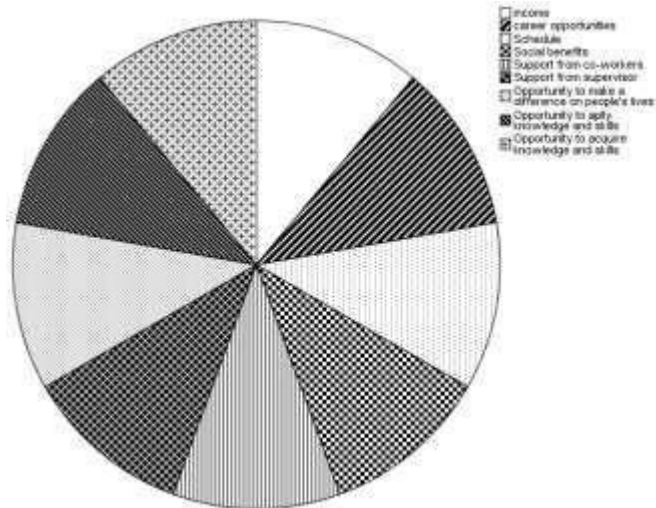


Figure 7 - Least satisfying features of the job – Portuguese sample

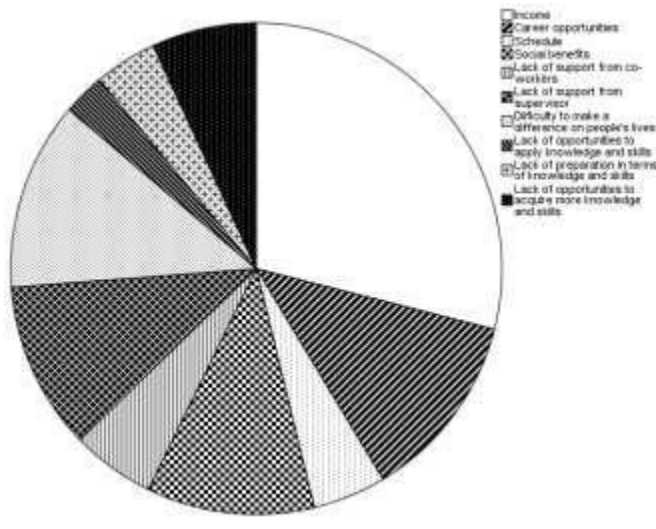
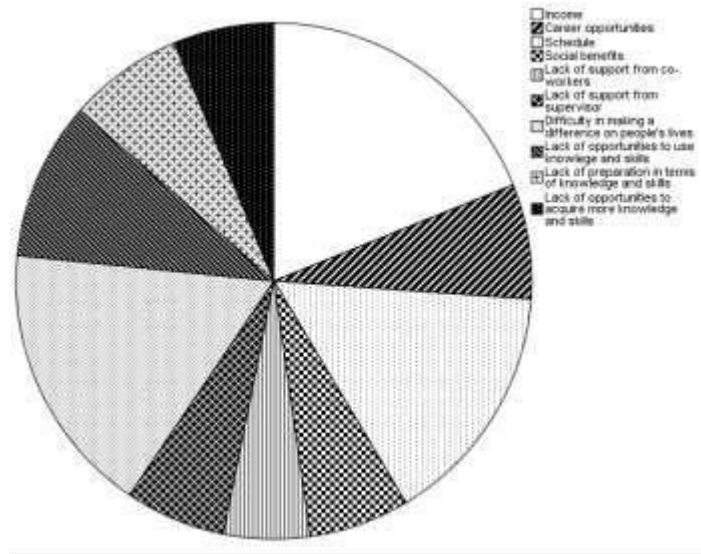


Figure 8 - Least satisfying features of the job – Greek sample



II) Perception of support

Family and friends are the sources of support that inspire higher levels of satisfaction among Spanish (figure 11) ($M= 4.53, DP=.73$ and $M= 4.15, DP=.89$), Greek (figure 10) ($M= 4.06; DP=.96$ and $M= 3.77; DP=.95$), and Portuguese (figure 9) ($M= 3.20, DP=.93$ and $M= 2.76, DP=.94$) participants. On the other hand, participants are less satisfied with the support provided by the State/Government (SPM= 2.69, $DP=1.02$; GR $M= 2.13, DP=.89$; PT $M= 1.62, DP=.86$), the Leaders of the institution (SPM= 2.55 $DP=.95$; GR $M= 2.96, DP=1.05$; PT $M= 1.99, DP=1.01$), and Community/stakeholders (SPM= 3.27 $DP=1.10$; GR $M= 2.96, DP=.89$; PT $M= 1.97, DP=.98$).

Figure 9 - Perception of support – Portuguese sample

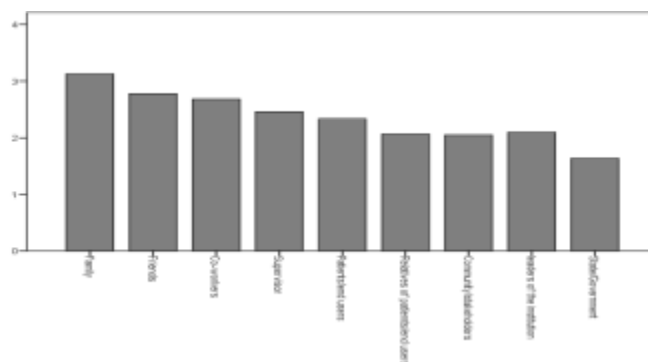


Figure 10 - Perception of support – Greek sample

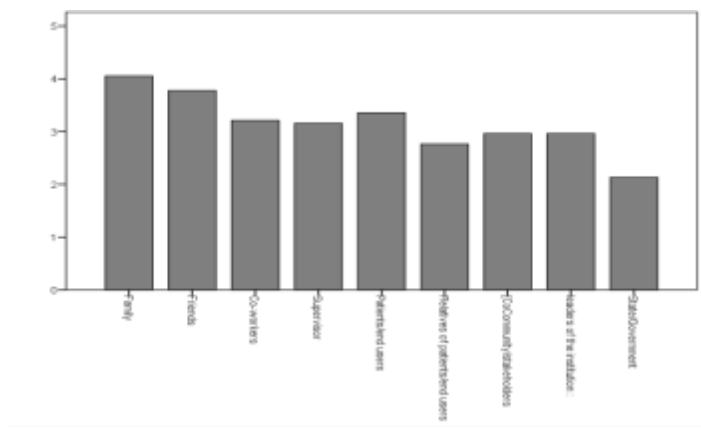
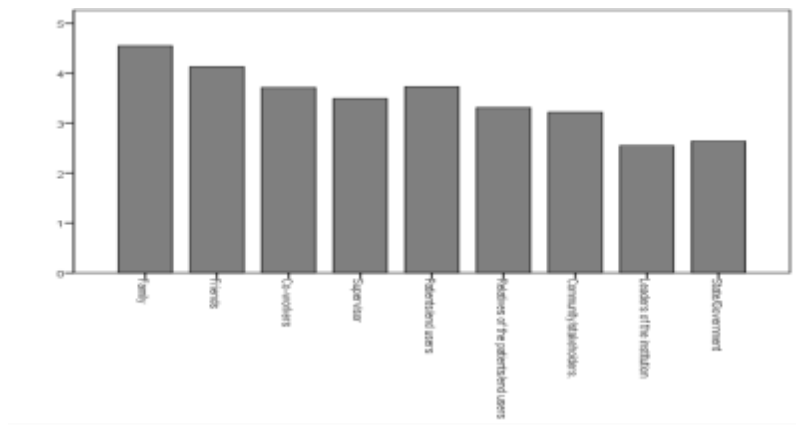


Figure 11 - Perception of support – Spanish sample



III) Satisfaction with the job and impact of pandemic Covid 19

The professionals of the three countries seem to be averagely to highly satisfied with their job (SPM= 3.86, DP=.59; GR M= 3.72, DP=.90; PT M= 3.32, DP=.85) (figures 12, 13 and 14).

As regards to the impact of the pandemic of Covid 19 on the answers to the survey, professionals seem to rate its impact as medium (SPM= 2.94, DP=1.12; GR M= 2.39, DP=1.23; PT M= 2.23, DP=1.19), suggesting a perceived moderate impact of this pandemic on the performance of the job.

Figure 12 – Job Satisfaction and Impact of Covid 19 – Portuguese sample

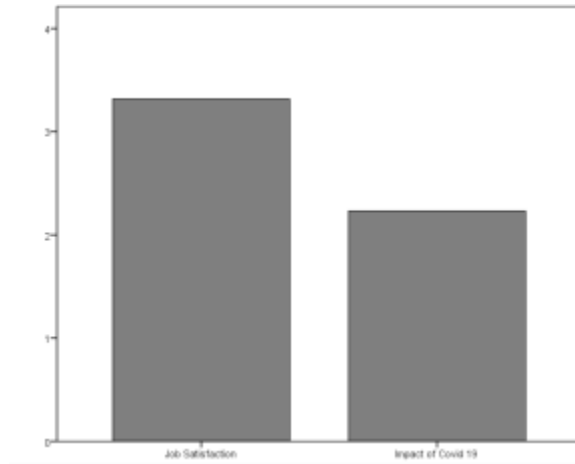


Figure 13 – Job Satisfaction and Impact of Covid 19 – Greek sample

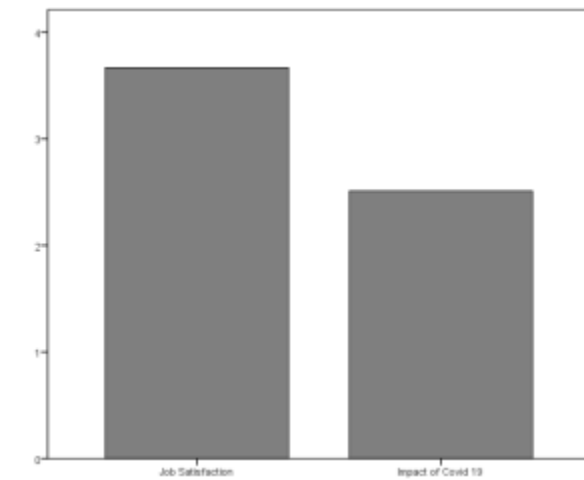
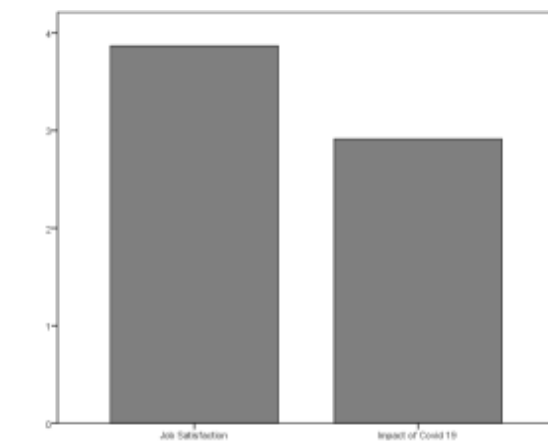


Figure 14 – Job Satisfaction and Impact of Covid 19 – Spanish sample



IV) Burnout

Both Greek and Portuguese participants present significant differences on their levels of burnout on different scales comparing with reference cut off points: they present lower levels of *Emotional Tiredness/Exhaustion* (EE) [GR $t(67)=-4.06$, $p<.001$, $d=49$, $M=16.9$, $DP=7.88$; PT $t(78)=-5.35$, $p<.001$, $d=60$, $M=15.58$, $DP=8.77$] and *Depersonalization* (DE) [GR $t(67)=-2.94$, $p=.005$, $d=36$, $M=6.32$, $DP=3.64$]; PT $t(78)=-8.16$, $p<.001$, $d=91$, $M=4.08$, $DP=3.86$], but also of *Personal Fulfilment* (PF) [GR $t(67)=-2.47$, $p=.016$, $d=30$, $M=33.6$, $DP=7.15$]; PT $t(75)=3.13$, $p=.003$, $d=36$, $M=33.35$, $DP=6.56$].

