VET MODULES FOR THE REHABILITATION OF VICTIMIZED AND OFFENDER CHILDREN

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CHAPTER ONE VIOLENT CRIMES

ABOUT VIOLENT CRIMES

Violence is a growing problem throughout the world, particularly among the youth. Further, there is a lack of a clear definition of this problem and what constitutes a violent crime varies in different countries in the world. It is difficult to decide on a common definition because social norms and values in different cultures changes how people see and evaluate problems like violence. A few decades ago, corporal punishment of children at school was a regular practice even in European schools but now such behaviors can be prosecuted and punishable with several years in prison (WHO, 2002:13). Likewise, domestic violence was once viewed as part of the parents' right to discipline their children, or the husband's right to "correct" his wife's mistakes. Even today, there are many countries that do not view domestic violence as a crime (e.g., Alfred, 2014; Amnesty International, 2015). Recent statistics on crime and victimization, and particularly data on violence against children and women show that violence is likely to grow even further in the near future (Baliki, 2014; Pinheiro, 2006; UNICEF, 2014; United Nations, 2009; van Dijk et al. 2007).

Previously, violence was considered a problem of criminal justice systems. However, the scope, complexity, and the extent of the problem required states to recognized violence as a public health issue in the early 1980s (Dahlberg & Mercy, 2009). In 1996, the 49th World Health Assembly declared violence as an important public health priority and as a serious problem for "people of all ages and both sexes, but especially women and children" that needs to be tackled all over the world with special programs that improve the recognition of the problem, promote multisectoral involvement, promote research on violence, and in prevention activities, develop policy recommendations for all nations across the globe (WHO, 1996).

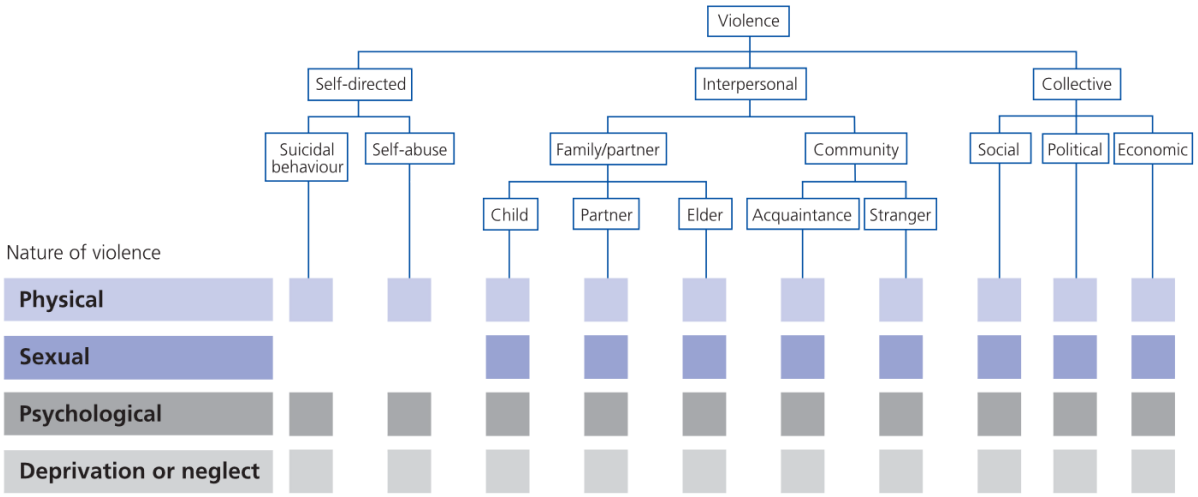
World Health Organization (2002:4) defines violence as:

> "*the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."*

WHO's (2002) definition involves a wide range of acts that goes beyond mere physical violence and includes deprivation, psychological harm, intimidation and threats as well. A typology of violence by WHO (2002) based on type of violence and the relationship between the target and the perpetrator of violence is actually quite comprehensive in terms of putting pieces together to organize different types of violence and how they relate to each other. Depending on its nature, violence is classified into four types: physical violence, sexual violence, psychological violence, and deprivation or neglect. According to the target &

perpetrator, violence is divided into three types: self-directed, interpersonal, and collective violence. Self-directed violence involves suicidal behaviors and self-abuse. Interpersonal violence ranges from violence against family members such as children, siblings, spouses, and elders to violence against community members such as violence among acquaintances and strangers. Collective violence includes social violence, political violence, and economic violence. Figure 1 below is a summary of this typology.

FIGURE 1: Typology of violence



Source: WHO (2002:5)

In legal texts, different types of violence are defined as different crimes. For example, in the USA, the Federal Bureau of Investigation (FBI) defines violent crimes as "offenses which involve force or threat of force" (FBI, 2012). In Uniform Crime Reporting (UCR) Program, FBI considers murder and non-negligent manslaughter, aggravated assault, robbery, and forcible rape as four main types of offences that constitute violent crime. The UCR program has a hierarchy rule that puts different violent crimes in the following descending order: "murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault, followed by the property crimes of burglary, larceny-theft, and motor vehicle theft" (FBI, 2012). Arson is also considered as a violent crime but its status is evaluated based on the seriousness of the incident.

In Europe, Eurostat is the chief agency responsible for collection data in European Union. Eurostat's (2014) data for violent crime is composed of sexual crimes (including rape and sexual assault), robbery, and violence against persons. However, murder is excluded from this classification and evaluated as a separate category. Eurostat (2014) views a detailed analysis of violent crime as difficult because of a lack of standard definition among EU Member States. Eurostat statistics on crimes recorded by police between 2002 and 2012 indicates that, with

some exceptions among the EU Member States, the amount of violent crimes in Europe is declining at a rate of 10% (Eurostat, 2014). Figure 2 is a summary table for these statistics.

FIGURE 2: Violent crimes recorded by the police in Europe

	Number (1 000)											Index (2007 = 100)				
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2008	2009	2010	2011	2012
Belgium	108.0	108.6	109.2	111.5	114.0	115.6	119.7	122.2	123.1	128.1	120.4	104	106	106	111	104
Bulgaria	12.2	12.8	11.3	10.6	8.8	8.7	8.5	9.2	9.1	7.4	7.3	98	106	104	85	84
Czech Republic	24.0	22.8	24.0	22.1	19.5	20.0	18.2	17.4	18.7	20.1	19.0	91	87	93	101	95
Denmark	18.8	19.2	19.4	19.1	19.6	20.6	24.9	26.2	26.4	26.4	25.3	121	127	128	128	123
Germany	197.5	204.1	211.2	212.8	215.5	217.9	210.9	208.4	201.2	197.0	195.1	97	96	92	90	90
Estonia (1)	:	2.4	3.3	4.8	5.2	5.8	9.1	7.4	5.3	6.1	6.7	156	127	92	104	115
Ireland (2)	12.0	10.0	9.6	9.4	9.9	10.2	10.8	10.8	12.1	11.1	10.3	106	106	119	109	101
Greece	7.5	10.1	10.1	10.3	10.4	10.9	11.2	12.2	12.3	9.8	8.7	103	113	113	90	80
Spain (3)	120.6	109.8	108.8	112.4	114.2	113.5	116.3	113.1	106.5	109.4	116.9	103	100	94	96	103
France (4)	288.9	292.7	292.1	307.5	326.1	324.8	331.8	341.9	351.1	353.1	277.5	102	105	108	109	85
Croatia	8.8	10.0	11.3	12.4	13.2	13.0	13.0	12.2	11.0	10.2	8.6	100	94	85	79	67
Italy (5)	106.6	111.2	131.8	136.3	145.2	154.0	146.6	131.6	127.7	141.5	147.4	95	85	83	92	96
Cyprus	0.2	0.3	0.4	0.3	0.3	0.3	0.3	0.5	0.4	:	:	106	150	145	:	:
Latvia (6)	3.4	3.2	3.4	2.9	2.8	1.9	1.9	1.9	1.4	1.4	1.4	100	98	74	73	70
Lithuania (5)	5.5	6.0	6.6	6.6	5.5	4.8	4.4	4.2	3.7	3.4	2.8	92	88	78	72	58
Luxembourg	2.1	2.1	2.4	2.4	2.5	3.2	3.2	3.3	3.3	3.8	4.5	99	101	103	118	138
Hungary	31.2	31.5	33.4	32.8	29.7	29.6	33.0	32.0	38.4	37.2	37.4	111	108	130	125	126
Malta	:	:	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	91	89	88	72	73
Netherlands (7)	104.3	106.4	109.9	138.9	138.2	138.9	133.5	136.6	129.5	127.4	123.4	96	98	93	92	89
Austria	37.0	40.0	41.0	42.9	43.3	46.2	47.0	47.6	44.6	46.7	47.6	102	103	97	101	103
Poland	74.9	77.2	74.6	68.1	61.4	54.6	52.1	51.1	49.2	48.4	45.6	95	94	90	89	83
Portugal	22.9	23.4	24.3	23.2	24.2	21.7	24.5	24.4	24.3	24.0	22.0	113	112	112	111	101
Romania	7.1	6.3	6.4	6.5	7.2	5.6	5.5	5.5	5.5	5.0	6.2	98	99	98	90	110
Slovenia	3.1	2.9	2.9	2.9	3.1	3.1	2.6	2.8	2.8	2.5	2.5	85	91	90	80	82
Slovakia (7)	15.0	13.7	13.8	13.6	11.6	10.3	9.7	9.0	8.1	7.8	7.2	94	87	79	76	71
Finland (8)	34.2	35.3	36.5	37.1	38.0	41.7	42.2	39.6	39.6	47.8	46.0	101	95	95	115	110
Sweden	79.5	83.8	86.1	94.2	98.2	104.6	108.4	111.7	113.3	116.5	113.2	104	107	108	111	108
United Kingdom:																
England and Wales	875.7	963.4	997.6	997.2	972.3	885.7	839.3	827.1	795.6	754.2	719.8	95	93	90	85	81
Scotland (5)	28.2	27.4	27.4	26.6	27.6	25.2	24.8	21.7	21.5	20.1	17.2	98	86	85	80	68
Northern Ireland	32.4	32.7	32.4	34.3	35.1	32.4	32.5	32.8	32.6	33.5	33.3	100	101	101	103	103
Liechtenstein	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	108	110	100	100	98
Norway (5)	20.4	20.0	21.4	21.4	22.6	23.2	23.8	24.3	24.2	25.0	25.4	103	105	104	108	110
Switzerland (9)	9.3	10.2	11.9	11.5	12.8	13.5	12.6	15.4	14.1	14.0	14.4	93	113	104	104	106
Montenegro (7)	4.2	3.9	4.3	0.2	0.3	0.3	0.3	0.4	0.4	0.3	0.3	111	134	130	113	125
FYR of Macedonia	0.7	0.9	1.1	1.1	1.0	1.0	0.9	1.0	1.1	0.9	0.8	87	101	102	91	81
Serbia	31.4	25.5	28.0	29.1	28.9	29.3	29.6	32.1	32.2	34.2	33.7	101	109	110	117	115
Turkey (10)	94.9	96.2	108.4	125.5	165.1	138.6	167.1	206.7	234.7	229.1	248.0	121	149	169	165	179
Albania	:	:	:	:	:	:	0.2	:	:	:	:	:	:	:	:	:
Bosnia and Herzegovina	:	:	:	:	:	:	1.5	1.8	:	1.9	1.9	:	:	:	:	:
Kosovo	:	:	:	:	:	:	17.2	16.2	18.2	22.8	23.1	:	:	:	:	:

(1) 2006, 2008 and 2009: break in series.
(2) 2007: break in series.
(3) 2005 and 2008: break in series.
(4) 2012: break in series. Data from the gendarmerie excluded.
(5) 2004: break in series.
(6) 2004, 2005 and 2006: break in series.
(7) 2005: break in series.
(8) 2009: break in series.
(9) 2006: break in series.
(10) 2005 and 2006: break in series.
Source: Eurostat (online data code: crim_gen)

Source: Eurostat, 2014

VIOLENT CRIMES AND CHILDREN AS VICTIMS AND OFFENDERS

"Violence" and "children" are two words that do not seem to belong together, yet the growing number of news and scientific literature show that violence against children and violent acts committed by children is more common than we want to accept. Violent victimization is one of the most important warning signals for future violent offending for children and adolescents (Shaffer and Ruback, 2002). Existing research shows that there is a clear link between abuse and victimization during childhood and offending in later stages of life (e.g., Xavier, 2014; Wiebush et al., 2001). In fact, early age victimization causes a cycle of violence for adolescence and beyond. (WHO, 2007). Therefore, we need to understand the causes and consequences of violence for youth if we really want to deal with violence as an ever growing problem for our societies and this endeavor should begin with the relationship between victimization and offending.

Children as Perpetrators of Violence

Global news media is full of news that portrays children as perpetrators of violence. In these news, sometimes we read about child soldiers who kill people in the ranks of paramilitary groups, sometimes juveniles burn cars and act like savages as members of terrorist groups, sometimes we see child offenders in school shootings, sometimes we read news about juvenile gangs storming the cities and intimidating adults and mainstream society. Unfortunately, these news are not fiction or false statements about juvenile offenders. Children bully their classmates, act violently, form gangs, carry guns & knives, use alcohol and illicit drugs, paint graffiti on the walls, violate social norms and break laws. Children of this age seems to be much more violent than previous times. Delinquency and violence among youth is a bitter fact of this century.

Juvenile delinquency has been one of the hot topics in criminological research since the first studies of the Chicago School of Criminology. Delinquency and particularly violence among youth has been studied by criminologists, sociologists, psychologists, biologists, and other social scientists from different perspectives. Although they have similar correlates, in many cases adult criminality has its roots in adverse childhood experiences and juvenile delinquency is different from adult delinquency. In this part, we will first summarize the leading ideas, models, and theories on causes of violent behavior and delinquency among youth and then we will analyze the statistics on violent crimes committed by juveniles across the world.

Even though it is hard to prove scientifically what causes of crime and violent behavior, more than 100 theories have been developed to explain causes and correlates of crime and delinquency (e.g., Dolu, 2015). The theories that focus on youth crime stress the importance of

family, social disorganization, subculture, and deviant peers. We will briefly summarize the main ideas of the leading work in this field.

Clifford Shaw and Henry McKay (1942), the two leading Chicago School of Criminology and Sociology, investigated the crime problem in Chicago during the first three decades of the 20th century and they paid a special attention to juvenile delinquents. Because of the high volume of juvenile delinquency in the City of Chicago, Illinois, the world's first juvenile court was established in Cook County more than 100 years ago with the "Juvenile Court Act of 1899" (McCord, Widom & Crowell, 2001:154). After careful analysis of the crime statistics that they obtained from Chicago Police and Cook County Juvenile Court, Shaw and McKay showed that the reason behind high crime rates in Chicago was social disorganization in the city. The breakdown of informal social controls in the city, according to the authors, was the chief cause of deviant and criminal behaviors in the streets and youth delinquency. Without effective social controls, the authors argued, individuals, particularly those of younger ages, were set free of external controls, which function as protective factors in social life. In fact, Thomas and Znaniecki (1918-20) mentioned social disorganization before Shaw and McKay (1942) as the main cause of crime for Polish immigrants in Europe and America, where large immigrant population had no effective social controls to prevent them from engaging in criminal activities. Benefitting from their work in Chicago, Clifford Shaw published *The Jack-Roller* in 1930, *The Natural History of a Delinquent Career* in 1931, and *Brothers in Crime* in 1952, all focusing on how juveniles developed their criminal careers in the disorganized neighborhoods of Chicago.

Following the influential works of the Chicago School, a flood of criminological research on the impact of social environment on crime and delinquency were produced. In 1958, in his famous book "Family Relationships and Delinquent Behavior", F. Ivan Nye stressed the importance of family in preventing juvenile delinquency. Nye (1958) mentioned four types of control, which revolve around the concepts of attachment to family, effective parental supervision, internal locus of control, conscience, and self-control. Nye (1958) believed that family plays a key role in containing violent and non-comforming urges while providing guidance and direction for ideal role models.

In 1944, John Bowlby published his seminal paper "Forty-four juvenile thieves: Their characters and home lives", in which he developed his *Maternal Deprivation Hypothesis.* According to Bowlby, relationship between the child and her mother is crucial for socialization during the first five years of the child and tested his hypothesis that loss of the mother, separation from the mother (or the primary caregiver), and failure to develop an attachment

with the caregiver might result in social, psychological, cognitive and emotional difficulties for the baby. Any disruption in this attachment would lead to increased probability of aggression, antisocial behavior, juvenile delinquency, emotional difficulties, depression, and psychopathy.

In 1969, Travis Hirschi published his famous book "Causes of Delinquency". Hirschi argues that what prevents individuals, particularly youth, from engaging deviant, criminal, and violent behavior is the social bonds between the individual and the society. Hirschi (1969) lists attachment to family and the immediate social environment; commitment to future goals & dedication to a conventional and a future oriented life style; involvement in conventional activities; and belief in social norms as the key components of his social bond theory. The stronger social ties between individuals and the society the less likely the individuals will engage in delinquent and violent behaviors. As a theory that stresses an "external locus of control", social bond theory emphasizes the role of social bonds in preventing criminal behavior.

Gottfredson and Hirschi (1990), on the other hand, developed an individual oriented theory stressing "internal locus of control" and argued that low-self control is the root cause of juvenile delinquency. The authors define self-control as the capacity of a given individual to resist temptation to do harm to others, act violently, and engage in risky behaviors. According to the authors, as the level of self-control increases the likelihood of criminal and violent behavior also increases. Those who have low self-control are more likely than others to commit crime, use aggression, do self-harming behaviors and take risks. A great deal of research across the globe show that low self-control is a strong predictor of violence and delinquency.

Violent Crime Victimization

Despite considerable differences of prevalence and incidence of juvenile victimization across different cultures, research shows that a good portion of all children fall victim of a violent crime, particularly in family and school settings where they are supposed to be safe and by those who they trust and know. For example, according to a 2014 national study of juvenile offenders and victims in the United States by the National Center for Juvenile Justice Violence, victimization among American children is considerably high (See Figure 3 for a summary of findings). 46.3% of the juveniles in the United States were victim of at least one type of physical assault. This figure is huge and it means that almost half of all juveniles were victim of a physical assault. Of all these assaulted children, 10.2% were victimized with an assault causing injury, 36.7% were assaulted without injury, 13.2% were bullied, 19.7% were exposed to severe emotional stress (Sickmund, 2014).

