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SUPPORTING VICTIMS OF GENDER-BASED VIOLENCE WITH COGNITIVE DIVERSITY: GAPS IN TRADITIONAL CURRICULUM [*]

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ABSTRACT

Gender-based violence (GBV) primary prevention has been recognized as a crucial dimension in professionals' work in several areas of education, social work, psychology, medical and nurse sciences as well as in the judicial system. However, a detailed analysis of curricula established at undergraduate levels usually shows the absence of providing students with the knowledge and specific skills to deal with gender-based violence victims, namely when involving more vulnerable groups, such as those with cognitive diversity. In this way, more initiatives are needed in this field to fill the gap in professionals' training skills in order to improve the quality of services and give more adequate responses to victims. In this way, the project ATHENA BEGIN was designed to provide evidence-based material for professionals who deal with victims of GBV with cognitive diversity, using a set of complementary methodologies. This paper presents the main findings of the

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Project ATHENA BEGIN highlighting the empirical data collected and the prominent professional training needs.

Key-words: gender-based violence; primary prevention; cognitive diversity; curriculum studies.

Introduction

Primary prevention regarding violence has been increasingly recognized as a crucial strategy to eradicate it, and promote inclusive societies and well-being for all. Through primary prevention, professionals may empower people who they work with. This way, they may play a decisive role in preventing, identifying, and intervene in case of being targeted or observer of any violent behaviour or attitude.

Gender-based violence (GBV) is one of the most prevalent forms of violence in our society. It is often normalized and, in consequence, not problematized. However, since early childhood, many persons are exposed or even victims of GBV at home (domestic violence (DV)). For others who have not been exposed nor victims of DV, GBV have been a common and usual dimension of social life, ranging from "less ofensive" to severe violence — sexual harassment, gender symbolic violence, sexual coertion, dating violence, sexual violence, rape, among others. Several studies have been reporting the prevalence of these forms of gender violence not only against adults, but also against children and youth (FRA 2014).

In parallel, societies have been increasingly asked to guarantee inclusion of all the people, regardless of their gender or any other minority status, such as cognitive diversity People, especially women and girls, with cognitive diversity are perceived as more disempowered and vulnerable, less able to defend themselves from the perpetrators or to be believed by society if they disclose GBV.

Aiming to increase protection, safety, and empowerment of people with cognitive diversity, the Project ATHENA BEGIN addressed the training needs of professionals and informal caregivers to prevent and to support victims of GBV among people, in particular girls and women, cognitively diverse. The consortium involved three European countries (Spain, Portugal and Greece) and four organizations of these countries supporting either victims of GBV or people with so called intellectual disabilities, here identified as intellectually or cognitively diverse (ATADES, A LA PAR, UMAR and EDRA).

This paper presents the main findings of the Project ATHENA BEGIN regarding the training needs identified, qualitatively and quantitatively, by current and future professionals and informal and formal caregivers. These results may inform curricular and intervention changes in order to better assist, prevent and protect people with cognitive diversy from GBV, in particular girls and women.

1. Gender-based violence and people with cognitive diversity

Gender-based violence against women (GBVAW) is an umbrella term that encompasses several forms of abuse which affect women and girls disproportionately such as rape, sexual exploitation, sexual harassment, genital mutilation, and domestic violence. GBVAW is a pervasive form of human rights violation, affecting 1 in 3 women worldwide (WHO, 2013). The everyday risk is especially experienced by girls and women with disabilities, since evidence shows that abuse is more frequent against this 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). 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, GBV will be used to refer only to the violence perpetrated against women, and also men, with intellectual disabilities (ID), henceforth also named as cognitive diversity (CD). In this regard, it is essential to mention that women with CD are equally exposed to the same forms of violence as 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).

The relation between disabilities and gender-based violence have been neglected for decades. The victims/survivors of gender-based violence with intellectual disabilities remain left out both in theoretical as well as in practical terms This marginalisation is more apparent regarding girls and women with intellectual disabilities (ID), as those victims remain in an invisible intersection between gender and their disabilities. However, being a cognitive doverse woman means an additional risk factor for gender-based violence, namely, domestic violence (Pestka & Wendt, 2014). In the same way, being exposed to abuse can substantially increase the odds of mental disorders and suicidal ideation among women.

Literature on the vulnerability to GBV of children and girls with CD is still scarce, but three main points may be highlighted. First, the importance of being aware of the similarities, but also the specificities, of gender-based violence and domestic violence against people/women with and without CD; Related to that, second, the risk factors for gender-based violence and domestic violence that seem to be more relevant for people/women with CD. Finally, the challenges that professionals and services face in the intersection of gender-based/domestic violence and intellectual disabilities.