Pairwise comparisons were implemented using Repeated Measures ANOVA in order to explore differences between dimensions of burnout within the same sample. Amongst both Portuguese ($F(2,1.59)=206.9$; $p<.001$ partial $\eta^2=.824$) and Greek professionals ($F(2, 1.49)=342.9$; $p<.001$; partial $\eta^2=.755$) significant differences were observed, suggesting that professionals report higher levels of *Personal Fulfilment* (PT $M=4.18$; $DP=.83$; GR $M=4.20$; $DP=.87$) and lower levels of *Depersonalization* (PT $M=.80$; $DP=.74$; GR $M=1.26$; $DP=.73$).

In the Portuguese sample, no differences were observed according to the type of population professionals work with in any of the dimensions of burnout [EE $F(3,63)=1.47$, $p=.23$; DE $F(3,63)=2.49$, $p=.07$; PF $F(3,63)=1.76$, $p=.16$]. No differences were found according to the type of contract (full time or part time) [EE $KW=784$; DE $KW=734$; PF $KW=734$] or the number of work years [EE $F(3,63)=1.55$, $p=.21$; DE $F(3,63)=2.58$, $p=.06$; PF $F(3,63)=.64$, $p=.69$].

In the Greek sample, differences were observed in the *Personal Fulfilment* (PF) dimension [$Welch(3,16.08)=10.48$, $p<.001$]: professionals who work with people with ID present lower levels of CF ($M=40.8$, $DP=2.59$) when compared with those who work with both populations (ID and GV/DV) ($M=30.7$, $DP=6.08$, $p=.021$). No differences were found according to the type of contract (full time or part time) [EE $F(2,65)=1.31$, $p=.28$; DE $F(3,63)=1.67$, $p=.20$; PF $F(3,63)=.97$, $p=.39$] or the number of work years [EE $F(3,63)=.37$, $p=.76$; DE $F(3,63)=.90$, $p=.45$; PF $F(3,63)=.86$, $p=.47$]. This Burnout instrument was not included in Spanish survey

Figure 15 – Burnout – Portuguese sample

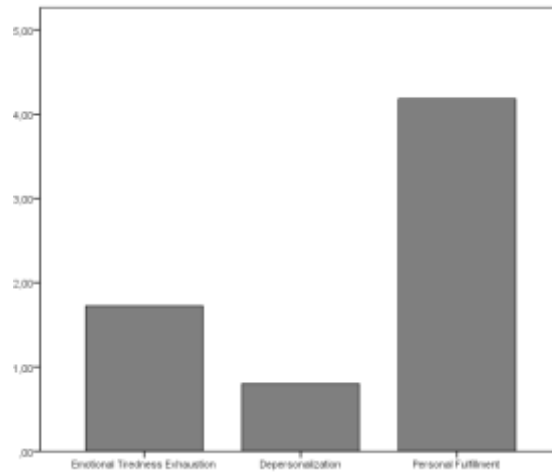
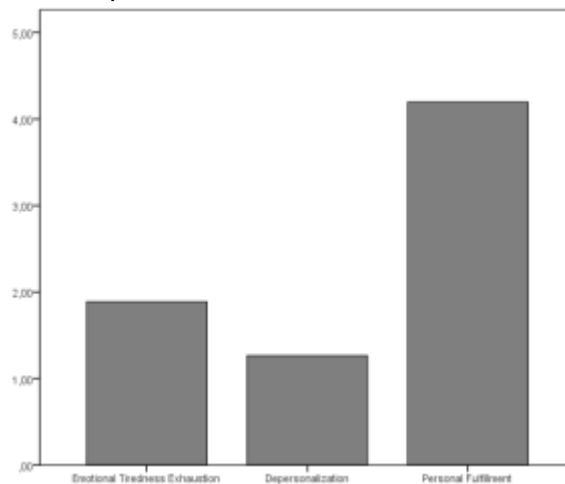


Figure 16 – Burnout – Greek sample



3.1.2 Analysis sheet for open answers in the questionnaire

Below sheet is a quantitative compilation of data organized in relevant categories. Three main categories each with the respective subcategories are as follows: support for victims (family and emotional support; accessibility and inclusion; specific services and monitoring; state's support), professional's aspirations (making a difference, salary and labour market, network, teamwork) and risk factors identified (workload, lack of specific training, lack of personal, specific tools and services, barriers, emotions and burnout, lack of available resources, infrastructure and bureaucracies, pandemic effects). These categories and subcategories represent the dimensions mostly mentioned by professionals and future professionals. For each category, a collection of quotes has also been selected to further corroborate and

justify the creation of those categories. All quotes are referenced by country, with the corresponding abbreviation between brackets (references used per country: GR – Greece | PT – Portugal | SP – Spain).

MAIN DIMENSIONS	TOPICS	RELEVANT EXAMPLES
SUPPORT FOR VICTIMS	Family and emotional support	<ul style="list-style-type: none"> • No progress has been made in the comprehensive treatment of victims with intellectual disabilities, prioritizing individual attention and neglecting attention to the caregiver context, especially the family, which is not seen as deserving of care (SP) • Help them feel loved, self-esteem, supportive social groups of peers who see that there are more like them and realize that what they are experiencing is mistreatment or abuse; they need people who make them understand that the bad guy is their abuser and not the one who is trying to help you (SP) • That more professionals are willing to help these people, that they find support at any time or when they need it most (SP) • More personalized attention to the resident «is needed» (SP) • More support is needed for family members of people with disabilities (PT) • Greater sensitivity and greater involvement of families in promoting the autonomy of «victims» (PT) • Support for the capacity for autonomy and individual rights as citizens (PT)
	Accessibility and inclusion	<ul style="list-style-type: none"> • (...) allowing young people with intellectual disabilities to participate in society both in education and in employment (PT) • Need to carry out close work with the community, in order to raise awareness of issues of diversity and inclusion (PT)
	Specific services and monitoring	<ul style="list-style-type: none"> • Need to have specific planning of the nursing care required by patients with intellectual disabilities. A Holistic approach, individualized care plans and action protocols in various situations (SP)
	State's support	<ul style="list-style-type: none"> • Mental health costs. There should be more state benefits and mostly better quality (GR) • There is a lack of state support to help the most vulnerable people (PT) • Greater budgetary allocation to increase resources to work with the disadvantaged population «is needed» (PT)
PROFESSIONALS' ASPIRATIONS	Making difference/Vocation	<ul style="list-style-type: none"> • I like what I do, and I'm happy to help (SP) • To help people and create an impact on their lives (SP) • (...)I am very willing to offer and do the best I can for these people (GR) • I am excited and willing to offer 100% of myself for the care, love and dignified living of these great children (GR) • «It is essential to have the» ability to make a difference in a challenging context and where culture and the lack of regulation, support and training is still scarce due to real needs (PT) • The most important thing is to have a vocation for work, in addition to having completed specific training programs for the field (SP)

	Salary and labour market	<ul style="list-style-type: none"> ▫ «a common quote» I need a higher salary (SP and GR) ▫ «there is» Non-compliance between salary with work requirements (GR) ▫ I observe that we are going through difficult times and there are not many opportunities (GR) ▫ Salaries compatible with the work performed «is essential» (PT)
	Network	<ul style="list-style-type: none"> ▫ Effective networking, increased resources and responses «is needed» (PT)
	Teamwork	<ul style="list-style-type: none"> ▫ Unfortunately, there is unsatisfactory support from partners (GR) ▫ (...)and less authoritarianism on the part of management (PT) ▫ I believe that sharing knowledge/information between professionals is essential (PT)
RISK FACTORS IDENTIFIED	Workload	<ul style="list-style-type: none"> ▫ «Professionals commonly have» difficulty in providing direct care due to the accumulation of tasks and emergencies (SP) ▫ We reject positions of greater responsibility for not being able to reconcile family life, something that men never reject because the woman is already in charge of everything (SP) ▫ Low economic recognition and high workload (SP) ▫ (...) colleagues are not sufficient for the volume and needs that exist (GR) ▫ Small teams with little capacity to respond to existing needs (PT) ▫ Need for rest as we live a lot due to users and their weaknesses and concerns (PT) ▫ In the public service, there is a need for more professionals in the field of psychology to be able to respond to so many cases that come to us (PT) ▫ The number of cases has increased exponentially, which also translates into a more significant burden on the professional who attends more and more urgently (PT) ▫ People are exploited in their jobs, and in most cases, they are unable to perform their duties well (PT)
	Lack of specific training	<ul style="list-style-type: none"> ▫ I believe that social care tasks with vulnerable groups (social work, social education, psychology) are not technically valued, believing that good intention and common sense are the only necessary tools. This does not promote the professionalization of these tasks, nor the training of professionals (SP) ▫ Training is essential in all fields. In this one in particular, one must know the legal framework as a protocol of action and know how to design projects adapted to each situation to allow this group at risk of social exclusion, to get ahead with dignity and all the existing social guarantees (SP) ▫ «It is essential to have» Gender perspective and work in a transversal way in education (SP) ▫ «professionals need more» training in treatment and development of people with disabilities and on mistreatment or abuse of any kind; Know the legal mechanisms, how to treat the affected person; Training in communication, psychosocial and legislative support; Greater knowledge about the treatment of people with disabilities and victims of violence and about the resources available to help (SP) ▫ I work at an internship level, so mainly empirical knowledge on how I can manage some situations immediately if they arise (GR) ▫ Need for specific training (in terms of increased vulnerabilities; legislation, procedures) (PT) ▫ I still don't have all the professional skills, which allow me to help victims of domestic violence for all their needs (PT) ▫ The basic training does not prepare me, in practice, for the development of empathic understanding (PT)