FIGURE 3: Violent crime victimization among juveniles in the United States

Boys were more likely to be the victim of assaults; girls were more likely to experience sexual victimization

	Percentage exposed to violence in the past year							
	Youth ages 0–17			Age of youth				
Type of violence	All	Male	Female	0–1	2–5	6–9	10–13	14–17
Assaults and bullying								
Any physical assault	46.3%	50.2%	42.1%	17.9%	46.0%	55.6%	49.8%	46.9%
Assault with injury	10.2	12.7	7.7	0.8	5.6	7.5	13.4	18.8
Assault, no weapon or injury	36.7	38.9	34.4	17.4	38.6	47.5	37.3	32.4
Bullying	13.2	16.7	12.8	NA	19.1	21.5	10.7	8.0
Teasing or emotional bullying	19.7	20.6	23.5	NA	13.5	30.4	27.8	15.8
Property victimization								
Any property victimization	24.6	28.1	27.0	NA	27.8	30.1	24.8	27.6
Robbery (nonsibling)	4.8	6.4	4.2	NA	7.6	5.1	5.1	3.7
Vandalism (nonsibling)	6.0	7.2	6.2	NA	5.2	6.3	6.7	8.6
Theft (nonsibling)	6.9	7.8	7.8	NA	2.3	5.2	10.4	13.0
Sexual victimization								
Any sexual victimization	6.1	4.8	7.4	NA	0.9	2.0	7.7	16.3
Sexual assault	1.8	1.3	2.3	0.0	0.4	0.8	1.4	5.3
Sexual harassment	2.6	1.4	4.4	NA	0.0	0.2	5.6	5.6
Maltreatment								
Any maltreatment	10.2	9.7	10.6	2.2	8.1	7.8	12.0	16.6
Physical abuse	4.4	4.3	4.4	0.6	3.5	2.7	5.2	7.9
Psychological/emotional	6.4	5.5	8.8	NA	4.5	4.5	7.3	12.1
Witness to violence								
Witness any violence (excludes indirect)	25.3	26.1	24.6	10.5	13.8	13.7	33.0	47.6
Witness family assault	9.8	9.0	10.7	7.6	9.6	6.4	11.0	10.1
Witness assault in community	19.2	20.4	17.9	NA	5.8	8.5	27.0	42.2
Exposure to shooting	5.3	5.4	5.1	1.9	2.2	3.1	7.2	10.2

■ Maltreatment victimization increased with age: youth ages 14–17 were twice as likely to report maltreatment as were youth ages 2–5.

NA: Violence type not applicable to age group.

Source: Sickmund (2014:37)

The same study also shows that 25.3% of the juveniles witnessed at least one type of violence personally. 9.8% of them witnessed family assault, 19.2% witnessed assault in community, and 5.3% witnessed to a shooting incident. According to the findings of this research, 6.1% of all juveniles were sexually victimized (1.8% sexual assault & 2.6% sexual harassment), 10.2% were maltreated in their families (4.4% physical abuse & 6.4% psychological/emotional abuse), and 24% were victim of property crimes (4.8% robbery, 6% vandalism & 6.9% theft by non-family perpetrators) (Sickmund, 2014).

In Europe, victimization rates are generally similar to the figures for the USA but with a great deal of disparities across nations. For example, Using the "Juvenile Victimization Questionnaire" (Finkelhor et al. 2005), a 2014 study in Spain found that 68.6% of the 1,107 youth (590 males and 517 females) experienced at least one type of victimization in the past year and 83% at some point in their lives. Type of victimization varies between boys and girls. Females are more likely to be victims of sexual victimization (13.9%) and emotional abuse by parents, guardians, or any other type of caregiver (23%) and males are more likely to be victims of conventional crimes (68%). The study reports that one in every three adolescent was exposed

to violence by witnessing it in a communitiy setting. Perhaps, the most striking finding of the study was that one in every five children were considered as polyvictims, who were victimized with at least 4 or more different types of misbehavior, maltreatment, abuse, or violent behavior. In other words, 20% of Spanish children were repeatedly victimized during their lifetime (Pereda, Guilera, and Abad, 2014).

In the United Kingdom, juvenile victimization seems to be lower than Spain. A 2013 study in the UK reports that 6% of youth between the ages of 11 and 17 and 2.5% of children below 11 had at least one type of physical or sexual victimization, maltreatment, emotional trauma, abuse or neglect in the past year. 21.9% of those at the ages of between 11 & 17 years old and 8.9% of children below 11 years old hat at least one type of victimization and maltreatment mentioned above in their childhood. Sexual victimization was particularly high among female youth: 7.2% of females whose ages are between 11 & 17, and 1.6% of females whose ages are between 18 & 24 were sexually victimized (any kind of sexual crime) by a peer or an adult. Perhaps, the most interesting finding in this study is its emphasis of polyvictimization: among all the 2275 children and young people who participated the study, juveniles who were maltreated, abused or victimized were more likely than other children to be a victim of similar misbehaviors and experience high levels of trauma (Radford et al. 2013).

FIGURE 4: Violent victimization of youth in Europe (%)

	Robbery	Assault	Hate crimes	Cyber-bullying	Physical punishment
Belgium	3.8	4.6	5	15.3	21.3
Bosnia & Herzegovina	4.8	6.7	3.5	15.3	21.4
Croatia	3.8	3.6	2.5	13.7	22.2
Czech Republic	3.7	4.1	4	14	38.7
Denmark	3.1	3.5	3.4	8.3	3.6
Estonia	3	7.8	6.5	16	15.8
Finland	8.1	2.9	5.2	13.6	12.9
Germany	4.4	4.6	5.3	12.1	11.5
Italy	3.7	4.1	3.9	15.9	26.7
Kosovo	6.2	1.5	1.5	12.9	11.3
Lithuania	3.5	4	3	14.5	18
Serbia	7.5	7.4	4.5	15.4	25.9
Switzerland	3.3	3.8	5.6	8.7	19.1
Ukraine	4.2	3.9	2.2	16.7	21.6

AVERAGE SCORE	4.5	4.5	4	13.7	26.4

Source: The author created the table based on figures from Marshall et al (2015)

The 3rd wave of the ISRD (International Self-Reported Delinquency Study) reports on victimization and offending experiences of children between the ages of 12 & 16 from 30 countries across the globe in 2014. The Figure 4 is a brief summary of some of its findings for selected European nations. According to these findings, on average, 4.5% of children in the following countries were victims of robbery, 4.5% victim of assault, 4% victim of hate crimes, 13.7% victim of cyber-bullying, and %26.4% target of physical punishment from their parents. Further, on average, 5% of these children were also targets of maltreatment of their parents. The most interesting finding here is the very high ratio of physical punishment by parents. On average, one in every four children in the selected European nations below report that they were subject to corporal punishment by their parents in the past year.

All the studies mentioned above used different methodologies and their findings are for children of various age groups. As a result, it is hard to make a comparison between nations. However, ISRD study is the most comprehensive study that allows researchers to make cross-cultural comparisons of juvenile victimization and delinquency.

Victimization-Offending Link

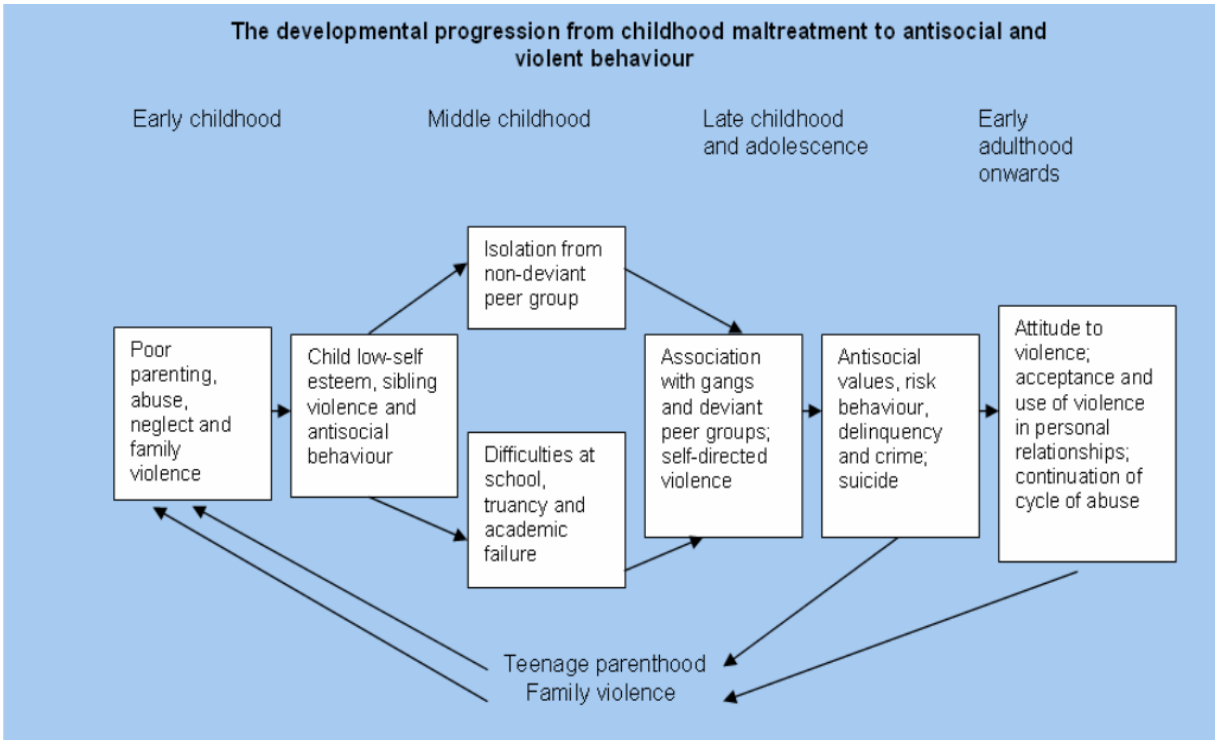
Victimization, abuse, and neglect during early ages of childhood have a great potential for destructive consequences in the adolescence and beyond. World Health Organization's (2007:7) special report entitled "Cycle of Violence…" lists alcohol and drug abuse, increased risk of further victimization, victims becoming offenders, and antisocial and criminal acts as a result of child maltreatment and victimization.

Research suggests that victimization and maltreatment have serious negative effects on children and long-term negative consequences for physical health, mental health, and behavioral problems. Victimized and maltreated children are more likely to have psychological problems such as low self-confidence, poor self-worth, self-injury, suicidal behaviors, hopelessness, severe stress, depression, mood and anxiety disorders, sleep disorders, post-traumatic stress disorder, emotional disorders, mental illness, and other psychological problems; more likely to have behavioral problems such as truancy, poor academic performance and other school related problems, isolation from non-deviant peer groups, risky sexual behavior, smoking, alcohol and drug abuse, and taking unnecessary risks; more likely to have serious health problems such as physical disability, obesity, diabetes, heart disease & stroke, liver disease, cancer, and even death (Gilbert et al. 2009; Osofsky, 2003; Wathen, 2012; WHO, 2007). We will deal with physical and mental health issues in the following sections. Here we

will focus on behavioral problems, particularly deviant, antisocial, and criminal behaviors that early age victimization might cause in later stages of life.

In terms of victimization-offending link, maltreated and victimized children are particularly at great risk of being re-victimization, developing antisocial behaviors and engage in criminal activities, both in community and family settings (WHO, 2007). Figure 3 below is a summary of the developmental progression from childhood maltreatment to antisocial and violent behavior.

FIGURE 3: Early childhood victimization and maltreatment might cause antisocial behavior



Source: WHO (2007)

Violent victimization and maltreatment of children at home has a great potential for further victimization of violence at home and in the community, maladjustment in difficult situations, taking aggressive actions against the perpetrator or the other family members at home, acting violently in the community and engage in antisocial behavior and criminal actions (Fantuzzo & Mohr, 1999; WHO, 2007:8-9). Although whether the negative impacts of victimization goes beyond childhood and persists into adulthood is unknown, research suggests that maltreatment is a strong predictor of violent behavior among juveniles. A study on 1,539 low-income minority children, for example, found that child maltreatment predicted all types

of juvenile violence the study investigated (Topitzes, Mersky, and Reynolds, 2012). After reading all these facts and figures on victimization of children, increasing number of violent incidents among youth should not be a surprise.

Social-Psychology of Interactions between Children and Others in the Context of Violent Encounters

Early childhood is a stage where discrete instances of oppositional or defiant behaviors are fairly uncommon (Urquiza & Timmer, 2012). These types of disruptive behavior are strongly associated with serious delinquent behaviors and aggressive/violent behaviors in adolescence and adulthood (Fergusson, Horwood, & Lynskey, 1994; Tolan & Gorman-Smith 1998; Broidy et al., 2003).

A better understanding of the risk and protective factors that influence adolescent aggression is critical to prevention and intervention research. (Kramer-Kuhn & Farrel, 2016) Results from previous research suggest that persistent antisocial behavior is predicted by (a) early onset, (b) high levels of aggression, (c) neuropsychological deficits, (d) male gender, and (e) problems related to inattention, impulsivity, and hyperactivity. Peer rejection, especially in conjunction with aggression, has also been found to predict persistent difficulties at least through late adolescence (Coie et al., 1995). (Fergusson, Horwood, & Lynskey, 1995; Loeber et al., 1991; Moffitt et al., 1996; Stattin & Magnusson, 1989). Through observation and interpersonal interactions at home, with peers, and in the community, adolescents develop patterns of behavior based on what they perceive to be appropriate and inappropriate (Bernburg and Thorlindsson 2005).

There are competing risk factors and protective factors of offending. A risk factor is anything that increases the chances of an individual perpetrating an offence. On the other hand a protective factor is any factor that reduces the probability of offending, despite the presence of risk factors. For example, an increased combination of risk factors, in conjunction with few protective factors is highly associated with future offending (Farrington, 2003; Hart et al., 2007; Herrenkohl et al., 2000; Stouthamer-Loeber et al., 2002). Due to the complex nature of offending, an interplay of numerous risk factors are often more explanatory than a single factor (Mortimer, 2010). A risk factor model has been proposed by a number of researchers as a more proactive way of identifying offenders at the onset of their offending pathways. Such a model would also assist in targeting interventions to reduce the present risk factors and increase the protective factors. Hart et al. (2007) utilized a similar approach whereby risk factors were investigated in combination with a number of protective factors. They concluded that increasing protective factors may be more beneficial in comparison to reducing risk factors.

As a child ages, they will have more opportunity to experience risk factors. For example, individual and family related risk factors may be present from birth, whereas other peer and community related factors may not be present until later in childhood. This difference in the cumulative impact of risk factors may be the key to understanding the development of offending behavior. However, it is important to note that risk factors are not pre-requisites to offending and offending is not inevitable. This perspective therefore implies that intervention is possible. (Mortimer, 2010).

Focusing on increasing protective factors for individuals who experience a number of risk factors and negative life experiences may present as a more positive and encouraging mode of addressing their offending behavior. This approach may also be more achievable than removing risk factors (over which the individual may have little or no control).

It is best to keep in mind that children, adolescents and young adults who are repeatedly violent are very visible to those with whom they frequently interact: peers, family members and teachers (Chaiken, Chaiken & Rhodes, 1994). So, any initiative regarding the children's anti-social or disruptive behavior must include the effect of relationship between the children and these other social agents.

Adolescents who are already exhibiting high rates of aggressive behavior may need different or additional protective factors in place when they encounter various risk factors (Kramer-Kuhn & Farrel, 2016). General efforts to reduce or prevent aggressive behavior might include strengthening aspects of family functioning, such as cohesiveness, problem-solving, parental involvement, and positive parenting (Kramer-Kuhn & Farrel, 2016). Research show that high parental support for nonviolence (Malek et al. 1998) and low parental support for fighting (Orpinas et al. 1999) at the start of sixth grade were expected to have both promotive and protective influences. Adolescents are more likely to engage in aggressive behavior if they believe that it is accepted or encouraged by their parents and others that are closest to them (Bernburg and Thorlindsson 2005, Margolin & Gordis, 2000).

For example, McCloskey and Lichter (2003) found that children from partner-violent homes were at risk for becoming aggressive with peers and parents. Frequently observed problems in children exposed to intimate partner violence are aggression and antisocial behavior (Kolbo et al. 1996; Langhinrichsen-Rohling and Neidig 1995; Sternberg et al. 1993). A meta-analysis by Kitzmann et al. (2003), which included 118 studies of psychosocial outcomes of exposed children, identified a consistent and significant association between exposure and child problems including externalizing or behavioral problems.

Different parenting intervention styles have been developed to help the troubled children. In these programs the families are altered through modifying the behavior of both the parent and child (Kennedy et al., 2016). It is best to include both parent and child in these intervention programs. According to Kaminski, Valle, Filene, & Boyle, (2008) interventions with the largest effects focused on increasing positive parent-child interactions and emotional communication skills, teaching parents to use time-out and the importance of parenting consistency, and requiring parents to practice new skills with their children during parent training session.

On the other hand, even though the coercive cycle model (Chaffin et al., 2004; Urquiza & McNeil, 1996) posits that harsh discipline is rewarded by the temporary compliance of the child, the child learns to ignore parental directives until the point of aggression. This process creates a hostile parent-child relationship in which force and coercion are both the cause and effect of the child's behavior (Chaffin et al., 2004). Furthermore, children who display frequent defiance and opposition to those around them are likely to be disliked and shunned (Eddy, Reid & Fetrow, 2000).

Even though the family is very important in terms of determining the likelihood of a child's engagement in disruptive behaviors, schools and peer groups are the two other socialization agents which also have similar effects in adolescence and young adulthood. Especially children with externalizing behavior are at increased risk for diverse problems in adolescence and adulthood, such as academic underachievement, school drop-out, mental disorders, substance abuse, violence, delinquency, and criminality (e.g., Dishion, French, & Patterson, 1995; Loeber & Hay, 1997; Moffitt et al., 2002).

Participation in positive interactions with peers and teachers may offer children feelings of assistance or security, and thus may facilitate adaptive behavior. On the other hand, problematic interactions, such as experiences of rejection by the peer group and negative interactions with teachers, may add to the development of behavioral problems (see Ladd, Birch, & Buhs, 1999).