To be a woman or a girl with ID/CD is an "additional vulnerability factor" (Nosek, Foley, Hughes, & Howland, 2001, p. 186), since that is intrinsically related to their limitations and healthcare needs (Walter-Brice, Cox, Priest, & Thompson, 2012). Women with CD are more vulnerable to suffer gender-based violence, as well as domestic violence (Barger, Wacker, Macy, & Parish, 2009; Pestka & Wendt, 2014; Douglas & Harpur, 2016). Researchers argued that this vulnerable group is especially under increased risk for sexual violence (Plummer & Findley, 2012; Bowen & Swift, 2019), and this risk can be four times higher compared to non-disabled women (Martin et al., 2006). Despite that, data related to the risk factors for abuse is scarce. As pointed by Brownridge (2006), there are three main categories according to which the risk factors can be gathered, and for each category, the author lists the main risk factors associated: category 1) *Relationship factors* (e.g. direct dependence associated to the severity of disability and duration of the relationship); category 2) *Victim-related characteristics* (e.g. socioeconomic status and age); category 3) *Perpetrator-related characteristics* (e.g. control over victims and substance use). An additional category of risk factors can be mentioned 4) *Society-related characteristics*. This category encompasses the specific social constructions and social representations about women with CD and about GBV in a particular society and the potential interaction between those factors that may increase the victimisation risk for women with CD. Some society-related factors are, for example, the stigmatisation and stereotypes. Disabled women are invisible, undervalued and often labelled as an undesirable and asexual person (Foster & Sandel, 2010), or as someone who is unable to understand and to give or withdraw consent in intimate relationships. The economic oppression (or disadvantage) is another risk factor related to the status of disabled women in the society, namely in the labour market since women with disabilities have been historically marginalised from participating actively in these contexts (Mays, 2006).

Violence against women with disabilities is, then, a complex and multidimensional challenge for supporting victims. The intersection between gender, type and severity of the disability may increase the challenge to provide more appropriate services for victims. It is what Bowen and Swift call as the "appropriate evidence-based services" (2019, p. 703), meaning that in the front-line support, the various professionals need some specific knowledge and the adequate training to give effective care, reducing risks for (re)victimisation. However, there is a lack of studies in this field, and this gap is even more significant considering intellectual disabilities, which is also probably reflected in the lack of specific training of professionals. On the one hand, professionals and institutions that support victims have not (enough) knowledge and skills to deal with women, girls and some boys and men with CD; on the other hand, professionals and institutions supporting people with functional and cognitive diversity have not (sufficient) knowledge and skills to approach primary prevention and/or support the victims of GBV. It adds additional challenges for the professionals who work and assist people/women with cognitive diversity, often struggling with limitied resources.

Additionally, because disabled women are exposed to the same forms of GBV and domestic violence as well as non-disabled women, it is essential to "develop disabilitysensitive abuse screening instruments and techniques for determining the vulnerability for abuse that can be attributed to disability, beyond the vulnerability experienced by women in general" (Nosek, et al., 2001, p.187). Another critical challenge for support services is related to the victim's capacity to recognise the abusive behaviour (Nosek, et al., 2001), which is directly related to the severity of the CD. Even when victims are able to identify the violence suffered, they may have to face some discredit on reporting abuse since the perpetrators frequently hold a trustworthy status (Plummer & Findley, 2012).

2. Method

The Project ATHENA BEGIN proceed with a mixed method research to identify the needs of the professionals and caregivers to better protect and support women, girls and other people against GBV. Using qualitative and quantitative instruments, the researchers were able to understand where are the gaps in training, both in knowledge and in skills, as well as the dilemmas and difficulties faced when dealing with potential or effective victims of GBV. Among these professionals are teachers, kindergarden educators and educators in general, psychologists, social workers, and other caring professionals as well as police officers.