	Lack of personal, specific tools and services	<ul style="list-style-type: none"> ┆ Lack of communication tools, lack of sensitivity in society in general and in judicial and police bodies in particular, lack of forensic training and in the therapeutic work of trauma (SP) ┆ Lack of resources to meet the specific needs of the population we work with (SP) ┆ Little or no facility on the part of the competent resources and institutions to solve the problems faced by women in their intervention process (SP) ┆ Lack of knowledge on the part of other professionals, services and entities, both public and private, about the group and the services (SP) ┆ Lack of tools and aids to improve patient functionality (GR) ┆ The lack of social responses, which work reliably in quantity and quality (PT) ┆ Lack of logistical resources and support institutions (PT) ┆ In the exercise of my duties, there is an urgent need for logistical and human capacity to face the fulfilment of the mission (PT)
	Barriers, emotions and burnout	<ul style="list-style-type: none"> ┆ My inexperience, my youth when dealing with patients «are barriers» (SP) ┆ The economic benefits are valued more than the welfare of the users (SP) ┆ I need to develop more self-confidence but also more knowledge (GR) ┆ Due to lack of knowledge and experience, it isn't easy to accept me in a structure (GR) ┆ As I have been working in this area for 42 years, I feel tired; I think the institution where I work is needing young people with other skills to be admitted (...) (PT) ┆ The bosses do not put themselves in our role and do not see what our difficulties are: emotional, financial, physical, environmental (PT) ┆ Lack of superior support, misunderstanding by society or poor perception of my work, undue appreciation of the work developed, poor prospects for the future (PT) ┆ «I need to learn how» to separate personal and professional life (<i>take cases to home</i>) mainly in violent cases when the victims are killed or severely molested during the therapeutic course being able to outline that there are limits to performance and that there are things that are beyond our control (PT) ┆ I could see that the professionals are sometimes exhausted as the work with this population is emotionally demanding and because the professional is often the main support and support of the victim of violence (PT)
	Lack of available resources, infrastructure and bureaucracies	<ul style="list-style-type: none"> ┆ Internal communication by the administration is often scarce, non-existent or opposed, which blurs the procedure and hinders and slows down all processes (SP) ┆ Administrative barriers to request economic and social benefits from users (SP) ┆ There is no one to guide my course, the staff is incomplete, and the essentials are not provided to the patients (GR) ┆ «It is» difficulty connecting with government agencies and structures (GR) ┆ «There is a» lack of digitization, much bureaucracy (GR) ┆ Inadequate infrastructure, a chaotic legal framework (GR) ┆ Lack of human, material and financial resources that directly impact the intervention that is intended to be carried out (PT)
	Pandemic effects	<ul style="list-style-type: none"> ┆ Limiting interaction with families due to COVID, difficulty forming groups due to restrictions from COVID (GR) ┆ «It is important to» have the necessary means to facilitate communication with users since the pandemic is making interventions difficult (SP) ┆ We are currently working in the middle of a pandemic, so we are working remotely. It is, therefore, an anomalous situation. The absence of face-to-face contact with customers and companies, colleagues, superiors makes relations and their "interpretations" more fragile (PT) ┆ Increased work and difficult responses (PT) ┆ Difficulty in a more natural and close relationship with the people I support (PT) ┆ The tiredness and emotional exhaustion of the pandemic situation goes beyond other components of life, namely the way work is perceived (PT) ┆ The fact that I am more isolated, with little freedom to enjoy things that are important to me and that I am with significant people has influenced my psychologist status (PT) ┆ The problem with Covid19 is overwork (PT) ┆ (...) people with intellectual disabilities with more significant support needs, as well as their families, live moments of great difficulty and also because the current context favours an increase in situations of violence (PT)

		<ul style="list-style-type: none">The pandemic brought emotional maturity and more willingness to exercise in order to help people. Therefore, I conclude that the pandemic did not only bring negative things but came to teach us to be good professionals (PT)
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Given that the dimension regarding the risk factors seems to be the dimension most mentioned by the participants in the questionnaires, a word cloud was elaborated that refers to the frequency of the expressions most commonly mentioned. The purpose of this resource is to make visible the relevance that each of these aspects have in the responses given by the participants regarding the potential risk factors identified, highlighting its relevance for this report:

Figure 16 - Word cloud for risk factor identified in the questionnaires



3.2 Results of the focus groups:

3.2.1 Necessary knowledge for intervention in GBV-ID

l) In the field of intellectual disability

In terms of necessary knowledge in the field of ID, it was commonly agreed that there are five major dimensions in need of significant deepening: degrees of disability, sexuality, validate a voice, infantilization, intersectionality and interdisciplinarity.

For starters, in regards to intervention, it is imperative to consider that there is a gap in the available information concerning the outcomes of the existing types and **degrees of disability**. The most known types of disability are: I) visual, II) mental, III) auditive, and IV) motive disability. While the most known degrees of disability vary between mild, moderate and severe. The difficulty arises when it becomes necessary to discern and to explain the repercussions that different degrees of intellectual disability have in the disabled individual to intercept and interpret an outcome. According to the collected data, it was significantly emphasized that it is a challenge to understand what mild, moderate and severe stands for in the framework of disability, not only in terms of what can be expected as a behaviour, but also in regards to the impact it has on the person with ID and his/hers caregivers. This lack of knowledge/training has been pointed out by professionals, by caregivers and by people with ID also, as a barrier for providing more adequate support to victims of GBV, in particular for people with ID. It allows interveners from having a better understanding of the victims' real condition, even though there was agreement on the similarities among the feelings of the victims (shame, fear, blame...) despite the fact that they have ID or not. The training on these subjects ought to start early in academic life, especially, social work, psychology, nursery and other academic degrees that are oriented to the possibility to provide services to people with ID. And it shouldn't stop there. This training ought to be continuous and updated accordingly.

Some relevant quotes from the focus groups bring light on this topic:

P4 [Technician for victim support within the Public Prosecution, FG Professionals, Portugal] - *“Qualification must also be oriented towards the development of the attendance services. Aside from the ongoing training of professionals, I feel that we need to adapt or create tools and instruments that provide support to all professionals who come face-to-face with such vulnerabilities. The RVD does not consider certain risk factors that are essential in these cases.”*

P3 [Police Officer, FG Professionals, Portugal] – *“I think that instruments and legislation are very good. The problem is that, despite their existence, it is needed that the medical staff gain awareness of its existence and on how to use them. There is a set of constraints in the field that do not correspond to what one has in terms of legislation and instruments. Training, training, training is needed! There are many projects that are stagnated due to the lack of investment. I believe that all actors who partake in the intervention towards these victims ought to have training to do so.”*

P6 [Worker of a support unit to persons with intellectual disabilities victims of violence, FG Professionals, Spain] - *“The very first step is the creation of a security context for María. The professionals must feel María always secure, heard and never judged. Sometimes the women with intellectual disability cannot understand what is GBV. If Maria doesn't show important injuries she wouldn't see herself as a victim. Identifying psychological mistreatment is difficult.”*

P2 [Manager of an association provider of integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“At the hospital they need to adapt their resources. Only a card with a telephone number is not enough. Maria needs support, emotional support. At least it is going to be Maria, the one who decides if he demands it or not, but we cannot leave her alone. Especially now when she is annulled by her boyfriend. Again a good formation about how the persons with intellectual disabilities are very important. Without this knowledge we cannot achieve good communication with her. Her comfort area is the mistreatment. For her to be so difficult to escape from that, we need to understand how a person with intellectual disability Works in order to explain very well what is going to happen.”*

P1 [First degree relative of women with ID, FG Informal Caregivers, Spain] - *“I think that prior to reporting to the police, the first step would be the intervention of a psychologist and a social worker because if it is reported to the police before the woman has reached awareness of the situation, the success of the intervention is more difficult. In my experience with people with ID, it is very difficult for them to be aware that they are being dominated by others.”*

P1 [Professional in a Mental Health structure, FG Professionals, Greece] - *“Depends on the degree of disability, health and the general case of Maria.” The therapist / specialist must have knowledge of mental disabilities, knowledge of the abuse and in particular of women with disabilities, empathy, communication skills, the ability to set limits.”*

Following the degrees of disability, **sexuality** was also a well discussed topic, but curiously enough, only amongst informal caregivers (in particular, close relatives),

as their need to explore such topics becomes an urgent matter. As per the collected data, medical and institutional support seem to fail in providing the means for informal caregivers to approach information regarding intimacy and the impact of sexual growth with people with ID, whilst professional caregivers do not approach them at all. Nevertheless, the possibility that the professionals themselves do not have the knowledge to provide this kind of support and to cope with it has also arisen. On the other hand, there are cases when parents as caregivers of a child presenting a certain degree of disability have a tendency to somewhat see them as not having sexual needs or as having a lack of it, therefore, depriving them from having access to further explanation on what they are experiencing and on what is happening to their physical and emotional bodies. Women with ID who are fully capable of experiencing motherhood and actually having that desire, have been submitted to tubal ligation, in some cases, without their knowledge or consent, upon the order of their parents/legal guardians. Hence the reason why informal caregivers parenting children with ID who are more aware of the consequences of the deprivation of this knowledge and who want to provide a better quality of life to their children, experience the need to search world-wide to find further support on how to act towards sexual subjects. Some relevant quotes from the focus groups bring light on this topic:

P1 [Retired teacher with an adult daughter with ID, FG Informal Caregivers, Portugal] – *“In terms of sexuality, there is still a long path to be done and, as P2 said, people are not comfortable to do it. (...) How to react to topics such as these (masturbation)? Repress it? It is difficult to make them understand that this is normal. (...) The professional speaks conservatively about it. (...) There is no possibility to speak to parents about this subject. (...) There is no opening to speak about it. (...) Something has improved, yes, but there is still a long way to be done.”*

P1 [Retired teacher with an adult daughter with ID, FG Informal Caregivers, Portugal] – *“Parents have difficulty in understanding, or in accepting, that these women (with ID) have their sexual and affective life. (...) Parents must understand that these people have the right to their sexual and affective life. They have rights, like everyone else. It is necessary yes to be careful and yes, if not the family, then, it should be the community to intervene.”*

The need to **validate a voice** or to have a **voice facilitator**. The presence of some degree of ID is often associated with the inability to provide a valid speech and arguments. Such limited beliefs lead to the fact that people with ID are not seen in

terms of the credibility of their speech, they are seen as “not having a voice”. This condition stands up as a barrier for all kinds of interveners as some of them find themselves entrenched in these same beliefs, with or without their awareness of it and, when providing support to this vulnerable group, these interveners fail to understand the vulnerable group’s real needs, their perception of the situation and, consequently, the most adequate means of support to be offered. When it comes to GBV, if the victims addedly carry some kind of disability, their voice loses even more power. In most cases, the victims are not even aware of what they have been victims of and the fact that their voice has no validity stands for an even higher barrier.

Also, there are cases where it is common to find people with ID who have a legal guardian to speak up for them - a voice facilitator. In cases of GBV, for example, it can be highly beneficial for the person with ID to be able to rely on this voice facilitator who can stand up for him/her, defend him/her and his/her rights. The voice facilitator can emerge in the form of a person (family member or not) or an institution. Unfortunately, situations have been reported where the voice facilitator (person or institutional collaborators) has also become the offender, hence the need to deepen and to root the validity of the person with ID. Understanding and validating their voice is the only tool available for prevention. There is a need to tear down these beliefs and to raise awareness on how limiting they are. Early (and continuous) training on communication towards people experiencing different degrees of disability would be a major achievement in surpassing this barrier, consequently, it would allow professionals to better understand and reach people with ID who find themselves in cases of GBV. A more specialized service or a hotline was also proposed as an alternative to bridge this need as it would enable access to quicker and adequate information/resources and services.