Previous research has shown that when children are not accepted by their classmates, their classroom participation often decreases (e.g., Buhs & Ladd, 2001; Ladd, Kochenderfer, & Coleman, 1997; Ladd, Price, & Hart, 1990). The lack of classroom participation, in turn, can make the teacher feel incompetent or unliked by the child and, as a result, teachers might like the child less and prefer to spend less time with him or her (Skinner & Belmont, 1993). Yet previous studies have found empirical evidence for the effect of teacher-child interactions on peer interactions (e.g., Chang et al., 2007; Hughes & Kwok, 2006; Hughes, Zhang, & Hill, 2006; Taylor, 1989; White, Sherman, & Jones, 1996). For example, research with elementary

school children has shown that teacher support is negatively linked to children's externalizing behavior (e.g., Baker, 2006; Hughes, Cavell, & Jackson, 1999; Meehan, Hughes, & Cavell, 2003; Silver et al., 2005). Children's externalizing behavior can mitigate positive interactions with the teacher (low support), which may further amplify the child's externalizing behavior over time (Patterson, Reid & Dishon, 1992; Sutherland & Oswald, 2005).

On the other hand, Leflot et al. (2011) have found that the relationship between externalizing behavior and peer social preference was independent of the influences of support from the teacher. This highlights the uniqueness of the relationship between peer social preference and externalizing behavior. So, it is possible to state that peer social preference is more central to the development of externalizing behavior when compared to teacher support in adolescents. This is perhaps not surprising considering that teenagers spend increased time with peers both in and out of school and may begin to rely more heavily on peers, and less on the family and teachers, in relation to discovering their own identity. So, general antisocial behavior and negative peers may be more relevant when considering juvenile delinquency and the likelihood of this developing into adult offending behavior (Mortimer, 2010) and a delinquent peer network not only influences the initial onset of aggression, but also contributes to the stability of aggression over time (Huizinga, 1995).

With regard to peers, it is now well established that when children enter elementary school, classmates immediately start to evaluate their peers (see Dishion, Patterson, & Griesler, 1994). As a consequence of this evaluation process, some children become liked and accepted by their classmates, whereas others are disliked or rejected (Boivin, Vitaro, & Poulin, 2005; Deater-Deckard, 2001; van Lier & Koot, 2008). When children are liked by few classmates, and disliked by the majority, these children have a low social preference and are seen as actively rejected by peers (Leflot, 2011). Children with low social preference are likely to be deprived of contact with mainstream peers. As a result of the limited social interactions with mainstream peers, these children receive little social correction and guidelines for their behavior, which may facilitate, maintain, or exacerbate problem behavior over time (Deater-Deckard, 2001; Patterson, Reid & Dishon, 1992; Schrepferman et al, 2006).

Research has also provided evidence for the links between low social preference (or peer rejection) and externalizing problems. For instance, it has been shown that low social preference=peer rejection can predict future aggression, delinquency, and other externalizing behaviors (e.g., Coie et al., 1995; Ialongo, Vadan-Kiernan, & Kellam, 1998; Kupersmidt, Burchinal, & Patterson, 1995; Kupersmidt & Patterson, 1991; Miller-Johnson et al., 2002). Simultaneously, one of the best predictors of becoming rejected by peers is the externalizing

problem behavior of the child (e.g., Boivin et al., 2005; Laird et al, 2001; Morrow et al., 2006; Pedersen et al., 2007; van Lier & Koot, 2008). Thus, the findings indicate a transactional relationship between externalizing behavior and social preference. That is, initial low social preference is frequently the consequence of early externalizing problems (Leflot, 2011), and experiences of low social preference, in turn, add to the development of children's externalizing problems (Miller-Johnson et al., 2002; Vitaro, Pedersen, & Brendgen, 2007).

Finally, there are several reasons to hypothesize that aggressive adolescent offenders with a recent history of rejection by their peers will be more likely to persist in their aggressive offending. First, individuals showing stable patterns of disorder across adolescence are likely to have been both aggressive and rejected during childhood (Coie et al., 1995), suggesting that a history of rejection increases the likelihood of persistent aggression toward others. Second, rejected children are more likely to become involved with deviant peer groups during adolescence (Dishion et al., 1991), which may contribute to the maintenance of antisocial behavior (Dishion, Patterson, & Griesler, 1994). Third, aggressive children who are also unpopular typically have low levels of prosocial skills (Bierman, Smoot, & Aumiller, 1993), making it more difficult for them to establish supportive relationships with nondeviant peers who might inhibit their tendency to aggress against others (Rabiner et al., 2005).

APPROACHING THE VICTIM/OFFENDER

Signs of Violent Crime Victimization and Offending Among Youth

Exposure to violence both as victims and offenders has several complications for children in terms of physical and mental health, social maladaptation, emotional disturbances, etc. Therefore, it is necessary to act proactively to detect the existence of violent victimization or offending at earlier stages in order to avoid the negative consequences of violence. Even if the experience of violence, either as a victim or an offender, is unknown to the parents, guardians, caregivers, teachers, rehabilitation professionals and other relevant people who are in touch with the child, it is possible to identify the signs of violent victimization, key characteristics of violent children. If the following behaviors are noticed, we should suspect that the child is being victimized or s/he is engaged in violent behaviors. These symptoms might reveal themselves in behavioral, physical, and psychosocial forms.

University of Colorado Boulder's Center for the Study and Prevention of Violence (2000) identified the following warning signs as early indicators of violence among youth:

- Social withdrawal
- Excessive feelings of isolation and being alone

- Excessive feelings of rejection
- Being a victim of violence
- Feelings of being picked on and persecuted
- Low school interest and poor academic performance
- Expression of violence in writings and drawings
- Uncontrolled anger
- Patterns of impulsive and chronic hitting, intimidating and bullying behaviors
- History of discipline problems
- Past history of violent and aggressive behavior
- Intolerance for differences and prejudicial attitudes
- Drug use and alcohol use
- Affiliation with gangs
- Inappropriate access to, possession, of and us of firearms
- Serious threats of violence

Further, UCB Center for the Study and Prevention of Violence (2000) also warns about the following imminent warning signs as important indicators of risk for the juvenile to be "very close or has a very high potential of being violent". If the parents, teachers, and other relevant people observe these children to make sure whether the children are demonstrating these behaviors, the likelihood of early intervention and successful communication with the juveniles shall increase. These imminent signs are:

- Serious physical fighting with peers or family members
- Severe destruction of property
- Severe rage for seemingly minor reasons
- Detailed threats of lethal violence
- Possession and/or use of firearms and other weapons
- Other self-injurious behaviors or threats of suicide

These early warning signs can be very helpful in identifying risky individuals and in developing proactive intervention strategies. In this section, we will briefly explain general characteristics of these signs of violence among youth so that parents, guardians, caregivers, teachers, and relevant professionals might anticipate and detect the existence of violence for early intervention.

Social withdrawal & isolation: Exposure to violence has the potential for problems in socialization of children. Juveniles who were subjected to psychological and physical violence

tend to alienate themselves from public and spend time alone and don't want to share anything with other people. In other words, social withdrawal & isolation are developed as an emotional disorder during childhood as a result of adverse childhood experiences, particularly violence. These children feel low self-esteem and low self-worth and they feel they are vulnerable to violence again. Further, research indicates that relationship between social withdrawal and violence seems to work both ways: SW→V & V→SW (Rubin, Coplan & Bowker, 2009; Walkup & Rubin, 2013).

Anxiety: There are a many of anxiety disorders, for instance post-traumatic anxiety, obsessive-compulsive disorder and specific phobias etc. Children may respond to anxiety associated with a traumatic event is on a behavioral level. Children want to avoid the victimization associated with the physical and mental aspects of their anxiety. Anxiety can be defensive way for a victimized child.
(http://academicdepartments.musc.edu/ncvc/resources_public/victim_reactions_child.pdf)

Uncontrolled anger can occur for different reasons in children. But the causes of uncontrolled anger in the **victimized** children are the differences from other uncontrolled anger types. If child show negative behavior from his/her parent or families let the child to use aggression for to keep safe him/herself or e parent who uses violence for something, this behavior towards Children can cause uncontrolled anger in time. Briefly, uncontrolled anger arises directly or indirectly in children exposed to violence. (http://psychologicalselfhelp.org/Chapter7.pdf)

Expression of violence in writings and drawings is important behavior in victim children. If child witnesses and exposes to violence in this case it is clear that the kid can adversely affect childhood. In such cases the victim child exposed to violence can be projected out indirectly. The studies on this issue clearly shows that victim child tell his/her victimization out in this way. (http://ijecer.net/pfi-depo/v1n1/kandir.pdf)

There are also several more dangerous symptoms of chidren being made into a victim. These symptoms, which are different cases as a result of, children can be found in the action resulting in death or wounding as **different** from the results of other Psychosocial and Pysical or Behavioral symptoms.

Acts & threats of violence: Children who act aggressively towards their environments, show hostility, engage in physical fights, make serious threats of violence should be watched carefully and specialized intervention and treatment programs should be considered for such youth. Victims of violent crimes are especially in danger of using violence against aggressors and other people in their social environment. These youth can demonstrate severe rage for

seemingly minor reasons. Their violent acts might involve destruction of property, harming others, or threatening to use violence against other people. *Fight or flight* (escape) is the common reaction against victimization: victimized children either run away from home or escape from the abusive environment or they can fight back and use violence and threats of violence as a defense mechanism. Chronic exposure to violence will have long lasting serious consequences for children. These children might even consider killing certain persons. Children who grow up in violent environments learn violence as a highly effective problem solving method (Garbarino, Dubrow, Kostelny & Pardo, 1992; U.S. National Institute of Mental Health, 2006; National Association for the Education of Young Children, 1993).

Drug and alcohol use, there is relationship between drug or alcohol use and childhood abuse. For example the children whose family use alcohol or drugs can to the abusive treatment.

Self-harming & suicidal ideation: Suicide and self-harming behaviors are associated with exposure to violence, mental & sexual disorders. Psychiatric disorders are present in 80% to 90% of suicides, for example mood, anxiety, conduct and substance use disorders are important situations. Suicides and suicide attempts in family members of child, A family history of violence, misuse and substance abuse, unstable family relations and unresolved conflicts in the family, missing social support by family members can cause threat suicide in child in future.

Intolerance for differences and prejudicial attitudes are antipathy towards diversity. This antipathy manifests itself with Anti-Immigrant Attitudes, Racism, Anti-Semitism, İslamafobia, Homophobia such behaiver. Child victims wants to cover his/her victimization by creating enemy to him/herself. "*social learning theory suggests that prejudice is learned in the same way other attitudes and values are learned, primarily through association, reinforcement and modeling." Through the messages they receive in the world around them, "children may learn to associate a particular ethnic group with poverty, crime, violence and other bad things (http://www.adl.org/assets/pdf/education-outreach/How-Do-Children-Learn-Prejudice.pdf)*". Also victimized child can learn prejudice and intolerance by observing or listening his/her parents, teachers or friends.

Mistakes in Approaching Victimized and Offender Children

Unfortunately professionals dealing with victimized or offender children do not always behave professionally, make serious mistakes, and follow established rules and procedures while taking care of these children. Benefitting from the works of the U.S. Department of Justice, Themeli and Panagiotaki (2014), and Gil (2012), we have compiled a list of the most common mistakes professionals make in dealing with victimized and offender children.

Laypersons may make these mistakes and it is more or less understandable to some extent. However, professionals must avoid them to prevent further victimization of children.

Ignoring to obtain a medical assessment: In case of a violent offense a medical assessment of the child should be performed as soon as possible. Otherwise a potential injury or needs for treatment cannot be identified (U.S. Department of Justice, 2014).

Not being aware of that children do not like to talk about the abuse: Professional should understand that victim or offender children may delay disclosure or give limited details about the story (U.S. Department of Justice, 2014).

Not being aware of that Instances of abuse are typically not isolated incidents: Professionals dealing with victim and offender children should be aware of that the abuse takes place over a period of time and the severity of the incident may increase as the time passes (U.S. Department of Justice, 2014).

Interviewing children without special attention: It should be kept in mind that most of the abuse incidents occur in an isolated environment with no witnesses, there for professionals should pay special attention while interviewing the children (U.S. Department of Justice, 2014).

Ignoring to treat children as children: In many cases, professionals ignore that they are dealing with children and treat them like adults which eventually leads to mistakes and misunderstandings (Themeli and Panagiotaki, 2014).

Not introducing the self to the child and other team members who may be present: Professionals dealing with victim and offender children should explain their roles and the focus and goals of the interview/investigation etc. (U.S. Department of Justice, 2014).

Ignoring to speak a common language: Officials dealing with victim or offender children be able to speak common language. Professionals should talk to children in accordance to their level of physical and mental development. For instance, using specialized medical and legal terms may lead misunderstandings and collecting loose of information (U.S. Department of Justice, 2014).

Ignoring the evaluation of the child's understanding abilities: It should be kept in mind that each child has an ability to distinguish truth from false which may directly affect the quality and the level of information gathered from the children (Themeli and Panagiotaki, 2014).

Ignoring to let the child to relate what happened in his/her own words: Professional should give the opportunity to narrate what happened with his/her own words. They should not paraphrase what the child said. Suggestive questions should not be employed during the interview with the child (Themeli and Panagiotaki, 2014).

Ignoring to use pre-prepared and structured question: Professionals dealing with victim and offender children should develop a well-structured questionnaire regarding the features of the event and the development level of the child before having a conversation with him/her (Themeli and Panagiotaki, 2014).

Repeating questions: Professionals interviewing with victim and offender children should avoid asking repeating questions. Doing so may lead children to feel that the answers provided are not "right" or "desired" (Themeli and Panagiotaki, 2014).

Ignoring that children are more likely to have higher level of fear and stress: Professionals dealing with victim and offender children should be aware of that both victim and offender children are more likely to have higher level of fear and stress than adults. Therefore professionals should pay additional attention while having interviews with children (Themeli and Panagiotaki, 2014).

Ignoring to create a warm environment: Professionals dealing with victim and offender children should build a warm rapport by using their skills of empathy and reflection of emotions before and during interaction with the children (Themeli and Panagiotaki, 2014).

Ignoring that the reaction of children against abuse incidents is a unique one, and many abused children may not show behavioral symptoms: Professionals dealing with victim and offender children should be aware of that exhibiting symptoms such as "*anxiety, depression, self-mutilation, suicidal gestures/attempts, low self-esteem, running away from home, use of alcohol or other drugs, academic/behavioral problems in school, hostile, aggressive or verbally abusive towards others, fearful or withdrawn behavior, breaks windows, sets fires, etc., out-of-control behavior/poor anger management, wariness of adults, discomfort when other children cry, fear of parents/caretakers or of going home*", does not necessarily mean that an abuse incident has been occurred. However, these symptoms should be taken into consideration by professionals as the warning signal to look further (Gil, 2012, p11).

Ignoring to use open-ended questions in case of observing the signs of possible child abuse: Professionals dealing with victim and offender children should not ask leading questions or employ questions directly accusing someone. For example, professionals should not ask "Did your parents do that?" if they observe an unusual bruising on children's body. Rather they may ask "How did it happen?" It should also be kept in mind that professionals should talk to children privately if they need to get information about what make child nerves, fearful and unhappy (Gil, 2012).

Ignoring to conduct the discussion in private: Professionals who deal with victim and offender children should arrange an appropriate place where they can privately talk with children about possible abuse (Gil, 2012).

Ignoring the seating arrangement: Professionals dealing with victim and offender children should prefer to sit next to the child rather than sitting behind a desk while interacting with children (Gil, 2012).

Ignoring to conduct the discussion in a language the child understands: Professionals who deal with victim and offender children should avoid using technical terms or complex sentences while communicating with the victim or offender children (Gil, 2012).

Ignoring to talk with the child privately: Professionals who deal with victim and offender children should have conversation with children privately. In other words, individuals who may have potential influences on the child, such as the parents of the child or the suspect, should be kept away from the place where professionals interview and discuss the incident with the child (Gil, 2012)**.**

Ignoring to manage professionals' own emotional response: Professionals dealing with victim and offender children should not judge the child and his/her parents and show feelings like shock, disapproval, or disgust about them (Gil, 2012).

Ignoring to make realistic promises to the child: Professionals dealing with victim and offender children should be honest, clear, and realistic against the victim or offender child. Unrealistic promises like not telling or reporting what the child told to anyone else may distort the relationship and trust between the child and professionals. Therefore professionals should explain legal procedures and explain the child that suspicions of abuse must be reported to legal authorities (Gil, 2012).

Exhibiting inappropriate interest and physical contact: Professionals should keep in mind that if it is employed properly physical contact can positively motivate children and be used to confirm him or her. However touching is considered as a problematic behavior if it happens privately and away from the eyes of other people. It is not always easy to determine whether touching is an appropriate behavior since it changes according to child's age, gender, culture, religion, and personal background (Gil, 2012).

Preventing Violence Among and Against Children

Increasing concerns about raising statistics on juvenile delinquency led United Nations to consider this problem as a responsibility of international community as a whole and adopted a resolution entitled "United Nations Guidelines for the Prevention of Juvenile Delinquency"

(*Riyadh Guidelines*) on 14th of December 1990. After briefly mentioning fundamental principles regarding basic human rights of children and key matters regarding the best interest of children, Riyadh Guidelines puts a special emphasis on socialization processes as an overall delinquency prevention strategy. This resolution places family, education, community, and media as four pillars for positive socialization of youth.

Non-violent problem solving programs, teaching conflict resolution and reconciliation techniques, and improving verbal communication skills are very important in reducing the risk of violence in conflict situations.

To end the violence against children, UNICEF published the following strategies (https://www.unicef.org.uk/Documents/Publications/Unicef_ChildreninDanger_ViolencereportW.pdf):

Strategy 1. Support parents, caregivers, and families to reduce levels of violence that children face at home, while strengthening their ability to care for and protect their children to reduce levels of violence that children face at home, while strengthening their ability to care for and protect their children.

Strategy 2. Help children manage the risks they face by ensuring they can protect their own rights to a life free from violence and can face challenges and solve problems without resorting to violence.

Strategy 3. Change attitudes and social norms that encourage violence and discrimination support through far-reaching campaigns to ensure no form of violence is seen as justifiable.