2.1. Instruments

Specifically, in regards to the **quantitative** methodology, a twenty question survey on needs assessment of professionals who work with vulnerable populations was used to collect data amongst professionals and future professionals. This survey was composed by four groups: the first group with one question concerning the informed consent; afterwards, a set of sixteen affirmations related to the individual's personal and professional situation, the most and least valued features of the work, perceived support, and satisfaction; followed by the Maslach Burnout Inventory (MBI); and lastly, one question about the impact of COVID-19's and further comments/suggestions that the participant could be interested in sharing. In regard to the MBI, this instrument was sought to better assess the needs that professionals who work with vulnerable populations face in their daily professional activities. It has 22 items with likert scale answer (ranging from 0 =never to 6 =every day). The items are divided into three subscales: Exhaustion or Emotional Tiredness (EE), Depersonalization (DE), and reduced Professional Achievement or Professional Achievement (rRP). The EE consists of nine items and refers to both physical and mental exhaustion, the feeling of having reached the limit of possibilities, while the DE corresponds to five items and consists of changes in the attitudes of individuals when coming into contact with the users of their services, starting to demonstrate cold and impersonal contact with suffering. Finally, the rRP comprises eight items. measuring the perception of the influence of others, well-being with work, as well as the professional's relationship with their problems, showing the feeling of dissatisfaction (Maslach et al., 1996).

As regards to the **qualitative** study, all project partners implemented focus groups, following the guidelines elaborated and agreed by the researchers. Two focus groups were carried out in each partner country with current professionals and future interdisciplinary professionals, such as psychologists, educational scientists, criminologists, involved in the field of domestic violence and victim's assistance.

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

2.2. Participants

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

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

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

In the Spanish sample, participants were not asked to identify themselves with a gender. Most of the participants were aged between 35 and 55 years old (47.5%), were single (52.5%) and had no children (58.8%). Most of them have a Bachelor (47.5%) or Master degree (31.3%) mostly in Education, Psychology, Disabilities and Social Sciences. 31.3% of the Spanish participants work with people with ID, 3.8%% with victims/survivors of domestic/gender-based violence and 23.8% with both, the others work with other vulnerable groups or prefer not to answer. Most of them have a full-time work schedule (52.5%) for a period of 1 to 10 years (40%).

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

2.3. Procedure

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

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

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

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

3. Main findings

3.1. Quantitative results

Regarding quantitative results, *To make the difference on people's lives* was the most selected motives for Portuguese and Greek professionals (68.8% and 37.8% respectively); this was the second motive among Spanish professionals (17.5%) who chose as the first one *To help people with intellectual disabilities and/or victims/survivors of gender based/domestic violence* (40%), the second most selected one among Portuguese professionals (28.2%). Greek participants chose as the second main motives *income and career opportunities* (16.8%) which were the least chosen by Portuguese professionals (8.5%) along with schedule and social benefits (4.2%). It must be said that most of the professionals are not related with schools and the results were not disaggregated by professional areas.

Other very satisfying features were *The opportunity to use knowledge and skills* (27.5% and 64%), *The opportunity to acquire more knowledge and skills* (28.8% and 61.8%), which were the most valued features for Greek professionals (50.6% and 64.7%).

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

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

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

3.1. Qualitative results

As far as qualitative results concern, three main categories and the respective subcategories are as follows: i) support for victims (family and emotional support; accessibility and inclusion; specific services and monitoring; state's support); ii) professional's aspirations (making a difference, salary and labour market, network, teamwork) and iii) risk factors identified (workload, lack of specific training, lack of personal, specific tools and services, barriers, emotions and burnout, lack of available resources, infrastructure and bureaucracies, pandemic effects). These categories and subcategories represent the dimensions mostly mentioned by professionals and future professionals.

Needs in terms of knowledge for dealing with GBV-ID, both in the field of intellectual disability and in the field of gender-based violence victimization, skills for intervention with victims wit ID, ethical issues and specific training arose as the main themes approached during focus groups implemented in the three partner countries. Hence, the findings from the focus groups were grouped in five main categories: i) needs in terms of knowledge to deal with GBV against children with cognitive diversity; ii) the need to validate a voice or to have a voice facilitator; iii) the need for training families and caregivers to foster people with ID/CD's autonomy; iv) the need for intersectional approach with adequate resources; the need of training in ethics.

In terms of necessary knowledge in the field of CD, it was commonly agreed that there are five major dimensions in need of significant deepening: degrees of disability, sexuality, validate a voice, infantilization, intersectionality and interdisciplinarity. For starters, in regards to intervention, it is imperative to consider that there is a gap in the available information concerning the outcomes of the existing types and degrees of disability. According to the collected data, it was significantly emphasized that it is a challenge to understand what mild, moderate and severe stands for in the framework of disability, not only in terms of what can be expected as a behaviour, but also in regards to the impact it has on the person with ID and his/her caregivers. This lack of knowledge/training has been pointed out by professionals, by caregivers and by people with ID also, as a barrier for providing more adequate support to victims of GBV, in particular for people with ID. It allows interveners from having a better understanding of the victims' real condition, even though there was agreement on the similarities among the feelings of the victims (shame, fear, blame…) despite the fact that they have ID or not. The training on these subjects ought to start early in academic life, especially, social work, psychology, nursery and other academic degrees that are oriented to the possibility to provide services to people with ID. And it shouldn't stop there. This training ought to be both during the initial training in respective courses, including teacher initial training *and* in-service training in order to update the knowlege and skills.

