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ATHENA BEGIN

TRAINING MATERIALS

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

έδρα social cooperative activities for vulnerable groups

U.PORTO FACULDADE DE PSICOLOGIA E DE CIÊNCIAS DA EDUCAÇÃO UNIVERSIDADE DO PORTO

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1. ATHENA PROJECT.

This project addresses the vulnerability of people with disabilities to become victims of abuse. In particular, domestic violence and G-BV (DV/G-BV). It offers resources and tools to professionals who assist people with ID who are victims of domestic violence, and empower the victims themselves to improve their quality of life by developing their skills and abilities.

This achievement requires that both context and circumstances where the violence occurred is properly addressed in order to identify hidden realities, to tackle them professionally and effectively, and to minimize any secondary victimization that these people may suffer during the process.

The main outputs of project are: manuals and guidelines for intervention; training professionals involved in the care of victims of DV/G-BV; written contents for prevention; development of guidelines for different actions; Implementation of a new training method for professionals; numerous prevention workshops that are directed towards people with ID who may be at risk of suffering DV/G-B V.

It is expected that ATHENA benefit 2800 women and men with ID, 600 professionals from different fields (healthcare, psychologist, social workers, jurists, police agents, caregivers) and over 7140 citizens from the three countries involved, in a direct or indirect manner.

Other results of the project are the capacity building actions for professionals which take place in the three partner countries; the Handbook on Prevention and Awareness Building on VD/G-BV directed to professionals who work with people with ID; several prevention workshops directed to people with ID; the development of a guideline with recommendations about providing services to women with ID who suffer DV or G-BV , which is aimed to complete and improve the action protocols already established by the pertinent authorities in the area of DV/G-BV in each partner country;

In addition, other results from the research division of the project such as the State-of-Art report, and the Needs Analysis Report result very valuable contributions to the knowledge about this scarcely studied field.

2. INTRODUCTION TO GENDER-BASED VIOLENCE AND ID.

The international legal framework on G-BV not only refers to violence against women within the domestic sphere perpetrated by their spouse/husband, partner or ex-partner even without cohabitation, but also establishes a broad concept of gender-based violence, introducing other types and contexts of violence considering many areas of people's lives.

At the European level, the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul, 2011) differentiates between violence against women and domestic violence, noting that domestic violence affects women disproportionately, as per following definitions:

A. “Violence against women” should be understood as a violation of human rights and a form of discrimination against women, and shall designate all acts of G-BV that imply or may imply harm or suffering for women. of a physical, sexual, psychological or economic nature, including threats to carry out such acts, coercion or arbitrary deprivation of liberty, in public or private life.

B. “Domestic violence” means all acts of physical, sexual, psychological or economic violence that occur in the family or in the home, mostly between spouses or partners or other relatives, in former or current events, regardless of whether the perpetrator of the crime shares or has shared the same address as the victim.

C. By “gender”, we mean the socially constructed roles, behaviours, activities and attributions that a specific society considers proper to women or men.

D. “G-BV against women” means all violence against a woman because she is a woman or that affects women disproportionately. By "victim" is understood any natural person who is subjected to the attitudes or behaviours specified in sections a and b.

E. The term “woman” not only refers to adult women, but also includes girls under 18 years of age.

The Convention defines G-BV from a broad perspective, considering various forms of violence against women in this concept, for example: physical, psychological and sexual violence, including rape, female genital mutilation, forced marriage, harassment, forced abortion, forced sterilization.

Likewise, this broad concept of G-BV would include: the sale of human beings for the purpose of forced sexual prostitution, directly or indirectly, the situation of special vulnerability in which migrant or refugee women find themselves, and institutional violence.

In short, due to its characteristics and dynamics, G-BV can be considered as a particular form of violence (Larrosa, 2010), different from other types of

interpersonal violence. Although G-BV and domestic violence are similar in many ways, these are distinct concepts. The domestic violence suffered by women is a manifestation of gender-based violence, and G-BV is a much broader concept that includes all the forms of violence against women referred to above.

The impact of G-BV on women with ID

The concept of ID has evolved over the years. Previous explanatory models focused on the functional limitations of people with disabilities, their deficiencies and shortcomings, putting the focus of the problem on the individual, attributing the difficulties to adapt to the environment on the person with disability and their limitations, considering any outside variables as non-existent or as non-contributory. (Cendra, J., Alemany, A., y Hernández, M. 2016)

Fortunately, as of 1992 and thanks to the change of model proposed by the UN Convention on the Rights of Persons with Disabilities, the International Classification of Functioning, Disability and Health (CIF), and the American Association on Mental Retardation (now called the American Association on Intellectual and Developmental Disabilities, hereinafter AAIDD), this conception is changing.

It contributes to a change of vision of the disability where this does not reside only in the individual, but in the interaction of him/her with his/her environment. Therefore, a large part of the disability that is associated with the person actually resides in society, which imposes barriers that incapacitate some people. If the necessary resources and support were available, the individual functioning of the person with ID would not be harmed, being able to carry out a full and autonomous functioning.

From this conception, ID is a condition of the person that is characterized by being multidimensional (physiological, psychological, medical, educational and social aspects intervene), by being multi-causal (disability can be due to genetic pathologies, neurological damage, environmental, educational or social factors) and enormously heterogeneous (the differences between people with ID are even greater, if possible, than the differences between people in the general population without disabilities). (AAIDD, 2010)

Despite the enormous disparity between the different people who share the diagnosis of ID, according to the AAIDD, it must necessarily include three components:

- Significant limitations in intellectual functioning.

- Significant limitations in adaptive behaviour.

- Starting age prior to 18 years.

Unfortunately, although almost three decades have passed since the UN, the CIF and the AAIDD contributed this new conception of ID, many people are not aware of the dimensions of this change, still anchoring themselves in previous models. This favours their stigmatization through a look of pity or sorrow towards the

group with disabilities and, therefore, the risk of carrying out an intervention based on paternalism.

It is in recent years when society begins to become aware of the vulnerability of people with ID to being victims of abuse (Westcott and Jones, 1999; Sullivan and Knutson, 2000). Foreign literature has for decades shown the alarming prevalence of abuse in people with ID (Brown, Stein and Turk, 1995; Sobsey, 1994; McCarthy, and Thompson, 1997), providing data such as that up to 80% of the people with ID have been or will be victims of any type of abuse throughout their lives (Brown, Stein and Turk, 1995; Horner-Johnson and Drum, 2006; McCarthy and Thompson, 1997; Sobsey, 1994; Verdugo, Alcedo , Bermejo and Aguado, 2002).

The Fundamental Rights Agency (FRA, 2014) released a report providing the main results of the survey on the violence against women in the EU providing particular evidences concerning women with disabilities. According the report researchers interviewed 42,000 women across the 28 Member States of the European Union, asking women about their experiences of physical, sexual and psychological violence. The responders reported experiences of stalking, sexual harassment as well as abuse in childhood.

The results show that extensive G-BV persists in the EU member countries. 34% of women with disabilities reported having experienced some form of physical or sexual violence since the age of fifteen, compared to 19% of women without disabilities. Moreover, 46% of women with disabilities said they suffered from a physical, sexual or psychological violence before the age of 15 (FRA, 2014).

When it comes to psychological violence and harassment, the numbers are even higher. 61% of women with disabilities faced a sexual harassment since the age of 15. Stalking was experienced by 26% of respondents with disability (FRA,2014)

The additional vulnerability of women with ID is influenced by various factors that can be grouped into three major variables:

1) Old conceptual frameworks or the social conception of ID itself

As mentioned above, families, professionals and society in general continue to be anchored in a vision of disability based on previous models, which hinders the full development of people with ID, making them the perfect victims.

This happens, not so much because of their condition as a person with ID, but because of the conception that the context has about them and their families, that is, the way in which society looks at people with disabilities. This perception of society about disability has an impact on the identity of the person with a disability and their family, which can generate low self-esteem and insecurity (Avilés, 2019).

From this misaligned social conception of disability, it is common for the person with a disability to be infantilized, equating the individual with a disability with a minor or with a person without the capacity to act or to decide. This aggravates the difficulty of the person with a disability to function on his/her own and to seek his/her own autonomy, generating relationships with the environment of dependency and submission.

This vision of society about ID, together with the frequent contempt and isolation that people with disabilities suffer due to their condition, cause high rates of social desirability and difficulties to be assertive and defend their own rights. (Manzanero et al. 2011)

Likewise, the lack of training for people with disabilities in sexual affective matters, in sexist violence or in the prevention of situations of abuse or mistreatment, causes this group to lack the necessary tools to distinguish and identify what may be harmful or unprotect them. Traditionally, PDI have been seen as children without sexuality, or asexual without any sexual desire.

2) Difficulties in the elaboration of the primary grief.

The person with ID and their family members faces the emotional damage caused by grief over the disability and the added difficulties throughout the different stages of the family life cycle. This grief involves assimilating the loss of expectations and facing the reality that the arrival of a member with an ID implies.

This impact is called primary trauma (Sinason, 1992) and it is generated by the vision, already mentioned above, that society has on ID, affecting all family members and how they are going to relate from the different roles (fathers, mothers, children or siblings) and how they are going to interact with people outside the family nucleus, either with professionals, in friendships, in romantic relationships, etc.

For this reason, primary grief is a factor of vulnerability. On the one hand, because grief provokes in the families of a person with a disability a tendency to isolation and difficulty in generating the necessary resources to prevent or detect any situation of abuse. And, on the other hand, said trauma can generate psychological damage throughout the life of the person with a disability, which may influence the increase in vulnerability and coping resources in the face of a possible situation of violence.

3) Lack of resources to care for victims with ID

Currently, there are very few specialized resources for victims with ID. Until 2010 there was no specific resource and that is when the UAVDI of the Carmen Pardo-Valcarce Foundation (A LA PAR) was created as a national reference, whose trajectory has led it to create other specialized Units in different parts of Spain (Catalonia, Castilla-La Mancha, Aragon and La Rioja).

In Greece there are not specific state resources indented for victims with ID. Legal entities and mental healt institutions are in a continuous effort to develop resources that have been created within the frame of EU co-financed

programmes (i.e. StaySafe/ https://staysafeproject.eu/, DESEM/ https://www.desemproject.eu/, etc.). The same situation exists in Portugal, and there is a lack of specialized resources for victims with ID.

Likewise, the scarcity of specialized resources, the lack of training for direct care professionals in matters of abuse or mistreatment of people with disabilities and the overload of these professionals creates great difficulties in carrying out the necessary work in terms of prevention and detection of possible cases, which contributes to maintaining the high levels of abuse of this group that is so present today.

On the other hand, the lack of knowledge and sensitivity about ID among professionals in the police or legal field makes them fall into erroneous myths about disability, such as giving less credibility to people with disabilities due to believe that this group tends to fantasize and lie, or myths about the sexuality of people with disabilities from which it is considered that they either have no sexual desire, or are highly promiscuous people.

The belief in these myths will affect the treatment received by the person with a disability in their passage through justice (Manzanero et al, 2011).

It is important to note that, for the most part, the vulnerability factors depend on the context of the person, being a direct consequence of the previously mentioned erroneous and archaic conception of ID.

Therefore, as society advances, transforms this vision of disability and includes the participation of this group in society, many of these vulnerability factors will disappear, thus reducing the number of abuses and situations of violence and, therefore, improving the quality of life of people with ID, specifically women with disabilities.

3. REGULATORY FRAMEWORK.

3.1. STATE IMPLEMENTATION OF ISTAMBUL CONVENTION

At the international level, there are several legal instruments that contain provisions on G-BV. The most important ones are listed below:

Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention).

The importance of the Convention lies in the fact that it is the first binding instrument at European level in the field of violence against women and domestic violence, and it is the most far-reaching international treaty to address this serious violation of human rights, establishing zero tolerance for violence against women.

Violence against women is recognized in the Convention as a violation of human rights and as a form of discrimination, holding States responsible if they do not respond appropriately.

The Purposes of the Convention (Article 1):

"a. protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence;

b. to contribute to the elimination of all forms of discrimination against women and promote substantive equality between women and men, including by empowering women;

c. design a comprehensive framework, policies and measures for the protection of and assistance to all victims of violence against women and domestic violence;

d. to promote international co-operation with a view to eliminating violence against women and domestic violence;

e. to provide support and assistance to organisations and law enforcement agencies to effectively co-operate in order to adopt an integrated approach to eliminating violence against women and domestic violence."

The Convention recognizes as forms of violence against women: physical, psychological and sexual violence, including rape; female genital mutilation, forced marriage, harassment, forced abortion and forced sterilization. This implies that States must introduce these terms into their legal systems.

Practically all the conducts included in the Convention are prosecuted under several legal systems. For example: Organic Law 1/2015, of March 30, which modifies Organic Law 10/1995, of November 23, of the Penal Code, incorporates gender as a reason for discrimination and as an aggravating factor, understood in accordance with the Convention of the Council of Europe on preventing and combating violence against women and domestic violence, that is "the socially constructed roles, behaviours or activities and attributions that a specific society considers to be those of women or men." Gender as an aggravating factor may constitute a basis for discriminatory actions different from that covered by the reference to sex.

With regard to other forms of violence against women, it typifies for the first time the new crime of forced marriage, to comply with the international commitments assumed by Spain in the Istanbul Convention (Article 172 bis).

The agreement was ratified by the Greek Parliament in 2018 and has the force defined by article 28 par. 1 of the Constitution of Greece. The arrangements introduced for the implementation of the provisions of the Istanbul Convention include:

(a) strengthening the criminal law to address crimes against women (genital mutilation, stalking, "honour crimes")

b) the highly anachronistic provision of article 339 par. 3 of the Criminal Code is abolished (non-prosecution if a marriage took place between the perpetrator of seduction of a minor and the victim)

c) Law 3500/2006 on domestic violence is amended, with the aim of wider and more effective implementation of

d) Law 3811/2009 on the Hellenic Compensation Authority is amended, with the aim of making it easier for victims to access the compensation provided by this law

e) Law 2168/1993 on weapons is amended so that licenses are not granted to those who are prosecuted or have been convicted of domestic violence offenses

(f) Aliens who are victims of domestic violence and come to the competent authorities to lodge a complaint are protected from return;

g) the General Secretariat for Gender Equality is designated as the monitoring authority of the Convention.

Portugal ratified the Convention on 5 February 2013. According to the recent report of the GREVIO (Group of Experts on Action against Violence against Women and Domestic Violence), the monitoring body mandated to monitor the implementation of the Istanbul Convention, Portugal has taken important steps in fighting against domestic violence and gender inequality; however, some gaps still need to be filled, namely regarding more vulnerable groups. The report encourages Portuguese authorities to “review spending levels to remedy existing gaps in the provision of specialist support services for victims of all forms of violence against women, including more vulnerable groups of victims such as girls, elderly women, women with disabilities, (…) guarantee equal access to services for all victims throughout the national territory by ensuring that appropriate human and financial resources are allocated at all levels of public responsibility” (GREVIO, 2019, p. 20).

The foundations and scope of the Convention are in accordance with the regulations and actions carried out by the countries of the consortium in this matter, since among the obligations to the States of the Istanbul Convention some measures already consolidated in the countries of the consortium stand out, such as:

A) The training of the different groups of professionals who intervene in situations of G-BV.

B) The 016 information and legal advice service on G-BV, free and available 24 hours a day, 365 days a year.

C) The design and permanent updating of a statistical information system for data related to G-BV.

D) Public awareness and prevention of G-BV through information and awareness campaigns.

E) The existence of the obligation to report those who by reason of their positions, professions or trades have news of a public crime, such as the various crimes of violence against women.

F) Ensure that victims have access to special protection measures.

EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS AND EUROPEAN SOCIAL CHARTER

The European Convention for the Protection of Human Rights and Fundamental Freedoms, better known as the European Convention on Human Rights or Rome Convention, was adopted by the Council of Europe on November 4, 1950 and entered into force in 1953, expressly inspired by the Universal Declaration of Human Rights, proclaimed by the General Assembly of the United Nations on December 10, 1948.

Its purpose is to protect the human rights and fundamental freedoms of the persons subject to the jurisdiction of the Member States.

In order to allow judicial control of effective respect for human rights, the Convention established in 1954 a judicial body, the European Court of Human Rights (or European Court of Human Rights), based in Strasbourg.

The Partner Letter it is a Council of Europe treaty signed in Turin on October 18, 1961 and revised in 1996, which constitutes the natural complement to the European Convention on Human Rights, by guaranteeing social, economic and human rights.

In particular, the European Social Charter specifies the rights and freedoms and establishes a supervisory mechanism that guarantees their respect by the States parties. The rights guaranteed by the European Social Charter are housing, health, education, employment and legal and social protection, freedom of movement of people and non-discrimination.

This treaty has been signed and ratified by Spain on two occasions: on May 6, 1980 and, on the occasion of the revision of the 1996 Charter, on October 23, 2000.

In 1953, the Hellenic Parliament unanimously ratified the Council of Europe's human rights treaty, the European Convention on Human Rights, and its first protocol. In 1967, following military coop the Greek junta abolished democracy, bringing itself into conflict with the Council of Europe. After the fall of the junta, Greece re-joined the Council of Europe on 28 November 1974 and the convention came again in force. After a dictatorship that lasted more than 40 years, Portugal finally ratified the Convention on September 9, 1978.

CONVENTION OF THE COUNCIL OF EUROPE ON THE ELIMINATION OF TRAFFICKING IN HUMAN BEINGS

The Council of Europe Convention on the Elimination of Trafficking in Human Beings, adopted on May 3, 2005, opened for signature in Warsaw on May 16, 2005, and in force since February 1, 2008, after ratification by 10 countries, it is the first European Treaty in this area that comprehensively addresses both the protection of victims of trafficking and their rights as well as the prevention of trafficking and the persecution of perpetrators. Spain signed the Treaty on July 9, 2008 and ratified it on April 2, 2009, entering into force on August 1, 2009.

It addresses all forms of trafficking, nationally or internationally, regardless of whether or not they are related to organized crime and whoever the victim is, women, men or minors and whatever the form of exploitation (sexual exploitation, forced labour or services, etc).

3.1.1 IN GREECE.

The Greek Constitution 2001 by virtue of article 4, par.2 recognizes (FEK (Official Gazette) 85 / A / 18-4-2001) that "Greek men and women have equal rights and obligations." With the article 116 par.2, also states that "It is not gender discrimination to take positive measures to promote equality between men and women. The State ensures that inequalities that exist in practice are removed, especially to the detriment of women. "

At the Legislative level, the organic Law 3896/2010 (FEK 207 / A '/ 8-12-2010) "Implementation of the principle of equal opportunities and equal treatment of men and women in matters of labor and employment - Harmonization of existing legislation with Directive 2006/54 / EC of the European Parliament and of the Council of 5 July 2006 and other relevant provisions "regulates matters relating to: (a) equal reimbursement for women and men, (b) equal treatment in occupational social security schemes, (c) equal reimbursement treatment in relation to access to employment in professional development and training and working conditions;

At the same time, definitions of the concepts of sexual harassment, direct and indirect discrimination as well as harassment are presented (Article 2). Sexual harassment is defined as: "any form of unwanted verbal, non-verbal or physical sexual conduct, with the intent or effect of insulting the dignity of a person, in particular by creating an intimidating, hostile, humiliating, humiliating or aggressive environment." The law prohibits both direct and indirect discrimination based on sex, harassment, sexual harassment, discrimination based on pregnancy or motherhood and less favorable treatment of a person associated with gender reassignment (article 3).

Law 4351/2018 (FEK 62 / A '/ 5-4-2018) ratified the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention). Characteristic of the Istanbul Convention, which is a comprehensive text of great importance for the protection of women's rights, is its reference to G-BV and its emphasis on prevention. Indicatively, the Convention stipulates the obligation of the Contracting States to ensure the training of professionals dealing with victims of violence, the implementation of treatment programs for perpetrators of crimes of domestic violence and violations of sexual freedom, as well as to organize publicity actions to break down stereotypes and ensure respect for diversity.

Significant provisions for the protection of victims require Member States to step up their care for their support. Article 40 specifically states that in the case of sexual harassment "Parties shall take the necessary legislative or other measures to ensure that any form of sexual, verbal or non-verbal sexual misconduct intended to infringe upon the dignity of the individual, specifically in the event of the creation of an intimidating, hostile, degrading, humiliating or offensive environment, shall be subject to criminal or other legal sanctions. "

On 26-3-2019 the new law number 4604 initiated by the Ministry of Interior was published in the Official Journal of the Hellenic Republic. Its first part (articles 1-30) is dedicated to the issues of substantive gender equality and sexual and gender-based violence. Its basic characteristics are summarized as following:

1) The specific law constitutes an integral legal framework on gender equality and elimination of discriminations against women. Female gender is not treated as a “special category” or a “vulnerable group” and all its provisions are in accordance with the Constitution, EU Directives, international Conventions ratified by the Greek State, as well as Greek family law, labour law and social security law.

2) All basic notions, mechanisms, institutions and stakeholders are explicitly clarified aiming at the implementation of the principle of equal treatment of sexes, gender mainstreaming and the formulation of a network of permanent structures all over the country for the prevention and elimination of violence against women.

3) The panhellenic SGBV network by the General Secretariat for Gender Equality and the Municipalities is institutionalized (Counseling Centers, Hostels, a 24-hour SOS 15900 hotline).