Strategy 4. Promote and provide support services for children. Ensure children receive help, support and care when they experience violence, and that they can safely report violent incidents.

Strategy 5. Implement laws and policies that protect Children. Support ensuring that all citizens realize that violence against children is unacceptable and will be punished when it occurs.

Strategy 6. Carry out data collection and research. Support ensuring that violence is no longer hidden, while creating a growing understanding of the most effective ways to prevent it.

Privacy Issues in Working with Children

Privacy issues are one of the important matters in dealing with juvenile offenders and victims because protecting the best interest of the child requires maintaining the highest possible standards in abiding by basic human rights of the children and their right to privacy.

Helping victimized and offender children should be realized without causing any harm to their physical, social and psychological integrity. Particularly, how data will be collected, how these information be processed, how they will be stored and protected, and how these information will be shared, if any, with other parties must be regulated and these activities should be carried out according to the international and national laws, regulations, and ethical principles on data protection.

Rights of children have a very well established foundation in the international documents and European regulations. The United Nations (1989) Convention on the Rights of the Child is the chief document on rights of children. The Article 16 of the UN Convention is on the child's right to privacy:

"1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honor and reputation.

2. The child has the right to the protection of the law against such interference or attacks".

European Union (2000) recognizes the rights of children in Article 24 of the European Charter of Fundamental Rights. Paragraph 2 of this article stresses that:

"In all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration"

In a communication document entitled "Towards an EU strategy on the Rights of the Child", Commission of the European Communities (2006) mentions "children's rights as a priority for the EU". The Commission also puts a special emphasis on this matter in its Communication on Strategic Objectives 2005-2009 with the following phase:

"A particular priority must be effective protection of the rights of children, both against economic exploitation and all forms of abuse, with the Union acting as a beacon to the rest of the world".

Along the same lines, the Group of Commissioners on Fundamental Rights, Non-discrimination, and Equal Opportunities "decided in April 2005 to launch a specific initiative to advance the promotion, protection and fulfillment of children's rights in the internal and external policies of the EU" (Commission of the European Communities, 2006).

The Data Protection Working Party, which was established based on the Article 29 of Directive 95/46/EC, is an independent European advisory body on data protection and privacy. This Working Party prepared a special opinion document on the protection of children's personal data entitled "General Guidelines and the special case of schools". This document prioritizes the protection of the best interest of the child in all situations. The opinion discusses

situations which involve a conflict between the best interest of the child and the child's right to privacy and his data protection rights. In any case, the Working Party concludes, the best interest of the child should be preferred over all other rights of the children, including privacy. Medical matters and issues related to social work are given as examples of such situations. However, this statement should not be misunderstood as children have no privacy rights or that the existing data protection rules do not apply to them. Instead, this approach should be properly interpreted as protection of children in all situations.

Rights of children are not limited to those we have discussed so far, however, they are the leading statements on the privacy rights of children.

Children's data protection and privacy rights are in fact no different than those of adults. In this vein, Seamus Carroll (2014), the chair of CAHDATA (Council of Europe, Ad Hoc Committee on Data Protection) asserts that:

"Children, like adults, are holders of data protection rights under the Council of Europe's Data Protection Convention ("Convention 108"). They may not, however, depending on their age and their level of maturity and understanding, have the capacity independently to exercise these rights. Children's lack of capacity to exercise Convention 108 rights should not be misunderstood as an absence of such rights".

Therefore, one should assume at least the same level of sensitivity towards the privacy and data protection rights of children with adults, if not more. In video surveillance research, all researchers should take extreme caution regarding the privacy rights of children and hold the best interest of the children above all other interests at all times.

Data protection and privacy rights of children are mentioned in the laws and legal documents of the nations above, except for Turkey. Since Turkey does not have a data protection law, more specific issues like data protection for children are not regulated. However, other countries above (the UK, Spain, and Israel) have adequate legal safeguards. In fact, data protection laws in these countries apply to people of all ages, not only those 18 and older. However, data protection agencies provide additional guidance for vulnerable groups, mainly for children. These regulations basically advise making sure that the child in question gives his or her consent and understands the meaning and consequences of his or her agreement. For example, the United Kingdom's Information Commissioner states,

"…children who are old enough to understand what is being asked of them should be given the opportunity to give their own consent with regard to Data Protection issues. ... Although no guidance has been given as to how to establish that a child understands what is being asked of them, … once a child becomes 12 years of age that he or she is likely to be able

to understand the implications of what is being asked. This is commonly referred to as the "Gillick Principle". (Belfast Education and Library Board, 2007:2).

Keep in Mind

To prevent:

- Teaching good parenting practices to families to reduce violence
- Teaching non-violent problem solving techniques to children
- Effective supervision by parents at home and by teachers at schools to intervene violent incidents at early stages.
- Make laws and regulations to prevent violence against children.
- Nation-wide campaigns against violence at home, violence at schools, violence in the streets, violence in work place and violence in elsewhere in the community.
- Initiate social programs that teach public no form of violence is justifiable and violence against children is unacceptable.

How to act in cases of violence by and from children (To do list)

- Make sure the child receives proper medical check-up and treatment if there is such a need
- Create a warm and private environment to facilitate the interview by helping the child to relieve from the emotional stress and feelings of insecurity, guilt, and isolation.
- Be an active listener
- Let the child explain him/her-self with his/her own words
- Try not to intervene when s/he speaks
- Encourage the child to elaborate the incident(s)
- Try to fully understand what happened
- Do not blame the victim for his/her own victimization
- Use plain words, be simple, avoid complex sentence structures and advanced vocabulary
- Use standardized questions to make sure that all aspects of the victimization/offending are covered.
- Be ready to ask for elaboration with open ended questions whenever necessary.
- Learn about the perpetrator, victim, and the general environment that breeds violence.

- Be ready to take protective measures for the child, seek help from relevant professionals whenever you deem necessary (i.e., legal advice, protective custody, psychological counselling, therapeutic treatment, etc).
- Consider participation of the child's family members/parents in the rehabilitation process if it is appropriate and applicable.
- Try to identify risk factors for present and future violence.
- Record everything from the first day of entry till the release from the rehabilitation institution/program and document the progress of the child with periodical reports.

Don't List

- Do not forget to introduce yourself (and your team mates) to the child
- Do not get into the subject directly
- Do not forget that your subject is a child
- Do not use technical language, use plain language
- Do not use a blaming/offending language that can ostracize the child and cause alienation and isolation
- Avoid physical contact with the child if it is not truly necessary.
- Do not be pushy and insistent for getting answers, respect the child's privacy
- Do not ask repeating questions that may lead children to feel that the answers provided are not "right" or "desired"
- Do not leave the child alone or unsupervised in the facility; anticipate violent behaviour against others or self-harming behaviours (self-mutilation, suicide, etc).

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CHAPTER TWO SEXUAL CRIMES

ABOUT THE SEXUAL CRIMES

The Sexual Offences Act of 1956 contains a no statutory definition of 'consent'. Juries must be told that the word should be given its ‘ordinary meaning’, and that there is a difference between 'consent' and 'submission'.

Lack of consent may be demonstrated by:

- The complainant's assertion of force or threats;
- Evidence that by reason of drink, drugs, sleep, age or mental disability that the complainant was unaware of what was occurring and/ or incapable of giving valid consent; or
- Evidence that the complainant was deceived as to the identity of the person with whom (s) he had intercourse.

A boy or girl under the age of 16 cannot consent in law, Consent should be carefully considered when deciding not only what offence to charge but also, whether it is in the public interest to prosecute. Sometimes consent is given, or appears to be given, but the law does not treat it as effective consent.

The law does not allow a person's consent to sexual activity to have effect in the following situations:

- where the person giving consent did not understand what was happening and so could not give informed consent, for example in the case of a child or someone suffering from a severe mental disability;
- Where the person giving consent was under the relevant age of consent.

These two situations are different. In the first, the apparent consent is not treated as real consent because the person consenting did not understand enough to give real consent. This is a question of fact. In the second, consent is real as a matter of fact but the law does not allow it to count.

Where the victim has consented in fact but not in law alternative offences may be appropriate. Examples include incest or unlawful sexual intercourse (in the case of a female victim) or, where consensual intercourse with a male under the age of consent, the offence of buggery[1].

[1] http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/consent/

In order to also have a more objective view based on an international organisation that is dedicated to understanding need and fighting inequality, it is useful to also include the WHO's definition . The WHO (2012) states that: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" is a sexual crime and consequently, it is important to see the overall definition regarding the means of coercion also, as this can also be an indirect way of bullying. Other sexual offences listed among them are: varying degrees of force; psychological intimidation; blackmail; or threats (of physical harm or of not obtaining a job/grade etc.) WHO (2012)

There are numerous reports from the WHO that are willing to define the means and explanation of the sexual abuse, many of which are focused on the abuse against women and children as the most vulnerable sections of the population who are a result need more attention from governments and world organisations[2].

As we can appreciate, there are several definitions in different countries and organisations, but those that are commonly agreed on by all are the following:

- Non consent
- Direct abuse
- Indirect abuse
- The age of consent

The age of consent tends to raise a lot of arguments in developing countries, girls and especially teenagers are increasingly at risk of sexual abuse and of catching sexually transmitted diseases due to some cultural traditions that would seemingly "normalise" sexual abuse, child brides or even authority figures having taken advantage of their positions in order to have relationships without either protection or consent. Dorothy Shaw (2009).

The most common sexual crimes that children commit and are exposed to

[2] *Demographic and Health Surveys (4), CDC Reproductive Health Surveys (5), and the WHO multi-country study on women's health and domestic violence against women (3)*

Key Statistics about Sexual Violence in England and Wales. These figures come from "An Overview of Sexual Offending in England and Wales", the first ever joint official statistics bulletin on sexual violence released by the Ministry of Justice (MoJ), Office for National Statistics (ONS) and Home Office in January 2013 taken from the Rape Crisis website: http://rapecrisis.org.uk/statistics.php

It is important to note that official statistics collected by the Crime Survey for England and Wales (2013) focused on the most recent experience of adults as a victim of sexual offence in the previous 12 months (and so for example, **do not** include sexual offences experienced by children or those aged 60 or over)

In that bulletin, sexual offences have been defined in two main groups:

> "Most serious sexual offences", covering all rape, attempted rape and sexual assault offences; and "Other sexual offences", which includes sexual activity with minor (excluding rape and sexual assaults), exposure, voyeurism etc. Ministry of Justice (2013)

For an overview of offences and victimisation through to police recording of crimes in England and Wales, statistics show that between 2009 and 2012, a total of 473,000 adults have been victims of sexual abuse (404,000 females and 72,000 males) on average per year, 2.5% of these victims are female and 0.4% are male, (see table 1) (NSPCC, 2013). The big picture exposes the range from rape and sexual assaults to indecent exposures and unwanted touching. The average number females reported as victims of serious offences (i.e. penetration) was 85,000 per year, an average of 0.5 of the total female population. Furthermore, nearly 90% of victims who report any kind of abuse previously knew the perpetrator.

In the UK, and according with the rates of the bulletin "An Overview of Sexual Offending in England and Wales" (January 2013), we can conclude that the most common sexual crimes reported from the rates of 2011/12 are "rape" (16,000 offences) and "sexual assault" (22,100 offences), totalling 71% of sexual offences. It is also important to note that most crimes that are being reported are the more serious sexual offenders, whereas those crimes regarded as being "less serious"(e.g. "exposure or voyeurism" accounting for 7,000 crimes and "sexual activity with minors" accounting for 5,800crimes) aren't being reported by the victims, largely because these crimes are deemed to be "embarrassing", or the victims "didn't think the police could do much to help", or even that the incident is "too trivial or not worth reporting ", or is a "private/family matter and not police business."

Table 1.

Prevalence of being a victim of a sexual offence in the last 12 months among adults aged 16 to 59, average of 2009/10, 2010/11 and 2011/12 CSEW

Persons aged 16 to 59

England and Wales	Percentage who were victims once or more		
Offence	Males	Females	All
Any sexual offence (including attempts)[1]	0.4	2.5	1.5
Most serious sexual offences (including attempts)	0.1	0.5	0.3
Rape (including attempts)	0.1	0.4	0.2
Assault by penetration (including attempts)	0.0	0.2	0.1
Most serious sexual offences (excluding attempts)	0.1	0.4	0.2
Rape (excluding attempts)	0.0	0.3	0.2
Assault by penetration (excluding attempts)	0.0	0.1	0.1
Other sexual offences	0.4	2.3	1.3
Unweighted base[2]	*20,692*	*24,203*	*44,895*

(1) Subcategory figures will not add up to the figures above them because respondents may have been victims of separate incidents of different types of sexual offence.

(2) The bases given are for any sexual offence, the bases for the other measures presented will be similar.

From: Ministry of Justice, Home office & The Office for National Statistics (2013) (p, 12) websites at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf

Alongside, it is also important to note the following statistics:

- In England and Wales, 30% of all prosecutions for sexual crimes were aimed at individuals under the age of 21. (Vizard et al, 1995)
- In the United States, adolescents (aged between 13 and 17 years) are responsible for nearly 20% of all rapes and 50% of all cases of sexual crimes committed each year. (Barbaree, et al. 1990).
- In a third of all cases confirmed as sexual abuse committed both in the Republic of Ireland and Northern Ireland, the perpetrator was an adolescent. (McKeown & Gilligan, 1990; Kennedy et al. 1990)

Facts and Statistics on sexual abuse of children in the UK:

- 1 in 20 children in the UK have been sexually abused[3]
- 1 in 3 children sexually abused by an adult did not tell anyone[4]
- Over 90% of sexually abused children were abused by somebody they knew[5]

[3] Radford, L. et al (2011) Child abuse and neglect in the UK today.
[4] Ibis
[5] Ibis

- Over 2,800 children were identified as needing protection from sexual abuse last year[6]
- 14% of contacts to NSPCC's helpline last year were concerns about sexual abuse[7]
- The NSPCC's helpline responded to over 8,800 contacts about sexual abuse last year[8]
- There were over 11,000 counselling sessions with children and young people who talked to ChildLine last year about sexual abuse – this is an increase of 8% on 2013/14[9]
- There were over 3,000 counselling sessions with young people who talked to ChildLine last year about online sexual abuse – this is an 11% increase on 2013/14.[10]
- Over 36,000 sexual offences against children were recorded in the UK last year[11]
- Child sexual abuse costs the UK £3.2bn a year[12]
- Nearly 30,000 registered offenders have been convicted of offences against children.[13]
- Over a third of sexual offences recorded by the police are against children[14]

Alongside an overall view of sexual abuse in the UK taken from official reports and research on the national situation, we also wanted to add broader, more worldwide perspective to this report. In order to do so we have looked to research from a number of publications, including the studies of Marije Stoltenborgh, where she states that: It should not hurt to be a child: prevalence of child maltreatment across the globe" *Leiden University. Repository* (2012). Stoltenborgh carried out a meta-analysis study on childhood sexual abuse (CSA) reported from 1980 to 2008 using217 publications, 331 independent samples and a total of 9,911,748 participants. This study showed that:

The overall estimated CSA prevalence was 127/1000 in self-report studies and 4/1000 in informant studies. Self-reported CSA was more common among female (180/1000) than

[6] NSPCC (2015) Child protection register statistics
[7] NSPCC (2015) How safe are our children? 2015 Indicator 8
[8] ibis
[9] NSPCC (2015) "Always there when I need you": ChildLine review: what's affected children in April 2014 - March 2015.
[10] ibis
[11] NSPCC (2015) How safe are our children? 2015 Indicator 4
[12] Saied-Tessier, A. (2014) Estimating the costs of child sexual abuse in the UK.
[13] NSPCC (2012) FOI request
[14] Office for National Statistics (2014) Appendix table A4 in Crime in England and Wales, Year Ending March 2014 (xls)

> among male participants (76/1000). Lowest rates for both girls (113/1000) and boys (41/1000) were found in Asia, and highest rates were found for girls in Australia (215/1000) and for boys in Africa (193/1000). The results of our meta-analysis confirm that CSA is a global problem of considerable extent, but also show that methodological issues drastically influence the self-reported prevalence of CSA. (Stoltenborgh, 2012, p.12)

This meta-analysis uses a large amount of data and in doing so helps to identify the set of studies with optimal design features for comparison across time and cultures. (Stoltenborgh, 2012, p.16) In the Stoltenborgh report, they conduct a broad comparison between self reported cases and police reports around the world, and in doing so attempt at gathering a true meaning of what CSA really is and what should be known on the subject. One of the conclusions that we can see in this investigation, is that the self reporting of abuse rate is bigger than police or other official reports provided. It's also significant to think about victims deciding not to report what has happened to them as a way of not acknowledging the harm that has been inflicted upon them. By not externalising the reality of what has happened to them, the victims do not need to relive the experience or worse still, have any sort of contact with their abuser which could lead to a second victimisation, if the victim does not receive the adequate support. This is one of the biggest challenges facing those who work with victims, in ensuring that the right level of support is widely available, particularly when dealing with children, a child cannot always be aware or understand what is wrong and the extent of what they may have been exposed to or the harm inflicted upon them.

On the other hand, for a more formal definition of Child Sexual Abuse, we can consult the following four definitions from: "**Specific Form of Maltreatment" (Stoltenborgh, 2012, p.54)**

- **Penile Intrusion**
- **Intrusion by Finger or Any Object**
- **Molestation with Genital Contact**
- **Other or Unknown Sexual Abuse**

In the Appendix, they provide a lengthy definition that supports all the studies mentioned and also serves as the bedrock of this module where we have considered the various definitions during the research process.

SEXUAL CRIMES AND CHILDREN AS VICTIMS AND OFFENDERS

Psychology of sex offender and victimized children

All children are different and behave in different ways, but you may have noticed that something has changed. Children can show signs of sexualised behaviour from pre-school age right up to their teenage years. Many are normal and healthy, but some signs may give cause for alarm. Children with learning disabilities may vary in their development and parents and/or carers may need expert advice if there are any concerns.

As a general rule:

- Pre-school children (up to five years) should not be talking about sexual acts or using sexually explicit language, having physical sexual contact with other children or showing adult-like sexual behaviour or knowledge.

- School-age children (six to 12 years) should not be masturbating in public or showing adult-like sexual behaviour or knowledge.