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

The presence of some degree of CD is often associated with the inability to provide a valid speech and arguments. Such limited beliefs lead to the fact that people with ID are not seen in terms of the credibility of their speech, they are seen as "not having a voice". This condition stands up as a barrier for all kinds of interveners as some of them find themselves entrenched in these same beliefs, with or without their awareness of it and, when providing support to this vulnerable group, these interveners fail to understand the vulnerable group's real needs, their perception of the situation and, consequently, the most adequate means of support to be offered. When it comes to GBV, if the victims additionally carry some kind of disability, their voice loses even more power. In most cases, the victims may not be aware of the victimization and if their voice has no validity it stands for an even higher barrier.

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

Institutions, including schools, are responsible to care for all children, but this responsibility is shared with the families or legal tutors and the caregivers. In this sense, there must be institutional offer of training for families and caregivers in order to accomplish oour duty of fulfil the rights of people with ID/CD.

It is commonly observed that people with ID are approached and addressed in an infantile way. This infantilization is noticed from close relatives and formal and informal caregivers, and it is often presented as a means of showing affection. The question is that these high levels of affection and overprotection expressed via infantile expressions could end up, to a certain degree, stealing the autonomy of people with ID, even in cases of very low levels of ID. The family has been pointed out as having a major role in setting the example of tearing down stereotypes and raising the value of people with CD as the human beings that they are, instead of approaching them with a "childlike attitude". Professionals ought to be trained in terms of educational tools for parents of children with ID, since the moment these parents are informed about the existence of a disability in their children (a significant lack of support was also experienced by parents when they are informed about the existence of a disability from the medical group). There is a need to fuel parenthood when it comes to CD in order to start prevention early on, to offer these children a sense of autonomy (as much as it can be reached), to teach them to express themselves and to stand up for themselves in whichever areas they feel the need to do so, instead of being approached as disabled. Such educational tools should be provided to professionals of the social and medical field (preferably) in early stages of their academic life. Participants whose field of activity is not directly related to people with ID mentioned repeatedly that one of the major difficulties they need to deal with is the lack of understanding and lack of specific education on intellectual and developmental disabilities, this lack of knowledge causes reticence in professionals to deal with people with ID, perhaps, hence the reason why these professionals tend to approach people with CD in such infantile ways. Professionals argue that, due to this need of training and understanding, professionals are worried about causing psychological harm in people with ID and are also concerned about not being able to do their job properly. Additionally, professionals tend to feel rejection towards people with CD who have behaviour problems and this attitude could be strongly related to the lack of training and information.

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

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

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

Confidentiality and anonymity must also be ensured. Even though intervention against GBV (in some countries called DV) needs a multiagency network and multiprofessional actions, the sharing of information must be done without breaching the rights of the victim to maintain her/his life private. These principles are of double relevance: Firstly, it ensures the respect of citizenship rights; secondly, it is important and closely related to the success of the intervention. In fact, it contributes to establishing a relationship of trust, crucial for the further steps in the process of escaping from violence. We must not forget that especially in GV/DV in intimate relationships the offender has violated the integrity and the self of the victim. So, we should act countering this feeling of being violated and not taken as a person, and work on a pathway to re-establish her/his self confidence and trust in the professionals.

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

4. Conclusions and recommendations

Quantitative and qualitative data compiled in this work complements each other. On the one hand, with the quantitative approach we sought to understand circumstances and risk factors to which professionals (young and senior) who work with vulnerable populations are exposed to when in their daily activities, namely when it comes to people with ID. On the other hand, with a qualitative approach, we sought to understand the needs that professionals (young and senior) and caregivers (formal and informal) encounter under those same work circumstances when dealing with this vulnerable group. The results from both methodologies have been exposed, and some important reflections came from the joint analysis. First, it is remarkable to observe that Portuguese and Greek participants presented the **lack of preparation** and the **lack of opportunity to use and acquire** more **knowledge and skills** as the least selected items concerning the less appealing features of the job. On the other hand, the most pointed out needs throughout the Focus Groups were the need for knowledge and skills for intervention in gender-based violence against people with ID, which can be equated to the lack of preparation as well. In regards to **needs for knowledge**, the following dimensions were pointed out: the need to have more knowledge to what regards to the existing degrees of disability; to have more information on sexuality and how caregivers ought to approach it in regards to people with ID; the need to have more tools to validate the voice of people with ID; the need to overcome infantilization; the need to cope with in intersectionality and embrace interdisciplinarity; the need to have more knowledge concerning the probability for people with ID to suffer domestic violence, sexual violence and other types of gender-based violence; the need to assess risk assessment and finding adequate instruments for people with ID; the need to have more knowledge in identifying signs amongst children, adolescents and adults and better understanding the consequences of GBV on people with ID; and, lastly, the need to intervene towards protection, security and recovery. These dimensions stood out in terms of need for knowledge and it was commonly agreed that the absence of it may lead to feelings of helplessness from professionals. It may also have irreversible consequences on victims of GBV-ID, hence the need to deepen these results.