4) Public and private enterprises are encouraged to draft and implement “Equality Plans” with specific targets, strategies and practices and the General Secretariat for Gender Equality of the Ministry of Interior can award “Equality Labels” to them as a reward for their engagement in favor of equal treatment and equal opportunities for their male and female employees.

5) The use of gender-neutral language in official documents is incorporated as a distinctive task of the public administration. Greek language, like a number of

other European languages (e.g. French, Italian, Spanish), is characterized by the use of male and female nouns and adjectives. The tendency has been to use the male noun collectively when we refer to both sexes, despite the fact that this practice clearly implies gender discrimination. For example, in English there is the word “students” for both boys and girls, but in Greek there is the word “μαθητές” for boys and “μαθήτριες” for girls.

6) The system of quota 40% in favour of women is institutionalized for the lists of candidates in each electoral prefecture at the parliamentary elections. This is a clear measure for women’s empowerment in political decision-making. It is noted that the same increased quota has already been in practice for the elections for Local Authorities (Regions and Municipalities). Furthermore, the absence of quota system in the composition of Councils of the Public Administration arouses legal penalties.

7) An Autonomous Equality Office is established in each of the 13 Regions of the country, the Central Union of Greek Municipalities and the Union of Greek Regions, while the Municipal and the Regional Equality Committees are upgraded.

8) Special provisions have been put in place in the crucial field of education (primary, secondary and tertiary education) aiming at the elimination of gender stereotypes and the advancement of healthy attitudes for the future citizens of the country.

9) In addition, the principle of gender mainstreaming is set in the fields of health and social solidarity (e.g., special attention to the status and the needs of vulnerable groups of women), while a special leave of seven working days is attributed to female employees who attend prescribed programs of medically supported fertility.

10) In the fields of mass media and advertisement special provisions are activated against gender stereotypes and discriminations

At the criminal level, sexual harassment can be prosecuted as the offense of insulting sexual dignity under Article 337 of the Penal Code. (Law 4619/2019, A '95 / 11-6-2019) which provides:

«1. Anyone who brutally insults the honor of another with sexual gestures, with proposals related to sexual acts, with sexual acts performed in front of another or with the display of their genitals, shall be punished with imprisonment of up to one year or a fine. Prosecution requires a complaint.

3. An adult who, through the internet or other media or information technologies, makes contact with a person under the age of fifteen and with gestures or suggestions, insults the honor of a minor in the field of his/her sexual life, shall be punished by imprisonment of at least two years. If an encounter follows, the adult is punished with imprisonment of at least three years.

4. Whoever makes sexual gestures or makes proposals for sexual intercourse to a person who is dependent on them for work or taking advantage of a person's need to work, shall be punished by imprisonment of up to three years or a fine. Prosecution requires a complaint.

Competent Bodies in Greece

Ombudsman

The Ombudsman is appointed body to monitor and promote the implementation, in the private and public sector, of the principle of equal opportunities and equal treatment of men and women. An important innovation of Law 3896/2010 is the provision of paragraph 7 of article 25 which stipulates that especially and only when receiving reports of discrimination on grounds of sex, the Ombudsman will no longer stop the investigation if the person concerned goes to court but will continue the mediation effort to resolve the issue until the first hearing of the case or until a request for temporary judicial protection is considered.

General Secretariat for Demography and Family Policy and Gender Equality

The General Secretariat for Gender Equality has the responsibility for sexual harassment issues, and as the competent government body to design, implement and monitor national gender equality policies, has set the fight against violence against women among its strategic objectives. The National Program for the Prevention and Combating of Violence against Women has been implemented since 2010, when it took for the first time a comprehensive and coherent form, and concerns all forms of violence against women (domestic violence, sexual harassment, rape, trafficking etc).

3.1.2 IN PORTUGAL.

In Portugal, although marital abuse was present in law documents since decades, this form of violence was officially recognised as a crime and a social problem only in the 1980s, with the ratification of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1980 (which came into force in September 1981).

However, only in 2000 (reinforced in 2007 by the changes in Penal Code), domestic violence with an emphasis in gender inequalities was established as a crime of public concern. At the moment, G-BV poses a severe problem in Portuguese society, due to the alarming number of femicides and also for the setback in issues that women are facing.

Portugal was a pioneer country when learning about violence against women while contemplating abuse as a public crime in the Penal Code (1982). There is also other scarce legislation hardly applied on other crimes against person

physical and sexual integrity, including against rape, childhood sexual abuse and sexual “teasing”[1] .

Some advances in law and public services for women are also the result of the Istanbul Convention (2011, ratified by Portugal in February 2013), as well as the growing public awareness that the prevention of G-BV should be considered a priority.

Successive Portuguese governments have been allocating funding to projects (national and international) with regards to the prevention of gender and domestic violence, mainly since 2001, when the legislation on the support network for victims of domestic violence was implemented. Since 1999, a total of five National Plans have been approved and implemented in Portugal which are guiding instruments for the development of policies designed to prevent and intervene in the field of domestic violence.

Its design, implementation and monitoring are the responsibility of the Secretary of the State for Citizenship and Equality (SECI) and the Citizenship and Gender Equality Commission (CIG).

More recently, Decree-Law 112/2009, September 16, represents an essential step forward in the fight against G-BV in Portugal. It shed light on the prevention of G-BV (domestic violence according to Portuguese rules), offering protection and assistance to many victims from this atrocious tanning violence.

This law establishes a series of measures, among which we can highlight: Providing the rights of victims, which guarantees rapid and effective protection. In 2015, the Victim’s Statute was created (Law 130/2015 to provide women with a series of tools as a means to fulfil victims’ rights, such as information about legal processes, services and organizations where they can find help. Under these provisions, especially vulnerable victims (which include women with ID) are entitled to special protection by the State.

Although Portugal is building a path to consolidate rights and expand the protection of women victims of violence, some important gaps still need to be filled. The baseline report from the Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO)[2] encouraged the Portuguese authorities to

“a) develop studies and data regarding G-BV affecting groups of women who are discriminated against or at risk of being discriminated against, such as migrant, refugee and asylum-seeking women, women from ethnic minorities, including Roma women, **women with disabilities**, women from the LGBTI community, women in rural areas and women in prostitution;

b) integrate the perspective of such groups into the design, implementation, monitoring and evaluation of comprehensive and co-ordinated policies for **preventing and combating violence against women**;

c) mainstream preventing and combating violence against women in policies and programmes which are tailored to the **specific needs of such groups**.” (p.14)

The same report also stresses the importance of having a more comprehensive victim support service from the point of view of intersectionality, enabling to develop specialised responses mainly for women in special conditions of vulnerability.

In this way, GREVIO encourages the Portuguese authorities to “review spending levels to remedy existing gaps in the provision of specialist support services for victims of all forms of violence against women, including more vulnerable groups of victims such as girls, elderly women, women with disabilities, women from ethnic minorities - including Roma women - and migrant, refugee and asylum-seeking women” (p. 30).

[1] Which includes some behaviours of sexual harassment.

[2] Full report available at: https://rm.coe.int/grevio-reprt-on-portugal/168091f16f

3.1.3 IN SPAIN.

In Spain, the central axis of the legislative area that regulates the country's legal system in matters of equality is made up of the Spanish Constitution, Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against G-BV, Organic Law 3/2007, of March 22, for the Effective Equality of Women and Men and the State Pact against G-BV.

The Spanish Constitution (CE. BOE, December 29, 1978, no. 311) by virtue of article 14, recognizes the right to equality between men and women under the established principle of non-discrimination on the basis of sex: “The Spanish they are equal before the law, without any discrimination on the basis of birth, race, sex, religion, opinion or any other personal or social condition or circumstance ". Article 15 recognizes that “Everyone has the right to life and to physical and moral integrity, without, in any case, being subjected to torture or inhuman or degrading treatment or punishment […]”. Likewise, article 9.2 establishes that “It is the responsibility of the public authorities to promote the conditions so that the freedom and equality of the individual and of the groups in which they belong are real and effective; remove the obstacles that prevent or hinder its fullness […]”.

The Organic Law 1/2004, of December 28, on Comprehensive Protection Measures against G-BV (BOE, December 29, 2004, No. 313) aims to act against violence that, as a manifestation of discrimination, the situation of inequality and the power relations of men over women are exercised over them by those who are or have been their spouses or by those who are or have been linked to them by similar emotional relationships, even without coexistence (Art. 1.1) This law includes as G-BV any act of physical and psychological violence, including attacks on sexual freedom, threats, coercion or arbitrary deprivation of liberty (Art. 1.3).

Based on this law, a series of comprehensive protection measures are established aimed at preventing, punishing and eradicating this type of violence and providing assistance to women, their minor children and minors subject to their guardianship, or guardianship and custody. Likewise, this law includes the rights of women victims of G-BV (Title II) in relation to the right to information, comprehensive social assistance and free legal assistance (Chapter I), labor rights and Social Security benefits (Chapter II), rights of public officials (Chapter III) and economic rights (Chapter IV).

This law provides Institutional Guardianship (Title III) establishing coordination mechanisms between the agents involved in the fight against G-BV with the creation of the Special Government Delegation against Violence against Women (Art. 29), the State Observatory on Violence against Women (Art. 30) and specialized units in the State Security Forces and Bodies for the prevention of G-BV and in controlling the execution of the judicial measures adopted (Art. 31).

In addition, it is endowed with Judicial Protection (Title V) with the creation of Courts for Violence against Women (Chapter I), guaranteeing the specialized training of professionals. The Public Prosecutor (Chapter V. Art. 70) and the Sections against Violence against Women (Art. 71) are also created in each Prosecutor's Office of the Superior Courts of Justice and the Provincial Courts (Art. 72).

The Organic Law 3/2007, of March 22, for the Effective Equality of Women and Men (BOE, March 23, 2007, no. 71), aims to make effective the right to equal treatment and opportunities among women and men, in particular through the elimination of discrimination against women, whatever their circumstance or condition, in any of the spheres of life and, particularly, in the political, civil, labour, economic, social and cultural spheres […] (Art. 1).

This law establishes the principle of equal treatment between women and men, which supposes the absence of all discrimination, direct or indirect, on grounds of sex, and, especially, those derived from motherhood, the assumption of family obligations and civil status. (Art. 3).

This law introduces modifications to the legislation on sexual harassment and harassment for reasons of sex (Title I. Art. 7), understanding sexual harassment as any verbal or physical behaviour of a sexual nature that has the purpose or produces the effect of attempting to against the dignity of a person, in particular when an intimidating, degrading or offensive environment is created. And understood as harassment for reasons of sex which refers to the same type of behaviour, but carried out based on the sex of a person.

Furthermore, it contemplates discrimination based on pregnancy or maternity, which constitutes direct discrimination on the grounds of sex all unfavourable treatment of women related to pregnancy or maternity (Art. 8).

This law contemplates the legal consequences of discriminatory acts, so that the acts and clauses of legal businesses that constitute or because discrimination based on sex will be considered null and void, and will give rise to liability through a system of reparations or compensation that are real, effective and proportionate to the damage suffered […] (Title I. Art. 10). In those proceedings in which it is sued for discriminatory actions, on grounds of sex, it will be up to the defendant to prove the absence of discrimination […] (Title I. Art. 13.1).

Likewise, measures are established to prevent sexual harassment and harassment on the grounds of sex through the creation of equality plans in companies and other measures to promote equality, promoting prevention and awareness, as well as amendments to the Law of the Workers' Statute in this matter.

The State Pact against G-BV (Ministry of the Presidency, Relations with Courts and Equality, 2017) was approved in 2017 with the aim of eliminating any type of violence against women and defending their fundamental rights and freedoms.

Through the Government Delegation for G-BV, the central government promotes the measures for the development of the Pact in coordination with the rest of the dependent Ministries and Autonomous Organizations, as well as with the Autonomous Communities and Local Entities represented by the Spanish Federation of Municipalities and Provinces.

Another important point in the Spanish law is the Law 4/2015, 27th April, "The Legal Status of the Crime Victim".
This law is an important step in the Spanish legislative framework because it emphasizes the right to understand and to be understood (Article 5).
It is also regulated in this Statute of the Victim of the crime, the right of every victim to restorative justice services. Restorative Justice is an alternative model of Justice whose objective is to repair the damage caused to the victim. The most widespread practice of Restorative Justice is criminal mediation, although other practices such as circles and conferences have been more fully restorative. It is a process in which a third person outside the conflict between the victim and the person denounced always intervenes so that the latter helps the victim to overcome the situation that she herself has caused.
At the same time, the interest of the Law in the search for tools that avoid or minimize the "secondary re-victimization" typical of criminal proceedings deserves special attention, but that in the case of people with intellectual disabilities can be accentuated especially by the lack of understanding of the process, the rigidity of the usual methodology, and the traditional vocabulary of the legal field.
In the case of a person with a disability, the Law establishes two specific tools:
Art.26.1.a.- The recording of the statements. Its objective is to validate the first testimony avoiding as far as possible, always taking into account the principle of contradiction, infinite repetitions that lead the victim to relive the damage

produced on many occasions, as well as to preserve the testimony with the greatest number of details.
Art.26.1.b.- The statement may be received through experts. Subsequently, this support figure will also regulate Law 8/2021, of June 2, for other areas with the purpose of eliminating the barriers of people with ID in relation to communication, the right to understand and the right to be understood .
To sum up, another important point in this law is the figure of the facilitator psychologist. The main objective to the facilitator is to ensure the right to understand and to be understood with people with intellectual disability who are involved in legal procedures. In point 8 more will be said about the importance of this figure and its functions.

4. ABSTRACT OF THE ATHENA NEED ANAYLISIS REPORT.

G-BV 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).

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 ID. 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 ID, 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 minimize 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 ID (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 ID 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 (SOA), where a thorough research on information about gender-based violence against people with/without intellectual disabilities was conducted;and the Needs Analysis Report (NAR), where results and data analysis are presented jointly, integrating information from all countries.

This analysis identifies the main challenges in terms of knowledge and skills raised by professionals and informal caregivers of people with ID to effectively support this vulnerable group.

5. DIFFICULTIES IN DETECTION AND ATTENTION.

5.1. INTRODUCTION

Disability constitutes a risk factor for domestic violence, namely sexual abuse and mistreatment in both child and adult populations. Despite the scarce prevalence research in this regard, this is a reality that is beginning to be known. Recent data from Spain (Martorell, Alemany, 2017) points out that minors with disabilities are up to seven times more likely to suffer abuse than minors without disabilities. We were unable to find data related to the Portuguese reality within this aspect.

Whether considering the prevalence investigations of mistreatment and abuse in the general population or those that compare its incidence in the group of people with disabilities with respect to the general population, it is concluded that the non-disclosure of the crime is still the norm. This is clear from the one study in Spain that analyses complaints in the Civil Guard in which people with disabilities are involved (González, Cendra, Manzanero, 2013).

Different belief systems seem to upsurge when it regards to people with intellectual disability and mistreatment and/or abuse:

- ✓ children with ID are seen as cognitively incompetent and immoral beings who invent stories of abuse to engage successful adults, or as erotically seductive creatures;
- ✓ The equating of people with ID to minors (they continue to be selected as “eternal children”), are also transferred to the group of people with ID, to whom there are also myths that are still very frequent today day. (Losada, 2019)
- ✓ **Another myth is that people with ID are problematic. They cannot rule their lives, they lack sexuality or, on the contrary, that they have an outrageous sexuality. All of them constitute the alarming fact that their testimonies are considered less credible than those of the general population;**
- ✓ The fear that they will not be believed is one of the factors that maintain the secrecy of abuse, to which is added the ignorance of what abuse means, the imposition of the law of silence and threats from of the aggressor, shame, or the inability to express it. Therefore, the ability of the direct family or professional carer to know how to detect and intervene when a person with ID is being abused is crucial. (Del Moral, 2001).

Early detection can avoid a serious imbalance in the mental health of the person, but it is a complex task. Professional or family performance at the time of disclosure is key. Collecting the revelation properly, with an attitude of closeness and active listening, but with enough distance in a manner that does not contaminate the testimony or that allows acting from a non-critical credibility. Coordination with experts is necessary because the consequences arising from

the assessment may involve removing the person from their nucleus of coexistence, to reporting and facing a judicial process. All these involve the risk of a second victimization, which can only be stopped with an intense work of coordination between the family members, the professionals who provide direct care to the victim and the experts. (Alemany, 2012) Together they must implement the correct actions that will achieve an effective collection of evidence and testimonies, that facilitate the prosecution of the crime and that ensure the rights of the victim throughout the police and judicial procedure.

Police and judicial officers are key agent in this process. But often, they lack training and experience in interviewing people with ID. It is common to see the agents':

i) impatience and inattentive posture as the people with ID give their testimony;

ii) their feelings of pity and grief which in turn can prevent the adequate survey of their testimony;

iii) another difficulty encountered by people who interview people with ID is the one that arises from the confusion that the interviewer arouses the responses from the person with ID. Not being clear about what the interlocutor wants to say, causes the level of details obtained to be insufficient and, in many cases, conditioned by the type of questions, more closed and intimate.

For all these reasons, it is essential that direct informal and professional carers or trusted persons to actively accompany the PIDs who has been victim of abuse as they pass through the police and judicial system, deploying the necessary supports and demanding the pertinent adaptations (Alemany, 2012).

This Module is designed to provide all those family members, caregivers, teachers, instructors, psychologists, therapists, social workers, etc. which live and work with PIDs with some key resources which may allow them to respond to the challenge of a possible mistreatment or abuse, to assist the disclosure of the case and to accompany them in the social and legal services.

5.2. THE DETECTION

The possibility of considering, on the part of professionals or family members, that a person with ID might become the victim of abuse or mistreatment should

not be limited to cases in which there are confidences or direct disclosures of the person.

Precisely because now, more than before, minors and adults with disabilities are at greater risk of being abused and because, for a long time, myths associated with disability have prevented (Martorell, Alemany, 2011) a more attentive eye to signs, to indicators and to the presence of accompanying symptoms.

The indicators refer to:

→ the observable facts that point to abuse or mistreatment that are likely to be happening (remains of body fluids or physical signs in the genitals, fractures or bruises);

The symptoms refer to:

→ possible psychological consequences that the abuse or mistreatment may have on the person, but in no case, these are not the only ones, since there is no syndrome associated with the abuse.

Factors that condition the impact that the abuse leaves on the person may vary amongst:

i) the type of abuse;

ii) the relationship with the aggressor;

iii) the family support after the disclosure;

vi) or the consequences derived from passing through the judicial system. This impact can manifest itself in a multitude of ways.

Regarding abuse, the symptoms that can appear most frequently are:

- ✓ the presence of behavioural problems (behavioural alteration) related to a disorganized attachment style;
- ✓ PTSD, which frequently appears in the form of conduct disorder, especially in people with severe ID;
- ✓ Anxiety;
- ✓ depression (constant rejection of a person);
- ✓ deviant sexualized behaviour;
- ✓ learning problems that, as expected, in the group that concerns us, the latter are hardly detected, since they are frequently associated with the same diagnosis of ID;
- ✓ problems in self-esteem.

In relation to the latter, in the group of people with ID, the s osing effect" (the tendency of the clinician to attribute ID as th tric symptoms, overshadowing the presence of mental illnes h which the disability hypothesis ends up being the protag

Kendall-Tackett et al., after their meta-analysis on the i xual abuse, clearly show that sexually abused children have mo ns than

non-abused children, despite the fact that the presence of these is very heterogeneous. However, the sexually abused children had no more symptoms than other symptomatic children who came to a clinic for other reasons, except in the case of PTSD and sexualized behaviour.

The absence of symptoms associated with abuse and mistreatment should not detract from the credibility of the alleged victim's allegations, in the same way that the absence of emotional expression does not mean that the events have not happened. Taking these considerations into account in the context of disclosure is therefore a necessary, but not sufficient, requirement to act responsibly.

The eclipsing effect is alluded to refer the phenomenon by which psychiatric symptoms can go unnoticed when a person presents, at the same time as a mental illness, ID or cognitive impairment (Martorell et al., 2011)

5.3. The context of the revelation.

When there is spontaneous disclosure of a situation of abuse, it will be necessary to act to carry out an adequate assessment of the facts and, if necessary, protect the person. It is important that the person is cared for without questioning the veracity of the testimony (Manzanero, Recio, Alemany, 2013).

The initial attitude on the part of the person receiving the revelations should not be:

- ☹ one of disbelief, neither should these verbalizations be given uncritical credibility.

Instead:

- ☺ the person should be listened to and try to corroborate that the events described did indeed occur. For this, in most cases the participation of specialists in the assessment of abuse is required, since this type of act constitutes a crime and they can contribute to subsequent investigation processes. The indication to the person who receives it is to show an attitude of active listening, without showing shock but closeness, leaving the person to express herself freely and the time he needs, not interfering with it;
- ☺ a responsible action, which includes an adequate assessment of the disclosure of abuse that requires, in most cases, the planning of the necessary assessment interviews by experts in the field, as detailed in the following sections.

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There is a risk that, in order to verify the veracity of their disclosure, the person will be asked to repeat over and over again how the events happened. This constitutes an inadequate professional practice, since it implies an interference with the possible memories of the facts, in particular among PID, through re-

interpretations and could lead to their later manifestations not being taken into account during the judicial process.