- Adolescents (13 to 16 years old) should not be masturbating in public nor having sexual contact with much younger children or older adults.

At any age, certain changes in behaviour can indicate that there's a problem, such as:

- having nightmares or sleeping problems
- becoming withdrawn or very clingy
- changes in their personality; they might seem insecure
- outbursts of anger
- using toys or other objects in a sexual way
- sudden changes in their eating habits
- showing an inexplicable fear of particular places or people
- going back to younger behaviours, such as thumb sucking or bedwetting
- Becoming secretive and reluctant to share things with you.

In isolation, setbacks like this might seem like part of a child's normal development. But if a child is behaving in more than one of these ways, it may be a sign that something is wrong and the appropriate help should be sought out.

How can you identify an abuser?

Unfortunately, abusers look like any other person and may be either male or female. They are often someone who is close to the child and their family, a parent or parent's partner, a friend or relative, or a trusted person such as a babysitter or club leader. Knowing the difference between a close relationship and an inappropriate one can be difficult, particularly if they have gained the trust of the family.

In many sexual abuse cases, there are certain risk factors that could be linked to the development of sexually abuse behaviour in some vulnerable young children. For instance:

- Prior Traumatisation. This may be sexual abuse or another traumatic event.
- Lack of Intimacy. The child may not have a wide social support network. They may have poor social skills resulting in poor relationships.
- Impulsiveness. These children may have particular difficulty with self-management relying on external controls.
- Lack of Accountability. These children may have a general tendency to deny responsibility for their actions and are less likely to consider other feelings.
- Over sexualised Home Environment. Child exposed to adult sexuality via inappropriate TV/Video viewing or adult behaviour.
- Sexually Repressive Environment. Normal sexuality denied or viewed negatively.
- Sexualised models of compensation. Children who look to sexualised behaviour as a "solution" to their problems, are often found to be those who lack an adult they can confide in, or who have experienced:
    - Parental loss
    - Unempathic parenting
    - Inconsistent care in early infant care giver relationships (Ryan, 1999)[15]

Sexual abusers may build a relationship with an individual family member over a period of time in order to build their trust and be allowed to be close to the children.

[15] Understanding & Managing Sexualised Behaviour in Children & Adolescents

Some signs to look out for include:

- refuses to allow your child sufficient privacy or to make their own decisions on personal matters
- displays physical affection such as kissing, hugging or wrestling even when the child clearly does not want it
- takes too much interest in the sexual development of your child or teenager
- wants time alone with your child with no interruptions
- wants to spend most of their spare time with your child or has little interest in spending time with people their own age
- regularly offers to babysit the children for free or take children on overnight outings alone
- buys your children expensive gifts or gives them money for no apparent reason
- frequently walks in on your children or teenagers in the bathroom
- Treats a particular child as a favourite, making them feel 'special'.[16]

Psychological effects of sexual abuse

A study carried out by the American Public Health Association entitled: "Child sexual abuse and subsequent psychopathology: results from the National Co-morbidity Survey", examined the relationship between child sexual abuse (CSA) and subsequent onset of psychiatric disorders, accounting for other childhood adversities, CSA type, and chronicity of the abuse.

METHODS: Retrospective reports of CSA, other adversities, and psychiatric disorders were obtained by the National Co-morbidity Survey, a nationally representative survey of the United States (n = 5877). Reports were analysed by multivariate methods. RESULTS: CSA was reported by 13.5% of women and 2.5% of men. When other childhood adversities were controlled for, significant associations were found between CSA and subsequent onset of 14 mood, anxiety, and substance use disorders among women and 5 among men. In a subsample of respondents reporting no other adversities, odds of depression and substance problems associated with CSA were higher. Among women, rape (vs. molestation), knowing the

[16] Ibis

perpetrator (vs. strangers), and chronicity of CSA (vs. isolated incidents) were associated with higher odds of some disorders.

CONCLUSIONS: CSA usually occurs as part of a larger syndrome of childhood adversities. Nonetheless, CSA, whether alone or in a larger adversity cluster, is associated with substantial increased risk of subsequent psychopathology.[17]

Consequences as a result of CSA are very broad and diverse, mainly for the victims who have to live with the situation and with the trauma. That trauma could be increased if they are not offered the right treatment. There are many examples of children who have been abused and years later they go on to become sexual offenders, although it must be said that one does not imply the other. What it does mean is that the core treatment needs to be carried out following the incident or after the abuse is detected. In some cases, it might not be necessary to have treatment and with the natural growth and development as well as education and stability, the trauma could pass.

The explanation for the range of issues that can arise as a result of abuse is a broad and complex one and there are many variables that need to be taken into consideration. Consequences of abuse vary from effects on health, to developing learning disabilities, social, emotional and behavioural difficulties as well as problems making relationships, engagement or development of fears and anxieties. It can also be a trigger for mental health problems such as: Schizophrenia, Language Disorders, Communication Disorders, DHA, Movement Disorder and Traumatic Stress Disorder amongst others

Social interactions between violent children/children exposed to violent crimes and others

"It's true that various social systems (home, school, community, peer relations) can contribute to the serious anti-social behaviour of children and young people. Although evidence about the needs and behaviours of young people who sexually abuse or are victims of abuse, cannot be formulated into a neat and precise pattern, some typical observations include:

[17] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446666/

- Young people have frequently experienced sexual, physical or emotional abuse[18]
- A significant proportion show poor social competence and high impulsivity[19]
- A significant proportion of young people have educational difficulties or learning disabilities[20]
- Young people are often coping with disrupted and neglecting family backgrounds[21]

Sometimes there aren't any defining differences in the backgrounds of young people who commit sexual abuse and other young offenders. There could feasibly be a number of common characteristics between sexual abusers and young people involved in other kind of crimes[22].

We cannot try to produce typologies for the young people, because it is not practical and also doesn't produce reliable results[23]. It's extremely difficult to and also not professional to generalise. If we do this, we can easily make mistakes when trying to produce reliable information concerning primary risks in the population. This is the main reason why current approaches towards assessment and treatment are more focused on the "…individual needs at the point of the behaviour coming to official attention." (Veneziano and Veneziano, 2002)

The needs of young people who sexually abuse are complex and often ongoing. Young people have typically suffered abuse, which can have important mental health consequences and may affect the impact of future intervention for their sexually abusive behaviour. They show poor social skills and a tendency to impulsiveness, and are coping with disrupted and neglecting family backgrounds. While there are a significant proportion of young people who have learning disabilities, these needs are often shared with the wider population of young people who offend. Where appropriate, their non-sexual offending needs should be fully recognised and addressed.

As such, assessment has been interpreted as a cyclical and systematic process. The studies of assessment have revealed promising approaches that help to advance knowledge about effective practice. The development and implementation of a common assessment model and framework

[18] Burton et al, 2002; Kenny et al, 2001; Dent and Jowitt, 2003
[19] Righthand and Welch, 2001; Rutter et al, 1998; Righthand et al, 2005
[20] Manocha and Mezey, 1998; Hickey et al, 2006; Timms and Goreczny, 2002
[21] Veneziano and Veneziano, 2002
[22] Rutter et al, 1998; Hickey et al, 2006; van Wijk et al, 2005; Seto and Lalumiere, 2006
[23] Veneziano and Veneziano, 2002

– the AIM Model – has indicated that there is potential to draw usefully on the contributions of agencies, families and young people.[24]

Although again not a generalization, research has found that juveniles who sexually offend against peers or adults generally display higher levels of aggression and violence when they commit their sexual crimes than those who offend against children. Young people who sexually offend against peers or adults are also more likely to use weapons and to cause injuries to their victims than those who sexually assault children.

Otherwise, the violence is another part of the behaviour that is presented in the huge range of behaviours in the sexual offenders. "Within the overall population of juveniles who sexually assault children, there are certain youths who display high levels of aggression and violence. Generally, these are youths who display more severe personality and/or psychosexual disturbance (e.g. psychopathy; sexual sadism, etc.). Juveniles who sexually offend against children have often been characterized as suffering from deficits in self-esteem and social competency." (John A. Hunter, Ph.D., 1999, p.3)

Depression is a big factor linked to this behaviour, mainly associated with young people who have been victims of abuse, as are difficulties to maintain good relationships with peers or feel empathy or awareness for the needs of others. [25]

When searching for a reliable and relevant guide to detect needs and use as a guide for behaviour, we have followed Professor Kieran McGrath's guide entitled: "Understanding & Managing Sexualized Behaviour in Children & Adolescents" (Kieran McGrath, 2010).In this guide, he follows a particular framework to detect signs that a child might have been abused using a flag system of Yellow, Red and Black classifications (developed by Ryan and Lane, 1997). By making a distinction between different age groups 0-12 years and 13-18 years[26], this guide aims to detect types of behaviour that can then be compared with more conventional patterns of behaviour, such as sexual experimentation at certain ages. These markers can help parents as well as professionals to better understand what to look out for and be aware of.

[24] Youth Justice Board (2008) Author: Roger Grimshaw "Young People who sexually abuse"
[25] Hunter, J.A PHD "Understanding juvenile sex offenders: research findings and guidelines for effective treatment and treatment." Institute of Law, Psychiatry and Public Policy, University of Virginia (1999)
[26] Kieran McGrath, Understanding & Managing Sexualised Behaviour in Children & Adolescents (2010)

Signs of violent victimization, characteristics of violent children/child victims of violent crime

As we have mentioned before, young people exposed to sexual or violent victimization are at risk of developing serious behavioural difficulties, similar to those caused by any sort of traumatic incident. Symptoms could be similar to those experienced by someone with Posttraumatic Stress Disorder (PTSD) according to DSM-5 American Psychiatric Association (APA) (2013) and may include "nightmares, flashbacks, sleep disturbance, mood disorders, suicidal ideation, avoidance and hyper arousal in response to trauma related stimuli." (C. L. Leon, 2015)

Alongside these, another symptom could also be: hyper-arousal, where the person in question is in a constant state of alert which could consequently cause them to have behaviour alterations resulting in aggressive and self-destructive behaviour, sleep disturbance etc[27]

When considering this type of behaviour, it is important to take into account the factors that can increase the risk of violent behaviour, which are can in themselves be quite complex or a combination of previous aggressive or violent behaviours, such as having already been a victim of physical or sexual abuse, or having been exposed to violence in the community or home, or a victim in of bullying, through social media or even a combination of a stressful family environment (such as poverty, severe deprivation, marital breakup, single parenting, unemployment, loss of support from extended family), brain damage…[28]

In addition, most people generally don't link violent behaviour with the origin of the problem, for example, sometimes, hyper-arousal could be related to previous experiences trauma, and the violence and aggressiveness that is expressed could be masking a depressed state or other emotional disorder. In these instances, when these connections are not made, the focus is placed on the behaviour itself rather than on the trauma and causes of the behaviour. There are a number of warning signs that could be considered when assessing children for signs of sexual abuse including: intense anger, frequent loss of temper or blow-ups, extreme

[27] Catherine L. Leon with Contribution from C.J Hunter, M.A. "DSM-5 Category: Trauma and Stressor-Related Disorders" Theravive, (2015)

[28] American Academy of Child & Adolescent Psychiatry.(December 2015n.55) From https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Understanding-Violent-Behavior-In-Children-and-Adolescents-055.aspx

irritability, impulsiveness, becoming frustrated. Parents and teachers should be careful not to minimize these behaviours in children as they could well be a means of communicating a deeper issue.

If we were to look at societies where people live in ghettos or neighbourhoods surrounded by violence, it would not be unusual to find children growing up in aggressive environments. One of the reasons mentioned previously, is the environment as a major risk factor. As such, it is of vital importance to be aware of the risk factors so that they do not go unnoticed and can lead to greater problems in the future. The biggest concern is that a victim can fall under the radar and go on to become an offender or live with untreated trauma.

In addition, according to research by the American Academy of Child and Adolescent Psychiatry (AACAP 2015) the following strategies can lessen or prevent violent behaviour:

- Prevention of child abuse (use of programs such as parent training, family support programs, etc.)
- Sex education and parenting programs for adolescents
- Early identification and intervention programs for violent youngsters
- Monitoring child's viewing of violence during their screen time including the Internet, tablets, smart phones, TV, videos, and movies.[29]

Possible health issues related with the child exposed to a sexual crime. Precautions

Sexual abuse affects victims not only psychologically, but also physically, depending on the level of violence of the abuse, the age and other characteristics pertaining to the child or young person assaulted. Both of these effects, the physical and psychological can have serious and long term implications for the victims, particularly if the abuse has taken place over a prolonged period of time. Some physical effects might only last a short time, as the physical damage might disappear from the skin or body quickly, but other effects might stay for a long

[29] https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Understanding-Violent-Behavior-In-Children-and-Adolescents-055.aspx

time, or even forever. The National Society for the Protection against Cruelty to Children (NSPCC) website provides a short but important list about some health consequences such as:

- anal or vaginal soreness
- an unusual discharge
- sexually transmitted infection (STI)
- pregnancy[30]

Sexual abuse can also have physical consequences for children, from sexually transmitted diseases to pregnancy. (Whitehead. 2010)[31]

Unusual behaviour that a parent or carer might notice in their child if they are being abuse:

- withdrawn
- suddenly behaves differently
- anxious
- clingy
- depressed
- aggressive
- problems sleeping
- eating disorders
- wets the bed
- soils clothes
- takes risks
- misses school
- changes in eating habits
- obsessive behaviour
- nightmares
- drugs
- alcohol
- self-harm

[30] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/signs-symptoms-effects

[31] Whitehead, J. (2010) Back to basics: sexual abuse. Protecting Children Update, 71: 8-9.

- thoughts about suicide[32]

Sexual abuse can ruin childhood, and the impact can last a lifetime. Although we should remember that every child and situation is different. Children who are sexually abused experience a range of short and long term symptoms. Research often focuses on physical signs and symptoms but it's often the emotional and psychological effects that cause more harm in the long term.

If we want analyze the effects in childhood as the population with lack of emotional resources and who can be manipulated by adults, this cause that they believe that the abuse is their fault, or as Alexander (2011) calls "chronic neurologic disease" that can be prolonged by years and years.[33]

Being sexually abused as a child, especially when that abuse is not discovered, can lead to confused ideas about relationships and sexual behaviour.

Up to 40% of victims of sexual abuse exhibit no long-term negative consequences of their experience (Finkelhor and Berliner, 1995).

Other long term consequences that adults who were abused as children might experience include : emotional difficulties such as anger, anxiety, sadness or low self-esteem; mental health problems such as depression, eating disorders[34], post-traumatic stress disorder (PTSD), self harm suicidal thoughts; problems with drugs or alcohol; disturbing thoughts , emotions and memories that causes distress or confusion; poor physical health such as obesity, aches and pains; struggling with parenting or relationships; worrying that their abuser is still a threat to themselves or others; learning difficulties, lower educational attainment, difficulties in communication; antisocial behaviour. NSPCC (2016)

[32] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/signs-symptoms-effects/
[33] https://www.nspcc.org.uk/globalassets/documents/information-service/research-briefing-child-sexual-abuse.pdf
[34] https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/signs-symptoms-effects/

APPROACHING THE VICTIM/OFFENDER

One of the biggest problem that governments currently have in terms of violent and sexual crimes, is how best to define and deal with them. In this report, as previously mentioned, one of the most important treatments or interventions that can be carried out with regards to violent and sexual crimes is the education and prevention of them within society. In a society where violence is normalized and conflicts are resolved through violence, we have to take into account that children, who grow up in violent environments, have a greater tendency to act violently as a result.

The following research is based on ways to deal with the crimes once they have taken place.

The UK Government has a National Offender Management Service (NOMS) that offers accredited offending behaviour management programmes to offenders in order to reduce re-offending.

In order to create a guide of approaches that can help to us to see an overall view of some programmes that are running around UK that are working with offender of victim programs. In that list we can see a big range of approaches, some are quite different from one another, but all have a common aim: to get the offender to be aware and understand the harm they have caused[35]. For a detailed list please go to: https://www.justice.gov.uk/offenders/before-after-release/obp

Two examples of specialised programmes for sexual offenders (SOPT) are:

- **Sex Offender Treatment Programmes (SOTP)** - A range of programmes are available for sexual offenders, providing a menu which are offered according to the level of risk and need of the offender.
- **Internet Sex Offender Treatment programme (i-SOPT) –** Is used for internet-related sexual offenders. One third of the total of the offending are committed in Internet. D. Middleton, R. Mandeville-Norden & E. Hayes (2009)

[35] https://www.justice.gov.uk/offenders/before-after-release/obp

Multisystemic Treatment of Adolescents Sexual Offenders. Bourduin, Henggeler, Blake, Stein (1990) developed a comparative study on the effectiveness of multisystemic therapy (MST). In this programs the first aim is to reduce denial and increase accountability; increase empathy for the victim; provide insight into precipitating events; address the adolescent's own victimization, if appropriate; provide sex education; use conditions procedures to alter deviant arousal patterns; modify cognitive distortions, mentioned by Davis and Leitenberg, 1987. This approach can be considered one of the most respected ways to deal the treatment of sexual offenders. We can see more examples in the Unites States where this approach was developed. **ABSOP program in Alabama** is an assessment and treatment program designed to work from a responsive psychological service for juvenile justice-involved adolescents. The young people are supported to develop themselves with principles of community safety, holism, and empiricism through individual, group and alternative therapy. The project is run between the Alabama Youth Service Department and Auburn University Department of Psychology[36].

Restorative Justice, this program is a new approach that is in the first steps of the process of developing, although many countries have been developing this methodology for the past 20 years[37]. There are a lot of examples of this practice around the world, the main aim, is to involve victims and offenders in one process where victims have the opportunity to meet or communicate with offenders and tell them of the impact the crime has had on them and to find a way to repair the harm done. On the other hand, it also gives offenders the opportunity to listen and understand the victim's point of view and see the crime in a different way. The meetings or "conferences" should be transformative and help in the development of empathy. They can only take place if the offender admits fault, and the victim is not obliged to attend. The conference has to be led by a facilitator who supports and prepares the people taking part in the process[38].