Some relevant quotes from the focus groups bring light on this topic:

P1 [Director of an institution specialized in providing support to people with intellectual deficiency, FG Professionals, Portugal] – *“We have to know to evaluate the skills that a person with ID has to make their own decisions.”*

P3 [Professional of a Mental Health structure, FG Professionals, Greece] - *“Mediation by a social worker to a more specialized service or hotline to get in touch with other women who are experiencing violence and are in a phase of dealing with it.”*

P2 [Professional of a Mental Health structure, FG Professionals, Greece] - *“Individual responsibility, the awareness that something is happening, to contact a telephone helpline. Can she perceive that there is violence?”*

P1 [Student/Internship Psychologist in an Integrated Masters in Psychology, FG Young Professionals, Portugal] - *“Dark bruises, discussions, control. And the fact that she thinks that that was for her own good, maybe we could explore here the consequences of the aggressions that may result if the situation escalates, clarifying what eventually is healthy and what isn’t.”*

P4 [Student in an Integrated Masters in Criminology, FG Young Professionals, Portugal] - *“As professionals, we have the responsibility to try and understand the degree of risk that she is exposed to, and understand up until which level is she or is she not at risk of a greater threat.”*

P2 [Professionals of Mental Health structures, FG Professional Caregivers, Portugal] – *“Believing them, the fact that they have a voice, having someone who will defend them... We stand up for them and we get them to speak, we provide support, but even so, there is some fragility when questions such as “but she is intellectually disabled”; “but does she not want this?” arise. I think it is needed to raise the awareness of these people since they are people like everyone else.”*

P5 [Newly graduated psychologist, FG Young Professionals, Portugal]- (spontaneously) *“It is always important to involve the family in the process mainly because we are facing a situation where there is an intellectual deficit because the individual intervention may not suffice.”*

P3 [Intern on a NGO that provides support to victims, FG Young Professionals, Portugal] - *“It is not because she has a deficiency that she has no credibility.”*

P1 [Student/Internship Psychologist in an Integrated Masters in Psychology, FG Young Professionals, Portugal] - *“The speech of victims with ID is very discredited, especially in cases of domestic violence.”*

P1 [Lawyer specialist in GBV against persons with intellectual disabilities, FG Professionals, Spain] - *“When we need to act or when to respect the freedom of the people. The intellectual disability many times is the fact that determines our decision, but is that a good thing? Are we taking into account the rights of the persons with disability? Seek the natural support of Maria is a key to success. Delivering training to Maria in conflict resolutions and assertivity will help.”*

P3 [Psychologist of an association provider of integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“The situation becomes harder when the victim, instead of a family, has legal guardians. Sometimes the legal guardians are an institution and it's difficult to find a good intercommunicator. Without family it's difficult to reach a balance between intervention and invasion with victims. Identifying the professionals who are references to Maria is also important, they are those who can better help and support María right now.”*

P4 [Psychologist of an association which provides integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“Empowering and training the victim is important. Linking Maria with a professional is difficult but essential in this stage. Give spaces to Maria to talk and register everything. The more we register the more we can anticípate. The professionals of the Especial Employment Center need more training.”*

P2 [First degree relatives of women with ID, FG Informal Caregivers, Spain] - *“If the person is independent and is not legally incapacitated, there would be a problem because we could do something but with limitations. In that case, she should be helped to understand the situation.”*

P3 [Professionals of a Mental Health structure, FG Professionals, Greece] - *“The therapist / specialist must have knowledge of mental disabilities, knowledge of the abuse and in particular of women with disabilities, empathy, communication skills, the ability to set limits.”*

It is commonly observed that people with ID are approached and addressed in an infantile way. This **infantilization** is noticed from close relatives and formal and informal caregivers, and it is often presented as a means of showing affection. The question is that these high levels of affection and overprotection expressed via infantile expressions could end up, to a certain degree, stealing the autonomy of people with ID, even in cases of very low levels of ID. The family has been pointed out as having a major role in setting the example of tearing down stereotypes and raising the value of people with ID as the human beings that they are, instead of approaching them with a “childlike attitude”. Professionals ought to be trained in terms of educational tools for parents of children with ID, since the moment these parents are informed about the existence of a disability in their children (a significant lack of support was also experienced by parents when they are informed about the existence of a disability from the medical group). There is a need to fuel parenthood when it comes to ID in order to

start prevention early on, to offer these children a sense of autonomy (as much as it can be reached), to teach them to express themselves and to stand up for themselves in whichever areas they feel the need to do so, instead of being approached as disabled. Such educational tools should be provided to professionals of the social and medical field (preferably) in early stages of their academic life. Participants whose field of activity is not directly related to people with ID mentioned repeatedly that one of the major difficulties they need to deal with is the lack of understanding and lack of specific education on intellectual and developmental disabilities, this lack of knowledge causes reticence in professionals to deal with people with ID, perhaps, hence the reason why these professionals tend to approach people with ID in such infantile ways. Professionals argue that, due to this need of training and understanding, professionals are worried about causing psychological harm in people with ID and are also concerned about not being able to do their job properly. Additionally, professionals tend to feel rejection towards people with ID who have behaviour problems and this attitude could be strongly related to the lack of training and information. Some relevant quotes from the focus groups bring light on this topic:

P3 [Social assistant, mother of a young boy with trisomy 21, FG Informal Caregivers, Portugal] – *“What is missing? For me, as a mother, I need everything and all the information I can get. I devour everything I find. But there are no group of parents. It is necessary, for example, information about educational strategies for children with ID. (...) The topic of the body parts, for example, is something that needs to be explored. For me, this is a challenge. (...) The fact that, when he grew up, he had contact with people with ID, (...) and that sexuality exists. They deserve to be happy. (...) The fact that some people address them by “little boys”, I think it is, in a way, denying them the adult condition in which they find themselves. But to reach 14 years and for him to get to this phase of his life, we have to prepare him (...) to what is adequate, to his body parts, to relationships, man-woman, man-man, whatever. (...) This is a path that must be prepared early on. (...) And indeed, there is no information in this sense.”*

P3 [Social assistant, mother of a young boy with trisomy 21, FG Informal Caregivers, Portugal] – *“I was thinking about mistreatment, bullying and what concerns professional dimensions. If the integration of the person with ID is not properly done, focused on respect (loss of sound). This is something I worry about a lot. (...) And about addressing them as “little boys”, I witnessed an episode in an interview, a colleague that went to speak with a person with*

trisomy 21 that has a very strong personality. And the colleague asked: “Hello xx. I will address you by you (instead of Ms., Mrs). Is that ok?” And xx replies: “more or less”. And I thought that was fantastic. It was really well said. Because there are many cases where people with ID are addressed differently.”

P5 [Mother of a young girl with trisomy 21, FG Informal Caregivers, Portugal] – *“When our child is diagnosed with the condition of ID, nobody provides support. There is no psychological support. In my case, I had help but many parents don’t. And I think that acceptance is key. There are cases where there is no acceptance.”*

The existing societies, regardless of how developed they are, still experience social inequalities to some extent, and these inequalities often intersect. The **intersectionality and interdisciplinarity** is also observed among people with ID, moreover, when they are victims of GBV. Here, we have to consider all the factors that bring about the inequalities they are facing. Firstly, there is a massive discrepancy in the amounts charged by institutions specifically oriented for people with ID. The existing services do not consider the different socioeconomic background of the families who seek support. ID does not have a race, gender, age, religion. In most cases, families cannot afford to pay such highly qualified support provided only in institutions and this makes it difficult to have access to these services. Additionally, the existing governmental subsidies represent a very small amount in proportion to the real expenses. The information available also does not suffice for relatives to assume the position of a caregiver, hence the reason why (some of them) reckon the lack of training. In most cases, the informal caregiver believes himself/herself to be doing their best and could still be harming the care receiver. In other cases, the caregiver willingly harms the care receiver. This being said, connecting professionals of different areas to offer good training to others could be a feasible solution to bridge this gap. Alternatively or complementary, a common protocol and a common language baseline shared between all the institutions and professional profiles involved in the intervention with victims with intellectual disabilities. The collected data shows this as essential, along with reaching a common terminology. It is obvious that the support givers are in need of training, of a judicial terminology and that the police also need psychology terms to operate in.

Some relevant quotes from the focus groups bring light on this topic:

P5 [Mother of a young girl with trisomy 21, FG Informal Caregivers, Portugal] - *“In terms of support, there is a bonus of 63€ and an allowance of 120€. (...) Many times, things can be worked on in advance and I think prevention can be done.”*

P3 [Members of a police force specialized in GBV and DV Integrated Masters in Criminology, FG Professionals, Spain] – *“We’ve identified an error in the protocol. The health personnel must advise the police units when they know about a GBV case, never let her with the alleged abuser. We need more formation about the legal process that happens in a GBV case.”*

P1 [Municipal Police, FG Professionals, Spain] - *“The professionals need skills on empathy and dialogue, how to create a safe environment. Language skills are essential now.”*

P2 [First degree relatives of a women with ID, FG Informal Caregivers, Spain] - *“I would like to be informed about the institutions or resources of help where we could go. There is a lack of information and alternatives. I would like that reporting weren’t the only option, I’d like to be helped and informed.”*

P6 [National police inspector, FG Professionals, Spain] - *“We collect information, because it is difficult to obtain testimony, that must be done in the last instance, if you have sufficient information. First, medical information or any specialist and know how you can help that person, especially with more serious disabilities. In cases of mild disabilities, although it is easier to speak with them, they usually need support even though they have that verbal ability to express themselves, to sequence, the interviewer has to catch up with them and facilitate the way of entry, putting yourself at their level, which is the hardest thing to get used to. People who are not used to intervening with people with ID are suspicious and afraid to face it. I have detected that it is something that is learned, it requires an effort.”*

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“Professionals must be prepared. Training is important. Working at the family level is also necessary, with the support of the rest of the professionals as supervisors.”*

P1 [Young Professionals, FG Young Professionals, Greece] - *“Perhaps home visits to verify the couple's interaction. Probably a consultant for both of them.”*

P3 [Social assistant, mother of a young boy with trisomy 21, FG Informal Caregivers, Portugal] - *“From the medical point of view, there is a protocol where I was able to see if the monitoring was being properly made. But, from the parent’s stand point, there is no monitoring.”*

P2 [Representative of an ONG, retired doctor with an adult daughter with autism and other disabilities (decrease of eyesight and hearing, FG Informal Caregivers, Portugal] - *“It shocked me when we went to report a case to the police, where the agent would state that the person with ID was to blame. (...) It is very important that the police officers are prepared to deal with this. (...) Being told to: “look after her. If she is insinuating herself...”*

P3 [Professionals of Mental Health structures, FG Professional Caregivers, Portugal] – *“It is not about being a man or a woman, it is about the way people place themselves in relationships. Control becomes dominance and emptying the other. People with ID still have less instruments and skills to think and reflect about the matter. I think that there are no miracles, there are no fixed interventions that solve the matter at once, there are indeed certain situations that do alleviate a little...therefore, all our intervention will always be basic in which we focus primarily on the self-esteem of women so they have voice and control of the situation. We don’t know if Maria has a family network where she can find support, what is her capacity to financially socially support herself... Is there an instance to which she can go to? We need to know all this in order to give her “power” (to act in this situation).”*

II) In the field of victimisation under GBV

A number of participants agreed that women with ID are more prone to experience some type of violence. To complement their testimony and work experience, we did some research on this topic. Women with ID are more vulnerable to suffer **gender-based violence**, as well as **domestic violence** (Barger, Wacker, Macy, & Parish, 2009; Pestka & Wendt, 2014; Douglas & Harpur, 2016). Researchers argued that this vulnerable group are especially under **increased risk** for **sexual violence** (Plummer & Findley, 2012; Bowen & Swift, 2019) and this risk can be four times higher compared to non-disabled women (Martin et al., 2006). Despite that, data related to the risk factors for abuse is scarce.