When a spontaneous disclosure about possible abuse has been made, an appraisal interview can be conducted. There are a series of general principles (Manzanero, Recio, Alemany, 2013) that should be taken into account when conducting such interviews, the main objective of which will be to understand the discomfort that the person is expressing, not to confirm the abuse. These principles are:

• The victim must have confidence with the person who is interviewing, must be trained in this type of interview, or, at least, know the keys to their development.

• The fact of abuse or mistreatment should never be specifically suggested.

• Open questions will be used preferably. Closed questions will only be used in strictly necessary cases, in which the person has significant limitations in communication.

• The entire interview should be recorded literally. It´s also important, in order to keep the accessibility of the process, to adapt the language and support the person to ensure that the interview it´s fully understood.

Carrying out a meticulous record of both verbalizations and suspicions can be extremely useful in the event that the situation of abuse is indeed occurring or has occurred. All this information may be used for subsequent action by police, justice, health, forensic or clinical professionals, therefore preventing the victim from having to repeat his/her testimony.

If the person who is the custodian of the disclosure or their reference caregivers are not used to this type of assessment interview, or feel overwhelmed by the content of the disclosure, it is better not to rush into conducting the assessment interview and consult with a specialist.

Consultation with specialists or facilitators is essential (Martorell, Alemany, 2017) in those cases in which, due to the impairment of the capacities that affect the testimony, it is essential, as a preliminary work, to design and deploy the supports for the same interview.

Once the professional is the depositary of a confidence that points to a possible situation of risk or abuse, she must act, regardless of the doubts or fears that she may have in this regard. Professional intervention must be characterized by being responsible, which begins by assessing all the variables that can condition decision-making.

5.4. Recognition.

The complexity involved in any case of abuse or mistreatment committed to an adult (in cases of abuse committed to minors with ID there is no variation with respect to the protection actions that must be carried out with minors at risk) with

ID requires knowing how to act responsibly and the different variables that will condition the professional assessment and performance.

5.4.1 Type of abuse: intra-family or extra-family

Understanding the context in which the violence occurs is a fundamental element in assessing the case. It is clear that a case of sexual abuse in which the perpetrator is a stranger who assaults the victim is completely different from a case of sexual abuse in which the perpetrator is a family member, a caregiver, or a parent. Also, in other types of GB-V.

Whether it is one type of abuse or another will mobilize us to have the victim's family members from the outset or, on the contrary, to be cautious with the use that we make of disclosure with them. Thus, the general rule will be as follows:

A) If the abuse is committed by a known or unknown person, outside the family, the actions will be carried out in coordination with the family from the first moment, contrasting the professional response with the family's response to the disclosure, and deciding with them the following steps.

B) If the abuse is committed by a family member with whom the person with ID who reveals the crime lives, the professional's duty to protect the victim will prevail without involving the alleged aggressor in the pertinent assessments and actions. Nor will relatives participate in the proceedings whose ability to maintain the confidentiality of the assessment is doubted (Cirillo, 2013).

Different types of abuse determine different relational dynamics (Barudy, 1998):

- **Outside-family** sexual abuse (where the abuser, depending on whether he is known or unknown, will display different guidelines of conduct:

  i) An unknown abuser will act by exerting force and will enjoy the suffering of the victim. The degree of victim´s suffering will depend on the context and the degree of the aggression.

  ii) On the other hand, a known abuser will gain the trust of the family circle, and act to manipulate from that trust. He acts from a position of authority.

- **Intra-family** sexual abuse (refers to those cases in which the abuser is a relative. People who have suffered sexual abuse by a parent are not only abused by someone on whom they vitally depend, but it is difficult for them to understand it as a form of violence or an abuse of power by the adult. For example, if sexual abuse is perpetrated by the same person who performs hygiene care (as it can happen in people with a higher level of dependency), the ability to distinguish sexual acts from hygiene tasks can be very difficult.

Knowing the dynamics under which all kinds of GB-Vccurs by a family member or a known person of the trust of the victim or a relative, is useful to subsequently be able to make an adequate analysis of the validity of the testimony of the victim, and to be able to identify all those dynamics that underlie the establishment of an abusive relationship of this type, and that hardly a person with ID can invent (see table below).

Failure to identify these relational dynamics can lead the interviewer to reduce the credibility of the victim's testimony, considering that there is no emotionality accompanying the story.

There are different phases to recognition, and it´s useful to identify in which of them are the victim (Rivera, 2020):

i) Seduction phase: manipulation of the victim's trust and dependence. Inciting the victim to participate in erotic games, preparing the physical space where the abuses will take place.

ii) Abusive sexual interaction phase: gradual and progressive process. Exhibitionism, caresses with sexual intentions, masturbation, fellatio, penetration, exposure to pornographic/ sexually explicit material.

iii) The secrets: the abuser imposes the law of silence, the abused can only adapt to the situation, the relatives are absent or complicit.

iv) Disclosure: accidental or premeditated.

If the victim finds her/himself in a “sexually abusive” family in which the parents become direct or indirect complicit of the abuser, after the disclosure of the abuse, a phase may appear in which the family desperately seeks to rebalance itself, convincing the victim that what happened was not real, or that it did not matter.

Something similar can happen in those institutions where sexual abuse is committed by a caregiver of the person with ID. In these cases:

- the victim does not want to "risk" reporting it;
- the victim does not want to experience not being believed by the institutional parties when sharing the situation, therefore establishing a new “pact of silence”;
- the victim does not want to risk hearing that she has dreamed of it;On the contrary, if we find ourselves in a protective context, disclosure will inevitably lead them to assess a possible complaint.

5.4.2 Criminal case: if the crime is against sexual freedom or it is a crime of domestic or gender-based violence

A) If the crime is abuse or sexual assault, we are dealing with a semi-public crime, so the victim is the only person who can decide whether to file a complaint.

B) When the violation occurs in the private sphere of the victim, it is on the person to find the power to publicize it.

C) On the other hand, if the crime is of domestic or G-BV (which includes both the habitual aggression exerted by the members of the nucleus of coexistence, as well as by partners or ex-partners, as well as by professionals who hold their guardianship), we are facing a public crime and anyone who witnesses it must file a complaint. (See Module 3, section 3, for more information).

5.4.3. Whether or not the person is legally incapacitated

If the victim is incapacitated, the legal actions must be carried out in coordination with the guardian, who has the right to be present in the different police and judicial actions that are carried out with the victim. Note that having the right to be at the time of the report does not imply that any person with a disability, whether or not they are legally incapacitated, has the ability to report (see table below).

If the guardian is the alleged aggressor, then any judicial action will begin by notifying the Public Prosecutor of the person's situation of helplessness, and the request for a protection order with the necessary measures.

5.4.4. Time elapsed since the perpetration of the crime

If the sexual assault or abuse has been committed in the last 72 hours:

a) the medical examiner has the possibility to preserve the evidence;

b) For this, in most of the current protocols of intervention against sexual abuse, it is essential to have filed a complaint as memories are in continuous change (Baddeley, Eysenck y Anderson, 2010).

c) a rapid intervention will prevail. This means helping the person to decide if they want to report the case and, if so, to accompany them urgently to the specialized service of the State Security Forces and Corps, to be subsequently assessed by the forensic doctor.

If the abuse or sexual assault has been committed before the last 72 hours:

a) there will be no possibility of collecting samples;

b) . In these cases, however, other medical evidence may be collected (part of injuries, for example), as well as obtaining the testimony, for which the intervention of experts in the field will be essential.

5.4.5. Whether an emergency health intervention is required or not

When an emergency health intervention is required, it is the professional's obligation to transfer the victim to the reference health services.

The National protocols for health action against G-BV (2012) of the Spanish Ministry of Health, Social Services and Equality, which also includes sexual assaults, establishes “that the psychological impacts suffered by women should be reduced to the least possible number [or the victim] after the assault.

→ For this reason, it is not only justified, but it is recommended that the gynaecological evaluation and the forensic doctor be carried out in a single act, regardless of the health and expert actions, but ensuring that no new examination is required.

→ For this reason, and because there is no legal or ethical impediment - quite the contrary - for the examinations in cases of sexual assaults to be carried out simultaneously and in a coordinated manner, immediate communication via telephone with the Guard Court is necessary, which will agree to the assistance of the forensic doctor or entrust the doctor on duty with the collection of samples of legal interest”.

5.4.6. If the victim has the capacity to decide about the complaint

It is important that before activating the reporting process, it is assessed whether the person with ID can decide whether or not h/she wants to report. To carry out this assessment, it must be taken into account that a person with ID has the ability to decide to report if she:

• Is an adult;

• Knows the consequences derived from the complaint (positive and negative);

• She/he is not coerced, pressured or threatened to do so;

• Knows what it means to report or understands it if a responsible agent informs her/him of it;

In the inability to decide on the process of the complaint:

- she/he must be provided with all the necessary support so that she/he can decide if she wishes to report. Regardless of the given doubts, supporters will always benefit victims to face the police investigation (Contreras, 2015);
- In cases where all resources have been exhausted to implement the support so that they can decide, their family members and professionals will decide under the principle of the best interests of the victim.

The consequences that may arise from the complaint will have been considered and it will be ensured that the victim is not in contact with the alleged aggressor at the time of the complaint.

If the alleged aggressor is the victim's guardian or caregiver and lives with her/him, before the report is filed, the conditions must be carried out that allow the necessary protection measures to be activated:

The protection measures must always be agreed with the affected person (Contreras et al., 2015), offering all the support needed, and without precipitating a professional action that implies violating victim´s right to decide.

5.5. The implementation of support for the complaint and the judicial process.

In the face of a declaration of an abuse committed against a person with ID, there is a whole series of support that can be provided to the person when facing the police and judicial process (Recio, Alemany, Manzanero, 2012):

• Offer all the necessary explanations that (1) allow the person to understand what a report is, (2) why it should be reported, (3) what is going to happen at the police station, (4) why the police is going to ask them and (5) why it is important that they tell the truth. For this, easy-to-read materials for people with ID may be used.

• It is essential that the person is able to anticipate what will happen and that, before going to file the complaint, all their fears have been addressed (for example, the fear of not knowing what to answer, the fear of not understanding the questions, the fear that the aggressor finds out, the fear of seeing him again, the fear that they will not believe them, the fear of going home if they confess it, the fear for other people who may be at risk, etc.).

→ Addressing these fears in no way involves preparing the statement through rehearsals. The preparation of their statement through trials of possible interrogations should be avoided, firstly because they are a source of secondary victimization, and secondly because their manifestations will lose spontaneity and therefore credibility with possible subsequent forensic evaluations.

• Accompany at the time of the complaint and subsequent judicial process, demanding that the person not be left alone with the police or judicial agents if they do not want to, and offering the companion of "emotional support" at every moment of the process.

• Support throughout the process, in coordination with the victim's attorneys, with the Public Prosecutor's Office or with police and judicial agents, so that unnecessary repetitive statements are avoided and the required support is implemented throughout the entire process and in accordance to the UN Convention on the Rights of Persons with Disabilities.

• Carry out coordination with specialists in the intervention with victims with ID who help the professionals involved to activate the necessary protection measures and optimal adaptations during the judicial process, through the figure of the facilitator, and who guarantee that the forensic assessments are adapted to the person's disability.

5.6. The management of disclosure from the organization.

One of the main problems faced by organizations that work at the support services for people with ID who have been a victim of some type of abuse is the organization's handling of information related to abuse. (Recio, Alemany, Manzanero, 2012). This aspect becomes crucial if one takes into account that the handling of the information will largely depend on the well-being and mental health of the victim.

Inappropriate handling of such information can lead to:

i) increased stigmatization of the victim, with the consequent increase in feelings of shame or guilt;

ii) it can also affect negatively the justice procedure, increasing the negative consequences for the victim.

Prior to making any decision about how to handle the information related to the abuse, it is important to keep in mind that the victim's right to privacy must prevail. This right implies that the victim must be the one to decide how much information they want to share and to which person or persons will the access to the information be granted. It should be mentioned that the handling of the information from the institution to which the victim attends will depend mainly on the origin of the perpetrator of the crime. Two assumptions are considered:

a) When the perpetrator of the crime has no relationship with the organization. Knowledge of the abuse by professionals is subject to the wishes of the victim and / or her legal guardians, who must give their written consent. These will allow the victim to vent with the person (professional or user) that she chooses, regardless of the specialized services that are offered.

b) When the perpetrator of the crime is part of the organization's professional or user staff. The information regarding the abuse that is handled must respect the right to privacy of the victim and the right of the alleged perpetrator to the presumption of innocence. It will be guaranteed, from the professional duty of protection against a possible crime, that during the police and judicial investigation process the alleged perpetrator of the abuse does not have access to the alleged victim.

→ The experience should help the organization to carry out an assessment and evaluation of the facts and activate preventive measures against possible future abuses. It must emerge a responsibility evaluation of the organization. The police investigation needs to address the role of the organization in the case.

In all cases, if it is considered necessary for a professional to know certain information related to the abuse, the written consent of the victim and / or her legal guardians will always be requested. All of them should know the reasons why it is important that certain professionals know aspects related to abuse.

These professionals can be reference support people (teachers, instructors, job coaches or psychologists with whom the victim deals), who should be alert to possible manifestations or symptoms derived from abuse, and deploy the necessary actions for their treatment (Estellés, Alemany, Martín Caro, 2017)

The treatment that is made of all this information, once it has been obtained with the written consent of the victim and / or their legal guardians, must comply with the provisions of the Law on Data Protection.

5.7. Conclusion.

For an alleged abuse to reach specialized services or a police context, it must normally be a third party (usually a family member or professional close to the victim) who realizes that the person is suffering from a health concern, therefore carrying out a follow-up in order to understand the reason for the discomfort.

The response of the professional or family member to the manifestations of discomfort in the person with ID is crucial. There may be cases of negligent responses, such as:

i) those marked by an inability to observe and care;

ii) or by a denial of discomfort;

iii) or by a general attribution of the person's different behaviour to the same disability.

→ On the contrary, responsible responses will be characterized by the ability to know how to listen, care, and value, being able to tolerate the hypothesis of abuse, but without having an uncritical credulity.

Faced with verbalizations of abuse or mistreatment, and even with the presence of indicators, unfortunately the tendency on too many occasions, and regardless of the veracity that is granted, is to decide to cover it up, not to report it. In this decision intervenes the generalized belief that the police and judicial system is aggressive, that it is not capable of deploying the necessary support to vulnerable victims.

After the commission of a criminal act, it happens that, in addition to the physical, economic, psychological and social damage produced, the victim usually experiences a serious emotional impact, which is aggravated, on occasions, by coming into contact with the generally unknown legal-criminal framework. Victims with ID are rarely explained about this framework. They are not even asked if they want to participate in it:

a) the rights of the person with ID are generally ignored because no one provides the legal information in a way that is tailored for them to understand;

b) On the other hand, it is frequent that neither the clinical instruments nor the credibility reports used have been validated in this group. All of this leads to what the doctrine calls "second victimization", an experience that in many cases is even more damaging than the criminal activity itself, and that causes many feelings of helplessness.

→ Therefore, it is vitally important that the necessary adaptations are made so that people with disabilities, and especially the most vulnerable, those with an ID, have equal access to justice.

How?

- ✓ This goes through the capacity of the system, starting with the police officers and forensic professionals and experts, to offer the support and apply the necessary procedural adjustments.
- ✓ The adoption of specific measures for the group of people with ID is justified given the need to protect the person due to their lack of understanding and will, and is in accordance the United Nations Convention on the Rights of Persons with Disabilities, also obliges us to:

“States Parties shall ensure that persons with disabilities have access to justice on an equal basis with others, including through procedural and age-appropriate adjustments, to facilitate the performance of the effective functions of such persons as direct and indirect participants., including testimony as witnesses, in all judicial proceedings, including the investigation stage and other preliminary stages” (article 13.1).

Professionals and family members who report a possible abuse or mistreatment can contribute to opening the door of access to justice, acting responsibly and demanding that the supports be implemented in each of the phases of the police and judicial process, or, on the contrary, they can help to keep it closed. With these lines I hope I have encouraged the former.

6. SUPPORT AND STRATEGIES TO MINIMIZE SECONDARY VICTIMIZATION.

People with ID are highly vulnerable to any type of abuse and violence (Verdugo, 2002). In fact, the prevalence of abuse of people with ID is very high compared to the population without ID.

With this scenario, both people with ID who have suffered abuse or mistreatment, as well as their families, must also face a double challenge:

1) they must face the emotional consequences that the abuse or mistreatment has left behind;

2) these people often have to face a police and judicial system that is not suited to their condition, causing their access to justice to be unequal.

To respond to this double need of victims with ID (overcoming the damage derived from abuse and accessing the judicial and police systems on equal terms), a new model of methodological intervention is proposed both at the therapeutic, police and judicial level, highlighting in the latter the introduction of the figure of the facilitator (Martorell, Alemany, 2017).

This figure is based on the English model of the ISVA (Independent Sexual Violence Advisor), a public service specialized in cases of sexual abuse of vulnerable victims that adapts the entire criminal process to their needs. More info at: https://www.gov.uk/government/publications/the-role-of-the-independent-sexual-violence-adviser-isva

Through the figure of the facilitator, we want to:

1) adapt the passage of people with ID through the police and judicial systems;

2) contributes to a more effective access to justice for these people since it allows the procedures to be adapted to the limitations and capacities of each of the people with ID who have been the victim of abuse or mistreatment and have decided to report.

3) contribute to the awareness on the need for police and judicial agents to adapt their procedures according to the UN Convention on the Rights of Persons with Disabilities, 2006.

Regarding therapeutic intervention, the project proposes:

A) a new intervention model to restore damage derived from abuse in victims with ID, not limiting itself to the behavior modification strategies commonly used with this population;

B) it does not focus exclusively on the traumatic experience, but rather addresses the difficulties of the person and the family member derived from the disability itself.

C) It intends to include networking with all the agents that revolve around the victim, such as their relatives or professionals who work at her service (Martorell, Alemany, 2017).

On the one hand, all the vulnerability factors that condition, as indicated above, the identity of the person with ID and the relationship of society as a whole with them must be considered.

The vulnerability factor will have important consequences in the intervention because, (1) it can make chronicle the abuse (given the difficulties associated with its detection); and (2) amplify the severity of its consequences, not providing resources for protection or treatment for victims or even aggravating and doubly victimizing people who have been abused (Verdugo, 2002).

→ Women with ID who face the judicial process are much more likely to suffer what is called “secondary victimization”, defined as the damage caused by the institutions or professionals in charge of assisting the person with ID who is the victim of abuse and their context: judges / zas, experts, police officers, prosecutors, etc.

Both factors, the vulnerability of people with ID and the difficulties of professionals in detection, protection and intervention, are interconnected, since the vulnerability factors will condition detection, protection and intervention (less credibility, dependence …). And the impact of abuse and the consequences that derive from it, can reinforce and amplify these mechanisms of vulnerability.

The intervention will therefore be carried out in a network, in continuous coordination, adapting it to the needs, limitations and capacities of the person and the context itself.

In this way, it is intended that the label of ID does not eclipse the abilities that the person possesses and the new learning that could be achieved and that, in turn, will act as protective factors against future risk situations.

The three figures that will support the proceedings are:

Many of these actions overlap in time, so that both the victim and her/his context can make use of the different resources depending on the specific needs.

The role of the facilitator

1) constitutes one of the main procedural adjustments aimed at adapting judicial processes to people with ID;

2) is an independent and neutral psychology professional, an expert in ID and forensic psychology (and especially in the field of testimony psychology);

3) whose purpose is to assess the capacities and limitations of people with ID participating in legal proceedings, in order to design and implement the necessary support and procedural adjustments so that they can access justice on equal terms with other people.

This approach is based on the ISVA (Independent Sexual Violence Advisor) of the United Kingdom, which since the late 90s and during the 2000s exercised the role of professional intermediaries both in the police investigation and in the trial, to assist in communication and offer the necessary support so that victims with ID could offer a statement with guarantees. Specifically, the functions of the facilitator are as follows:

- Apply the Protocol for the Assessment of Capacities that Affect the Testimony of the person with ID (ECAT-DI) (see chapter 8, page 49). By applying this protocol, the facilitator assesses the capacities and limitations of the person with ID, in order to design and implement the supports and procedural adjustments necessary so that they can participate in the process with all the guarantees.

- Advise legal operators. Once the ECAT-DI Protocol has been applied, the facilitator prepares a report that refers to both the limitations detected and the supports designed. This report is provided from the beginning of the procedure, and the facilitator complements its content with detailed advice on the best way to practice the tests –especially the witness ones– based on the results of the ECAT-DI.

- Assist the person in the proceedings of evidence. In order to adapt the content and development of the test procedures to the limitations and capacities of the person with ID, the facilitator assists them during the practice of the same, intervening as necessary always in a neutral and independent way (p. e.g.: adapting the questions asked by the parties to their ability to understand).

- Adapt the expert evidence. On those occasions in which some type of expert evidence is carried out on aspects of the person that may be related to ID (e.g.: forensic psychological tests), the facilitator, as an expert on ID, actively participates in the practice of said experts, either by performing them directly, or by advising the experts appointed for this purpose.