When a victim suffers from Post Traumatic Stress Disorder as a result of sexual abuse or violent crime, there are some psychological therapeutic treatments that they can access, such as Cognitive Behaviour Therapy (CBT), psychotherapy, or Eye Movement Desensitization and Reprocessing (EMDR).,as well as the pharmacological interventions that can help the intervention Leon & Hunter (2015). Alongside these kind of therapies there are other

[36] http://dys.alabama.gov/absop.html
[37] http://restorativejustice.org/
[38] https://www.restorativejustice.org.uk/criminal-justice

approaches such as Mindfulness or other Therapies called **Third-Generation Therapies**, in that group: Acceptance and Commitment Therapy (ACT) ; Functional Analytic Psychotherapy (FAP); Dialectical Behaviour Therapy (DBT) or Mindfulness-Based Cognitive Therapy (MBCT) Hayes, S.C., Follette, V.M. y Linehan, M.M. (2004). As we have commented before, when working with the victims, there are many factors to take into consideration, including when the abuse was committed, the age of the victim, their personality, their resilience and the support that each individual can have and what their environment is like. All of these factors will undoubtedly have an effect on the type of intervention or treatment that is offered to them.

Currently in Youth Justice the Restorative Justice approach is being used with great success and high levels of satisfaction from both victims and offenders. As such, now is the time to take full advantage of this success and try to deliver key treatments and interventions. This approach is not just about working with offenders once they have committed a crime and are going through court. It is also an attempt at social cohabitation, starting in communities and schools as a way to better understand conflicts and deal with problems from the outset. The difficulty in this approach is that some sectors in society think it is not a tough enough approach, particularly for more serious crimes, so governments need to be aware of the benefits of Restorative Justice in all respects.

It is a fact that **Restorative Justice** is now an example of a new paradigm in the governments around the world and that this approach can save governments money as well as benefit society as a whole. Its outlook is more focused on restoration and reintegration rather than punishment. Diagrama Foundation is currently part of an EU Project entitled REVIJ, leading by Fundacion Diagrama Spain, and with the collaboration of International Juvenile Justice Observatory (IJJO), Istituto Calabria (Italy), Universidade Catolica Portuguesa Do Porto (Portugal) or Association Diagrama (France). In this project, the main aim is to find best practice and recommendations on Restorative Youth Justice in Europe.

Diagrama Foundation Psychosocial Intervention has worked with both victims and offenders in their centres for many years, and the approach that is always taken with both parties is a multi-systemic one. Our aim therefore, is to combine both interventions with external professionals specialised in working with young people with sexual behavioural issues with our daily work with victims of sexual abuse.

It is also important to note that the work that is carried out daily takes into consideration the individual needs and characteristics of each case and the young people that it concerns. Regarding clinical intervention, not all victims of sexual crimes require psychological intervention. In some cases, this type of therapy can lead to a second trauma or revictimisation[39]. This type of treatment is recommended for children who present deep psychopathological symptoms, such as: anxiety, depression, nightmares or sexual disorders or because of an inability to adapt to everyday life. There are a number of protective factors such as: family support, social relationships or the resuming of their daily life influence which can have positive outcomes for victims of sexual crimes without the need for medical intervention. In cases where psychological intervention is necessary, it is important to clarify exactly when to do so. Adapting the lines of work dependant on the age and the characteristics of the child is essential. A critical aim of the intervention is the work with families, as a psychosocial and judicial approach needs to be focused on the psychological intervention. It is essential to treat this difficult situation and everything that is related with the revelation to guarantee the protection of the young victim. To teach parents to have a positive attitude in front of the revelation of abuse, as well as to establish strategic risk management.

Most common mistakes in approaching offender and victim children of violent crimes

Victims

It is important to note that not all victims of sexual crimes require professional medical intervention. This can sometimes be the wrong approach that could result in further trauma, or a second victimization, and it is important to know in which cases it is advisable to carry out interventions with the family instead. Above all, the child must be safeguarded so that we can ensure they are safe and a protection strategy is defined and put into action.

One of the most common consequences for victims of sexual abuse when they are not dealt with in the right way through the Criminal Justice System, and other services is revictimisation. . Garcia-Pablos (1988) defines Secondary Victimization, Gutierrez et al. (2009) quotes (Kreuter, 2006; Soria 1998; Landrive, 1998) as the psychological, social, juridical and economical negative consequences on the victim through the Criminal Justice System, includes frustration and expectations about the reality of the system. There is also a lack of understanding about the intense suffering, both physical and psychological that these

[39] Enrique Echeburua y Cristina Guerricaechevarría Universidad del País Vasco; Ciberas (España)

crimes can provoke, especially if the victim is left without the adequate support or trust in the system.

Sometimes the victims are exposed to a confusing process, involving a lot of statements, trials, reports, etc. The confusion level about the repetition of statements, the slow process or the lack of clarity in the procedure, can have a negative psychological impact on both the child and the family. It is very important to try to be very clear from the outset, for example in terms of how the practitioner reacts in front of the family when faced with a revelation of sexual abuse. The child and the family must feel supported at all times and that they can trust the practitioner from the outset[40].

Otherwise it might be necessary to separate the child from the family, if a safeguarding issue arises. This is not advised as a first response, as the child might feel abandoned which could increase their anxiety. It could also reinforce feelings of guilt or stigmatization in the child or even worse, make them feel that they are to blame rather than the victim.[41]

Alongside the errors made in these sorts of cases, there are also a number of myths that exists with regards to these types of crimes such as: "Perpetrators of sexual crimes are all people with mental illnesses, crazy, strange, and weird and they aren't aware of their acts" However in reality, and based on research carried out about perpetrators, mental health issues amongst this group of people is the same as in the population at large. Another myth is that "Victims do not usually know who their perpetrators are." This is also untrue as two thirds of perpetrators are known by their victims

Other myths related to victims of sexual crime include: "Sexual Crimes are always against women" In truth, sexual crimes are also committed against children and to a lesser degree against men. Another is that: "Once you have been a victim of sexual assault, you can never lead a normal life or have normal relationships". With the right intervention and support, a victim could recover and lead a normal and fulfilling life.[42]

[40] Gutierrez, C., Coronel, E. & Perez, A. Theoretical Review of the concept of secondary victimization. Universidad Cooperativa de Colombia (2009)
[41] Translated from the Spanish: Tratamiento Psicológico de las víctimas de abuso sexual infantil intrafamiliar: un enfoque integrador(Enrique Echeburua y Cristina Guerrica Echevarria)
[42] http://www.violacion.org/falsas/default.html#1

Offenders

When dealing with offenders, the view most commonly taken is that they should be punished for the crime committed rather than treated for the causes behind their behaviours. Many people tend to think that sexual offenders are most likely to reoffend, however, after they have been caught; only a small minority of them will go on to commit another sexual assault. [43]

This being the case, it is all the more important to raise awareness on the need to report instances of sexual abuse. Another myth surrounding sexual abuse is that: "People who are victims of sexual assault when they were children, will become offenders when they are adults" However in reality, the percentage of sexual offenders who were abused as victims is the same as those who were not.

One of the most difficult aspects for perpetrators of sexual abuse is how they are reintegrated into society and whether society is able to accept them once again.

Preventing violence among and against children

Professor Kieran McGrath (October 2010) carried out an analysis on the behaviour of each child, which could serve as a guide for parents to prevent crime. "Observation, Exploration, Education, Limit Setting, Redirecting, Behaviour management" McGrath (2010). By trying to prevent something from taking place as opposed to reacting after the event has happened, doesn't mean that the parent or professional needs to be on a constant alert and in fear about their children. Children are impressionable, they can be targets for some offenders, but there are ways to support children to have better relationships and be aware themselves so as to avoid certain situations from arising.

In addition, we can also take into consideration the work that is carried out in Residential Settings, where there are large numbers of children living together and in addition to certain emotional needs; many suffer from specific mental, emotional and behavioural disorders. These include: involving all staff in the process, delivering training and meetings where everyone is put up to date on all relevant issues, having a Unit Culture, Policies and Procedures, Reporting

[43] http://nationalrsol.org/resources/ten-myths-about-sex-offenders/

Forms , desexualising the environment and above all ensuring that there is a lot of supervision from managers or those in charge. More in McGrath (2010)

Neglect is the most common maltreatment of children that has been reported in studies by Stoltenborgh (2012), on Child Sexual Abuse. Which means that it is as important to consider the consequences of neglect as much as those of abuse, as the delays in cognitive and emotional development, substance abuse, diminished economic well-being, risk sexual behaviour, post traumatic stress disorder and the likelihood of contact with social services can all increase dramatically. (Stoltenborgh, 2012)

Prevention for Victims

Echeburua & Guerrica Echevarria (2011) write that when working with child victims of sexual abuse, it is important to name what has happened. Children need to know what it is that has happened to them in an appropriate way for their age. The child must be aware that this was forced upon them and they must feel emotionally supported at all times so that they do not feel guilt or that there might be further reprisals following the revelation. They must be assured that the offender was wholly responsible for the abuse.

In order to help prevent abuse from happening again, it is essential that the child understands the differences between normal signs of affection and inappropriate sexual behaviour, so that they are able to identify them should they need to in the future e.g. not to be alone with an adult in a bedroom or the bathroom, not to expose themselves or be exposed to sexualized pictures or behaviour).

Resilience is another key factor in prevention and protection of children. Noemi Pereda (2011) stated that "To grow up in a context of abuse and mistreatment is an important risk factor to develop multiple adverse consequences, but some children are able to get over that experience and become capable adults, sane, healthy and integrated. Resilience explains this reality but it is necessary to know its variables and, specially, how we can help to develop it. Support before revelation of abuse and specialized and appropriate attention to the needs of the victims are two variables that we, as professionals, must take into account in such interventions". From her abstract "Resilience in children victims of sexual abuse: the role of the family and social context" (Noemi Pereda, 2011)

Legislation

Another approach to preventing and dealing with Children Sexual Abuse could be through an aimed at preventing and challenging the offenders. The UK has an example of this where it is working with the police and magistrates to prosecute offenders for every crime or action that they commit that involved sexual crimes.

The following example of controlled activity relating to children in the UK is designed to ensure that children and victims of sexual abuse are safeguarded:

Controlled activity relating to children

(1)A reference to a controlled activity relating to children must be construed in accordance with this section.

(2)An activity which falls within any of subsections (3) to (7) is a controlled activity to the extent that it is not a regulated activity relating to children.

(3)An activity falls within this subsection if—

(a)it consists in or is carried out in connection with any form of health care, treatment or therapy to which subsection (8) applies,

(b)it is carried out frequently by the same person or it is carried out by the same person on more than two days in any period of 30 days, and

(c) It gives the person an opportunity mentioned in subsection (9).

(4)An activity falls within this subsection if—

(a)it is carried out in a further education institution (within the meaning of section 140(3) of the Education Act 2002 (c. 32)),

(b)it is carried out frequently by the same person or it is carried out by the same person on more than two days in any period of 30 days,

(c)it is carried out by the person while engaging in any form of work (whether or not for gain),

(d)it is carried out for or in connection with the purposes of the institution, and

(e) It gives the person the opportunity mentioned in subsection (9) (a).

(5)An activity falls within this subsection if—

(a)it consists in making payments under section 17A of the Children Act 1989 (c. 41) or the provision of assistance either in connection with the making of such payments or securing the provision of services paid for out of them,

(b)it is carried out frequently by the same person or it is carried out by the same person on more than two days in any period of 30 days, and

(c) It gives the person the opportunity mentioned in subsection (9) (a).

(6)An activity falls within this subsection if it is carried out as mentioned in subsection (10) frequently and it gives a person carrying out the activity the opportunity to have access to—

(a)health, educational or social services records relating to children;

(b)information provided pursuant to section 117(1) of the Learning and Skills Act 2000 (c. 21);

(c)in the case of a person carrying out an activity mentioned in subsection (10)(b), records of family proceedings (within the meaning of section 8(3) of the Children Act 1989) held by the Children and Family Court Advisory and Support Service;

(d) In the case of a person carrying out an activity mentioned in subsection (10) (c), records of family proceedings (within the meaning of section 8(3) of the Children Act 1989) held by the National Assembly for Wales.

(7)An activity falls within this subsection if it consists in or involves on a regular basis the day to day management or supervision of a person carrying out an activity which falls within subsection (3), (4) or (6).

(8)This subsection applies to health care, treatment or therapy which is provided for a child—

(a)in pursuance of arrangements made by or under an enactment,

(b)in an establishment in relation to which a requirement to register arises under section 11 of the Care Standards Act 2000 (c. 14), or

(c)by an agency in relation to which such a requirement arise

From: The National Archives, Legislation, Government UK, Safeguarding Vulnerable Groups Act 2006 in Section 21 (2016)

To complete an overall view within a European context, we can look to the Directive 2011/92/EU of the European Parliament and of the Council of Europe from 13 December 2011. In this document, the European Parliament and the Council of Europe have compiled the basic law and sanctions related to sexual abuse committed against children, sexual exploitation or

pornography on-line or sexual tourism.[44] In this document the European Parliament marked a deadline for United Nations Member States to implement the minimum regulations within this legislation.

Privacy issues? Principles in sharing information about children with other parties?

Safeguarding is paramount when considering sharing information about children. In order to work with the most vulnerable populations in society, we must ensure that above all, they are protected[45]. This is why there are some many examples of government policies and legislation around these topics. Sometimes information is shared or recorded in the wrong way by professionals, which doesn't mean that it is wrong to share this information, but that a greater emphasis must be placed on ensuring that it is done in the right way by all the relevant parties. (HM Government, 2015) This document created by the government is based on the Data Protection Act of 1998 and provides a framework to be considered by different agencies when sharing information on how different practices should be reviewed so as to improve the way that practitioners work.

The government of England and Wales has created a legislative framework of all policies to be delivered and communicated it to the key organizations that have a duty under Section 11 of the Children's Act 2004 to have arrangements in place to safeguard and promote the welfare of children. These are:

- Local authorities;
- NHS England;
- Clinical Commissioning Groups;
- NHS Trusts, NHS Foundation Trusts;
- Local Policing Bodies;
- The British Transport Police Authority;
- Prisons;
- The National Probation Service and Community Rehabilitation Companies;[46]

[44] http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32011L0093

[45] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

[46] The duty under section 11 of the Children Act 2004 will apply to Community Rehabilitation Companies via contractual arrangements entered into by these bodies with the Secretary of State under Section 3 of the

• Youth offending teams; and

• Bodies within the education and /or voluntary sectors, and any individual to the extent that they are providing services in pursuance of section 74 of the Education and Skills Act 2008.

(HM Government, 2015)

Within this context, and in order to ensure the protection of all children's privacy whilst delivering legislation that is embedded in Directive 2011/92EU of the European Parliament and European Councils Framework Decision 2004/68/JHA, privacy and safeguarding must be at the heart of the relevant laws passed by government.

Cyber crime is another issue that is proliferating each year in relation to sexual abuse of children and governments are working to try to deal with this growing problem by identifying the ways in which perpetrators are attempting to capture and abuse children through technology. This was one of the reasons why the UK Prime Minister, David Cameron, invite a group of global representatives from governments, law enforcement agencies, non-profits and industry to London to a summit entitled #WEPROTECT to develop global solutions in this area and improve current practice.

In UK, the Child Exploitation and Online Protection Centre (CEOP), receives 1,600 reports of illegal material every month. In the United States, the National Centre for Missing and Exploited Children (NCMEC) received 17.3 million illegal images of children in 2011, a number that is increasing year on year. (E. Morris, 2015) The main aim of this summit therefore, is to enhance the work currently being carried out on this matter with the help and joint collaboration of the internet industry, UNICEF and world governments, so as to stay ahead of a rapidly evolving and challenging global problem.

As such, world governments, together with the European Union need to put all their efforts into creating relevant policy and innovating work so as to establish frameworks to be implemented nationally, regionally and by local authorities across the board.

Offender Management Act 2007.

Keep in Mind
To Do's

- Keep calm. When children start to talk about the abuse, we have to listen the speech, that can make you feel very strong emotions, but if you be altered, or you become angry, you are impeding that children can share what happened.
- Trust. Believe in them when they told you the story and make sure that they don't feel guilty about what happened. When they told you the sexual abuse, make them feel brave for talk with you.
- Protect. Protect them taking distance from the offender immediately and reporting to the Police.
- Ask aid. In addition to go to at doctor or pediatrician to assess any physic injury (even STD). is critical that children have the opportunity to talk with a specialist Psychologist in children's sexual abuse.
- Love and acceptance. Reaffirm that they can count on your love and the acceptation of the rest of the family. Ensure then that you are going to do all that you could, but never promise something that you are not going to fulfil.
- Keep them aware. Related with the next steps to do, specially with everything related with the court process.

Not To Do's

- Denied the Sexual abuse.
- Have a panic reaction.
- To blame the children about sexual abuse.
- Take the determination to speak with the offender.
- Make questioned extensively at children.
- Treat children in a different way after their confession.
- Overprotect them.
- Remember continually the fact or abuse.

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CHAPTER THREE DRUG ABUSE

ABOUT THE DRUG ABUSE

Drugs and drug-abuse are serious issues for population in Europe. They are the main cause of death in youths in Europe. Drugs provoke, direct or indirectly, illnesses, violence, accidents.

Therefore drugs represent a hazard to the protection and fettle of the community. Many organizations such as the European Commission have been researching about these matters for many years.

First of all, we will investigate the definition of the "drug" term considering that it has lots of uses.

"In medicine, it refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare. In pharmacology, it means any chemical agent that alters the biochemical or physiological processes of tissues or organisms.

In the context of international drug control, "drug" means any of the substances listed in Schedule I and II of the 1961 Single Convention on Narcotic Drugs, whether natural or synthetic."[47]

"*As United Nations Office on Drugs and Crime determines, this Convention aims to combat drug abuse by coordinated international action. There are two forms of intervention and control that work together. First, it seeks to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes. Second, it combats drug trafficking through international cooperation to deter and discourage drug traffickers*. "[48]

"*The United Nations drug control conventions do not recognize a distinction between licit and illicit drug, they describe only use to be licit or illicit. Here, the term illicit drugs is used to describe drugs which are under international control (and which may or may not have licit medical purposes) but which are produced, trafficked and/or consumed illicitly.*

Drug types are described in various ways, depending on origin and effect. They can either be naturally occurring, semi synthetic (chemical manipulations of substances extracted from natural materials) or synthetic (created entirely by laboratory manipulation)."[49]

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[47] UNODC - United Nations Office on Drugs and Crime: *http://www.unodc.org/unodc/en/illicit-drugs/definitions/*

[48] UNODC - United Nations Office on Drugs and Crime: https://www.unodc.org/unodc/en/treaties/single-convention.html

[49] UNODC - United Nations Office on Drugs and Crime: *http://www.unodc.org/unodc/en/illicit-drugs/definitions/*

Drug use can become drug abuse or addiction with the passage of time. If one consumes drugs constantly and feels dependent on them, one haa a problem. Consuming substances without control or excessively may cause many damages: physical and psychological harm, or even death.