Adapting the classification proposed by Brownridge (2006), there are three main categories according to which the risk factors can be gathered, and for each category, the author lists the main risk factors associated: category 1) *Intimate partner violence, including relationship factors* (e.g. direct dependence associated to the severity of disability and duration of the relationship); category 2) *The characteristics of the cycle(s) of abuse* (e.g. socioeconomic status, age, power and control); category 3) *Perpetrator control strategies*. Additional to the Brownridge (2006) proposition, an

extra category of risk factors can be mentioned, and it is the category 4) *Society-related characteristics*. This category encompasses the specific social constructions and social representations about women with ID and about GBV in a particular society and the potential interaction between those factors that may increase the victimisation risk for women with ID. Some society-related factors are, for example, the stigmatisation and stereotypes. Disabled women are invisible, undervalued and often labelled as an undesirable and asexual person (Foster & Sandel, 2010), or as someone who is unable to understand and to give or withdraw consent in intimate relationships. The economic oppression (or disadvantage) is another risk factor related to the status of disabled women in the society, namely in the labour market since disabled women have been historically marginalised from participating actively in these contexts (Mays, 2006).

Through semi-structured interviews with women with ID, Taggart, McMillan and Lawson pointed that there are three potential risk factors for abuse identified by the participants in the study: “‘being female and having an intellectual disability’, ‘not feeling like a woman and wanting a family’ and experiencing a range of ‘negative life events’” (2009, p. 327). In a qualitative study conducted by Pestka and Wendt (2014), the authors found that the search for belonging is a significant factor which keeps women with ID in abusive relationships. Some women both with or without ID believe in romantic love and are affected by its rules, and under what society define as the women’s role in this world, they “fight very hard to conform to the ascriptions that give women value, and possibly settle with or accept abuse in their lives to gain social value that has often been missing throughout their life course” (Pestka & Wendt, 2014, p. 1042).

Risk assessment plays a significant role in the screening of risk. We reckon that. Nevertheless, it is important to bear in mind that these instruments were not sought out to people with ID and are, therefore, inadequate for them. The **inadequacy of instruments for people with ID** has been a challenge and, consequently, it has emerged as a need for professionals to seek adequate instruments to rely on. Upon such facts and results, it is imperative to work not only within this dimension but also beyond risk assessment. Without putting aside the importance of risk assessment tools, violence ought to be more than the product of a quantitative instrument. A more

systematic and inclusive approach should be considered in order to bridge the existing gap within the different fields of expertise and reduce intersectionality.

Each case ought to be thought individually, be it in regards to intervention, be it in regards to approach, as this would allow professionals to better **identify signs amongst children, adolescents and adults**. Since the experience of victimization varies amongst these subgroups of people with ID, this represents a different type of demand in regards to intervention, hence the reason why adequate instruments would enable those professionals to retrieve a more real diagnosis as a complement to their intervention, and more real interpretations of the emitted signs.

In terms of **consequences of GBV**, the phenomena of victimization of women with ID goes beyond the physical act. It represents both the devaluation and the social subjugation of women as victims of a social stigma that is embedded in their gender and in their disability. Consequences of GBV towards people with ID have a shadow side attached to it. This happens because, in some cases, people with ID are not aware of the circumstances of victimization that they are under. This lack of awareness from their end does not prevent them from victimization, in fact, it could be the reason why they are four times more prone to GBV (Martin et al., 2006). On the other hand, families often tend to experience feelings of helplessness when realizing that their sons/daughters (regardless of their age) were victims of GBV and were not able to stand up for themselves and/or share it with their parents because they themselves were aware of it. GBV towards people with ID leaves its sores on them, as victims, and on their caregivers, as indirect victims. This raises the question on how extended their autonomy should be and on how far their levels of independence should go, hence the reason why it is a **priority to intervene towards protection, security and recovery**. Investing in a more preventive oriented intervention could significantly set the stage for lowering the odds of GBV towards people with ID. With preventive intervention, training was also significantly highlighted: training of professionals, of interveners and the family as well. There is a need for the families of women with ID who suffer GBV to be supported by specialised professionals and be advised on what to do. There should be a very close coordination among professionals and the family, without breaching victim's rights. Some relevant quotes from the focus groups bring light on these topics:

P3 [Psychologist of an association provider of integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“To train the persons with intellectual disability on what is GBV is always a good intervention and a good way to prevent IT.”*

P1 [Professionals who work in mental health structures, FG Professional Caregivers, Greece] - *“Mary should know what abuse is. Social skills, too.”*

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“As a teacher, I believe that we have a lack of training in communication skills. Situations like make professionals feel tense due to ignorance, and that tension prevents them from communicating properly with the person with ID, to create confidence and security for the victim. We lack training.”*

P3 [Professionals who work in mental health structures, FG Professional Caregivers, Portugal] - *“I think that the intervention ought to start in childhood. To enable people with ID is more complicated because they have some difficulty in being proactive and autonomous, of course that this will result in a relationship of dependency with the other. Our intervention in terms of community would undergo through education, awareness of all women as mothers and educators.”*

P3 [Police Officer, FG Professionals, Portugal] - *“This idea that we must wait for the victim to manifest himself/herself is overrated. This is a public crime. (...) assessing the condition of “ID” is always in a second stage when the victims are conveyed to a more specialized service.”*

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“Informing the victims about the resources available and about their rights is fundamental. One step that cannot fail is protection resources, these cannot be unsuccessful due to the difficulty that exists with these people with ID. Resources must be effective.”*

P4 [Technician for victim support within the Public Prosecution] - *“The need for more specific tools, it is necessary to also adopt support structures with multidisciplinary teams, mainly in the so called first line services. The police seem to have more difficulties in having multidisciplinary teams.”*

P6 [National police inspector, FG Professionals, Spain] - *“We must have a series of skills that can be trained and learnt and it is important to know the limits. This work is multidisciplinary and we should complement each other. We must also avoid victimization, minimizing the processes necessary to collect the necessary information. And it is important not to give false hope to the victims, you cannot promise to take a person to jail. Training is essential as important is knowing what should be done and what should be avoided.”*

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“Professionals must be prepared. Training is important. Working at the family level is also necessary, with the support of the rest of the professionals as supervisors.”*

P6 [National police inspector, FG Professionals, Spain] - *“The very first step is the creation of a security context for María. The professionals must feel María always secure, heard and never judged. Sometimes the women with intellectual disability cannot understand what is GBV. If Maria doesn't show important injuries she wouldn't see herself as a victim. Identifying psychological mistreatment is difficult.”*

P3 [Professionals, FG Professionals, Spain] - *“María needs to see herself as a victim. And that is going to take time and work.”*

P2 [Professionals, FG Professionals, Spain] - *“It's important to know exactly what are the changes in María's behaviour. Sometimes the professionals of support employment couldn't help Maria because of the lack of formation that they have about GBV. So it's important to explore the support net of Maria: their Friends and family. The main goal now is obtain information about why and how María is changing. Is going to be difficult for Maria to identify their own changes and feelings.”*

P1 [First degree relative of intellectually disable women, FG Informal Caregivers, Spain] - *“Sanitary professionals should be taught how to deal with people with ID. We, as relatives, suffer very much the lack of knowledge and understanding about ID in, for instance, ER. There should be specific guidelines to help people with ID in health care.”*

P2 [First degree relative of intellectually disable women, FG Informal Caregivers, Spain] - *“I would like to be informed about the institutions or resources of help where we could go. There is a lack of information and alternatives. I would like that reporting weren't the only option, I'd like to be helped and informed.”*

3.2.2. Necessary **skills** for intervention with victims with intellectual disabilities

Intervention with victims of violence demands certain important personal and professional skills. This demand is even more evident when the intervention is carried out with specific groups whose special needs require greater sensitivity and care from professionals. At first, a much-needed **relationship of trust with victims and their**

families has to be built. This relationship of trust is challenging when it comes to victims with intellectual disabilities, due to some limitations that professionals might be facing during the attempts to establish communication. In this way, it is not uncommon for professionals to deal with the victims' family members, and this kind of triangular relationship can be even more challenging to manage - even though the family cooperation can be decisive to effectively protect victims with ID. On the other hand, as previously mentioned, some professionals referred to the lack of autonomy of these victims and the excessive *paternalism* regarding their self-determination can be a barrier that, in some situations, compromises their professional performance, negatively interfering in communication and in building the trust relationship. **Empathy** was also referred to as an important key to improve the communication and to reach the victim's and their family's trust. Some relevant quotes from the focus groups bring light on this topic:

P2 [Psychologist of an association provider of integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“Linking up the victim with a disability is the only way to respect self-determination. Only through a good link, we are going to achieve good communication, and we can prevent GBV situations. Avoiding paternalism, we need to explain to «the victim» the current situation.”*

P4 [Psychologist of an association provider of integral support to persons with intellectual disabilities, FG Professionals, Spain] - *“The professionals need skills on empathy and dialogue, how to create a safe environment. Language skills are essential now.”*

P6 [Worker of a support unit to persons with intellectual disabilities victims of violence, FG Professionals, Spain] - *“The very first step is the creation of a security context for María.”*

P1 [Municipal Police, FG Professionals, Spain] - *“(…) Keep contact with María in all moments, maintain her trust in us.”*

P3 [Members of a police force specialized in GBV and DV Integrated Masters in Criminology, FG Professionals, Spain] - *“If a demand is going to happen, we need the collaboration of María's family. They are going to be her best support, so a good intervention needs the collaboration of María's family.”*

More than giving attention to the victim, it is important to **actively listen** to her as well as to **validate their experiences**. In this way, professionals need to be

prepared to recognise that everyone can be a victim of DV or GBV and to deal with this particular vulnerable group in order to empower them and ensure their safety:

P1 [Municipal Police, FG Professionals, Spain] - *“The first step is to empower María as a possible victim of GBV. The more we empower María, the best protection she will have (...).”*

P6 [Worker of a support unit to persons with intellectual disabilities victims of violence, FG Professionals, Spain] - *“The professionals must «ensure that» María always feels secure, heard and never judged. Sometimes the women with intellectual disability cannot understand what is GBV. If Maria doesn't show important injuries she wouldn't see herself as a victim. Identifying psychological mistreatment is difficult.”*

To effectively protect victims with ID, it is also important to **deconstruct prejudices, stereotypes and taboos**. People with intellectual disabilities are commonly seen by society as “limited people”, unable to manage their lives or maintain a family or a loving relationship. There is an excess of infantilization and what raises certain taboos for both the professional who needs to deal with this vulnerable group and families. It is essential that, in professional activity, professionals have the ability to overcome these conceptions and barriers in order to be able to see people with ID as with a full right of protection and life and provide them and their families with adequate support, especially in situations of crisis and violence.