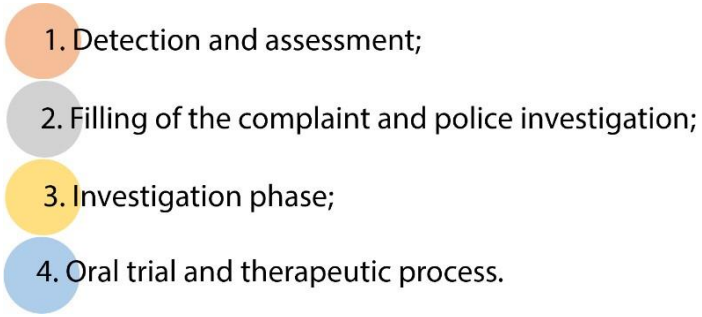
- Adapt judicial decisions. Throughout the procedure, a series of documents are generated that are directly notified to the person with ID (eg: rights sheets, citations, resolutions, etc.). The facilitator is responsible for adapting the content of this documentation to the capabilities of the person in order to facilitate the understanding of it and guarantee the rights of it.

Through the development of these functions, the intervention of the facilitator:

1) guarantees access to justice for people with disabilities in judicial proceedings;

2) complies not only with the Convention on the Rights of Persons with Disabilities, but also with other international and national legal instruments, such as the International Principles and Guidelines on access to justice for persons with disabilities, which define and promote the figure of intermediaries / facilitators (Martorell, Alemany, 2017).

The intervention may vary depending on the moment of the process in which it is, placing 4 phases within it:



The different professionals involved in the different phases are:

- Detection and assessment: a **psychologist** in charge of assessing suspicions and a lawyer who, together with the psychologist, provides advice to the person with ID, family members and professionals.

- Filling in the complaint, police investigation, investigation phase and oral trial: **facilitator and lawyer**. The facilitator will take care of all the necessary adaptations for the person with ID to face the judicial process with all possible

guarantees. And on the other hand, the lawyer can perform both advisory tasks and represent the case in the criminal process.

- Therapeutic process: **psychologist.**

Before beginning to describe each of the phases, it should be noted that all the interventions described below are recorded on audio-visual support, after the consent of the parties participating in them.

1. Detection and assessment;

In this phase, attention is divided into two fundamental tasks:

→ advice to professionals and family members, mainly in the identification of indicators and symptoms that can help in the detection of a case and in the protection and creation of a safe and violence-free context;

→ On the other hand, also in cases where it is required, either because in its first verbalization there are doubts about what has happened, or because nothing has been verbalized yet, but there are enough indicators, a testimony is obtained.

It´s important to respect always the self-determination of the victim, many times the perception of this process changes between PID and professionals (Giménez García, 2017)

This obtaining of the testimony consists of a series of actions in which support of different kinds will be deployed to help the person with ID to be able to verbalize what has happened to him. To do this, in the first place, all the information about the indicators and previous verbalizations is collected, as well as all the reports that are had in order to know both the context of the person, as well as all those variables that will help us in this performance.

After studying all the information and, prior to obtaining the testimony, an Evaluation of the Capacities that Affect the Testimony of people with ID is carried out through the ECAT-DI protocol (Recio, Alemany. 2014),

The objective of this assessment is to detect the limitations of the person in the different capacities that affect when giving a statement (expression, comprehension, memory, attention ...) and once detected, implement the necessary supports in relation to those capacities that are have been affected, in order to help the person, explain and verbalize everything that may have happened to them. After this assessment, the interview is carried out to obtain the testimony.

At the end, a report is prepared that reflects the conclusions of the obtaining of the testimony, the limitations detected in the ECAT-DI and the supports and needs that the person requires for an adequate interview or statement are developed.

In this phase, counselling is tailored to the person and their immediate context on the most appropriate resources based on what has happened. If the person with ID or his / her family (in case they are a minor or legally incapacitated) decides to file a complaint, the facilitator may inform them about the different phases of the complaint and the criminal process (e.g., what is a complaint, phases of the criminal process, functions of the different legal operators, etc.).

Several specific tools have been created, both for people with ID, as well as for professionals and families for this purpose.

Diagnostic assessments of disability should also be carried out on those people who come to our attention from entities that work with victims of human traffick and it is suspected that they may have an ID, since in most cases it is not assessed.

In many cases, we are talking about people who have not had the opportunity to develop both academically and personally and socially, which causes many difficulties when learning certain content and having acquired adaptive and social skills.

The aforementioned collaborating organizations contact ATHENA or one of the resources you are going to find in this document, to refer the case and carry out an assessment that encompasses the victim's personal, cognitive and emotional aspects.

The intervention can be established in different phases.

- ✓ Professionals carry out, through different tests, an assessment of ID and, on the other hand, an assessment of the emotional state assessing the mental health of the person and the possible presence of a post-traumatic stress disorder, anxiety or depression, among others, through specific tests for ID and following the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the diagnostic criteria for psychiatric disorders for adults with ID (DC-LD).
- ✓ After the assessment of the victim, a report is made collecting the results of the evaluation for the ID request for the corresponding base centre.

2. Filling of the complaint and police investigation;

Sometimes, the referral of cases comes once the complaint has been filed, generally by other people who are not the person with ID and are the State Security Forces and Corps (Family and Women's Attention Unit of the National Corps Police, Local Police, Municipal Police Diversity Management Unit, etc.)

On these occasions, the objective of the referral will be to obtain the testimony in the best possible conditions and the facilitator will be in charge of this objective (Alemany, Quintana. 2012).

To do this, in coordination with the service that derives the case:

→ the first step is to study all the documentation available (previous reports, previous verbalizations of the fact to be investigated ...).
→ Afterwards, an initial interview is carried out in which the alleged victim and her closest context attend, with the aim of explaining the objectives and methodology that will be used to obtain the testimony.

As is done in the detection phase, before taking the statement, the ECATI-DI Protocol is applied to adapt the collection of testimony to the person evaluated, the testimony is collected and, finally, a report of the proceedings is prepared made which are attached, together with the recordings, to the police reports.

3. Investigation phase;

The actions carried out at this stage are similar to those described above. In this phase, there can be judges, lawyers or prosecutors.

→ This intervention consists of the preparation of an ECAT-DI report in order to facilitate the alleged victim's statement during the investigation phase and, in addition to the above, in participating in the statement as experts in the oral trial phase.

The participation of the facilitator in this stage is crucial. It will offer a greater guarantee for the safeguarding of the rights of the person with disabilities and therefore will be a useful instrument in the prevention of secondary victimization.

i) the tools available;

ii) the knowledge in the treatment of people with ID

iii) the experience in the forensic and clinical field

will guarantee the obtaining of testimony in the best possible conditions.

Finally, the facilitator also offers to adapt the testimony, depending on the limitations and capacities of the person with ID, thus allowing a better understanding of the terms and content of the sentence.

4. Oral trial and therapeutic process.

The objective of therapy is to restore the damage or mitigate the impact that the different traumas that the person with ID has to live with.

The conceptual framework, as indicated above, is a psychotherapeutic intervention model adapted to victims with ID, their families and their immediate context.

There are several modalities, depending on the impact:

- ✓ On the one hand, individual therapy is offered when the impact has mainly fallen on the victim, or family therapy when the impact has not only fallen on the victim, but also their closest context is affected by said abuse and this impact, in a circular way, is having an impact on the victim himself.
- ✓ Both in the vulnerability factors and in secondary trauma, elements are involved that will modulate the impact that ID and the situation of criminal victimization leave on the person respectively.
- ✓ Therefore, the therapeutic intervention suggested in these materials can not only be focused on the abuse but also on those factors that have contributed to this abuse being carried out (dependency, submission, the credibility of the person with a disability, self-esteem ...).

In other words, is how the label that is dragged from old explanatory models about ID and the patriarchal values of our society that have affected the identity of the person with ID and their context. The latter is often much more damaging than the violence itself.

7. DIFFICULTIES OF VICTIMS OF DV/G-BV WITH ID BEFORE THE COMPLAINT.

7.1. How to overcome the limitations of the victim with ID before the complaint?

One of the most important supports that we are going to use to face a criminal process with all the guarantees for the victim with ID is the:

→ report of the evaluation of their capacities. (Contreras, Silva, Manzanero, 2015):

This report is nothing more than an analysis of the limitations that each victim, due to their disability, may have when giving a statement, and in which one or more supports are offered to help police officers and legal operators to overcome each of these limitations, so that communication with the victim can be as fluid as possible and more accurate and detailed information can be achieved.

In principle, any professional who knows the victim, her limitations and what supports' work is necessary to overcome them, could prepare this document. However, to ensure ~~a~~ better quality in the report, it is advisable to have professionals who are experts in the field for this task.

7.2. What supports should be included in the filling of the complaint?

In this phase, the main difficulty is to ensure that the report reflects a good statement of what has happened to the victim with ID~~,~~ and that the account of the events is as accurate, coherent, and detailed as possible.

Notwithstanding the foregoing, and despite the progress made in the police officers regarding care and intervention with especially vulnerable victims, there continue~~s~~ to be external factors:

- perception of hostility and coldness that may emanate from police units;
- involuntary intimidation that agents and / or their uniforms may exercise;
- little training of agents in ID, etc.)

And factors inherent to disability:

- communication problems;
- poor spatio-temporal orientation;
- episodic memory problems;
- phenomena of social desirability and acquiescence

These make it extremely difficult to file a ~~good~~ sufficient complaint (Giménez-García, 2017).

Therefore, and given that the victim with ID - may have to repeat again in court – probably several times– the content of her statement, it would be preferable to avoid her presence in the filling of the complaint.

This with a double objective:

1) to avoid the impairment of her testimony caused by the constant repetition of the event,

2) to protect her from the effect of re-victimization.

To avoid her attendance at police stations, we can provide –if we have it– audio-visual support, or replace her statement with that of a reference witness (the first person to whom she told it). As it is not uncommon not to be able to count on either of these two possibilities or, even with them, the agent may request the presence and / or signature of the victim themself in order to file the complaint. It would be preferable to provide a capacity assessment report and request that a statement is taken is the assistance of a facilitator.

7.3. What is a facilitator?

The facilitator's work and concept can be found on chapter 8 in more detail. As an introductory note, the facilitator is:

I) an independent and neutral professional of psychology

II) expert in ID and in the evaluation of cognitive abilities that affect the judicial process;

III) who assists the person with ID in their communication during the police and judicial process;

IV)who offers the necessary support to guarantee a valid and reliable testimony (Martorell, Alemany. 2017).

The facilitator's main functions would be as follows:

- to emotionally accompany the victim with ID, so that the victim is as calm as possible, reducing the effect of secondary victimization;
- to inform the victim with ID about the functioning of the police and judicial system (what is a complaint, who is the police, why do they have to interview him, etc.);
- To advise police officers and legal operators on the relevant adaptations that should be carried out in the interviews with the victim with ID based on the capacity assessment carried out;
- to design the supports required for taking a statement (offering to be a translator in police interviews and judicial statements, reformulating the questions and explanations adapting them to the level of understanding of the victim, etc.).

On certain occasions - for example: absence or unavailability of facilitators, great communication difficulties, etc. - the figure of the facilitator may also be held by a person close to the victim, with whom the victim feels safe and with whom it has been established a fluid communication channel.

8. SUPPORT IN THE PROCESS: FACILITATOR.

Some persons with ID can have special difficulties, along a judicial or police process, to understand and tell some facts due to several limitations and communication problems (Giménez-García, 2017).

This fact couldn´t mean, in any case, the assumption that the persons with ID can´t offer a judicial declaration or even carry out an investigation full of guarantees. However, they are still considered by too many professionals as less valid witnesses or even less credible.

Behind that consideration, it hides a poor level of knowledge about the disability, being this the main barrier to achieve the general principles of no discrimination, the equality of opportunities and the accessibility to the judicial system (UNCPD, 2006).

Achieve that the principles of the UNCPD can be accomplished means the incorporation of supports and adaptations, as in the police investigation phase as in the judicial process.

A priority measure to break down the barriers that victims and witnesses with ID have to face is the presence of the figure of the facilitator, an expert psychologist in ID and Testimony Psychology. The introduction of it, accepted and introduced in the protocols of judicial action, would be a fundamental milestone to comply in partner countries with the guidelines set by the Convention.

Today, in London police forces, for example, the police interview of a victim of sexual abuse with ID is carried out with the figure of the "ISVA" (Independent Sexual Violence Advisor), an independent facilitator in cases of sexual abuse of persons. especially vulnerable. Officially the introduction of facilitators and the necessary adaptations in the interview with victims with ID were not introduced until a few years ago.

Its acceptance stems from numerous investigations (Contreras, Silva, Manzanero. 2015) that show that vulnerable people are not adequately interviewed and that in those cases in which they are interviewed inadequately, especially with suggestive styles, their testimony may be altered.

The coordinated work between the facilitators, the police and judicial agents seeks to guarantee equal access to justice for the person with ID, minimize the emotional impact of the person with ID in their passage through the judicial system, preventing secondary victimization and, therefore, lastly, to guarantee the obtaining of the witness evidence in the best conditions in terms of quality.

8.1 The role of the facilitator.

The facilitator is an independent and neutral professional. S/he can be psychologist, mental health professional, social worker or expert in ID, and can assist in the assessment of the capacities that could affect a judicial process and in the implementation of the necessary supports with the persons with ID along this process.

S/he can provide assistance to the person with ID along the process. The facilitator guarantees a valid a credible testimony.

They assist the latter in their communication during the police and judicial process as well as to the police and judicial agents, supporting them to guarantee valid and reliable testimony.

Thus, the facilitator ensures that the police and judicial agents are provided with the witness's evidence in the best conditions (Martorell, Alemany. 2017). More specifically, its functions would be the following:

• To inform the victim with ID about the functioning of the police and judicial system (what is a complaint, who is the police, why do they have to interview him, etc ...). For most of the population, going through the police and judicial systems is a stressful experience.

For people with ID, who have more difficulty understanding the complexities of the system, it is essential to insert supports that allow them to understand, for example, the reasons why they have to tell so many people about their victimization experiences or what it is the function of the different agents that appear throughout the judicial process.

• To help the victim with ID to decide if she wants to report (in cases where the victim is an adult). Usually, decisions concerning people with ID are made by third parties, thus nullifying the right of these people to decide about their lives.

Not counting on their decision not only violates their rights but also carries notable emotional consequences, since it leaves the person in a situation of incomprehension, defencelessness and powerlessness. In this sense, the supports that allow the person with ID to understand the implications and consequences of filing a complaint are essential and legally necessary.

• To evaluate all the capacities that may affect the police and judicial investigation, with special emphasis on those involved in the testimony. Later, in this Module, the importance of assessing the capacities of the person with ID is explained in detail. Failure to carry out this evaluation will significantly limit the good work of the police and judicial agents and will hinder access to justice for these people on an equal basis.

• To evaluate the ability to consent to sexual relations in the person with ID, since in many cases of sexual abuse this evaluation is essential for the judicial investigation, and must be adapted according to the capacities previously assessed.

• To advise police and judicial agents on the supports that must be implemented and the pertinent adaptations that must be carried out based on the evaluation carried out. In light of the aforementioned capacity assessment, supports must be developed that allow the agents involved to communicate adequately with the person and obtain a quality witness testimony. Thus, it is understood that the work of this expert figure is not only to facilitate the person with ID in their passage through the judicial system, but also to unblock their work from judicial agents.

• To accompany the victim and her relatives throughout the police and judicial procedures, adapting the explanations of each of the phases to the person with ID, as well as the orders and sentences.

• To serve as an expert during the testimony takings, the reconnaissance rounds or the pre-constituted tests, guaranteeing that these processes are adapted to the previously carried out capacity assessment and implementing the necessary support.

The pre-constituted test is intended to guarantee the obtaining of the testimony and to preserve it. It guarantees the protection of the victim and avoids their public exposure, limiting this to contact with specialists, avoiding as far as possible new traumatizing codifications of the criminal event.

The very characteristics of this test avoid the repetition of statements and guarantee the principle of contradiction, since the parties may intervene through the facilitating specialists.

Having an expert facilitator throughout the police and judicial process guarantees:

• Compliance with the right of the person with ID to participation and information (Directive 2012/29 / EU of the European Parliament and of the Council of October 25, 2012, which establishes the minimum standards on rights, support and protection of crime victims).

• Access to justice on equal terms with the others, through the necessary procedural adjustments (Article 13.1 United Nations Convention on the Rights of Persons with Disabilities).

8.2 Tools of the facilitator.

8.2.1. The Interview of Obtaining the Testimony by Phases Adapted to People with ID.

The Interview of obtaining the testimony by phases adapted to people with ID consists a tool that must be adapted to each case, taking into account the degree of disability and limitations in the communication of the person. Adapted by DI specialists, it needs to be applied to people with mild, moderate, severe ID, and in people with autism spectrum disorder. is considered as an obligatory task prior to their application.

Its application requires knowledge and experience in working with people with ID. They must be given to professionals who attend the specialized facilitator courses like this one, who have unanimously valued their use as fundamental in expert work with people with ID.

8.2.3 The ECAT-DI protocol

The ECAT-DI protocol is framed in a semi-structured interview format, through which the facilitator manages to evaluate all those capacities that affect the way of remembering and telling the facts that are investigated by the police and judicial system.

It is a proposal for the evaluation of the capacities that affect the testimony of the person with ID, whose main objective is not the evaluation of ID (for which there are already scientifically validated instruments used by technical specialists who work in public services of disability assessment) but rather the design of the supports that must be implemented in their access by the police and judicial system.

In a police, criminal or forensic investigation context, the ECAT-DI protocol is especially useful as work prior to obtaining testimony. In fact, it is constituted as the first phase of the Interview for Obtaining the Testimony by Phases Adapted to the Person with ID, which has been created in the Unit for Attention to Victims

with ID and which is already being used by the police, forensic psychologists and criminologists throughout Spain.

Optimal knowledge of the Protocol and the Interview can only be achieved after specialized training. However, presenting the different phases that compose it will allow the reader to have a first approach to the only work that, to date, is achieving those police and judicial procedures are adapted in accordance with the rights of people with ID, at the same time that facilitates the work of police and judicial agents, and of forensic psychologists when they have to intervene with people with ID.

As noted, the ECAT-DI protocol aims to implement the support that may be required throughout the police and judicial process. It a dual function: firstly, to deploy the support that the person with ID requires to guarantee their access to justice (whether they are a victim, witness or accused), and secondly, to provide the support that police and judicial agents may require. To carry out their work with a population whose relationship and communication modalities are often unknown.

For example, the facilitator may be asked to assess whether the person with ID has the ability to decide, to recall years later in Oral Trial (and, consequently, to determine whether measures to preserve testimony, such as pre-constituted evidence, should be implemented), to assess whether you can recognize a suspect in a recognition round or, what has become more common, to obtain a valid testimony (in which case it is applied framed in the Interview of Obtaining the Testimony by Phases adapted to the Person with Disabilities Intellectual).

Throughout the protocol, the capacities that may affect the testimony of the person with ID will be evaluated, as an essential step to achieve the deployment of all the necessary support during the judicial process (Recio, Alemany. 2014). These capabilities are as follows:

• Communication, which includes the analysis of how the person is able to express himself (verbal and non-verbal language) as well as his limitations, the terminology he uses and his vocabulary. In the cases in which the person with ID uses other communication methods, such as the use of pictograms or sign language, the use and skill made of them should be assessed.

• Perception, visual and auditory.

• Memory, episodic-autobiographical and semantic.

• Spatio-temporal localization, which will allow anticipating whether the person will be able to answer questions regarding the place and time of the events.

• Quantification, which will allow anticipating if someone will be able to answer the questions that require the ability to count or enumerate events, objects or actions.

• Attention, selective (to predict your ability to remember secondary details) and sustained (to anticipate the organization of the times during the taking of statement).

• Thought and meta-cognitive processes, which include reasoning, decision-making and the reflective function, which will allow evaluating the way in which the person's events are attributed, and the type of formulations, concepts and questions that the person will be able to understand.

• Suggestibility, in which cognitive factors and social factors such as self-esteem, emotional dependence and self-confidence intervene above all, which will make it possible to assess the information that the person with ID has been able to add or may add to their story based on the way they have had the different agents ask him about what happened.

• Social desirability or tendency to respond exclusively to satisfy the interview, regardless of whether the answer is true or not.

• The acquiescence or the tendency to answer "yes" or in the same line in which the question is formulated. It correlates with IQ and communication skills, as well as with language and memory.

The five phases that make up the ECAT-DI protocol are summarized in the following table, and subsequently detailed.

I	Collection of information with the main caregivers of the person with ID
II	Rapport phase and indirect capacity assessment
III	Direct assessment of capabilities
IV	Record of the evaluation of capacities and design of the supports
V	Report on the Assessment of Capacities that Affect the Testimony of the Person with ID

I. Collection of information with the main caregivers of the person with ID

Before meeting the victim, witness or defendant with ID, a careful record of the information is carried out with the primary caregivers or direct care professionals who know the person best. With them, a record of the following aspects should be made:

• Personal and occupational aspects (age, family composition, marital status, school, workshop or centre that you attend, schedules and routines that each day).

• Aspects related to disability (type of disability, syndrome or diseases associated with disability, time of diagnosis, awareness of disability, medication and associated side effects).

• Physical illnesses that can affect memory or testimony (visual disturbances or hearing disturbances).

• First approach to the basic capacities that affect the testimony: language, memory, attention, spatio-temporal localization.

• First approach to social skills: assertiveness, submission, dependency, social desirability.

• Knowledge of sexuality and the main elements involved.

In addition to these aspects, the basic information that allows it to be contrasted in the next phase with the person with ID object of evaluation must be collected, in order to obtain objective and valid data to evaluate her abilities directly. The information that must be collected is:

• The user's address.