There are five phases identified about the drug use. We can identify them because of the attitudes and behaviour of the consumers:

1st. In this period, people access the substances but they do not try them. It is very important to educate children to say no or not to be vulnerable to drugs in this period.

2nd. The use of drugs starts experimenting or using them occasionally. But the range is wide and it includes those who consume them regularly and weekly.

3rd. In this phase there is a progression and rise of quantity and frequency of consumption, the drug use is regular. It might include drug purchase, sale and trafficking of the teenager.

4th. Teens consume drugs regularly and have problems socializing, at school, with family… because of it. They feel worried about intoxicating.

5th. This is the most important and grave phase, where teens feel nothing special when consuming. There are many risks in this period: drug-trafficking, robbery, rows, driving under the influence of substances, unsafe sex or even be exposed to suicide thinking.

The matter of drugs is specially significant in the case of teens because people usually try drugs for the first time at this age. Teens might be more susceptible to them because of their young age.

Luckily, there is a large range of treatments to help teens to overcome their drug problem. Some studies demonstrate that if patients mix medicines with cognitive therapy the results are more successful. Medical treatments which are focused on each patient can help them live a free of drugs life. The main difference between drug addiction and other chronic illnesses is that addiction can be handled.

If a teen gets to know the stage of addiction, she / he has to seek professional help. The assistance of family, friends, doctors, psychologists… will be decisive to leave behind the use substances.

If young people are starting consuming substances but it still is not considered abuse, it is possible to ask for help. If a person is really interested to quit, there are many ways to overcome the use or abuse. Nevertheless, prevention is and will remain the basis in fighting drug abuse. For this reason prevention programmes are an interesting option for schools, families, community in general.

What types of drugs are commonly abused?

"Virtually any substance whose ingestion can result in a euphoric ("high") feeling can be abused. While many are aware of the abuse of legal substances like alcohol or illegal drugs like marijuana and cocaine, less well known is the fact that inhalants like household cleaners are some of the most commonly abused substances. The following are many of the drugs and types of drugs that are commonly abused and/or result in dependence:

Alcohol: Although legal, alcohol is a toxic substance, particularly to a developing fetus when a mother consumes this drug during pregnancy. One of the most common addictions, alcoholism can have devastating effects on the alcoholic individual's physical health, as well as his or her ability to function interpersonally and at work.

Amphetamines: This group of drugs comes in many forms, from prescription medications like methylphenidate (Ritalin, Concerta) and dextroamphetamine and amphetamine (Adderall) to illegally manufactured drugs like methamphetamine ("crystal meth"). Overdose of any of these substances can result in seizure and death.

Anabolic steroids: A group of substances abused by bodybuilders and other athletes, this group of drugs can lead to terrible psychological effects like aggression and paranoia, as well as devastating long-term physical effects like infertility -and organ failure.

Caffeine: While it is consumed by many, coffee, tea and soda drinkers, when consumed in excess this substance can be habit forming and produce palpitations, insomnia, tremors, and significant anxiety.

Cannabis: More commonly called marijuana, the scientific name for cannabis is tetrahydrocannabinol (THC). In addition to the negative effects the drug itself can produce (for example, infertility, paranoia, lack of motivation), the fact that it is commonly mixed ("cut") with other substances so drug dealers can make more money selling the diluted substance or expose the user to more addictive drugs exposes the marijuana user to the dangers associated with those added substances. Examples of ingredients that marijuana is commonly cut with include baby powder, oregano, embalming fluid, PCP, opiates, and cocaine.

Cocaine: A drug that tends to stimulate the nervous system, cocaine can be snorted in powder form, smoked when in the form of rocks ("crack" cocaine), or injected when made into a liquid.

Ecstasy: Also called MDMA to denote its chemical composition (methylenedioxymethamphetamine), this drug tends to create a sense of euphoria and an expansive love or desire to nurture others. In overdose, it can increase body temperature to the point of being fatal.

Hallucinogens: Examples include LSD and mescaline, as well as so-called naturally occurring hallucinogens like certain mushrooms. These drugs can be dangerous in their ability to alter the perceptions of the user. For example, a person who is intoxicated with a hallucinogenmay perceive danger where there is none and to think that situations that are truly dangerous are not. Those misperceptions can result in dangerous behaviors (like jumping out of a window because the individual thinks they are riding on an elephant that can fly).

Inhalants: One of the most commonly abused group of substances due to its accessibility, inhalants are usually contained in household cleaners, like ammonia, bleach, and other substances that emit fumes. Brain damage, even to the point of death, can result from using an inhalant just once or over the course of time, depending on the individual.

Nicotine: The addictive substance found in cigarettes, nicotine is actually one of the most addictive substances that exists. In fact, nicotine addiction is often compared to the intense addictiveness associated with opiates like heroin.

Opiates: This group is also called narcotics and includes drugs like heroin, codeine, hydrocodone, morphine, methadone, Vicodin,OxyContin, Percocet, and Percodan. This group of substances sharply decrease the functioning of the nervous system. The lethality of opiates is often the result of the abuser having to use increasingly higher amounts to achieve the same level of intoxication, ultimately to the point that the dose needed to get high is the same as the dose that is lethal for that individual by halting the person's breathing (respiratory arrest).

Phencyclidine: Commonly referred to as PCP, this drug can cause the user to feel extremely paranoid, become quite aggressive and to have an unusual amount of physical strength. This can make the individual quite dangerous to others.

Sedative, hypnotic, or antianxiety drugs: As these substances quell or depress the nervous system, they can cause death by respiratory arrest of the person who either uses these drugs in overdose or who mixes one or more of these drugs with another nervous system depressant drug (like alcohol, another sedative drug, or an opiate).”[50]

How many youngsters have tried drugs?

Many young people across Europe have sampled controlled drugs. Many more have sampled other psychoactive substances, such as tobacco and alcohol. Far fewer are regular users of drugs, and even fewer have drug-related problems – although the absolute numbers in Europe

[50] MedicineNet.com - http://www.medicinenet.com/drug_abuse/page3.htm

are large. The most recent ESPAD Survey (in 2011, covering 36 European, countries) found that, among 15 to 16-year-old:

On average, 54% of the students in participating countries reported that they had smoked cigarettes at least once and 28 % that they had used cigarettes during the past 30 days. 2 % of all students had smoked at least a packet of cigarettes per day during the past 30 days.

In all ESPAD countries but Iceland, at least 70 % of the students have drunk alcohol at least once during their lifetime, with an average of 87 % in the 2011 survey.

On average, nearly six in ten students had consumed at least one glass of alcohol at the age of 13 or younger and 12 % had been drunk at that age.

Most alcohol-related problems are more common, on average, among boys.

Nearly one in three (29 %) of the students in the ESPAD countries perceived cannabis to be (fairly or very) easily available

On average, 21 % of the boys and 15 % of the girls have tried illicit drugs at least once during their lifetime

The vast majority of the students who have tried illicit drugs have used cannabis.

On average, more girls than boys report non-prescription use of medical drugs (tranquillisers or sedatives)

The average proportion of students having tried alcohol together with pills in order to get high is lower in 2011 (6%) than it was in 1999 (9%)[51]

Regarding youth attitudes on drugs (Flash Eurobarometer 2011), young people considered cannabis to be the most easily accessible of the illicit substances. Besides, a vast majority thought that it would be very easy for them to obtain alcoholic drinks (82%) or tobacco products (81%). What's more, roughly a quarter of young EU citizens participating in the survey said they have used cannabis. For illicit drugs – heroin, cocaine, ecstasy and cannabis – the results were more heterogeneous.

Moreover, the preferred source to look for drug-related information is internet for more than 6 in 10 (64%) respondents. They said they would use the Internet to get information about illicit drugs and drug use in general. In significant contrast, just 15% of young people would

[51] European Monitoring Centre for Drugs and Drug Addiction

http://www.emcdda.europa.eu/system/files/publications/927/TD3012613ENC_399947.PDF

"Council of Europe - European Union"- http://pjp-eu.coe.int/it/web/youth-partnership/drug-abuse

consult other mass media sources – TV, radio, newspapers and magazines – to get informed about illicit drugs and drug use in general.

In addition, almost 4 in 10 (37%) respondents would turn to a friend in order to discuss issues relating to the effects and risks of using illicit drugs.

Referring to health risks associated with drug use, more than 90% thought that using cocaine or ecstasy on a regular basis would pose a high risk to a person's health. In contrast, 30% said that using cannabis once or twice posed only a low risk to a person's health and 14% said there was no risk involved. Furthermore, young people who had used cannabis also perceived the health risks associated with its use to be less serious. When the students were asked about bans or regulation of drugs, new phychoactive substances, alcohol and tobacco; there was a broad consensus among young people that heroin, cocaine and ecstasy should continue to be banned in EU Member States. But the opinions of young people in the different Member States were more diversified when they were asked if cannabis should continue to be banned. [52]

Which are the most common drug crimes that children commit and are exposed to?

The use and abuse of alcohol and substances often affect consumer's environment. Relatives, peers and society are usually victims of users. Drugs and alcohol are usually associated to crime in many ways. Using, possessing, manufacturing or distributing drugs classified as potential for abuse (cocaine, heroin…) are considered crimes. The chart below summarizes the different ways that drugs and crime are linked:

[52] Flash Eurobarometer - July 2011 - European Comission

http://ec.europa.eu/public_opinion/flash/fl_330_en.pdf

Summary of relationship between drugs and crime

Drugs/crime relationship	Definition	Examples
Drug-defined offenses	Violations of laws prohibiting or regulating the possession, use, distribution, or manufacture of illegal drugs.	Drug possession or use. Marijuana cultivation. Methamphetamine production. Cocaine, heroin, or marijuana sales.
Drug-related offenses	Offenses to which a drug's pharmacologic effects contribute; offenses motivated by the user's need for money to support continued use; and offenses connected to drug distribution itself.	Violent behavior resulting from drug effects. Stealing to get money to buy drugs. Violence against rival drug dealers.
Drug-using lifestyle	A lifestyle in which the likelihood and frequency of involvement in illegal activity are increased because drug users may not participate in the legitimate economy and are exposed to situations that encourage crime.	A life orientation with an emphasis on short-term goals supported by illegal activities. Opportunities to offend resulting from contacts with offenders and illegal markets. Criminal skills learned from other offenders.

Office of National Drug Control Policy - https://www.ncjrs.gov/ondcppubs/publications/pdf/ncj181056.pdf

According to the National Council on Alcoholism and Drug Dependence in U.S, there are essentially three types of crimes related to drugs:

Use-Related crime: These are crimes that result from or involve individuals who ingest drugs, and who commit crimes as a result of the effect the drug has on their thought processes and behavior.

Economic-Related crime: These are crimes where an individual commits a crime in order to fund a drug habit. These include theft and prostitution.

System-Related crime: These are crimes that result from the structure of the drug system. They include production, manufacture, transportation, and sale of drugs, as well as violence related to the production or sale of drugs, such as a turf war.

As stated before, there is a connection between drugs or substances and users' antisocial behavior. When they are under the influence of substances and alcohol, abusers can commit crimes or they can commit a crime to get money to buy drugs. When considering youths, the cases of delinquency increase. *"Delinquency is a term that is used to describe illegal or antisocial behaviors and activities. Delinquent behavior may include drug use, underage drinking, violence, sex crimes or property crimes. Individuals who are delinquent typically express antisocial opinions, are involved in activities that are dangerous, harmful and wrong and are often outspoken in their rejection of punishments associated with their crimes."*[53]

[53] Alcohol Rehab - http://alcoholrehab.com/drug-addiction/delinquency-and-substance-abuse/

On the other hand, alcohol is legal and it is legally consumed in most countries of the world, and it is linked to a large range of crimes (even more than other, illegal, substances). Nevertheless, we must not forget that many people who commit crimes do not take drugs, so crime are drug-users are not always related.

Drug Possession

Medications, drugs and substances are usually regulated and monitored by each country's legislation and regulation. People in possession of illegal substances can be penalised because of the possession itself. The phenomenon associated with drug possession, when the person who owns the substances is under the age of 18, is called youth drug possession.

Such phenomenon is associated with detection from the police forces (while they control the driving licence and smell marijuana, for instance) but generally speaking it is not usual to order a detention for a youth in possession of drugs or substances. If a teen is arrested she / he can be taken to a juvenile detention center, juvenile community… but youth drug-possession usually does not result in an arrest (unless having a criminal record or under other special circumstances: possession of big quantities, when drug possession is detected after a robbery or after violence occurred, or when teens repeat their criminal behaviours).

Violent Crime

In U.S, for instance, the main percentage of youths who have a record are related to drugs and substances. There are many violent crimes committed by youths under 18 who had used drugs or alcohol. These young people will probably not act in this way without the "help" of substances. Besides, the teens' violent behaviours can continue developing until adulthood. In United States, for example, *"alcohol and drugs are implicated, for example, in an estimated 80% of offenses leading to incarceration such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses."* [54]

Drug-trafficking is often associated to violence and crime. There are some reasons to think about the relationship of these two terms. Firstly, the competition for drug markets and customers. Secondly, the fights and swindles the customers and dealers are involved. Finally, some of the individuals who deal with drugs tend to have a violent behaviour.

[54] National Council on alcoholism and drug dependence - U.S - https://ncadd.org/about-addiction/alcohol-drugs-and-crime

Besides, drug markets and dealers are usually located in slums that are critical points. Controls and laws against drug-trafficking and violence are not effective in there. In some of them, even the police has a difficult access.

Nevertheless, the association between drugs and crimes is difficult to quantify. Most of the crimes are usually the result of more than one reasons or causes; even when drugs are the main cause, they are not the only one. Personal, cultural, economical, health situation can affect the criminal attitude. What is true is that evidence shows that people who consume drugs is more likely to use violence and commit crimes than those who do not take drugs.

Generally speaking, one could say that drugs tend to generate violence in people. However there is problematic evidence, and it is not possible to demonstrate how much drugs influence each crime.

DUID (Driving Under Influence of Drugs)

Drugs can affect each person in unique ways and, unlike the situation with alcohol, no singular test exists for the presence of all drugs in the body. Driving under the influence of drugs is very dangerous and it can be punishable by law, from fine or community services to suspension of driver license and getting arrested or being jailed.

How is the presence of alcohol and drugs proved?

Police may ask the driver to make a test for the presence of drugs and alcohol. Driver should blow into a machine that quantifies the alcohol in one's body. For testing the presence of drugs, the police may ask the driver to provide urine, blood, saliva or hair.

Compared with alcohol, it can be much harder to determine from a chemical test whether a person is currently impaired due to drug use. Some drugs, like marijuana, stay in the bloodstream long after the high has worn off. Other drugs, like cocaine, wear off quite quickly. Some drugs do not show up in some tests.

Driving Under Influence / Driving While Intoxicated Laws & Penalties (Alcohol)

Every country has her own driving laws. For this reason, even the Blood Alcohol Content limit depends on the country. In states with a .00% limit, for example, it is a crime for a person to drive after drinking any amount of alcohol.

Penalties can vary depending on the type of crime committed. If an accident causes injury or death, then the punishment will be much harder because it is not a mere traffic law violation. Consequences may include from payment for damages, community services to jail time or time in a juvenile facility.

DRUG ABUSE AND CHILDREN AS VICTIMS AND OFFENDERS

Psychology of children who commit drug crimes and are exposed to drug abuse

As stated before, drug use and, especially, drug abuse is a health and social problem in many countries of the world. Drugs have many negative effects in drug users, developing emotional, psychological and physical diseases on people who consume them. Some studies done around the world associate drugs with antisocial behaviors in drug users. Antisocial behavior refers to, for instance, being disrespectful to community and violate rights. But it is very difficult to define which of those antisocial behaviors occurred before the person started using drugs or after.

Some experiments in Geneva (Switzerland) since 2001 seem to prove that crime is sometimes a consequence of the use of drugs: the Quai 9 experiments, started back in 2001, managed to reduce crime related to the use of drugs in the “city island”.

Quai 9, managed by Première Ligne, offers a reception area for drug users. Open daily from 11h to 19h , the center is located behind the Cornavin train station. Green modules nested into each other are easily spotted.

The Quai 9 accommodates 60 to 80 people per day to about 150 drug taken by injection, inhalation or sniffing. Four employees were on hand to supervise and users . The place provides sterile equipment and a room for safer consumption.

Since 2001 criminal behaviour related to the use of drugs has been reduced in the city.

Drug abuse and behaviour

It is known that drugs change the behavior of the person who consume them, as well as the personality. Besides, it has been shown that some persons tend to consume more than others.

Drug consume does not lead to abuse in all cases. Moreover, there is no defined level when drug use is casual and when it becomes problematic or drug abuse. It depends on the individual, but we should remember/know that the first decision of teens to consume drugs is usually voluntary. In case of drug addiction, hers/his self-control would vanish and it would be very difficult for him/her to quit drugs without any help.

"Brain-imaging studies from people addicted to drugs show physical changes in areas of the brain that are critical for judgment, decision-making, learning, memory, and behavior

control. Scientists believe that these changes alter the way the brain works and may help explain the compulsive and destructive behaviors of an addicted person."[55]

Drinking alcohol and using drugs at a young age when the brain is no completely developed increases the risk for future addictions (to drugs or alcohol) radically.

We should not define drug addiction or abuse by the amount of substances used or the frequency, but by the consequences of this use. In other words, it would not matter how often one uses drugs, or even if one does not use them much. If drugs become a problem while being at school, at work, with friends or at home with your family, you may probably have an addiction or drug abuse.