P1 [Lawyer specialist in GBV against persons with ID, FG Professional Caregivers, Spain] - *“The intellectual disability many times is the fact that determine our decision, but is that a good thing? Are we taking into account the rights of the persons with disability?”*

P1 [Director of an institution specialized in providing support to people with ID, FG Professionals, Portugal] - *“As a citizen, he/she has the right to access all available institutional support”.*

P3 [Professional Caregiver, Portugal] - *“Family see people with ID as incompetent, as less capable and that need to be protected to the maximum extent. With this attitude, they steal their autonomy from them and also their voice.”*

P2 [Technician for victim support, FG Professionals, Portugal] - *“Only an inclusive way of thinking allows us to gain conscience of the existence of paternalism and maternalism behaviours towards people with ID”.*

P3 [Professional caregiver, Portugal] - *“(...) we focus primarily on the self-esteem of women so they have voice and control of the situation”.*

P2 [Professional Caregiver, Portugal] - *“We stand up for them and we get them to speak, we provide support, but even so, there is some fragility when questions such as “but she is intellectually disabled”; “but does she not want this?” arise. I think it is needed to raise the awareness of these people since they are people like everyone else.”*

The support for women with ID and victims of gender-based violence or domestic violence also requires that professionals have skills in recognizing this intersectionality. **Intersectionality** is a concept first used in 1989 by Kimberle Crenshaw when advocating for black women’s rights. In this Project's context, the concept can be extended to understand the intersection and necessary interaction between gender and intellectual disability of women. Although violence against women is a cross-cutting phenomenon, its effects are not felt by all people in the same way. In this sense, women with ID also add increased vulnerabilities due to the type and degree of their disability. Professionals must be able to recognize this intersectionality and act following this understanding. During the focused discussion groups, this need was widely debated since, sometimes, and due to each training area's specificities, many professionals feel unprepared to deal with these situations in their daily lives, so the need for **specific training** was a unanimous demand:

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“Professionals must be prepared. Training is important. Working at the family level is also necessary, with the support of the rest of the professionals as supervisors.”*

P4 [FG Professionals, Spain] - *“Empower and training the victim is important. (...) The professionals of «special centers» need more training.”*

P3 [Social assistant, mother of a young boy with trisomy 21, FG Caregivers, Portugal] - *“All technicians that work in this field already have the information and the competences they need on how to proceed but, afterwards, on their everyday work, many aspects fail in their procedures”.*

P2 [Professional Caregiver, FG professional caregivers, Portugal] - *“This kind of training is necessary for people who work in institutions and care homes. Whenever a new coworker joins the staff, it is necessary for him/her to have*

specific training and to be made aware. But I think there is still a long way to go.”

P1 [Nurse with a management position in the official nursing association, FG Professionals, Spain] - *“The basic academic training is not enough. Additional training helps you understand others and to emotionally connect with them. You need to train much more.”*

Due to the specificity of this group, another claim made by professionals is the development of **specific responses and protocols** to support in cases of violence against people with ID. Risk assessment instruments as well as protocols of action are not sufficient to address the needs of people with ID. According to professionals and caregivers, the absence of these resources together with the absence of specific training makes it impossible to intervene more directly and efficiently.

P7 [FG professionals, Spain] - *“People with ID should have more specific resources. It is necessary to provide more resources at the institutional level”.*

P4 [Technician for victim support within the Public Prosecution, FG professionals, Portugal] - *“The need for more specific tools (...)”.*

P4 [University professor of the Social Work Faculty, FG professionals, Spain] - *“Informing the victims about the resources available and about their rights is fundamental. One step that cannot fail is protection resources, these cannot be unsuccessful due to the difficulty that exists with these people with ID. Resources must be effective”.*

P4 [Technician for victim support within the Public Prosecution, FG professionals, Portugal] - *“Qualification must also be oriented towards the development of the attendance services. (...), I feel that we need to adapt or create tools and instruments that provide support to all professionals who come face-to-face with such vulnerabilities. The RVD «risk assessment tool» does not consider certain risk factors that are essential in these cases”.*

P2 [Public prosecutor, FG professionals, Spain] - *“From the professional point of view, I think we need the right tools to deal with these issues”.*

P3 – [FG professionals, Spain] - *“(…) María needs protection. They must have adapted material for persons with intellectual disability”.*

Given this complexity and absence of specific instruments and protocols, sometimes professionals face the need to act **beyond the protocol**. They seek

alternatives that can respond to the victims' needs, even if these alternatives are not adequately formally defined. This need for adaptation of professionals and services is a reality transversal to all partner countries. Besides, **networking and interdisciplinarity** are useful tools to ensure that assisted people receive multidisciplinary support, namely regarding the police activities. And this network that enhances the results of the intervention, as observed by the participants:

P6 [National police inspector, FG professionals, Spain] - *“(...)This work is multidisciplinary and we should complement each other.”*

P4 [Technician for victim support within the Public Prosecution, FG professionals, Portugal] - *“(…), it is necessary to also adopt support structures with multidisciplinary teams, mainly in the so called ‘first line’ services”.*

P4 [FG professionals, Spain] - *“Now it's time for the police forces. Offering and maintaining a relationship with a psychologist is going to be a good idea.”*

Another important dimension of care for victims of gender-based violence and domestic violence with ID is the **human and emotional aspects of professionals and caregivers** working in these areas. Whether it is the absence of instruments, adequate resources, or dissatisfaction with remuneration and the labour market, or even the overload of tasks, caregivers and professionals' mental health is an essential factor that impacts their performance in crisis situations. It was observed, especially during the pandemic, a sharpening of emotional problems and work overload of some crucial sectors of the economy directly impacted by the effects of confinement and suspension of face-to-face activities. In this sense, **emotional exhaustion and burnout** are commonly referred by professionals and caregivers as a significant risk factor, which has been, to some extent, despised by superiors and administrative decision-makers. A recent study on the effect of the COVID- 19 pandemic on the mental health of carers of people with ID shows that “despite their greater mental health needs, carers of those with intellectual disability received less social support from a variety of sources” (Willner et al., 2020).

3.2.3. Ethical considerations

In regards to ID and to violence (DV, GD, SV), both professionals and caregivers are in danger of crossing the ethical border. It is necessary that ethical considerations are also included in the training agenda, be it in terms of primary prevention (walking towards acceptance and inclusion of differences from an early age), and be it in terms of professional training. According to the American Psychology Association - Ethical Principles of Psychologists and Code of Conduct¹, Psychologists work under the premises of **five ethical principles**: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice and respect for people's rights and dignity. To what concerns the ethical premise of respect for people's rights and dignity, it has been easily found as violated in regards to people with ID, whether we are referring to professionals or caregivers.

Moreover, considering the ethical intervention with victims of gender and domestic violence, there are some principles that should be taken in account both to provide help and for effective protection and empowerment of the persons who were victimized. These principles have to embrace the rights of the victims of crime accordingly to the Directive by the European Parliament and Council (2012/29/UE D), mainly: a) protection from future violence, retaliation, intimidation and secondary victimization extensive to family relatives; redress (compensation) for the harms of the violence suffered; state support for recovering and rebuilt their lives. As a first step, intervention has to take in account the harms of violence. As Kelly et al (2016) state:

“Violence removes control over one’s body and mind, it changes the internal sense of self and the relationships to others. All intervention should, therefore, begin from a recognition that every subsequent inter- action can be part of re-stitching social connections or compounding the harm. The challenge is not just to protect from further abuse but to expand ‘space for action’ to restore the freedom/liberty that has been interfered with, to come to terms with difficult experiences, and in families to enable positive parenting.” (pg 2)

¹ American Psychology Association - Ethical Principles of Psychologists and Code of Conduct. Effective date June 1, 2003 with amendments effective June 1, 2010 and January 1, 2017. Copyright © 2017 American Psychological Association. All rights reserved. <https://www.apa.org/ethics/code>

dimensions of the intervention, articulated with the needs of protection and safety which have to be assured from the beginning.

As previously mentioned, respecting the rights of the victim must be the axis of the intervention, even though the condition of ID demands specific support to accomplish this aim.

From the beginning, professionals must keep the focus on the purpose of the intervention against violence that is to secure freedom and restore dignity of people affected by violence. It implies not only to diminish, and hopefully stop, violence, but also ensuring a holistic intervention that aims at helping the victim to (re)establish and rebuild her/his life without violence and with quality of life.

This holistic intervention, in order to be effective, has to be based on the respect for self-determination and to establish the conditions to give space and time for victim participation in the definition of the process of escaping from violence. With victims with ID, these principles should not be put aside, although they may be much challenging and tailored according to the person's needs of support. This means to balance the need of consent by the victim, as well as the respect for her/his voice, sometimes throughout the "voice facilitator". Even more, this means that intervention to counter GBVAW is a long process, not just an appointment, and the team of the professionals must be multidisciplinary and with proper economic and human resources to implement the intervention. Thus, in order to guarantee victim's participation in the process, professionals need to accept uncertainty and carefully ponder a timely intervention articulated with a life rebuilt plan elaborated with the victim, and, in case of people with ID, most probably, with the person of reference (voice facilitator).

Confidentiality and anonymity must also be ensured. Even though intervention against GBV (in some countries called DV) needs a multiagency network and multiprofessional actions, the sharing of information must be done without breaching the rights of the victim to maintain her/his life private. These principles are of double relevance: Firstly, it ensures the respect of citizenship rights; secondly, it is important and closely related to the success of the intervention. In fact, it contributes to establishing a relationship of trust, crucial for the further steps in the process of escaping from violence. We must not forget that especially in GV/DV in intimate

relationships the offender has violated the integrity and the self of the victim. So, we should act countering this feeling of being violated and not taken as a person, and work on a pathway to re-establish her/his self confidence and trust in the professionals.

The respect for human dignity and citizenship rights of the victim also means to take into account his/her culture, socio economic background, ethnicity, and, also his/her ability to understand and to elaborate the experience. The recognition of intersectionality is, in fact, a stepping stone to guarantee a real process of dialogue and conscientization (Freire 2003[1970]), recovery and healing of victims or survivors of DV/GBV, despite their socio demographic and individual characteristics. Foremost, protection, safety and recovering should always be in professionals' minds, and be at the center of their decisions concerning possible ethical dilemmas faced during the intervention process.