• The itinerary from home to the centre, workshop, school or resource you go to each day, as well as the estimated time it takes (if you do not go to any resource, you should choose a place where you go regularly).

• If this route is done alone or with a companion

• How was the day like at the work or community or at home/ Mental health structure

• The tasks performed during day time.

• What she usually does with her friends in her free time.

• Record of specific past episodes, with which the autobiographical memory of the person can be evaluated.

For example, a significant episode experienced by the person will be chosen in a time close to the events that are the subject of the criminal investigation. The caregiver will be asked to report in as much detail as possible everything that happened that day - such as an excursion, a visit to the doctor, an accident, an outstanding incident - and later, in the second phase, the person will be asked directly for that incident.

With this little exercise the facilitator will have a first approximation to the number of details with which the person is able to express the memories of them. In addition, from this evaluation, the number of details and the richness of the testimony can be assessed without the insertion of support and with it.

With this first record, the evaluator will have enough information to anticipate the main adaptations to be made in the communication with the person, as well as the support that may be needed if an interview at the police or judicial headquarters is necessary.

Finally, this first interview with the primary caregiver or direct care professional of reference, will serve to clarify the need to record the interviews carried out with the person, and obtain the informed consent for this purpose (which must be signed by the tutor in those cases in which the victim is a minor or is legally incapacitated).

It is strongly recommended to record on audio-visual support each interview carried out both with the person with ID and with her family, for which everyone must give their informed consent. This should have an easy-to-read version for the person with ID.

II. Rapport phase and indirect capacity assessment

This phase will allow the evaluator to understand the way in which the person communicates, establish a relationship of trust, familiarize the person with ID in the “big rules” of any expert interview and specifically evaluate the capacities that affect the testimony and the process. police and judicial.

After introducing the interviewer, explaining the reason for the interview (getting to know him or her, learning to communicate with them and helping them throughout the police or judicial process), and requesting their consent for the interview to be recorded, the interviewer begins by explaining “the great rules of the interview”, which are:

• "Tell the truth". For example, you can say: it is very important that everything you and I say is only the truth. If I say something that is a lie, you tell me. For example, if I tell you that my sweater is red - the interviewer has a different color sweater than red - is it true or a lie? It is very important that everything you tell me is only the truth. The interviewer must verify that the person interviewed knows the differences between the truth and the lie with as many examples as necessary.

• "Feel free to show doubts." People with ID, due to their high social desirability and their insecurity in unfamiliar contexts, when they do not understand something, they do not usually express it. For this reason, it is very important to rate it and that they can practice, from the first moment, to be assertive when they do not understand a question. Failure to practice these questions before any interview significantly increases the risk of obtaining answers subject to acquiescence.

For example, you can say: sometimes I do not express myself well or I use strange words and it is important that you correct me and tell me "Maria, I don't understand you." In the same way as with the first rule, as many examples as necessary will be practiced with the interviewee until she can directly verbalize that she is not understanding or does not know how to answer.

• "Feel free to stop the interview." Due to their social desirability, it is also necessary to make it clear that they can stop the interview whenever they want, referring to them in a concrete way (for example, saying: if you are tired, bored, need to go to the bathroom, or want to stop, please tell me).

• "Feel free to express ignorance or lack of memory." Similarly, to the above, due to their high social desirability, many people with ID may have difficulties expressing ignorance or lack of memory about some of the questions that are going to be asked during the interview. For this, it is essential that the possibility of not answering questions for which the answer is unknown or not remembered

is made explicit. (For example, saying: sometimes I ask difficult questions, if you do not know the answer or do not remember it is important that you tell me. It is preferable to say "I do not know" or "I do not remember" than to invent the answers).

• "Feel free to correct the interviewer." It is not uncommon for the interviewer to confuse concepts or terms used by the person with ID throughout the interview.

Encouraging the possibility that the interviewee can correct the interviewer will reduce the effect of suggestibility (for example, by saying: if I have not understood something of what you have said, it is important that you tell me, sometimes I am wrong. that today is Tuesday (when he said Monday), right? You see, I was wrong, it is important that you tell me, "Maria, I said Monday, not Tuesday."

After specifying and practicing the great rules, they proceed to ask a series of neutral aspects of their life, in order to begin to establish a relationship of trust with the person at the same time as their abilities are evaluated.

The following table shows examples of questions that can be used in this phase, and how with each of them, while establishing a relationship of rapport or trust with the person, the evaluator is obtaining an indirect evaluation of the questions. Capabilities that may subsequently affect the obtaining of testimony.

Questions	**Evaluated capacities**
Can you tell me what day is it? In what month we are? In what year? When it´s your birthday? So, if you tell me that it was on... how long it´s from that? Where do you live? Have you spent too much time to come here?	Language. Temporal localization Spatial localization
What´s your job / studies? Could you tell me how it´s an ordinary day at your work / school? From the very beginning until you finish, please give me as more details as you can, even if you think that they are not important. What is the thing that you like most at your work / school? Why? Don´t you like more...? What it´s the thing that you like less?	Language (the total amount of details that he/she provides, the structure of the content) Semantic memory. Reasoning. Social desirability. Assertiveness. Acquiescence.
Your parents told me that before summer you went to... Could you tell	Episodic memory

me everything that you did that day? Since you woke up until you fall asleep. Please, give me all the details that you can, although you think that they are not important.	

III. DIRECT CAPACITY ASSESSMENT PHASE.

In this phase, the evaluation of those capacities that can affect the testimony continues, in a more direct way.

The direct assessment of capacities is composed of a series of exercises through which a rigorous assessment of the support needs is carried out, through the use of different photographs that the person must describe, answer specific questions, and remember once they have been removed.

In this phase, the use of psychometric scales specially designed for this purpose can also be evaluated, if specific deficits are detected in important areas (and which are seen to require important adaptations in the judicial process). For example, if it is seen in the rapport phase, in an adult with Down syndrome, who has a special impairment of memory, it will be necessary to promote, in the instruction phase, the implementation of the pre-constituted test.

This measure is the only one with which the testimony can be preserved and prevent the person from having to testify years later. The pre-constituted test proposal, therefore, may be based on the expert report with the ECAT-DI protocol.

During these phases, the evaluator must have sufficient expertise to, in the case of detecting obvious limitations in the person, include the supports that are known to be useful to alleviate them.

For example, if in these phases it is found that the person does not have the capacity to locate the events temporarily, a graph can be designed with them in which the main episodes of the last year appear, which can be used to locate when the events occurred that are talked about in interviews. This same graph could, later in the police context, serve as a support to locate the criminal acts that are being investigated.

IV. Register of the assessment.

Since the evaluation of capacities has been recorded in audio-visual support, once the evaluation with the person is finished, the responses are recorded and the degree of affectation of the capacities that may affect the testimony is determined, and the supports that must be implemented during the judicial process.

If the assessment of capabilities is to be used for expert purposes, the registration methodology must be inter-judge, that is, two assessors with experience in the matter must view the assessment separately, and determine the possible impact on capabilities.

After the inter-judge agreement, all the supports that are estimated to be necessary during the police and judicial intervention with the person will be specified.

V. Capacity assessment report.

The assessment of capacities, as well as the support deemed necessary during the process, will be clearly defined in a report. This report must be delivered to any police or judicial agent (be they magistrates, prosecutors, lawyers or forensic psychologists). It is intended to help you carry out your investigation, for which a valid testimony is essential. And a valid testimony can only be achieved by planning the testimony gathering interview that happens, when it comes to people with ID, for carrying out all this previous work.

The Interview for obtaining the testimony in phases adapted to people with ID, which is presented in the following section, incorporates the ECAT-DI protocol as a fundamental work prior to obtaining the testimony.

8.2.3 The adapted interview.

It is foreseeable that different communication problems will arise during an interview with a person with ID (Contreas, Silva, Manzanero. 2015). Some of the most frequent peculiarities of the speech of the person with ID are the contradictions, the silences, its slower pace, the confusion and the insecurity.

The problems that may arise in understanding the person with ID are not caused by the person interviewed or the interviewer, but are due to differences in communication skills. These can only be corrected by carrying out the pertinent adaptations and implementing the necessary supports (AAIDD, 2011).

The Interview for Obtaining the Testimony by Phases adapted to people with ID constitutes a proposal that guarantees the adaptations and supports mentioned, and seeks to obtain a testimony with the greatest number of details that the person can offer and free of contamination by the interviewer. For this reason, the interview has, in turn, three phases:

• A first phase composed of the ECAT-DI Protocol for the Evaluation of Capacities that Affect the Testimony of the Person with ID, whose objective is the planning of the interview and the design of the supports that should be implemented during it.

• A second phase of Addressing the Event to Investigate or Obtaining the testimony (with the pertinent adaptations based on the implementation of the previously planned supports).

• A third phase of Closing.

Audio-visual recording of the interview is highly recommended, in order to obtain a faithful record of what the interviewee says and how they say it, since this will ensure his testimony over time, the recording can be studied with posteriority (by

the interviewers themselves, and by other forensic experts), and could serve to prevent the person with ID from having to testify again and again before different actors in the criminal process.

Phase 1: ECAT-DI protocol and interview planning

After having applied the ECAT-DI Protocol, the person will be allowed to rest, and will be summoned at another time to proceed to the second phase of obtaining the testimony with the necessary support. Carrying out the ECAT-DI protocol on the same day and obtaining the testimony, due to the complexity and fatigue that it can cause both for the person interviewed and for the person interviewed, should be limited exclusively to the strictly necessary cases.

In any case, it is essential to pause between the ECAT-DI protocol and obtaining the testimony. This is the only way to avoid improvising support and the interview can be properly planned.

During this pause, the interviewer must determine the extent of the affectation of the main capacities that could condition the narrative of the events, (and thus be able to anticipate if they will have many or few details; with central or only peripheral details; with concrete or abstract; with high / moderate / low risk of social desirability and, therefore, acquiescence, etc.), as well as the supports that should be deployed by the interviewer to obtain the most accurate and reliable testimony possible.

If a great need for support is observed, it is advisable to turn to a facilitating psychologist or, failing that, to an ID specialist accustomed to designing person-centred support systems.

Phase 2: Addressing the Event and Obtaining the Testimony

The second phase of the interview will be the one in which the event to be investigated is already addressed with the supports previously designed for this purpose. The approach to the event is crucial to obtaining a good testimonial, and requires, once again, the application of a series of steps:

- Step 1: Introduction and big rules

Despite the fact that the norm in forensic contexts is not to suggest the topic of which one wants to talk, it is likely that the person with ID is completely unaware of the reason why they have to talk to a stranger.

The first step before asking about the event, therefore, will be to ask if you know the reasons why you are in the interview, and then close the question (for example, "Do you know why we are here?", "Is there something that you want to tell us / me? ", “we have come to talk to you so you can tell us something that has happened to you”, “we have come to talk about something that you already told…”).

It should be noted that the primary role of the evaluator is to facilitate, not to interrogate. It is essential not to ask too many questions in the initial part of the

testimony gathering phase, as it is much better to obtain the information as spontaneously and uncontaminated as possible.

Before beginning to relate what happened, it is important to remind the person of the "big rules" of the interview, which were being practiced in the phase of the ECAT-DI Protocol. Remembering the big rules is useful not only to prevent acquiescence and assertiveness problems common in people with ID, but to continue to establish a climate of trust before proceeding to recall the potentially traumatic event.

- Step 2: Free narration

People with ID often begin to report peripheral aspects at the beginning and will not address central themes of the events until they are ready or comfortable. It is very important not to immediately start asking about these central aspects, but rather to endure and tolerate their rhythm, the pauses, even those that are long, and the silences.

Therefore, even if you are working with a person with ID, and regardless of their difficulties of expression and understanding, the approach to the topic to be investigated will be carried out through free narration. However, asking for it can be a novel situation, since they are usually used to their interlocutors being the ones who control and direct the conversations.

Knowing that the testimonies that can best be analysed are those in which the free narration is extensive, open questions should prevail in the interviews, which will be closed as you want to delve into certain details. It will be the open questions that get the most precise answers and with the greatest amount of detail. On the contrary, there are questions that have an adverse effect on the responses of people with ID.

In general, the more closed the question, the less precise the answer will be, since people with ID are more sensitive to social desirability, leading them to respond acquiescently in a greater proportion than the population without ID (AAIDD, 2011).

OPEN NARRATIVE	We try to obtain information without pressing or managing the answers "*Could you tell me, with all the details that you want, what has happened?"*
OPEN QUESTIONS	We try to clarify the information given by the person *"You have said that he was talking with you in the park. Could you explain me more about that?"*
CLOSE QUESTIONS	They must be done, if it´s possible, offering more than two answer options "*When you said that he touches with "that" you want to say with his hand, with a pencil, with a rule...?"* This question needs to be balanced, repeating the questions alternating the

	answer options in order to value if the answer is under the effects of acquiescency

Since the free narrative of a person with ID is always more expansive to understand than the answers to questions, there is a risk that the interviewer will put aside the free and spontaneous account of the events and focus more on questions than her/him. They provide answers that are easier to understand. However, the vast majority of people with ID have the ability to make a free account of the event. When in doubt, resources should always be exhausted to do so, even if their ability to express themselves is limited.

- Step 3: Closed questions

Only once the free story has been obtained (regardless of the number of details available), and after having exhausted the open questions, will the question be formulated closed. Dichotomous questions, answered only with the answer “yes / no”, will be limited to people with ID with serious expression difficulties.

Phase 3: Closing the interview

Before ending the interview, proceed to the third and final phase, which constitutes the closing of the interview and which has three objectives:

• Correct possible distortions in the testimony, due to communication failures that may have occurred between the interviewer and the interviewee. The testimony obtained should be reviewed, giving the person with ID the opportunity to correct, expand or delete the information they consider. For this, it is essential, given its frequent problems of social desirability, to make an explicit request to correct those data that are erroneous and add what it deems appropriate.

• Answer any doubts that the interviewee may have. Given that in most cases people with ID hardly feel free to express their doubts, it should be the interviewer who proactively asks if they have any doubts about what has been discussed.

• Soften the possible impact that the interview may have left on the person, thanking them for the effort (regardless of what has been achieved) and ending with a neutral and pleasant topic that helps reduce tension before saying goodbye to the interviewer.

In conclusion, the interview to obtain the declaration of a person with ID should not be carried out without knowing the support that they will need during the interview, for which it is recommended to apply the ECAT-DI Protocol for the Evaluation of the Capacities that Affect the Testimony of the person with ID as a job prior to approaching the event under investigation.

Once applied, the possible supports that the interviewer must deploy from the very beginning of the interview can be anticipated. In this, the interviewer must be patient and exhaust all her/his resources to have a free narration of the event, to later use the questions that allow her/him to have a valid testimony. The

interview should be closed responding to the doubts of the person interviewed and with a warm climate that mitigates the impact of the memory of the events.

8.2.4. The Evaluation of the Ability to Consent to Sexual Relationships in People with ID.

Historically, it has been thought that people with ID, regardless of their age, did not have the right to have sex and that any sexual relationship constituted abuse. Fortunately, society is becoming more and more aware of the right of these people to access their sexuality in a healthy and freeway. Consent in the adult person with ID is crucial in deciding whether a particular sexual relationship or sexual act is abusive.

Deciding it, due to its complexity, requires having knowledge that allows to conclude in the most rigorous way possible, and always bearing in mind that no conclusions can be made about the general capacity to consent, since a person may be unable to make certain decisions in her/his life and may be able to take others.

The determination about whether or not the person is capable of consenting to a sexual relationship is not easy to be answered, but the facilitators can help to make this determination by providing valuable information through a rigorous evaluation and the design of the appropriate supports for such an effect.

It goes without saying that not all cases in which a person with ID has been allegedly abused requires an assessment of his or her ability to consent to sexual intercourse; There are cases in which it is evident whether or not there is consent, but there are many cases in which doubts may arise, and it is in these cases that an assessment must be made by professionals specialized in the matter.

The current regulation does not punish every sexual encounter between an adult and a person suffering from ID, since if this were the case, it would be understood that adults with ID cannot have sexual relations. In attention to what is stated by jurisprudence, two types of scenarios must be differentiated:

a) Cases in which the victim has such a degree of disability that any sexual contact established with the victim must be considered non-consensual. In such cases, it is understood that the active subject necessarily has to be taking advantage of the victim's disability, as the person who suffers from it has no notion of what sexuality is, nor its implications, for what you will never be able to give your consent to participate in it.

b) Assumptions in which the victim suffers from a not so severe disability, which nevertheless allows her to have a certain notion of sexuality and to harbor an even elementary idea about its implications.

“These are cases in which there is normally manipulation by the active subject through implausible threats –that do not have the seriousness of intimidation- or

banal promises, but capable of bending the will of the victim precisely because of the scarce intellectual resources of the herself" (Núñez, 2011). In these cases, it is essential to carry out a specific assessment of the ability to consent to a sexual relationship.

An assessment of the ability to consent to a particular sexual relationship requires that it be specifically about the abilities to understand the specific sexual and interpersonal relationships that the person experienced.

Therefore, what must be assessed is whether there is the capacity to consent to a given sexual relationship and whether the consent was actually given. It is important to note, therefore, that a person with ID may have the capacity to consent to a sexual relationship in a certain context and relationship and not in another.

Therefore, the evaluation in this sense must be unique and counting on the elements that have come into play in a particular sexual relationship. It is recommended that any assessment of the ability to consent to sexual intercourse be based on the following premises:

• The person must have certain knowledge about sexuality in order to consent to sexual activity.

• The person should understand the main elements of sexual behavior and should be able to distinguish that sex is different from other caring relationships such as helping with bodily hygiene or a medical examination.

• The person should understand that sex can have foreseeable consequences such as pregnancy or sexually transmitted diseases.

• The person should understand that sexual relations must be free and consensual, in no case mandatory.

• The person should understand that sexual relations cannot and should not be maintained with anyone.

Considering these premises, it is understood that there are clear situations in which consent to have sexual relations cannot be considered valid:

• If the person does not understand what is being asked.

• If the person does not know the consequences that can be derived from a sexual relationship.

• If the person does not know that he has the right to refuse to have sex with the other person.

• If the person does not know how to express his rejection of a sexual relationship.

• If the person is not aware that having sex does not have to be uncomfortable or painful.

• If the person does not know that he is being used when he receives a gift in exchange for sex.

• If the person does not know that some sexual relationships are not socially acceptable, such as those with her parents, or between subordinates and bosses.

With all these, it can be concluded that consent can be taken as valid if the person knows what she is consenting to and has a real option to communicate said consent. Regarding the latter, it could be wrongly concluded that if a person with ID shows significant limitations in their verbal expression, then they may not have the capacity to consent to sexual relations.

Because of this idea, there are many cases among people with ID who, after knowing that they are having sexual relations, the question arises as to whether there was consent or not, precisely because of the difficulties of verbal expression of the alleged victim.

For this reason, the professionals in charge of facilitating the assessment of the ability to consent to sexual relations in people with ID must have adaptations aimed at people with significant limitations in their communication. Said assessments should only be carried out when there is a suspicion that they may have consented because there was intimacy with the active subject, when they could communicate between them and there was a certain relationship of trust (for example, between colleagues from the occupational center), not superiority.

If the sexual relationship is by a person with whom you do not have a regular relationship and, therefore, you do not know how to understand this person, it is understood that there is no capacity for consent due to the inability to express your decision.

In cases in which the person presents severe communication limitations, extremely complex, it is essential to have materials specifically adapted to know what happened, as well as to evaluate the ability to consent to sexual relations in people with ID, being the materials of the British Institute for the Learning Disabilities especially recommended. For more information consulted: https://www.gov.uk/government/publications/the-role-of-the-independent-sexual-violence-adviser-isva

If the facilitator has previously evaluated the capacities that affect the testimony of the person with ID, this evaluation will allow him/ her to have the necessary support for the interview exclusively aimed at evaluating her capacity to consent to the facts that are investigated.

If the assessment is carried out by a professional other than the facilitator, they must, in order to guarantee a valid assessment, carry out a prior assessment of the capacities that affect their way of telling the facts.

Before proceeding to assess the ability to consent to a sexual relationship, it is important to explain to the person with ID what is going to be discussed.

It´s important not to assume that they know what they are talking about by referring to "sex" or "sexual intercourse." They may refer to it and not know what it means or think it means something that it is not (for example, for a person with ID, "sex" may exclusively mean kissing). The same with other terms such as "fellatio", "masturbation" or "rape".

Every time they mention an expression of this type for the first time, ask what he means by the word he mentioned, using exactly the term used by the person evaluated. ("What do you mean ... -and use the same words-?").

Subsequently, the presence of the aforementioned factors that affect the ability to consent to a specific sexual relationship would be evaluated, adapting the questions to the previously evaluated level of understanding. This evaluation must consist of two parts:

Part a (general consent): it is used to evaluate if there were clear situations in which the consent to have sexual intercourse cannot be considered valid namely:

- they are not able to understand what is being asked of them,
- they do not know that they can refuse what is being requested asks,
- they do not know how to express their rejection,
- they do not understand the consequences of relationships or they do not know with whom one can or cannot have relationships.

If incompetence or serious difficulties are observed in any of these four, the person does not have the capacity to consent to said relationships.