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

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

Professionals and caregivers have reported throughout the Focus Groups that working with people with CD can be a very rewarding experience, but it is also perceived as overwhelming. In the Greek sample, for example, differences were observed in the *Personal Fulfilment* dimension, being that, professionals who work with people with ID present lower levels of PF when compared with those who work with both populations (GBV & ID). When exploring differences between dimensions of burnout within the same samples: Portuguese and Greek professionals' significant differences were observed: higher levels of *Personal Fulfilment* and lower levels of *Depersonalization.* Working with vulnerable populations may present itself as a fulfilling commitment as professionals embrace their motivation to make a difference in the world and in the lives of peoples with ID. However, there is a shadow side attached to it. It regards the fact that professionals tend to experience feelings of depersonalization as a means of defence to better cope with emotional barriers and these are later on perceived as risk factors for their professional performance. Risk factors identified were workload, lack of specific training, lack of personal, specific tools and services, barriers, emotions and burnout, lack of available resources, infrastructure and bureaucracies and lastly, but not less important, pandemic effects.

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

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

This training ought to be implemented early on the academic levels or earlier on in schools. The inclusion of specific curricular classes in the curricular plans of bachelor's, master's and doctoral degrees (as well as in other courses of professional qualification), in the fields of work related to social, psychologic, medical and public security matters ought to be mandatory. Or, in cases where mandatory is not a possibility, it ought to be optional so that those interested in working with this group could make the choice to learn more and be better prepared. The current reality is that basic training is not enough. In academic degrees such as Social Work, for example, there are no subjects to approach and to bridge communication skills' gap, moreover, topics such as sexual education for people with CD and respective caregivers; what do the different degrees of CD represent in terms of behaviour and their perception of it for professionals who work with people with CD on a daily basis and for professionals who may encounter such cases on their daily tasks; are absent from academic training. A higher investment should be allocated to this field of work in order to make up for the lack of training and for the lack of resources that both professionals and caregivers have testified to be in need of. Here, feasible and helpful services were brought up: providing multidisciplinary teams for attendance services, creating a common protocol, building support centres for specific services such as GBV for people with CD and creating accessible helplines to provide specific support for both professionals and caregivers to give information and refer to proper and specialised services.

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APOIAR VÍTIMAS DE VIOLÊNCIA DE GÉNERO COM DIVERSIDADE COGNITIVA: LACUNAS NO CURRÍCULO TRADICIONAL

RESUMO

A prevenção primária da violência de género (GBV) tem vindo, crescentemente, a ser reconhecida como uma dimensão crucial no trabalho de profissionais em diversas áreas do cuidar, tais como educação, psicologia, serviço social, saúde, e da proteção e segurança, como as forças de segurança e do sistema judicial. Contudo, a análise dos currículos académicos mostra a ausência de disciplinas com conteúdos acerca de conhecimentos e de competências específicas para lidar com vítimas de violência de género (GBV), nomeadamente quando pertencentes a grupos mais vulneráveis, como por exemplo, as pessoas como diversidade cognitiva (DC). Neste sentido, será necessário introduzir mudanças nestes campos, para preencher as necessidades de formação de profissionais para que possam melhorar a qualidade dos serviços de apoio, educação, atendimento, proteção e acompanhamento de vítimas ou potenciais vítimas. Usando metodologias complementares, o Projeto ATHENA BEGIN teve como objetivo identificar, providenciar e desenhar conteúdos e materiais de formação para lidar com pessoas com diversidade cognitiva (CD) potenciais ou efetivamente vítimas de violência de género. Este artigo apresenta os principais resultados da pesquisa empírica realizada junto de professionais e cuidadores/as informais acerca das necessidades de formação para prevenir, proteger e apoiar pessoas com diversidade congnitiva face à violência de género.

Palavras-chave: violência de género; prevenção primária; diversidade cognitiva; estudos curriculares.