3.2.4) Training

The **lack of training in the field of DV, GV and SV against people with ID** was significantly highlighted as an important need by all participants. Communications skills set the stage for understanding the victim and for the victim to understand the professionals. When **communications skills** are missing, professionals tend to experience tension and tension prevents them from the commitment to communicate properly with the person with ID and, consequently, it prevents the professional from creating an **environment of confidence and security** for the victim. Training is essential to understand others and to emotionally connect with them.

This training ought to be implemented early on the **academic levels** or earlier on in **schools**. The inclusion of specific curricular classes in the curricular plans of bachelor's, master's and doctoral degrees (as well as in other courses of professional qualification), in the fields of work related to social, psychologic, medical and public security matters ought to be mandatory. Or, in cases where mandatory is not a possibility, it ought to be optional so that those interested in working with this group could make the choice to learn more and be better prepared. The current reality is that basic training is not enough. In academic degrees such as Social Work, for example,

there are no subjects to approach and to bridge communication skills' gap, moreover, topics such as sexual education for people with ID and respective caregivers; what do the different degrees of ID represent in terms of behaviour and their perception of it for professionals who work with people with ID on a daily basis and for professionals who may encounter such cases on their daily tasks; are absent from academic training. A **higher investment** should be allocated to this field of work in order to make up for the **lack of training** and for the **lack of resources** that both professionals and caregivers have testified to be in need of. Here, feasible and helpful services were brought up: providing **multidisciplinary teams** for attendance services, creating a **common protocol**, building **support centres** for specific services such as GBV for people with ID and creating accessible **helplines** to provide specific support for both professionals and caregivers to give information and refer to proper and specialised services.

P1 [First degree relatives of intellectually disable women, FG Informal Caregivers, Spain] - *“Sanitary professionals should be taught how to deal with people with ID. We, as relatives, suffer very much the lack of knowledge and understanding about ID in, for instance, ER. There should be specific guidelines to help people with ID in health care.”*

P3 [Police officer, FG professionals, Portugal] - *“Training, training, training is needed! There are many projects that are stagnated due to the lack of investment. I believe that all actors who partake in the intervention towards these victims ought to have training to do so.”*

P2 [First degree relatives of a women with ID, FG Informal Caregivers, Spain] - *“I would like to be informed about the institutions or resources of help where we could go. There is a lack of information and alternatives. I would like that reporting weren't the only option, I'd like to be helped and informed.”*

P7 [Professionals, FG Professionals, Spain] - *“Violence is the same for everyone, whether or not they have ID, the resources are out there. People with ID should have more specific resources. It is necessary to provide more resources at the institutional level, for example, there should be someone to accompany him to report, to the court to leave the home, working with the family.”*

P4 [University professor of the Social Work Faculty, FG Professionals, Spain] - *“Informing the victims about the resources available and about their rights is*

fundamental. One step that cannot fail is protection resources, these cannot be unsuccessful due to the difficulty that exists with these people with ID. Resources must be effective.”

P1 [Lawyer specialist in GBV against persons with intellectual disabilities, FG Professionals, Spain] - *“We can’t know when a GBV situation is going to appear, but a protocol is mandatory. The police forces must share protocols with other professionals. The institutions can offer training about intellectual disability to the health professionals and the judge.”*

4. Integrating discussion

Quantitative and qualitative data compiled in this work complements each other. On the one hand, with the quantitative approach we sought to understand circumstances and risk factors to which professionals (young and senior) who work with vulnerable populations are exposed to when in their daily activities, namely when it comes to people with ID. On the other hand, with a qualitative approach, we sought to understand the needs that professionals (young and senior) and caregivers (formal and informal) encounter under those same work circumstances when dealing with this vulnerable group. The results from both methodologies have been exposed, and some important reflections came from the joint analysis. First, it is remarkable to observe that Portuguese and Greek participants presented the **lack of preparation** and the **lack of opportunity to use and acquire more knowledge and skills** as the least selected items concerning the less appealing features of the job. On the other hand, the most pointed out needs throughout the Focus Groups were the need for knowledge and skills for intervention in gender-based violence against people with ID, which can be equated to the lack of preparation as well. In regards to **needs for knowledge**, the following dimensions were pointed out: the need to have more knowledge to what regards to the existing degrees of disability; to have more information on sexuality and how caregivers ought to approach it in regards to people with ID; the need to have more tools to validate the voice of people with ID; the need to overcome infantilization; the need to cope with in intersectionality and embrace interdisciplinarity; the need to have more knowledge concerning the probability for people with ID to suffer domestic violence, sexual violence and other types of gender-based violence; the need to

assess risk assessment and finding adequate instruments for people with ID; the need to have more knowledge in identifying signs amongst children, adolescents and adults and better understanding the consequences of GBV on people with ID; and, lastly, the need to intervene towards protection, security and recovery. These dimensions stood out in terms of need for knowledge and it was commonly agreed that the absence of it may lead to feelings of helplessness from professionals. It may also have irreversible consequences on victims of GBV-ID, hence the need to deepen these results.

In regards to **needs for skills**, the following dimensions were pointed out: the need to have more skills on building a relationship of trust and empathy with victims and their families; the need to develop skills on active listening and validating people with ID' experiences; the need to find skills to deconstruct prejudices, stereotypes, taboos, intersectionality and cultural competences; the need to create specific protocols to assist victims with ID which leads to the need to work beyond in seeking alternatives to help the victim's needs; the need to develop networking skills, professional self-knowledge, emotion management and burnout; and lastly, the need to have more training skills. It is essential to highlight that the need for better preparation/for more knowledge and skills prevails. On the other hand, results of the survey indicate the opposite. There needs to be rise in the awareness of the lack of knowledge and skills *in vigour* in this field of expertise, especially, when considering that *The opportunity to use knowledge and skills* and *The opportunity to acquire more knowledge and skills* were pointed out as other very satisfying features in the main motives to choose the job/career (in both Spanish and Portuguese populations). Only after awareness has been risen, would this item become the most selected one concerning the profession's less appealing. When the lack of preparation and knowledge/skills is seen for what it is indeed (scarce), then other measures would have to be taken and the need *To make the difference on people's lives*, as the most valued feature of their work would stand out even more.

Additionally, both qualitative and quantitative results give evidence that the support provided by the State/Government, the Leaders of the institutions and Community/stakeholders is far from satisfactory. The financial support available for people with ID represents a small share of the actual expenses undertaken by informal caregivers and it is perceived as a lack of support from governmental instances by this population. Professionals too reported being unsatisfied with the existing

governmental support, which leads to the understanding that all instances require higher measures.

Professionals and caregivers have reported throughout the Focus Groups that working with people with ID can be a very rewarding experience, but it is also perceived as overwhelming. In the Greek sample, for example, differences were observed in the *Personal Fulfilment* dimension, being that, professionals who work with people with ID present lower levels of PF when compared with those who work with both populations (GBV & ID). When exploring differences between dimensions of burnout within the same samples: Portuguese and Greek professionals significant differences were observed: higher levels of *Personal Fulfilment* and lower levels of

Depersonalization. Working with vulnerable populations may present itself as a fulfilling commitment as professionals embrace their motivation to make a difference in the world and in the lives of peoples with ID. However, there is a shadow side attached to it. It regards the fact that professionals tend to experience feelings of depersonalization as a means of defence to better cope with emotional barriers and these are later on perceived as risk factors for their professional performance. Risk factors identified were workload, lack of specific training, lack of personal, specific tools and services, barriers, emotions and burnout, lack of available resources, infrastructure and bureaucracies and lastly, but not less important, pandemic effects.

Needs and risk factors experienced by professionals, young professionals and caregivers (formal and informal) coexist. Needs, when not attended, can easily become risk factors - be it for these professionals, be it for the vulnerable populations they provide support to -, hence the urge to validate their experience and testimonies in throughout the work carried in this project in order to bridge the existing gaps and, consequently, avoid unnecessary suffering.

5. Conclusions

The respect for human dignity and citizenship rights of the victim also means to take into account his/her culture, socio economic background, ethnicity, and, also his/her ability to understand and to elaborate the experience. The recognition of

intersectionality is, in fact, a steppingstone to guarantee a real process of dialogue and conscientization (Freire 2003 [1970]), recovery and healing of victims or survivors of DV/GBV, despite their socio demographic and individual characteristics.

Foremost, protection, safety and recovering should always be in professionals' minds, and be at the centre of their decisions concerning possible ethical dilemmas faced during the intervention process. This holistic intervention, in order to be effective, has to be based on the respect for self-determination and to establish the conditions to give space and time for the victim to report her/his aggressor. With victims with ID, these principles should not be put aside, although they may be much challenging and tailored according to the person's needs of support. From the need analysis, it is possible to identify the fundamental needs for training professionals and informal caregivers of people with ID victims of gender-based violence and domestic violence. The training should cover four main dimensions (see Table I):

- i) knowledge about intellectual disability and skills to identify and to be able to provide relevant help;
- ii) knowledge about characteristics, causes and consequences of GBV/DV and skills to identify the signs and to provide appropriate help;
- iii) knowledge about ethical principles on intervention with people with ID to countering GBV/DV and skills to be able to deal with the dilemmas in intervention and supporting victims with ID;
- iv) Relevant knowledge and skills to prevent burnout.

The Project ATHENA BEGIN could be exploring new ground considering that the literature and professional experience in the field of preventing GBV/DV against people with ID is still scarce. However, the combination of the expertise of the different teams and countries and the diversity of professional areas is being well succeeded in the pursue of the necessary path in order to provide relevant guidelines and training for improving intervention to empower and re-establish freedom, rights and dignity for people with ID who have been harmed or are at risk of being victims of GBV/DV.