Part b (consent to a particular situation): the person may have a certain capacity to consent, because they have the basic notions of what sexual relations are and their consequences, they know that they can reject them, and they know with whom they cannot have relations, but it is estimated that this knowledge is very limited so that she may not have the capacity to consent to what was requested or performed particularly (for example, anal penetration or fellatio).

8.3. Conclusions.

After the commission of a criminal act, it happens that, in addition to the physical, economic, psychological and social damage produced, the victim usually experiences a serious emotional impact, which is aggravated, on occasions, by coming into contact with the generally unknown legal-criminal framework.

Therefore, it is vitally important that the necessary adaptations are made so that people with disabilities, and especially the most vulnerable, those with an ID, have equal access to justice. This depends on the capacity of the system, beginning with police officers and forensic professionals and experts, to offer the support and apply the necessary procedural adjustments.

→ The implementation of support can only be achieved if said professionals show the humility necessary to recognize their limitations when it comes to having to intervene with people with ID.

The heterogeneity that characterizes the group of people with ID is immense and knowing the way in which capacities are affected in a person with ID in question could be better achieved with specialized training and experience.

The adoption of specific measures for the group of people with ID, such as the figure of the Facilitator, is justified given the need to protect the person. The United Nations Convention on the Rights of Persons with Disabilities, in 2006, also obliges us to:

“States Parties shall ensure that persons with disabilities have access to justice on an equal basis with others, including through procedural and age-appropriate adjustments, to facilitate the performance of the effective functions of such persons as direct and indirect participants, including testimony as witnesses, in all judicial proceedings, including the investigation stage and other preliminary stages” (art. 13.1).

Given the specificities involved in working with people with ID when they are involved in a police and judicial procedure, it is necessary to be accompanied by specialized professionals or facilitators of the necessary support.

8.4. RECOMENDATIONS.

Through this project, victims with ID are accompanied and supported during the criminal process, their ability to participate in the process on equal terms with others is advocated, and the professionals directly involved in these cases are trained (judges, prosecutors, forensic and clinical psychologists, etc.) to help them communicate and interact with these vulnerable victims and witnesses in the most appropriate way.

Currently, an important part of the work of projects such as ATHENA consists of promoting the comprehensive application of this EU Directive and the United Nations Convention on the Rights of Persons with Disabilities. To further this endeavour, many organizations joined Trustlaw to conduct a comparative study of various EU Member States (Belgium, Finland, France, Germany, Italy, the Netherlands, Portugal, England and Wales, and Spain) on the regarding the rights and protection that each domestic legislation provides to especially vulnerable victims, all with the aim of highlighting and sharing the good practices detected. Two internationally renowned law firms actively participated in this study: White & Case and Wilmer Hale.

This investigation has concluded in a report published in 2017 that analyses each of the member states listed in the previous paragraph, and in which:

1) the laws and regulations that have been adopted in relation to the victims are identified during the criminal proceedings, and how each of the internal laws compares with the EU Directive;

2) a detailed description of the specific measures and procedures adopted to protect victims with special protection needs in criminal proceedings is made,

including measures applicable to judges, prosecutors, court officials, police officers, etc.;

3) a summary of the jurisprudence and of all the data that show how this legislation and the EU Directive are being interpreted, and how these special measures and procedures are applied in practice.

The most notable aspects of each of the states analysed are set out below:

- **Portugal**

To comply with the guarantees of the Directive, on October 4, 2015, Law 130/2015 came into force. This is a quasi-literal transposition of the Directive, which in some aspects goes even further than this, allowing access to care and support centres for the victim if its evaluation classifies it as in need of specific protection measures.

However, in the adopted regulations it has also been possible to detect some areas for improvement, such as:

- ✓ Although there is a provision to avoid contact between victim and offender, it is very general and therefore its application is difficult. In particular, it is not stipulated that there are different waiting rooms for one and the other.
- ✓ Although the new legislation mentions training that official who are in contact with victims must receive, it does so in a very general way and does not develop protocols for its implementation.

Among the support groups for victims that provide service in the Portuguese State, the following stand out:

- ✓ National Commission for the Protection of Children and Young People at Risk: supervises and coordinates organizations specialized in assisting children and adolescents at risk; it also creates safe homes for their protection and promotes the rights of these groups at risk.
- ✓ General Directorate of Social Affairs: attend inquiries of minors who participate in criminal proceedings, and assist and protect child victims of crime.
- ✓ APAV (Portuguese Association for Victims Support): inform, protect and support crime victims.
- ✓ Project CARE: specialized channel to support children and young people who are victims of sexual violence.
- ✓ IAC (Instituto de Apoio à Criança): responsible for the defence and promotion of children's rights.

- **Spain**.

The Directive was adopted in Spain by Law 4/2015, of April 27, on the Statute of the crime victim, which entered into force on October 28, 2015. As in the case of Portugal, this Law transposes practically identical to the body of the Directive, establishing a series of measures and rights relating to all victims regardless of

their condition and the crime suffered, and adding a chapter relating to additional protection measures for especially vulnerable victims.

As favourable aspects of the regulations, the following deserve to be highlighted:

- Law 4/2015 includes each and every one of the rights and measures contemplated in the Directive, and even extends some of them to cases not stipulated in it, such as the pre-constitution of the victim's statement in certain cases even though it does not is a minor, or to appoint a legal defender when the interests of the minor or disabled victim conflict with those of the legal representatives.

- The new regulations provide for the creation of Victims Attention Offices, as well as the training of all personnel (State Security Forces, Justice Administration personnel, lawyers, health personnel, professionals of the Services Social, etc.) who will come into contact with the victims.

- A regulation for the development of the Law has also been adopted that, among other aspects, defines the procedure for carrying out the evaluation of victims in order to detect their special protection needs.

- The State Security Forces and Bodies have specific protocols for the care of vulnerable victims.

However, some areas for improvement have also been detected, two of which stand out mainly:

- A protocol for the care of vulnerable victims has not been established within the courts.

- The type of training that police officers and legal operators will receive in order to provide the best treatment for victims, especially those with special protection needs, has not been specified.

As is the case in Germany, the Spanish territorial planning and the system of competences attributed to the Autonomous Communities causes that there are significant differences in certain matters included in the Law, such as the implementation of the Victims Attention Offices.

Within the framework of care and support institutions for victims, Spain has a considerably wide and specialized care network:

- At the state level, the offices for assistance to victims of violent crimes and crimes against sexual freedom stand out, which also have their respective counterparts in some Autonomous Communities that have jurisdiction over justice.
- At the regional level, there are other private entities that serve crime victims, such as CAVAS, FAVIDE or AMUVI.
- At the level of victims with special protection needs, the following stand out:

o FAPMI (Federation of Associations for the Prevention of Child Abuse in Spain): it is dedicated to the prevention, detention, care and intervention of child victims of abuse or sexual crimes, their families and their context.

o CIASI (Specialized Center for Intervention in Child Abuse) in Madrid.

o REVELAS-M, which serves minor victims in Castilla-La Mancha.

o KEEP ME SAFE: seeks to prevent violence and sexual abuse against youth with disabilities.

o Unit for Attention to Victims with ID: offers psychotherapeutic, forensic and legal support to victims with ID in their passage through the criminal process.

The conclusions of the study include the following:

1) Most of the countries analysed, except Belgium and the Netherlands, have complied with the transposition deadline established by the Directive, adopting to a greater or lesser degree the measures for the protection of victims' rights imposed by European regulations;

2) Many of the countries that are the object of this study have developed specific provisions and protocols for the care of victims with special protection needs (the majority, however, focus on minors, ignoring the rest of vulnerable groups);

3) Given the short time frame that the obligation for the Member States to adapt their domestic law to the Directive has been in force - a little more than a year -, there is very little or no data regarding its application, highlighting positively in this aspect countries such as Italy, England and Wales or Spain, which have been able to report jurisprudence and / or statistics on the matter; Y

4) Virtually all Member States have - and already had before the approval of the Directive - initiatives, both public and private, to address the needs of crime victims (especially when it comes to vulnerable victims), which still have currently a great protagonist in the defence of the protection and rights of victims.

9. THERAPY TO BREAK THE CYCLE OF VIOLENCE.

9.1 Introduction to the concept of trauma in the person with ID

The term "impact", "damage" or "trauma" is commonly and interchangeably used to refer to the consequences or physical or psychological imbalances that a certain negative event causes in the person. After a traffic accident, for example, one can refer to being "shocked", "damaged" or "traumatized". The use of the word "trauma" is based on the etiologic of the word (it comes from the Greek

concept that means "wound"), so it is understood, in common vocabulary, as an injury generated by an external agent, circumstance or experience.

A physical trauma would be linked to an injury or breakdown suffered by the body and alters the normal course of physical health, and a psychological trauma, on the other hand, is associated with an injury or breakdown that alters the mental health of the person (Salvador, 2019).

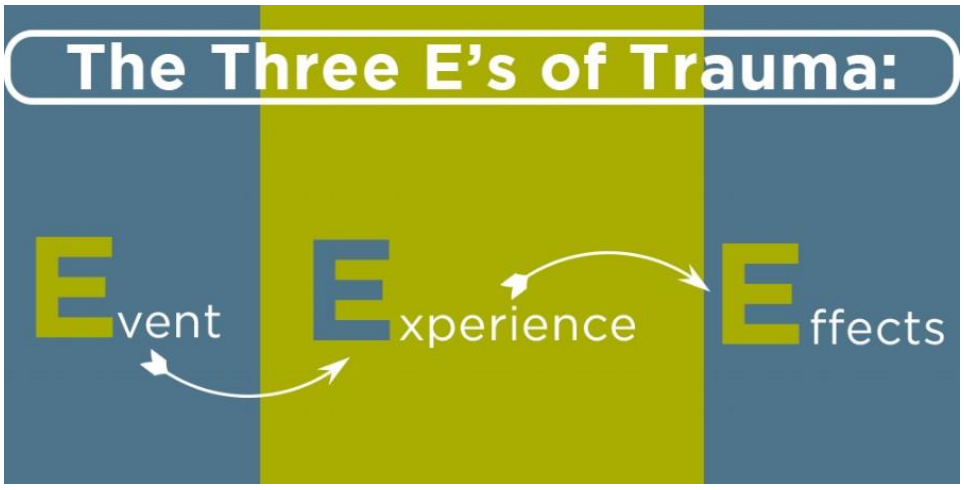
The causes of such alteration can vary enormously. However, there is consensus about the two dimensions associated with trauma:

I) the negative valence dimension, that is, traumatic events are coded as negative experiences,

II) the intensity dimension, which refers to the significant alteration in physical or mental health or excessive stress. Also, it has been described the links between representations of the trauma event and affective responses (Foa, Steketee, Rothbaum. 1989).

Therefore, the term “trauma” is usually used to refer to those negative events that have caused an intense impact or alteration in the person.

In relation to the second dimension, that of intensity, in the context of expert assessments of mental damage, other related terms are used that contribute to the complex web of concepts related to trauma.



Source: Image retrieved from Zebra Child Protection Centre

"Psychological damage":

- is used to refer to all those psychological imbalances derived from the exposure of the person to a situation of criminal victimization. On the other hand, “mental injury” refers to a clinically significant alteration that affects the person as a consequence of having suffered a violent crime and that significantly disables them to cope with the requirements of ordinary life.

Examples of frequent mental injuries after a traumatic event are adaptive disorders or post-traumatic stress disorder. Finally, "psychic sequela" refers to the stabilization and consolidation of psychic damage, such as permanent personality modifications.

When we apply these concepts to the clinical and forensic context in people with ID, we can begin to intuit the complexity that can involve the assessment of psychological damage in people who already have a previous injury or trauma due to the ID itself. We call this previous injury and that all people with ID are incapacitated to a greater or lesser extent to adapt to the demands of the environment.

It´s important to remind that PID have a higher rate of mental illness than people with normal intellectual function (Cooper & Bailey, 2007)

In any context of clinical or forensic assessment with victims with ID, both to diagnose the damage derived from a situation of criminal victimization, as well as to adequately establish the goals of psychotherapy, prevent psychic sequelae and achieve psychic, emotional and relational stability, it is essential to be familiar with two concepts:

1) The concept of **pathoplasty** in people with ID, which refers to the **forms that symptomatology takes in the group of people with ID**. The clinical manifestations differ significantly in people with ID with respect to the general population (Novel, Rueda, Salvador, 1990), so it will be necessary for direct care professionals, forensic experts and for psychotherapy professionals, to know the damage or trauma pathoplasty in people with ID.

2)The distinction between primary trauma and secondary trauma. The person with ID (and her family) already has a wound derived from the grief over the disability and the vicissitudes they have to suffer throughout the family life cycle.

This impact is called, in the assessment and intervention with victims with ID, primary trauma. The manifestations derived from this must be distinguished with respect to the psychological damage derived from the experience of sexual abuse, violence or a situation of criminal victimization, which we call "secondary trauma."

In both primary trauma and secondary trauma, factors intervene that will modulate the impact that ID and the situation of criminal victimization leave on the person, respectively.

In the group of people with ID, the assessment of protection factors and vulnerability to impact acquires an added complexity, which is intended to contribute to understand throughout this chapter.

The PDI are in a special situation of vulnerability (Hawking, 2014).

Primary trauma should be considered among the vulnerability factors that condition the psychological damage in the person with ID after a violent event. The ID itself will cause the person not only to face an expert or judicial process

with a previous vulnerability derived from their own disability, but also has a much higher probability of suffering what the doctrine calls "secondary victimization", which is will pay special attention.

Restoring the damage or mitigating the impact that the different traumas with which the person with ID who has suffered sexual abuse, or a situation of violence may have to live, in other words, a traumatic situation, a psychotherapeutic intervention model adapted to victims with ID and their families will be presented.

9.2. Pathoplasty in people with ID

The concept of pathoplasty refers to individual differences in the symptomatic expression of the same mental illness. Consequently, it is understood that the expression of mental health problems in each individual is unique.

When it comes to comparing the symptoms of a certain mental illness between individuals with ID and the rest of the population, the differences are even greater. They are such that it is necessary to develop criteria adapted to this group, which result in the creation of specific diagnostic manuals adapted such as the DC-LD (Royal College of Psychiatrists, 2001) or the DM-ID (Fletcher, R., Loschen E ., Stavrakaki, C., First, M., 2010).

→ The main difference between the population with ID and without it in the expression of mental health problems lies in the greater use of behaviour as a method of expression of psychiatric symptoms by individuals with ID. The concept of "behavioural equivalent" refers to the expression of psychiatric symptoms through behaviour. The greater expression of "behavioural equivalents" among individuals with ID is undoubtedly due to their communication problems (May, Kennedy. 2010).

Limitations of people with ID in cognitive skills can lead to difficulties in introspection (AAIDD, 2011). This limitation will make the detection of mental health problems difficult, since clinicians use this capacity to, in many cases, make their clinical judgments.

In order to understand the difficulties in properly diagnosing people with ID:

- ✓ the so-called “eclipsing effect” must be added to the limitations in communication, in cognitive function, and in plathopasty.
- ✓ the context that revolves around a person with ID ought to be considered;

This effect limits the implementation of the diagnostic and intervention systems for the mental health problems of these people. In addition, ID produces a distortion in the professional's clinical judgment, which entails minimizing the relevance of mental illness and its significance and importance for the patient's well-being.

For example, if an adult without ID hits his head hard with objects, no clinician would doubt the discomfort that the patient is suffering and, consequently, the pertinent therapeutic interventions would be deployed. If the same self-injurious

behaviour occurs in an adult with ID, it tends to assume that such behaviour responds to the ID itself and that it is not as worrisome as in the case of the adult without ID (Martorell et al. 2009).

Therefore, because of communication problems, difficulties in introspection, pathoplasty and the overshadowing effect, psychiatric disorders will be enormously difficult to detect in individuals with ID. Even when the professional detects a significant discomfort in the mental health of an individual with ID, it can be enormously difficult to make an adequate differential diagnosis. In the expert contexts of the assessment of damage, injuries or psychological consequences, this ignorance is serious due to the consequences that escrow, contributing to secondary victimization that will be detailed later.

Seeing the high incidence of these disorders, and the influence of trauma on their appearance in individuals with ID (Discapacidad intelectual y salud mental: evaluación e intervención psicológica. Plena Inclusión. 2014), it is essential to know:

- what form it takes
- how these disorders present in the population with ID.

The main difficulty in detecting these disorders in people with ID resides fundamentally in the limitation of some individuals with ID to identify and express complex cognitive phenomena present in any of these disorders, such as depersonalization, derealization or recurrent thoughts of death (APA, 2013).

One of the diagnostic criteria that are present in several of the anxiety disorders, such as phobias or agoraphobia, is the avoidance of certain situations or objects. In people with ID dependent on third parties, this avoidance is often not carried out since the autonomy of the individual is determined by other people.

→ In mood disorders, a decrease in interest and performance of activities is common. When talking about people with ID it is important to bear in mind that on many occasions, they do not have the possibility of reducing their number of activities since the choice in this regard is not allowed for them. Post-Traumatic Stress Disorder deserves a special mention on this Module. The basic criterion for this disorder is that the individual has been exposed to a traumatic event in which the integrity of himself or others has been in danger. **Due to the lower cognitive reserve and other deficiencies, in the attachment system, for example, explained later, the experience that can be traumatic for a person with ID is sometimes not so in the eyes of their context.**

Not considering this possibility can lead to assuming that a certain experience of a person with ID, such as the death of a pet in a run over, cannot be traumatic for the person. However, an experience of this type can be enormously shocking for a person with ID. Furthermore, certain diagnostic criteria for this disorder, such as re-experiencing and increased activation level, can be confused with certain behavioural disturbances.

The description of each of the adaptations of the diagnostic criteria for psychiatric disorders exceeds the objectives of this Module, for which the careful reading and application of the aforementioned manuals, DM-ID, is recommended (Fletcher et al., 2010) or DC-LD (Royal College of Psychiatrists, 2001).

Understanding the complexity and difficulty involved in detecting and diagnosing mental health problems in people with ID is already a big step. It is important that the professional becomes aware of the relevance of the behaviour as a method of symptomatic expression and not as a problem in itself. As has been stated, **a behaviour alteration in an individual with ID always reveals emotional distress.**

→ In order for the professional to understand which symptom explains a certain behavioural disturbance, a meticulous and conscientious recording of the behaviour is necessary, since the same behavioural disturbance can sustain different psychiatric symptoms. As thorough and detailed behavioural records are made through contextual information sources, the reliability and level of symptom identification will improve.

Thus, for example, an adult individual with ID throwing a tantrum at a certain activity can “signify” several symptoms. In the case at hand, that same tantrum may imply a “strong and persistent fear that is excessive and irrational, triggered by the presence (…) of a specific object or situation”.

However, it can also imply "a marked decrease in interest or in the capacity for pleasure in all or almost all activities (...)" which in the case of people with ID can be manifested through aggressiveness when one asks the person to participate in a certain activity. In the event that the tantrum is explained through the first assumption, we would be facing a symptom belonging to Specific Phobias and if it were explained through the second assumption, we could be facing a symptom of a Major Depressive Episode.

In order to know which symptom sustains the tantrum, and to be able to make an effective diagnostic judgment, it is important that the clinician can make a thorough record of the behaviour and provide the person with ID with therapeutic spaces that offer the possibility of giving an explanation to their experiences and their behaviours and thus be able to know which psychiatric symptom corresponds to said behavioural alteration.

→ In conclusion: professionals who work around people with ID ought to be trained to know the particularities in the expression and presentation of mental health problems of these people (NICE, 2016). Furthermore, it is essential for the clinician to understand that ID as such is never a valid argument to explain the different behavioural alterations and that if these occur, they do so as an expression of internal suffering.

9.3. The primary trauma derived from ID

9.3.1. Primary trauma in relation to family grief

If we review the conceptualization of the term “trauma”, it is understood that ID itself is constituted as a first trauma in the person, as a first impact that alters their balance, and that of all the members of the family to which they belong. And also, it´s important to remind that PDI are more vulnerable to develop a traumatic grief (Brickell, Munir. 2008).

Within the framework of any clinical or forensic assessment, it is necessary to distinguish:

- the primary trauma (originating from the same disability)

Versus

- the secondary trauma (derived from the situation of criminal victimization)

The news of a pregnancy triggers a wave of feelings in the whole family, but especially in the parents. Whether they verbalize it or not, they fantasize about the child to come and what they will be like as parents. A whole series of wishes and expectations are generated around the child to be born (he will be healthy, successful, handsome, he will look like ...). The support needs of these families are different (Giné, Balcels. 2011).

If every birth involves frustration when confronting wishes with reality, the news of the child's disability supposes an even greater loss, since among other difficulties, the distance between desire and reality is greater. All these feelings are assumed as part of the identity of the PDI (Sorrentino, 1990).

This fact produces feelings such as bewilderment, sadness or frustration, which place the family in a state of mourning. To speak of disability, therefore, is to speak of grief: grief of the parents, grief of the disabled child, grief of the family ideal, or grief of the family's ideal of lifestyle.

Thus, although each family is unique, and experiences and faces the experiences and vicissitudes in its own way, all those who receive the diagnosis of ID in a child must face the same fact, which is the grief for the child (or brother, nephew, grandson ...) who they did not have.

→ The grieving process and the demands, both external and internal, that families must face for their own care and for the child with a disability, can endanger the individual well-being of family members and the bond with the child, and therefore, the basic care that the baby needs for the development of its psychic structure (Dominguez, Vasques, 2017).

The establishment of an attachment in families with a child with ID becomes more difficult to achieve (Pérez-Salas, Santalices. 2009), not only because of:

a) the grief in the parents;

b) the ID itself (which entails special circumstances, such as being admitted very early (from the detection of disability) of figures outside the family to whom

families can delegate their own care functions; or the fact that the baby can be little stimulating for her parents due to her limitations, which reduces the moments of contact and interaction between the parents and the child.

It is common for a child with ID to find similarities with her parents or extended family disappear (“he has his father's nose”). The risk is that the reduction of the person with a disability appears to a diagnosis and is no loger seen as a whole, with the sum of her limitations and capacities.

→ The person with ID will identify only with the limitations of her disability and not with her resources and strengths, and his narcissism, or integrity, stability and well-being of the representation of himself will be damaged. The marker of this damage will show us the deficit in self-esteem of the person with ID (Rubio, 2016).

For the development of self-esteem, the look of constant concern towards the child, which we see so much in these families, does not help either. **One of the most frequent fears that parents tell us in our work is the fear that their child will suffer.**

It is important to make the child feel like:

When parents over use fear, it will inevitably lead to overprotection and control. Both overprotection and control contexts are known to have very negative consequences on the development of the subject's identity and on the adaptative skills (Domínguez, Vasques, 2016).

i. The exploration of the world,
ii. the differentiation of the self from the other (identity, desires, etc.),
iii. the assumption of responsibilities,
iv. emotional regulation,
v. the feeling of intimacy (both spatial and intrapsychic),
vi. the perception of the world as safe

- will be seriously engaged. **Overprotection and control stop the individual's growth, keeping him in an eternal childhood. (Torres, López. 2015)**
- However, it is important to note that **dysfunctions do not arise at the family level as a consequence of the disability, but rather according**

to the possibilities or not of the families to implement resources to adapt to this situation and to be able to rework the grief in a functional way in each of the stages of the family life cycle.

For the family, being able to count on professionals and resources to accompany them in this process constitutes an element of vital importance to achieve a good adaptation and minimize the risk of dysfunctions that endanger the family dynamics and that of its members.

9.3.2. Modulating factors of grief or primary trauma

Below is an evaluation model of all the modulating factors of grief in the family with a member with ID, which should be considered to evaluate the impact or primary trauma of the disability. This evaluation is considered a previous work required to evaluate secondary trauma or psychological damage derived from sexual abuse, mistreatment or the situation of criminal victimization.

The way in which each family will elaborate and process the grief is determined by multiple factors and by how they interact with each other. In addition, it should be noted that no factor is explanatory by itself, but rather **all the variables at stake must be taken into account to address and explain the grieving process in the family.**

FACTORS THAT MODULE THE GRIEF PROCESS AND THE PRIMARY TRAUMA IN ID.
I. INHENERENT CHARACTERISTICS OF THE ID TYPE.
II. AMBIENTAL FACTORS. - Culture and religion. - Resource disponibility - Diagnostic moment. - Medical, physical, social and emotional demands for the care of the person with ID - Interaction of the family with the treatment systems

III. FAMILY CHARACTERISTICS

- Family composition

- Family structure

- Family talking about disability, it´s causes and the help statement.

- Parent´s personality.

- Expectations about the child with ID.

- Social net and family support.

- Economical status.

IV. FAMILIY VITAL CYCLE.

I. Characteristics inherent to the type of disability

Disability may be:

- acquired
- or genetic

- the form of its evolution, the degree of affectation, the medical care it requires, if there is information on the evolution, life expectancy, etc., will be factors to take into account, since each of these aspects may trigger different responses (emotional, family burdens), which must be taken into account when assessing the course of family grief. (AAIDD, 2011). For example, syndromes associated with DI with a shorter life expectancy will produce a greater emotional burden and greater difficulty in grief.

Likewise, infrequent syndromes, little studied by the scientific community and with an uncertain evolution, will cause much more uncertainty in the family and also greater difficulty in the grieving process.

II. Contextual factors

o **Culture / religion**: The culture or religion to which the family unit belongs will modulate how the disability impacts on the family. The different ideas associated

with disability, the conceptualization that society or culture makes of it, are determining factors in the impact on the family throughout each of the phases of the life cycle.

o **Type of resources and** their **availability** for both the families and the person with ID at the different moments of the life cycle.

→ Although in recent years the number of services and intervention and treatment resources has increased considerably, in most cases they have focused on an individual intervention with the person with a disability, leaving family care to something residual and punctual. almost always linked to when these resources have encountered difficulties in individual treatment.

→ On the other hand, there are few resources for people with disabilities in adulthood and old age, which causes families a high level of stress and uncertainty.

o **Time of diagnosis**: An early diagnosis can favor the grieving process, since early treatments will be started, but it is also a risk when establishing early ties with the child, due to the grieving process itself. A late diagnosis can increase feelings of guilt about lost time, but it can also safeguard those early ties with the child.

It is also very relevant to whom the diagnosis is given and how (it is given to a single parent, and it is this parent who communicates it to the family; the diagnosis is given to both parents, etc.) as it can affect to the family organization and to the rhythm of the duel in each of the members.

o **Medical, physical, social and emotional demands** that the family must respond to for the care of the person with a disability. The more demands the family has to attend to, the greater the burden and the greater restructuring it will have to do.

o **Interaction of the family with the treatment systems**, which is of vital importance in families with children with ID, since these families, from the moment said disability is detected in the minor, come into contact with health teams, early care, social workers, psychologists, etc., and your relationship with them will be permanent and continuous over time. There are several risks that families must face: the first of them is the substitution or delegation of parental functions to professionals, as Núñez (2010) points out:

→ The feeling of paternal impotence in the face of the son who became strange to him, makes them delegate to the professional "knowing", "doing", because he is the expert. This results in a growing estrangement towards that child and an intensification of guilt for the incapacity and ineptitude shown by the parents.

→ Another danger is the continuous prosecution perceived by these parents by professionals, which again generates a feeling of guilt and ineptitude with respect to the upbringing and education of their child. An example of this are the words of a mother in a group of families and the applause that

she received from all the parents, affirming afterwards that they have felt like this on many occasions:

★ “Since my son was born, I have felt judged by every professional who has been in contact with my son: if I did not carry out the activity that they requested, they did not ask me why, but they immediately scold me; None of these professionals have asked me what I thought about the tasks and many times they did not explain what they were for”.

III. Family characteristics

o **Family composition**. There are many types of family compositions: traditional nuclear families (father-mother-children), single-parent families, reconstituted families (one or more of the parents has a child or several from previous unions), adoptive families, etc. Each of these compositions (Minuchin and Fishman, 1984) will have a series of characteristics, a series of demands, strengths and limitations that will be conditioned by the appearance and upbringing of a child with ID.

o **Family structure**. The flexibility of the family system, the ability of parents to adequately carry out their nutritional and normative functions, the possibility of expressing emotions among family members, clear boundaries between subsystems and towards the outside, as well as an adequate hierarchy They are protective elements that will facilitate the grieving process within the family.

o **Family stories about disability, its causes and about the request for help**. Our beliefs affect our perception of ourselves, others, and the world. All families will have a meaning about what the disability represents, its origin and the family's possibility of receiving help, be it from their closest environment or from specialized resources.

→ Such beliefs about disability or seeking help can help families or, conversely, be sources of guilt and shame. For example, if the family considers disability to be a divine punishment, they will have more difficulty in asking for help from the extended systems and will tend to isolation.

→ The guilt and shame generated by this feeling of punishment will generate these behaviours. Regarding the family's ability to request help, Imber Black (2000) describes how families have rules that determine the relationship with comprehensive or support systems. An example of this are the different rules about the gender that can request help (asking for help by men is seen as a weakness, only women can receive and request help) or rules that govern the gender that can help (only get help if it's coming from a woman). These rules can make it difficult for the family to access resources for help as well as limit the resources that can offer help to the family.

o **Parent's personality:** The personality of the parents will be a decisive factor both due to the different mechanisms that each of them have learned to deal with said grief and because of their own personality structure. The appearance of a duel activates previous duels that each parent has had. A duel not elaborated by any of them will act as an additional burden to the present situation, causing the same resources that then failed to be implemented (Blanca Núñez, 2010).

→ On the other hand, the different personality structures and the coding of the duel in function of that personality will facilitate or hinder the duel. For example, depressive personalities, prone to guilt, will code said grief in such a way that they will attribute responsibility for what happened to themselves.

→ The incidence of this factor in the parents and not in the rest of the family members is due to the fact that it will not only facilitate or hinder the grief for said parents, but it is they who through their care and the look they have on the baby, the person with a disability, will structure attachment, narcissism, or identity, basic structures in the construction of the psyche.

o **Expectations and place assigned to the child with ID**. The higher the expectations assigned to that child, the more difficult it is to accept the disability (Núñez, 2010).

o **Family social network.** The quality of the family social network allows it to have resources for emotional support and support in the face of difficulties that arise in the family life cycle. It is important to analyse the different support networks of all members of the family, including the person with disabilities and the quality of these networks (communication, support, etc.).

→ The grieving process itself and the feelings associated with it (anger, shame, sadness, anger ...) and the high demands to which these families are subjected can lead to a gradual abandonment of social networks and support resources. This abandonment can be caused either by the families themselves or by the support networks that, faced with the high emotional and physical demands of these families, feel overwhelmed and withdraw.

o **Economical level.** On the one hand, and generally speaking, families with few resources face crises with an attitude of greater resignation and submission. They may place a lower level of expectation on their children.

→ High-income families have more complex grieving processes, due, among other things, to a high level of expectations and narcissistic wounds. (Núñez, 2010) On the other hand, access to help resources (individual and family) is conditioned on the economic resources that the family has, which will influence their stress levels and family functioning.

IV. Family life cycle

The family is a system in continuous movement that changes over time based on two types of changes:

• **Evolutionary changes**: changes that obey the passage from one evolutionary stage to another, such as the constitution of the couple, the birth of the first child, the beginning of the children's schooling, etc. (Minuchin, 1984). The set of these evolutionary stages in the family is called the life cycle of the family (Carter and McGoldrick, 1980).

• **Accidental changes**: these are unexpected crises, which appear suddenly (eg, accidents, unemployment, birth of a child with ID, abuse, etc.). These changes consequently modify the positions of its members in the group, the rules that govern said family, the tasks that it has to face, and as a result of all this, the experiences of each member and of the system as a whole are modified.

→ To the evolutionary changes that every family has to undertake to face the different demands of each moment of the family life cycle, families with a child with ID have to add all those of the care of the person with a disability.

→ Disability will condition the way of facing the different evolutionary tasks and the family's ability to establish a functional structure, with a hierarchy and clear limits. Each stage of the life cycle will imply that the initial wound (the grief for the disability) is reopened, and therefore each stage offers the opportunity to re-signify said crisis.

❖ Aid professionals must know not only the tasks that families must face at each stage of the life cycle, but also how the family has adapted to each of them, and how the family faces the changes that must be made to achieve the family welfare and that of its members.

STAGES OF THE LIFE CYCLE (Carter y Mc Goldrick, 1980)

Stages of the life cycle	**Transition emotional process and clue principles**	**Second order changes, needed in the family status for it´s development.**
YOUNG SINGLE ADULTS	Acceptance of emotional and financial responsibilities about themselves.	- Differentiation of the ego related to the origin family. - Development of close relationships among peers. - Establishment of the ego at work and acquire of the economic independence.
THE NEW COUPLE	Compromise with the new family system.	- Creation of the conjugal system.

		- Redefine relationships with extended family and peer group to include the couple.
FAMILY WITH LITTLE CHILDREN	Acceptance of new members into the family system	- Adapt the marital system to make room for children - Sharing children's education as well as domestic and financial obligations - Redefine relationships with the extended family to include the roles of parents and grandparents
FAMILY WITHH TEENAGERS	Relaxation of family limits in order to take into account the independence of the children and face the reduction of strength of the grandparents	- Change the parent-child relationship to give the adolescent room to enter and exit the system - Focus on the marital and professional aspects of middle age - Beginning of the change towards the joint care of the older generation
FAREWELL OF THE OFFSPRING	Acceptance of the diversity of exits and entrances in the family system	- Renegotiate the family system as a dyad - Develop adult-adult relationships between parents and children - Redefine relationships to include in-laws and grandchildren - Coping with the illnesses and death of grandparents
AEGING FAMILY	Accept generational role changes	- Maintain interest in self and partner functioning in light of physiological decline; explore possible new family and social roles. - Support for the middle generation to assume a more central role

		- Make room for the system for the wisdom and experience of the elders - Coping with the loss of a spouse, siblings, and other peers and preparing for one's own death

The birth of a baby always entails a crisis (the man-woman dyad becomes the man-woman-baby triad), with its consequent restructuring and transformations in the conjugal subsystem and the emergence of the parental and filial subsystems:

→ To all the changes typical of entering this new stage of the family life cycle, in the families that concern us, is added the accidental crisis of the birth of their child with a disability.

→ Every family, depending on individual and family demands and needs, oscillates between periods of high family or centripetal cohesion (such as that which usually occurs in raising young children), and periods of lower or centrifugal cohesion (more present in adolescence).

→ During the centripetal period, the internal and intimate family life stands out, where the limits with the outside are reinforced and the borders between the members are somewhat blurred. All this favours the optimal fulfilment of the demands that the upbringing of the little ones demands. In the transition towards a centrifugal period, the structure of family life changes to adapt to objectives in which the interaction of each of the family members in the extra-family context stands out.

→ It is very likely that the disability of a family member exerts a centripetal attraction, creating pressures for greater cohesion in both the family unit and its individual members. Therefore, in families with a child with a disability, the centripetal cycles are lengthened, or even perpetuated. This fact leads to disconnected families being overwhelmed by the demands and needs of the child with a disability.

The following table summarizes the demands and needs that complicate the life cycle of the family with a member with ID.

Needs and demands faced by families with children with ID (own elaboration adapted from Heller, 1993 and Turnbull and Turnbull, 1986)	
Life cycle phase	**Needs and demands**
Childhood and preschool education	- Diagnosis of DI - Inform others of the diagnosis - Readjust expectations as parents - Impact on the sibling group

	- Adjustment of parental care for all children - Locate the necessary support services - Meet the physical needs of the child - Respond to the reactions of others - Child acceptance - Adaptation to the service provider systems
Years of primary education	- Diagnosis of DI - Transition to the school environment - Participation in personalized education programs - Admit the differences of the child in relation to other children of the same age - Greater discrepancy between the child's physical development and his capacity for intellectual development - Inclusion - Facing the relationships of the peer group with the minor - Facing the relationships of the context with the minor - Meet the physical needs of the child
Adolescence	- Emergence of sexuality - Possible isolation and rejection of equals - Planning the transition to adulthood - Greater need for independence of the child - Cover physical needs
Adulthood	- Readjustment of parental expectations regarding the child's independence - Readjustment of parental expectations of release from child care - Planning for custody needs - Adjustment to changes caused by the end of the school stage - Decision-making regarding resources for help and / or exit to the labor market of the child - Search boarding schools and residences - Ageing of parents - Concern for caring for the person with ID when parents are absent

	- Cover physical needs

9.4. Modulating factors of the psychological impact or secondary trauma derived from the situation of criminal victimization

In a context of assessing the impact derived from sexual abuse, domestic or G-BV on a victim with ID (which we call secondary trauma), the factors of protection and vulnerability to the impact must be considered.

It is more than documented that the damage, injuries or consequences that a situation of criminal victimization leaves on the victim will depend on:

A) the characteristics of the criminal victimization situation,

B) on the individual variables of the victim's personality,

C) on the variables of the family and the context variables.

In relation to the latter, the protection, police and judicial context around the victim with ID, if it does not guarantee the necessary support through expert facilitators, will most likely contribute to a process of secondary victimization.

The different modulating factors will be analysed, which should always be considered in the assessment of the psychic impact after an experience of criminal victimization. **Not considering them would lead to the error of overly adhering to the medico-legal model, which has traditionally focused on the detection of psychopathological signs derived from crime, leaving aside other vulnerability factors and protective factors.**

All factors must be understood as situated on different interrelated continuums. Depending on the position of the victim in these continuums, they will be in a situation of maximum vulnerability to suffer a psychological impact after an act of victimization, with serious consequences on their mental and emotional stability, or, on the contrary, in a situation less prone to instability by having more protection factors.

9.4.1. Primary trauma or situation of previous vulnerability due to ID

Analysing the modulating factors of the primary trauma of ID will be necessary to determine the impact derived from the situation of criminal victimization, since traumatic sexualization leads to the conditioning of the PID and the sexual activity itself makes them reexperience memories that are negative.

- **Example**: in a case of sexual abuse towards a person with ID whose sexuality has been denied (that is, his family has shown a belief about ID framed in the erroneous assumption that people with ID are eternal asexual children), the impact that sexual abuse leaves on the victim may

be minimal compared to the impact derived from the primary trauma of the disability that has led them to have their sexuality prohibited;

- In the same criminal case, in the cases of those people who do not know the meaning of sexuality, and who are used to having their privacy accessible to other people (let's think of all the cases of highly dependent people who need help with hygiene), a non-violent sexual abuse by a caregiver does not have to have a significant impact on the person either.

However, in both cases, if they have to count unknown persons (other resource professionals, police officers, forensic psychologists, prosecutors and judges) with unnecessary repeated interviews and without the insertion of the necessary supports that guarantee an adequate understanding between the judicial agents and the victim, then the impact will come from the situation of secondary victimization derived from their passage through the judicial system.

It should be noted that due to these circumstances, the emotionality that accompanies the account of the events may be neutral, which is why emotionality should never be considered as a criterion of credibility of the testimony.

9.4.2. Characteristics of the family or institution that amplify or mitigate the impact

In people with ID, due to their greater dependence and greater vulnerability due to having a disability, family circumstances constitute the main source of vulnerability or protection from impact after a criminal act. It is convenient to detail those families whose difficulties will condition a greater psychological impact after a specific experience of victimization:

- Transgenerationally disturbed families (Barudy, 1998) where child abuse is a “way of life”, so that adults tend to repeat patterns of interaction, beliefs and contexts that lead to chronically repeating abusive and violent behaviours about their children.
- “Uncontrolled” families, who overflow and abuse them in times of stress or crisis.
- Negligent families, in which adults are unable to care for their children, both in terms of nutritional functions and normative functions.
- Families with difficulty establishing secure bonds. Parents who are capable of establishing a secure bond or attachment with their children will activate in their children a system of behaviours aimed at seeking the protection of significant adults in moments of insecurity, fear or lack of protection.

Likewise, the security of the bond allows us to continue exploring, to continue facing the world, despite the vicissitudes that one may suffer. On the contrary, if the parents are not able to establish secure bonds, the children will have less capacity to ask for help and to face the world in the face of difficult or traumatic events.

- Families immersed in a grief not elaborated by the primary trauma of the child's disability.

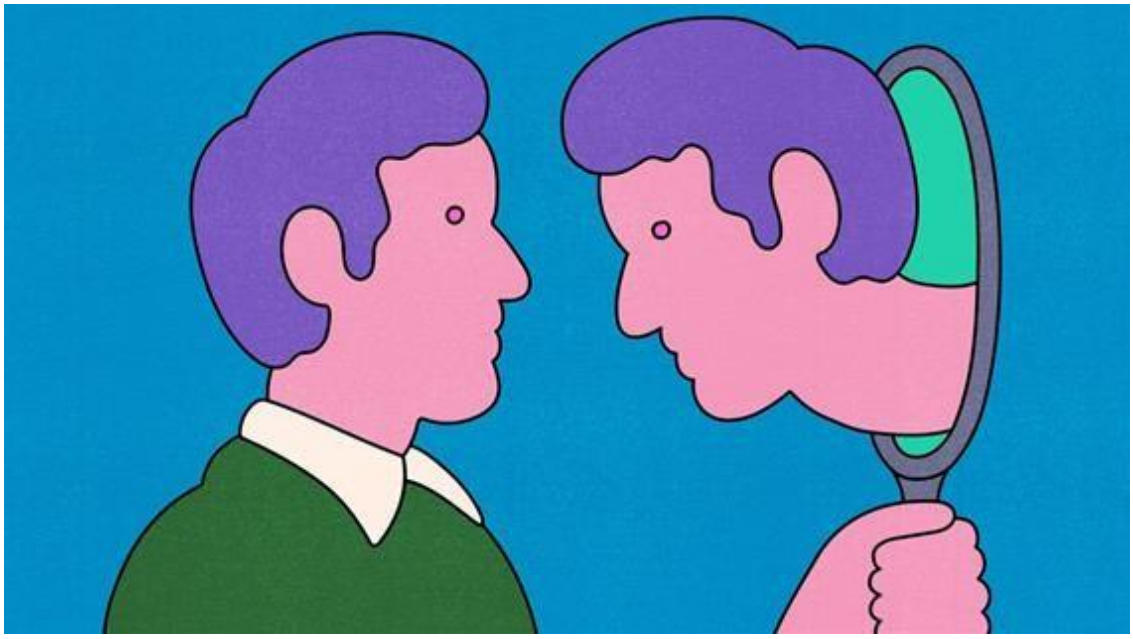
If we extrapolate these family variables to the institutional context that holds custody or is responsible for the care of the person with ID who has been a victim, it will be understood that negligent or unsafe institutions for users with ID will be those capable of amplifying the impact that the ID criminal act leave on the person.