Table I - Training dimensions identified:

DIMENSIONS	TOPICS KNOWLEDGE	TRAINING SKILLS
<i>In the field of intellectual disability</i>	<ul style="list-style-type: none"> • degrees of disability, • sexuality, • validate a voice, • avoiding infantilization, • intersectionality • interdisciplinarity/ multidisciplinaryintervention 	<ul style="list-style-type: none"> • how to evaluate; • how to deal with sexuality topics with women with ID from different ages and socio/cultural backgrounds; • how to create time and space for victims have voice; How to articulate with voice facilitator, previously verifying possible risk of abuse; • how to balance the needed support with respect for the person (possible) self-determination; • how to listen and understand cultural and social background • how to work with other professionals in the multiagency services without breaching victims' rights
<i>In the field of victimisation under GBV</i>	<ul style="list-style-type: none"> • Intimate partner violence (including relationship factors) • <i>The characteristics of the cycle(s) of abuse</i> (e.g. socioeconomic status and age, power and control) • <i>Perpetrator control strategies;</i> • <i>Society related characteristics</i> • Consequences of abuse; • Risk assessment • Surviving strategies • Areas, timings and methods for intervention; empowering the victims • The rights of the victims • Universal and primary prevention 	<ul style="list-style-type: none"> • How to identify the signs; • How to deal with women in different phases of the cycle(s); • How to share with victims the identification of the perpetrators' strategies; • Critical analysis of ideological myths (romantic love, ideal family...); • How to evaluate the consequences of abuse and establish a plan for escaping and recovering; • How to evaluate the risk of the perpetration of more violence; • How to balance the validation of women's strategies with the need for a safe plan; • When, how and who should intervene; • How guarantees their rights • Intervention plans with early ages, including schools;
<i>Ethics in intervention</i>	Ethical principles	Ethical practices
<i>Necessary skills for intervention with victims with intellectual disabilities</i>	Knowledge to improve ours skills; Self-knowledge about our prejudices and stereotypes; Specific knowledge on violence and culture;	<ul style="list-style-type: none"> • Relation of trust; • Empathy; • Respect; • Active listening; • Validation of victims experiences; • Cultural competence
Intervention protocol	Principles	Guidelines for action, including language and communication
Burnout	Identification of exhaustion or burnout Strategies for burnout prevention	<ul style="list-style-type: none"> • The need for adequate resources; • The need for cooperative work; • The need of time for ongoing training

References

- Alhabib, S., Nur, U., & Jones, R. (2010). Domestic violence against women: Systematic review of prevalence studies. *Journal of family violence*, 25(4), 369-382.
- Barger, E., Wacker, J., Macy, R., & Parish, S. (2009). Sexual assault prevention for women with intellectual disabilities: a critical review of the evidence. *Intellectual and Developmental Disabilities*, 47(4), 249-262.
- Bosch, E., Ferrer, V. A., & Alzamora, A. (2006). *El Laberinto Patriarcal. Reflexiones teórica-prácticas*, Barcelona: Anthropos.
- Bowen, E., & Swift, C. (2019). The prevalence and correlates of partner violence used and experienced by adults with intellectual disabilities: a systematic review and call to action. *Trauma, Violence, & Abuse*, 20(5), 693-705.
- Brownridge, D. A. (2006). Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence against women*, 12(9), 805-822.
- Dobash, R. E., & Dobash, R. (1979). *Violence against wives: A case against the patriarchy* (pp. 179-206). New York: Free Press.
- Douglas, H., & Harpur, P. (2016). Intellectual disabilities, domestic violence and legal engagement. *Disability & society*, 31(3), 305-321.
- Dunkle K., Van Der Heijden I., Stern E., and Chirwa E. (2018). [Disability and Violence against Women and Girls: Emerging Evidence from the What Works to Prevent Violence against Women and Girls Global Programme](#)
- Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA. Available at: <http://data.europa.eu/eli/dir/2012/29/oj>.
- Foster, K., & Sandel, M. (2010). Abuse of women with disabilities: Toward an empowerment perspective. *Sexuality and Disability*, 28(3), 177-186.
- Freire, Paulo (2003[1970]) *Pedagogia do Oprimido*, Rio de Janeiro: Edições Paz e Terra.

- Flury, M., & Nyberg, E. (2010). Domestic violence against women: definitions, epidemiology, risk factors and consequences. *Swiss medical weekly*, 140(3536).
- FRA - European Union Agency for Fundamental Rights (2014). *Violence against women: An EU-wide survey: Main results*. FRA, European Union Agency for Fundamental Rights.
- García-Moreno, C., Jansen, H. A. F. M., Ellsberg, M., Heise, L., & Watts, C. (2005). WHO multi-country study on women's health and domestic violence against women. *Geneva: World Health Organization*, 204, 1-18.
- Johnson, M. P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family*, 283-294.
- Kelly, Liz; Meysen, Thomas; Hagemann-White, Carol; Magalhães, Maria-José; and Jalusic, Vlasta (2016) Transnational Foundations for Ethical Practice in Interventions Against Violence Against Women and Child Abuse, CEINAV Project, accessible in <http://ceinav-irp.blogspot.com/>; or https://www.fpce.up.pt/love_fear_power/ceinav/publications.html; or https://www.londonmet.ac.uk/media/london-metropolitan-university/london-met-documents/faculties/faculty-of-social-sciences-and-humanities/research/child-and-woman-abuse-studies-unit/ceinav/Kelly_Meyesen-CEINAV_Transnational-Foundations_2016_Web_EN.pdf;
- Martin, S. L., Ray, N., Sotres-Alvarez, D., Kupper, L. L., Moracco, K. E., Dickens, P. A., ... & Gizlice, Z. (2006). Physical and sexual assault of women with disabilities. *Violence against women*, 12(9), 823-837.
- Maslach, C., Jackson, S.E., & Leiter, M.P. (1996-2016). *Maslach Burnout Inventory Manual (Fourth Edition)*. Menlo Park, CA: Mind Garden, Inc.
- Mays, J. M. (2006). Feminist disability theory: Domestic violence against women with a disability. *Disability & Society*, 21(2), 147-158.
- Nosek, M. A., Foley, C. C., Hughes, R. B., & Howland, C. A. (2001). Vulnerabilities for abuse among women with disabilities. *Sexuality and Disability*, 19(3), 177-189.
- Pain, R. (2014). Everyday terrorism: Connecting domestic violence and global terrorism. *Progress in Human Geography*, 38(4), 531-550.

- Pestka, K., & Wendt, S. (2014). Belonging: women living with intellectual disabilities and experiences of domestic violence. *Disability & Society, 29*(7), 1031-1045.
- Plummer, S. B., & Findley, P. A. (2012). Women with disabilities' experience with physical and sexual abuse: review of the literature and implications for the field. *Trauma, Violence, & Abuse, 13*(1), 15-29.
- Saraga, E. (2001). Dangerous places: The family as a site of crime. *The problem of crime, 2*.
- Straus, M. M. A., Gelles, R. J., & Steinmetz, S. K. (Eds.). (1988). *Behind closed doors: Violence in the American family*. Transaction Publishers.
- Taggart, L., McMillan, R., & Lawson, A. (2009). Listening to women with intellectual disabilities and mental health problems: A focus on risk and resilient factors. *Journal of intellectual disabilities, 13*(4), 321-340.
- Walter-Brice, A., Cox, R., Priest, H., & Thompson, F. (2012). What do women with learning disabilities say about their experiences of domestic abuse within the context of their intimate partner relationships?. *Disability & Society, 27*(4), 503-517
- Willner, P., Rose, J., Stenfort Kroese, B., Murphy, G. H., Langdon, P. E., Clifford, C., ... & Cooper, V. (2020). Effect of the COVID- 19 pandemic on the mental health of carers of people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 33*(6), 1523-1533.
- WHO - World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. World Health Organization.
- WHO - World Health Organization. (2012). *Understanding and addressing violence against women: Intimate partner violence* (No. WHO/RHR/12.36). World Health Organization.
- Yodanis, C. L. (2004). Gender inequality, violence against women, and fear: A cross-national test of the feminist theory of violence against women. *Journal of interpersonal violence, 19*(6), 655-675.

Attachments

Attachment 1

Story for Focus Groups

Phase one:

Maria (24 years old) is a woman with a mild intellectual disability. She is employed, working as an education assistant in a kindergarten for 1 year now. During her vocational education and training, she met Xavier and they started dating and now live together. Xavier says that he loves Maria and he is trying to protect her from all the people who may hurt her. However, they have lots of loud quarrels. Sometimes, Maria complains about Xavier's controlling behaviour, but she believes it is for her own good. Maria's friends and relatives are worried, because they also notice that sometimes she appears with some bruises and she seems to be afraid of some of her partner's reactions. However, Maria's friends and relatives feel they don't have the right to interfere since she doesn't want to seek help and it may question her autonomy.

Phase two:

Six months later, the situation had escalated and Maria had to go to the hospital. Her partner brings her to the hospital with bruises and a dislocated shoulder, he tells the nurse that she fell downstairs and she nods in agreement. He also tells that Maria is retarded and he wants to be present to help her to understand better. Health professionals are suspicious and ask Maria's partner to leave the room. While she is alone and being examined, she admits that Xavier caused the injuries. The hospital gives her a card with a helpline number she can call for advice and help. However, when the consultation ends and Maria leaves the room, she is too afraid to call the helpline and goes home with Xavier. Meanwhile, after Maria left, the doctor phoned a DV/GV institution to tell them about the situation.

Phase three

The violence has continued, and Maria is now ready to take action, possibly thinking about leaving the intimate relationship. She makes contact with a specialized NGO support worker and confides that she is frightened of what her partner might do to her if she makes a formal complaint. (He once said he would kill her if she ever left him).

The end of the phased story has to be appropriate to each country. Here, the paper about the situation in each country is crucial to anticipate what can be done. Depending on the country either:

a) The support worker explains that she is legally obligated to report this to the police, although Ana begs her not to do so, and she assures Ana that a court protection order can ensure that she is safe.

Or (where there is no mandatory reporting)

b) The support worker explains how a police ban/ protection order/ restraining order (to be specified by country) can work for her safety. and with this support, Ana applies successfully for such an order, A protection order/police ban is issued in which her husband is obliged to leave and to stay away from the residence, and also prohibited from making contact with Anna in any way for a period (check by country what is possible). Two days later the support worker calls her home and the partner answers the phone. He sounds nervous and aggressive and tells the professional that they have made up their quarrel and that the professional should leave them alone and stop putting nonsense ideas inside Maria's head otherwise she (the support worker) will regret it.

Attachment 2

Guidelines for focus groups

1st phase:

1st question: Imagine yourself working for an institution of your choice. Considering the case/story we just presented to you, what do you think should be the first step the institution should have towards the client?

2nd question: In your opinion, what do you think should be done?

3rd question: Considering that you are not yet working on the field, what kind of training (knowledge and competences) ought to be necessary in order to provide a more adequate support to the client?

2nd phase:

1st question: The story has progressed and, towards the present circumstances, how and when do you foresee that the institution in which you imagine yourself working should intervene?

2nd question: And in your understanding, what action is more important to be taken?

3rd question: Who should intervene firstly: psychologist, police officer, other? 4th question: Considering that you are not yet working on the field, what kind of training (knowledge and competences) ought to be necessary in order to provide a more adequate support to the client, bearing in mind this phase of the story?

3rd phase:

1st question: from the institutional standpoint, which ought to be the priorities in terms of intervention in order to better assist Maria at this stage of the story?

2nd question: From your understanding, what do you think should be done to promote a better quality of life for Maria?

3rdquestion: Considering that you are not yet working on the field, what kind of training(knowledge and competences) ought to be necessary in order to provide a more adequate support to the client, bearing in mind this phase of the story?

Final comments/suggestions/recommendations.

Thanking.

Attachment 3

Suggested Template for Report Focus Group Report with professionals who work and caregivers who give assistance to people with ID and/or victims of DV_GBV

Partner Organization	
Focus group date	
Place	
Number of participants	
Moderator's Name	
Assistant(s) moderator's Name	
Brief description of the participants and general conditions of FG	
Summary of main feedback received on Background information	

Relevant excerpts related to background information (extracted from participants' talk)
Summary of main feedback received on Interventions and competences needed
Relevant excerpts related to 1st phase of the story (extracted from participants' talk)
Relevant excerpts related to 2nd part of the story (extracted from participants' talk)
Relevant excerpts related to 3rd part of the story (extracted from participants' talk)

Summary of main feedback received and remarks

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