9.4.3. The personality

Family relationships will determine a series of personal variables that will make the person more or less strong to the experiences of victimization. It is known that the mind does not reside in the individual, as an independent structure, but that the mind is relational, it is built and changes from relationships with significant others.

An individual who throughout his life has developed insecure relationships or relationships characterized by abuse or neglect is more likely to present a series of imbalances in the basic personality, which make him more vulnerable to psychological damage.

These imbalances are, among others, emotional dysregulation, poor self-concept, low self-esteem, limitations in the ability to resolve grief (perception of the experience as something irreversible) or an internal attributional style regarding the responsibility of the crime.



9.4.4. Contextual factors related to the situation of criminal victimization and secondary victimization

The experts refer to the following factors to assess related to the situation of criminal victimization:

- Quantitative parameters (frequency, intensity and duration).

- Qualitative parameters (level of vexation).

- The bond of affectivity with the aggressor.

- The multiple negative consequences derived from the crime.

Finally, the impact that the same context of disclosure and the passage through the police and judicial system may have left on the victim, and that the doctrine calls "second victimization", will be considered. Among these factors, due to their high appearance in judicial contexts with people with ID, we highlight the following:

- The lowest credibility perceived in the testimony.

- The reiteration of unnecessary statements.

- The inadequacy of forensic instruments, and the widespread use of criteria-based credibility assessment instruments.

- The system's inability to adapt procedures to victims with ID.

All this warns about the direct responsibility of police and judicial agents, with their lack of training in intervention with victims, in secondary victimization.

It is enough to use the United Nations Convention on the Rights of Persons with Disabilities, in its articles referring to access to justice to obtain the keys for the prevention of secondary victimization in people with ID, adapting the process to their needs with fundamental support as the facilitator figure.

9.5. Psychotherapy with victims with ID.

9.5.1. An adapted diagnostic and psychotherapy model

People with ID have been and continue to be marginalized from psychotherapy. How many times have we heard "as they do not find out they do not suffer"? Behind this statement is the myth that disability protects them from the negative feelings that bitter or traumatic experiences cause. And delving into this myth, another belief appears that is perverse at best: that people with ID don't feel.

However, they feel, like everyone else, but with a psychic structure that in many people with ID is weaker, as demonstrated in the higher figures of mental illness

in the group of people with ID than in the rest of the population, or in the fact that they appear to be less resilient than people without ID to stressful or traumatic life events.

Therefore, contrary to the general opinion, it seems that "not understanding" (or "understanding with different capacities") makes the person more psychologically vulnerable. If he is more vulnerable, it is because feeling and being the same, and only because he has limitations, he is understood and listened to less.

Consequently, it remains a general consideration that due to their intellectual and introspection limitations, people with ID will hardly be able to avail themselves of the benefits that a psychotherapy context offers. One only has to do a review of the few publications concerning psychotherapy with people with ID to realize this and appreciate that they have not been offered much more than behavioural interventions based on reinforcement and punishment.

However, it is a fact that people with ID benefit from psychotherapy, and even from the most dynamic currents, in the same way as people without disabilities.

When a person with ID has been the victim of sexual abuse, a violent relationship or other traumatic experience, psychotherapy is one of the few ways to eliminate the discomfort derived from that experience, which can manifest itself with a variety of symptoms and in turn these they can take a different form because they are people with ID, as has already been pointed out in the section referring to pathoplasty in people with ID.

9.5.2. A knowledgeable intervention on pathoplasty in people with ID

The person who carries out psychotherapy must know the pathoplasty of the symptoms in people with ID, for two reasons: first, the symptoms will indicate the degree of discomfort or impact that the traumatic experience has left on the person, and secondly, they are one of the first ways for the therapist to communicate with his patient, to establish a therapeutic alliance.

For example, the disruptive or aggressive behavior that a person with ID who has been the victim of a sexual assault may present may indicate that the person feels anger, fear, or is reliving the traumatic event.

Properly hypothesizing about the possible origin, feeling or experience that causes the symptom, will allow, from a healthy therapeutic curiosity, knowing how to ask, and, therefore, being able to understand. Finally, understanding will allow creating contexts that can contain, regulate and, consequently, heal.

What will not allow cure is to fall into the influence of the eclipsing effect and attribute the symptom to the disability itself. The symptom always indicates discomfort and is in many cases the only way for the psychotherapist to begin to connect with the person suffering from it.

Any diagnostic map or psychotherapeutic intervention strategy that have traditionally been used with traumatized people must be adapted to the maps of psychotherapeutic work with people with ID.

For example, the traumatogenic model about the explanatory factors of the impact that child sexual abuse can have on the person serves to exemplify the adaptation that must be carried out when working with victims of sexual abuse with ID in psychotherapy. Finkelhor and Browne refer to four explanatory reasons for the traumatic impact of sexual abuse: traumatic sexualization, loss of confidence, defencelessness and stigmatization that continued sexual abuse in childhood leaves on the person. All this leads to a distortion of the self-concept and the vision of the world.

However, we could perfectly use those same four reasons to explain the trauma that ID itself leaves on the person, that is, the person who has ID is going to experience, with great probability, a traumatic sexuality because it is usually prohibited, secret and therefore disturbed; the barriers encountered throughout his life by an incomprehensible society devour his potential trust in the world; and, finally, if there are two concepts associated with the experience of disability, it is that of helplessness and that of stigmatization.

Consequently, it is possible to understand why there is talk of the need to work with the primary trauma of the disability, and the secondary trauma of the traumatic experience, not only in the context of assessing the psychic damage, but especially in the psychotherapeutic context.

9.5.3. The importance of approaching the primary trauma of disability and family grief

The elaboration of the secondary trauma derived from the situation of criminal victimization can hardly be done without the restoration of the possible primary trauma that the disability may have left in the family, and, consequently, in our patient. In order to evaluate the impact that the trauma of the disability has left on the family and, consequently, on the person with ID, a proposal has been offered of all those modulating factors of the family's grief with a member with ID.

Therefore, working with a family with a person with ID should always start from a work focused on grief. Elaborating it is essential to restore the primary trauma of disability, and, consequently, elaborating the secondary trauma of sexual abuse, violence or a situation of criminal victimization.

9.5.4. An attachment-focused psychotherapy

People with ID traumatized by a violent event, despite the fact that they may present a multitude of different symptoms, and the impact will depend on a multitude of factors, all of them, due to the intrinsic characteristics of the traumatic experience, have felt insecurity, fear and the lack of protection.

That is why the focus of psychotherapy will not be so much the traumatic experience itself as the attachment. Unlike other cognitivist therapies focused on the elaboration of trauma, weaving bonds of trust and security with the close and

significant people of the traumatized person with ID will be the transversal and central objective of the entire therapy process in the intervention model that we propose.

The works of Bowlby and Ainsworth, who conceived the laboratory procedure known as the strange situation (1978), which has become the most widely used test in attachment research around the world, have contributed to the fact that attachment theory has become the best foundation of the social-emotional development of children. Attachment is an independent primary motivation, aimed at satisfying the need for safety and security. It refers to any form of behaviour that has as a consequence the proximity of the other, who is considered a source of relief and well-being.

Let us remember that the establishment of a secure attachment on the part of the person with a disability with their main caregivers is often threatened by the family mourning process. For a child to develop well he needs to make a positive impact on the significant figures in her life.

The danger for children with ID is that this impact is almost always negative. Anger, communication problems, the challenges posed by the diagnosis, learning problems, can activate in parents doubts about their parenting skills and feel unprotected, insecure in front of the child with ID. Their worth as parents is constantly questioned.

The more history of insecure attachment in the parents, the greater negative effect it will cause. The story of parents with a child with ID usually begins with emotional trauma, pain, shock, grief and a sense of injustice, of being different. If these feelings are the ones you experienced in childhood, before becoming parents, they will surely be magnified in the parenting experience with a child with ID.

Thus, only an attachment-focused therapy can address the primary trauma of disability and the secondary trauma of abuse. In addition, it forms the basis for changing the internal operating models of oneself and the world.

Only if the person feels worthy of care and with the assurance that significant others will come to their aid in the face of life's vicissitudes, can they be encouraged to explore and, consequently, to develop their self-concept and self-esteem.

Only if a person feels loved can feel himself valuable. Therefore, only an attachment-focused therapy can help restore the damage that the person has in her narcissism. This, remember, refers to the integrity and balance in the representation of oneself, which in people with ID is usually very damaged.

9.5.5. Affectivity and sexuality in people with ID.

The bond that is established between the parents and the son or daughter with ID will condition the development of affectivity and sexuality. Both, like narcissism

and attachment, have their origin from the moment of birth and in the encounter and relationship with the other.

The perception of one's own body is determined in each person by the bond (parental desire, type of contact) that the parents establish with the baby. This body image will determine the possibilities of a full emotional and sexual life in each of us (image of the body as a source of pleasure).

The risks for people with disabilities are:

- Many of the contacts carried out in the early stages between caregivers and the minor are determined more by aspects related to stimulation and therapeutic objectives than by mere play and pleasure, fundamental aspects in the emotional development of any minor.

- The estrangement of the parents from this unexpected son or daughter can generate a rejection towards contacts with the body of the person with a disability.

- The development of fundamental aspects of sexuality such as the feeling of intimacy and privacy will be deficient. The invasion of the intrapsychic space of the disabled person by the environment that surrounds him (overprotection) puts at risk the development of his own space (private and intimate).

- Denial of the sexuality of people with disabilities, either because of the erroneous belief that people with ID are asexual, or another equally erroneous but alarmingly widespread belief that they have an outrageous sexuality that must be repressed.

- Sexuality is one of the engines that lead the individual to seek a way out of the family. Overprotection and fear of the outside world, or fear of the consequences of sexuality (pregnancy), are some of the factors that intervene in this denial at a family level.

- The fear of the professional services to confront the families, the overprotection and the lack of training are also some of the causes that sustain this silence.

The consequence of all this is a lack in education programs with agents who intervene with people with disabilities. Sex education programs not only prevent those negative aspects of sexuality (diseases, unwanted pregnancies, abuse), but also develop and teach those aspects related to the pleasure of one's sexuality.

However, it should be noted that the affectivity, sensuality and sexuality of the person with ID are needs to which the therapist must also be able to respond, working with the family and the context that surrounds them to build relationships based on respect for the intimacy of the person and their right to the development of a free and healthy sexuality.

9.6. Conclusions.

Attachment-centred psychotherapy implies that the therapist becomes a model of secure attachment with the patient and becomes a model of secure attachment with significant others. This entails an ethical and therapeutic responsibility and implies being responsive, knowing how to emotionally regulate, being differentiated, knowing how to communicate meaningfully and help in exploring the world.

The more damaged is the potentially protective context of the patient (being the clearer case that in which the abuse is committed by the parents or caregivers of the person), the more need to deploy contexts of protection and secure attachment around them.

A therapy focused on attachment will contemplate the different needs that must be responded to both at the individual level with the patient with ID and at the family level.

To detect the needs, a rigorous analysis of the different modulating variables in the impact of grief (primary trauma) must be started, and later in the impact of abuse, mistreatment or experience of criminal victimization (secondary trauma). and relational, the therapy objectives will be planned, the transversal objective of the same being the establishment of secure bonds that allow the person to restore their feelings of security and worth, allow them to go out into the world and develop a resilient personality.

10. OTHER RESOURCES. NETWORK.

I) IN GREECE.

The 15900 Hotline is a national service that enables female victims of violence or third parties to communicate directly with a gender-based violence agency. The line is staffed by psychologists and sociologists who provide immediate assistance for emergencies and violence on a 24-hour basis, 365 days a year. Equally, women can use the following e-mail address: sos15900@isotita.gr (Source: https://womensos.gr/15900-24ori-tilefoniki-grammi/).

The General Secretariat for Gender Equality (GSGE) operates Counselling Centres nationwide providing FREE information and counselling services to women who turn to them.

The Counselling Centres offer services providing:

- information on gender equality, violence and multiple discrimination against women,

- social, psychological, legal and employment support (from a gender-based perspective),

- referral to or escorting - whenever necessary - women to hostels, police and prosecutors' offices, courts, hospitals, health centres, mental health centres, welfare or other benefits bodies, employment and entrepreneurship promoters, child protection and support agencies, etc.,

- legal aid, in cooperation with the legal associations. For more information please visit: https://womensos.gr/sumvouleutika-kentra-ggif/

The Local Government Counselling Centres provide services locally throughout the country.

Equally, they implement actions for the prevention, information and sensitization of the local community. For more information please visit: https://womensos.gr/symvouleutika_kentra_ota-2/

II) IN PORTUGAL.

In Portugal there is one shelter suited for women victims of violence with disabilities, the “Casa de Abrigo para Mulheres Vítimas de Violência com Deficiência e/ou Incapacidade” (CERCIAG), which temporarily accommodates people under a list of conditions. Institutional website can be consulted at: http://www.cerciag.pt/servicos/casa-de-abrigo. Important information related to victim’s assistance in Portugal can also be found at the official of the The Commission for Citizenship and Gender Equality (CIG), at (in Portuguese): https://www.cig.gov.pt/

Other relevant contacts:

Comissão para a Cidadania e Igualdade do Género (cig@cig.gov.pt);

Delegação Regional (cidmdelnorte@mail.telepac.pt)

Estrutura de Missão Contra a Violência Doméstica (emcvd@seg-social.pt)

Amnistia Internacional Portugal (aiportugal@amnistia-internacional.pt)

Associação de Mulheres Contra a Violência (sede@amcv.org.pt)

Centro Anti-Violência (ca@amcv.org.pt)

Associação Portuguesa de Apoio à Vítima (apav.sede@apav.pt)

Rede nacional de Gabinetes de Apoio à Vítima (GAV)

Associação Portuguesa de Mulheres Juristas

Plataforma Portuguesa para os Direitos da Mulher (plataforma@plataformamulheres.org.pt)

A list of centers/institutions/associations which provide support to people with disability is available at: https://dges.gov.pt/en/node/938?plid=1752

Victims can also contact:

The National Support Network for Victims of Domestic Violence:

800 202 148

SMS: 3060

National Line for Social Emergency: 144

Alternative and Response Women's Association (UMAR):

Support centers:

City of Almada: 212 942 198

umar.almada@sapo.pt

City of Porto: 222 025 048 | 910 504 600

e-mail: umarprati@gmail.com

City of Porto - for victims of sexual violence: 220 933 787 | 914736078

e-mail: eir.centro@gmail.com

The following lines are also available for support to people with disabilities:

961 010 200, for written messages only (specifically developed by the Republican National Guard to provide support to people with hearing disability in need of urgent support);

213 649 773 (LINADEM - Liga Nacional para o Estudo e Apoio da Deficiência Mental).

III) IN SPAIN.

In Spain, the main resource for victims with intellectual disability is the **Unidad de Atención a Víctimas con Discapacidad Intelectual (UAVDI).**

This service is specialized in intervention with cases of abuse or mistreatment of people with intellectual disability. It works through three lines of work: intervention (facilitation in police and judicial processes and psychological therapy), investigation and awareness.

There are four headquarters around the country: Madrid (Fundación A LA PAR), Catalonia (Catalònia Fundació), Castilla La Mancha (Fundación Laborvalía) and Aragón (ATADES).

The contact is free and leaves no traces.

Contact information:

Phone number: 900 33 55 33

Web: www.nomasabuso.com

~~The following lines and emails are also available for contacting UAVDI:~~

- ~~UAVDI Catalònia (Barcelona): uavdi@cataloniafundacio.cat / 659 272 270~~

- ~~UAVDI Laborvalía (Ciudad Real): uavdi.laborvalia@gmail.com / 926 971 097~~
- ~~UAVDI - Fundación A LA PAR (Madrid): 917 355 790, Ext. 712 / Ext. 306~~
- ~~UAVDI Aragón de ATADES (Zaragoza): uavdiaragon@atades.org / 900 335 533~~
- ~~Equipo de Apoyo a la Víctima con Discapacidad Intelectual o del Desarrollo (EAVDID), FEAPS Plena Inclusión de la Rioja: eavdid@plenainclusionlarioja.org / 634 267 399/ 679 692 466~~

Another important resource is the **support line for gender-based violence victims**. This line is operated 24 hours during the whole year. Also, the contact is free and leaves no traces.

This service offers attention in 53 languages, general information, legal advice and psychosocial attention.

Contact information:

Phone number: 016

WhatsApp: 600 000 016

Email: 016-online@igualdad.gob.es

~~In the case of **sexual abuse in minors**, victims can also contact to Centro de Intervención de Abuso Sexual Infantil (CIASI): CIASI@madrid.org / 913312054~~

11. BIBLIOGRAPHY.

Alemany, A., Quintana, J. M., Recio, M., Silva, E., Manzanero, A. L., Martorell, A., González, J. L. (2012). *Guía de intervención policial con personas con discapacidad intelectual*. Madrid: Fundación Carmen Pardo-Valcarce.

Alemany, A. y Cartagena, I. (2016). Estadísticas de la atención a víctimas con discapacidad intelectual en España. *Haurdanik, Asociación Vasca para la ayuda a la infancia maltratada*, N./ZK.33, 8-9.

Brown, H., Stein, J., y Turk, V. (1995). The sexual abuse of adults with learning disabilities. *Mental Handicap Research*, 8, 3–24.

Cendra, J. (2013). El consentimiento prestado por personas con discapacidad intelectual en relación con el delito de abusos sexuales. *La Ley Penal: revista de derecho penal, procesal y penitenciario*, 104, 53-62.

Cendra, J. (2015). Seguridad ante la agresión. *Escuela de Bienestar, Módulo V*, tema 3, capítulo 2.

Cendra, J. (2015). Mujeres en situación de mayor vulnerabilidad: discapacidad intelectual. En F. Fernando Pombo - Proyecto EXEQUO (Ed.), *Guía práctica sobre la casuística legal habitual de mujeres víctimas de violencia de género*. Madrid: Fundación Fernando Pombo.

Cendra, J., Alemany, A., y Hernández, M. (2016). Abuso y discapacidad intelectual: la necesidad de un trabajo en red. *Actas de coordinación sociosanitaria*, 18, 21-32.

Etxeberría, X., et al. (2013). *El enfoque ético del maltrato a las personas con discapacidad intelectual y del desarrollo*. Deusto Digital, Instituto de Derechos Humanos Pedro Arrupe.

Fundación Carmen Pardo-Valcarce y FEAPS Madrid (2014). *Abuso y discapacidad intelectual. Orientaciones para la prevención y la actuación*. Madrid: Fundación Carmen Pardo-Valcarce.

Fundación Carmen Pardo-Valcarce y FEAPS Madrid (2014). *Protocolo de actuación ante los abusos sexuales y la violencia doméstica y de género a personas con discapacidad intelectual*. Madrid: Fundación Carmen Pardo-Valcarce.

González, J. L., Cendra, J., y Manzanero, A. L. (2013). Prevalence of disabled people involved in Civil Guard's police activity. *Research in Developmental Disabilities*, 34, 3781-3788.

Horner-Johnson, W., y Drum, C. E. (2006). Prevalence of maltreatment of people with ID: a review of recently published research. *Mental Retardation and Developmental Disabilities Research* Reviews, 12, 57-69.

Manzanero, A. L., Recio, M., Alemany, A. y Martorell, A. (2011). Identificación de personas y discapacidad intelectual. *Anuario de Psicología Jurídica*, 21, 41-48.

Manzanero, A. L. y Recio, M. (2012). El recuerdo de hechos traumáticos: exactitud, tipos y características. *Cuadernos de Medicina Forense*, 18(1), 19-25.

Manzanero, A. L., Contreras, M. J., Recio, M., Alemany, A. y Martorell, A. (2012). Effects of presentation format and instructions on the ability of people with ID to identify faces. *Research in Developmental Disabilities*, 33, 391-397.

McCarthy, M., y Thompson, D. (1997). *A prevalence study of sexual abuse of adults with ID referred for sex education. Journal of Applied Research in ID*, 10, 105-124.

Recio, M. y Alemany, A. (2013). *Guía NO+ABUSO para personas con discapacidad intelectual*. Madrid: Fundación Carmen Pardo-Valcarce.

Recio, M., Alemany, A., y Manzanero, A. L. (2012). La figura del facilitador en la investigación policial y judicial con víctimas con discapacidad intelectual. *Siglo Cero: Revista Española sobre Discapacidad Intelectual*, 43, 54-68.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Brookes.

Sobsey D. y Varnhagen C. (1991) Sexual abuse and exploitation of disabled individuals. En C. Bagley y R. J. Thomlinson (Eds.), *Child Sexual Abuse: Critical Perspectives on Prevention, Intervention and Treatment* (pp. 203-216). Toronto: Wall & Emerson.

Sullivan, P. M. y Knutson, J. F. (2000). Maltreatment and disabilities: a population based epidemiological study. *Child Abuse and Neglect*, 24, 1257-1273.

Tharinger, D., Horton, C.B., y Millea, S. (1990). Sexual abuse and exploitation of children and adults with mental retardation and other handicaps. *Child Abuse and Neglect*, 4, 301-312.

Verdugo, M. A., Alcedo, M. A., Bermejo, B., y Aguado, A. (2002). El abuso sexual a personas con discapacidad intelectual. *Psicothema*, 14, 124-129.

Westcott, H. y Jones, P. (1999). Annotation: The Abuse of Disabled Children. *Journal of Child Psychology & Psychiatry*, 40, 497-506.

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