"More than 23 million people over the age of 12 are addicted to alcohol and other drugs affecting millions more people -- parents, family members, friends and neighbours. "[56]

Risk Factors

As it is known, risk factors to drug addiction are different depending on the person. There are some individual risk factors which include psychological problems, emotional destabilization, physical or sexual abuse in childhood and post-traumatic stress disorder as a result of it, etc. But there are more factors to keep in mind: the genes of the person, the state of mental health and the environment when he/she is involved (family, friends, workmates…). For instance, those who suffered from mental illnesses such as Oppositional Defiant Disorders or Conduct Disorder tend to snort drugs like gasoline or glue. Drugs are frequently used by teens who suffer from mental and eating disorders like bulimia or schizophrenia. Besides, even the method of administration has a certain influence. The main risk factors which increment a person's vulnerability are therefore the following:

- The age of the first contact with drugs
- The social environment of the person (family, friends…)
- Mental disseases suffered from the person (if any)

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[55] National Institute on Drug Abuse

https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction

[56] Drug Abuse Kills 200,000 People Each Year: UN Report

http://www.drugfree.org/join-together/drug-abuse-kills-200000-people-each-year-un-report/

- Traumatic experiences, specially in childhood (if any)
- The habits the person has

As we can see, mental health or mental problems and drug consumption are sometimes linked. But it is difficult to determine which comes first. When teens are feeling depressed or they want to try new experiences use drugs to feel better. Nevertheless, some teens who use drugs can feel worse and depressed because of the use of drugs. The reaction can change depending on the individual's character. Adolescents who had no friends or strong friendships when they were children tend to abuse drugs and some other substances more than those who had many friends. Moreover, if they are feeling bad because they feel like they do not belong to anywhere or to anybody, it could be more than likely that they will find a compatible group of friends who consume drugs. So, it's probably that they will feel under pressure to consume substances and not to resist temptation.

Many factors are determining to identify the person who is likely to consume and abuse substances and those who are not so susceptible to take them. There have been identified two types of factors: risk factors and protective factors.

"*A protective factor can be defined as a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.*

Conversely, a risk factor can be defined as a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes."[57]

However, these factors are not completely decisive and may not affect all people in the same way. In fact, they affect mostly to a child's development and growth process.

What is true is that, if a person has many risk factors, she or he will probably start consuming drugs or abuse them easily than the ones who present less risk factors in life. Besides, if they usually use them, they can become addicted in the long run.

Nevertheless, some teens could have all of these risk factors but never use drugs or even try them. Why? Due to the many protective factors featured in the individual, family and community levels.

[57] O'Connell, Boat, & Warner, 2009 p. xxvii

These might include, at the individual level, a good sense of discipline, healthy self-esteem, good problem-solving skills, good self-expression abilities, a good ability to recognize and communicate emotions, an ability to maintain mental well being and to cope with stress or anxiety and an ability to establish personal goals.

At the family level, strong, healthy parental bonding and consistent family rules may help to protect family members from risky behaviour.

At the community level, the protective factors include attending a school that has explicit policies on substance abuse and living in a safe and caring community that supports the well-being of its members. Sadly, once a person starts abusing drugs, the risk factors tend to outweigh the protective factors.

Risk factors such as poverty, the availability of drugs and alienation grow even stronger as a person becomes more dependent on drugs. The good news is that the protective factors can be strengthened if young people learn new and improve existing skills before they experiment with or start abusing drugs.[58]

The table below describes how risk and protective factors affect people in five domains, or settings, where interventions can take place.

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

Preventing Drug Abuse among Children and Adolescents: Risk Factors and Protective Factors,National Institute on Drug Abuse (NIDA)
https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors

[58] United Nations Office on Drugs and Crime"

https://www.unodc.org/documents/drug-prevention-and-treatment/discussion_guide_final_2012_04.pdf

Reasons/Causes

There are many reasons and causes why teenagers drug abuse. The pressure on the individual to be accepted by a group who take drugs, or the wish to look great and super would be some of them. But there are many other causes that push teens to start using or abusing drugs. As we said, every person in the world is different, so the range of reasons to start taking drugs is very large. Some of the main reasons are explained in the next paragraphs:

• ***Lack of information and disinformation***

Many young people tend to ask friends for information about alcohol and other substances. Occasionally these friends tell them that the risks of consuming drugs are only a few. Many times they surf the net looking for information, and sometimes they find misinformation. So, to avoid this, family and schools have to inform and educate children about the effects and consequences of drugs by drug prevention programmes.

• ***Curiosity***

It is one of the main reasons to start using drugs. Adolescents usually want to try new experiences. Young people have heard about alcohol and drugs at school, home, media… or even have seen their friends or relatives using them and acting differently or having fun and want to experience them for themselves. So, it is usual that they want to experience how are they feeling when drinking alcohol or taking drugs.

• ***Lack of Confidence in Themselves***

Alcohol and spirits are stimulating substances. It inhibits the consumer's feelings of embarrassment, so many young people who lack confidence use them to deal with shyness. In this way they dance even if they don't used to, they flirt with other teens… They speak even with people who in other conditions would not speak to. They all have something in common, so nobody will isolate a person because of messing around. Moreover, they will laugh with you and think just you are drunk.

• ***Cost or price of drugs***

Young people often think of their wallets and saving money. We know that the gramme of cannabis costs about 6 euro, so teens have enough to smoke several joints. A beer costs between 2 and 6 euros, depending on the country. So, considering the effects after consuming them, teens sometimes prefer to pay a bit more for cannabis rather than for a beer. The same happens to other hard drugs.

• ***Because of other people, friends…***

Many adolescents are used to see people using drugs around them. They usually are in contact with adults (or even other teens) who smoke, drink alcohol and sometimes consume substances. So they are used to that environment. Sometimes even their parents offered them alcohol such as beer or wine. So it is easy for young people to start using drugs or alcohol because they are used to this milieu/atmosphere and they think it is normal to experience that when young.

• ***Rebellion***

Many teenagers use different kind of drugs depending on how their personality is. They want to be unique and "cool" so they use substances to express themselves and provoke their family or want them to get angry.

"Alcohol is the drug of choice for the angry teenager because it frees him to behave aggressively. Methamphetamine, or meth, also encourage aggressive, violent behavior, and can be far more dangerous and potent than alcohol. Marijuana, on the other hand, often seems to reduce aggression and is more of an avoidance drug. LSD and hallucinogens are also escape drugs, often used by young people who feel misunderstood and may long to escape to a more idealistic, kind world. Smoking cigarettes can be a form of rebellion to flaunt their independence and make their parents angry."[59]

• ***Environment***

[59] Partnership to Drug-Free Kids

http://www.drugfree.org/resources/top-8-reasons-why-teens-try-alcohol-and-drugs/

The environment surrounding the person can be a reason for the teens to consume drugs. The most important factors are the family's religion, faiths and attitudes and friends pressure to consume them. Family plays an important role because it is the main base in teenagers' development. Not only because they start socializing in this period of life but also because puberty is where they search for basic patterns to orientation in life. Basicly, family is the main area for teens to develop values, attitudes and skills so it is very important for parents to supervise and communicate with children. Those who live with irresponsible, heedless and violent parents are more tend to be drug addicts.

It is demonstrated that drug-abuse is more usual in surroundings which it is common or almost permissible. There are some places where drug trafficking is the daily bread and many people earn money doing it. So, if children grow up in a community with high unemployment and poverty the probability to use drugs would be high. Moreover, gender of the person, religion or ethnic could help to it too.

Nevertheless, drug-abuse does not exist only in areas of greatest poverty. It is a problem which exists in all around the world and affects to people from all walks of life.

- ***Family precedent***

As we said before, family is the main pillar and role model for children. When a teen consumes drugs or alcohol, a dependence or addiction could be develop because of genes. Drugs affect differently to every person and some people become addicted easily than others. If people have some family precedent of drug-abuse or alcoholism, they are 4 times more likely to develop them.

- ***Media***

Means of communication influence in people's point of view, opinions, values and so on. We receive lots of messages from television, advertisements, radio, internet… and usually some of them promote legal substances such as alcohol or medicines. In some countries, however, advertising tobacco is totally banned now. What is more, there are many promotions and marketing strategies the alcohol brands use. Some sports even use them as financial support or sponsorship. Underage people can easily get alcohol, tobacco or even illegal drugs, in spite of the banning to sell them to minors.

"Forty-seven percent of teens agreed that movies and TV shows make drugs seem like an OK thing to do, according to a 2011 study." [60] So, young people are tempted to consume drugs by media. Tobacco and alcohol industry tempt young people to consume them. Media show us men and women drinking alcohol and smoking cigarettes, and they look elegant and successful. The smoking man seems interesting and rebel, and the smoking woman is sexy and does whatever she wants. They use some other strategies such as connection between alcohol and success, alcohol and sex, alcohol and friendship and alcohol with sports.

• ***Escape reality***

Some children may not feel well or happy in their everyday life. For some of them, drugs are the way to escape from that reality. The effects of drugs do not last much time but the time they are under the influence of them, teens will feel much better and can forget their grim reality.

Social interactions between children who commits drug crimes & children who uses drugs and others

Friends play a very important role in the world of adolescents. This fact has been demonstrated noting the similarity of behavior among members of a group. Most of the teenagers drug users are introduced into consumption by friends , either because peers pressure them or because they need to feel accepted by the group. Teens intend to develop activities valued by their peers, independently from the fact that these are socially accepted or not. There is a highly significant correlation between consumer interaction teenage friends and their own consumption. It has been shown that teenagers who use drugs are more likely to have friends who consume than a non-user consumers. There is also a strong relationship between consumer perception of friends and own consumption. When changes occur in these perceptions they are also produced variations in consumption (Epstein et al., 1995).

Sometimes when kids cannot reach the same level of achievement than their peers, for one reason or other, this situation increases the likelihood to have problem behaviors in the classroom. This mismatch may induce them to unconventional partners. It seems that in some schools deviant behavior rates are lower; these schools classes are relevant and interesting to students; students will recognize their progress; relations between students and teachers are

[60] Partnership to Drug-Free Kids http://www.drugfree.org/resources/top-8-reasons-why-teens-try-alcohol-and-drugs/

satisfactory. This improves academic performance, increases self-esteem and improves control of the students about themselves.[61]

"A study published in the journal Psychopharmacology shows a common denominator: when a teen's social life turns south, drug abuse can follow. The study starts by pointing out that animals from mice to humans define themselves by social interactions – good social interactions reinforce our sense of self-worth and bad social interaction undermine this sense of self-worth. So we seek out positive social interactions: mice will choose the arm of a maze that lets them interact with a playful rather than drugged peer and the authors point out that teenagers' "social play" helps them form opinions about themselves.

Drugs change teens' desire and ability to be social up to a certain point and depending upon the drug of abuse. Opiods and alcohol make teens more social and cannabinoids and stimulants make teens less social.

First, all flavors of disruptive behavior disorders, including anti-social personality disorder, conduct disorder and oppositional-defiant disorder, go hand-in-hand with addiction. All of these disorders can decrease confidence and the ability to assess social cues. Subsequently, children and teens who struggle these disorders (and the disorder's affect on the ways they relate to others) are more than twice as likely as their peers to develop substance abuse problems, and tend to start earlier and use more aggressively.

Social isolation is also a major risk factor for teen drug abuse. In fact, the authors write that isolation "changes the neural substrate of reward and motivation." The brain of a socially isolated teen measures risk and reward differently than a social teen, making isolated teens more sensitive to the rewards of drugs. The researchers even show that socialization and drugs work on the same pathways within the brain: drugs are literally a way to attempt to get the neurobiological feeling of social connection.

But not all socialization is good. The authors put it this way: "Social insults in early life increase later drug taking." So be careful when pushing an isolated teen into socialization: healthy socialization may be one of the most protective factors against teen drug use, but negative socialization (i.e. being bullied or socializing with a drug-using peer) is a major risk factor."[62]

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[61] Psicothema, 1996. Vol. 8, nº 2, pp. 257-267- http://www.psicothema.com/pdf/24.pdf

[62] Eric Schmidt - CEO of New Roads Treatment Centers http://blogs.psychcentral.com/addiction-under-30/2014/05/how-teen-social-life-affects-drug-abuse-and-how-drug-abuse-affects-social-life/

"Many of the negative stereotypes that surround people who abuse drugs come from the way they are most often seen in public. Television and other media may portray people who abuse drugs as irrational, their unpredictable behaviour frightening. Heavy or dependent drugs users have often lost their job and/or home and lack many of the physical conditions needed for a healthy and productive lifestyle. The negative stereotypes, stigma and prejudice assigned to people who abuse drugs usually complicate the problem and make it difficult for those in need of treatment and social support to get help. People who abuse drugs are often cut off from their communities and relationships and often homeless and living on the streets."[63]

"Regular cocaine users have difficulties in feeling empathy for others and they exhibit less prosocial behavior. A study at the Psychiatric Hospital of the University of Zurich now suggests that cocaine users have social deficits because social contacts are less rewarding for them. Social skills should therefore be trained during the treatment of cocaine addiction.

In Europe as well as worldwide, cocaine is the second most frequently used drug after cannabis. Chronic cocaine users display worse memory performance, concentration difficulties, and attentional deficits but also their social skills are affected as previous studies at the Psychiatric Hospital of the University of Zurich suggested.

These investigations also revealed that cocaine users have difficulties to take the mental perspective of others, show less emotional empathy, find it more difficult to recognize emotions from voices, behave in a less prosocial manner in social interactions, and they reported fewer social contacts. Moreover, worse emotional empathy was correlated with a smaller social network.

The scientists now assume that social cognitive deficits contribute to the development and perpetuation of cocaine addiction."[64]

[63] UNODC Youth Initiative - DISCUSSION GUIDE

https://www.unodc.org/documents/drug-prevention-and-treatment/discussion_guide_final_2012_04.pdf

[64] University of Zurich. "Cocaine users enjoy social interactions less."

ScienceDaily. ScienceDaily, 20 January 2014. www.sciencedaily.com/releases/2014/01/140120173338.htm

Signs of drug abuse, addiction, and drug-crimes (selling, etc) among children (Offender and victim characteristics)

Signs of drug abuse and addiction: European School Survey Project on Alcohol and Other Drugs

The most recent ESPAD Survey (in 2011, covering 36 European, countries) found that, among 15 to 16-year-old:

On average, 54% of the students in participating countries reported that they had smoked cigarettes at least once and 28% that they had used cigarettes during the past 30 days. 2% of all students had smoked at least a packet of cigarettes per day during the past 30 days.

In all ESPAD countries but Iceland, at least 70% of the students have drunk alcohol at least once during their lifetime, with an average of 87% in the 2011 survey.

On average, nearly six in ten students had consumed at least one glass of alcohol at the age of 13 or younger and 12% had been drunk at that age.

Most alcohol-related problems are more common, on average, among boys.

Nearly one in three (29%) of the students in the ESPAD countries perceived cannabis to be (fairly or very) easily available

On average, 21% of the boys and 15% of the girls have tried illicit drugs at least once during their lifetime

The vast majority of the students who have tried illicit drugs have used cannabis.

On average, more girls than boys report non-prescription use of medical drugs (tranquillisers or sedatives)

The average proportion of students having tried alcohol together with pills in order to get high is lower in 2011 (6%) than it was in 1999 (9%)

Prevalence of drug use > School surveys > ESPAD > Other substances (%) > Total

Table permanent link: www.emcdda.europa.eu/data/2015#displayTable:GPS-153-1

Country	Year	Sample 15-16	Cannabis	Inhalants/ volatile substances	Amphetamines	Ecstasy	LSD and other hallucinogens	Cocaine

		years						
Austria								
Belgium	2011	1798	24	7	5	4	3	4
Bulgaria	2011	2217	24	4	7	4	3	4
Croatia	2011	3002	18	28	2	2	2	2
Cyprus	2011	4243	7	8	4	3	4	4
Czech Republic	2011	3913	42	8	2	3	5	1
Denmark	2011	2181	18	4	2	1	1	2
Estonia	2011	2460	24	15	3	3	2	2
Finland	2011	3744	11	10	1	1	1	1
France	2011	2572	39	12	4	3	3	4
Germany	2011	2796	19	10	4	2	2	3
Greece	2011	5908	8	14	2	2	2	1
Hungary	2011	3063	19	10	6	4	3	2
Ireland	2011	2207	18	9	2	2	2	3
Italy	2011	4837	21	3	2	2	3	3
Latvia	2011	2622	24	23	4	4	4	4
Lithuania	2011	2476	20	7	3	2	2	2
Luxembourg								
Malta	2011	3377	10	14	3	3	2	4
Netherlands	2011	:	27	7	1	4	2	2
Norway	2011	2938	5	5	1	1	1	1

Poland	2011	5933	23	8	4	2	3	3
Portugal	2011	1965	16	6	3	3	3	3
Romania	2011	2770	7	7	2	2	2	2
Slovakia	2011	2009	27	10	2	4	4	2
Slovenia	2011	3186	23	20	2	2	2	3
Spain								
Sweden	2011	2569	9	11	1	2	1	1
Turkey								
United Kingdom	2011	1712	25	10	4	4	2	5

(1) In surveys with small sample sizes results should be interpreted with caution.

(2) For methods of each survey presented in this table, see Table GPS-151

(3) 'Sample size' refers to the number of actual respondents to the survey (Net sample). In some cases, national surveys cover originally a broader age range ('original age range') than that presented here for the standard groups 'All adults'(15-64) and 'Young adults' (15-34). Sample sizes are presented respectively for the 'all adults' (15-64), 'young adults' groups (15-34) and 'younger adults' (15-24).

(4) Countries were asked to report results using, as far as possible, EMCDDA standard age groups (all adults: 15-64, young adults: 15-34). In countries where age ranges are more restrictive, prevalence estimates may tend to be slightly higher. Some countries have recalculated their prevalence figures using the EMCDDA standard age groups. For more information on the age ranges see Table GPS-151

(5) This table presents the results for the last surveys available in each country. It aims to present an overview of national surveys. Some city surveys reported by countries were not included as they tend to produce higher prevalence estimates which are not comparable with estimates for whole countries (or large regions with both urban and rural areas).

(6) (1) ESPAD 2011 data for Belgium refer only to Flanders. ESPAD 2011 Germany figures are based in only five out of sixteen federal states (Bundesländer).

(7) Sources: ESPAD (The European School Survey Project on Alcohol and Other Drugs) is coordinated by the Swedish Council for Information on Alcohol and Other Drugs (CAN)

(8) (2) ESPAD 2011 data for the United Kingdom has limited comparability.

(9) This table presents data on 15– to 16-year-old school students obtained from national surveys. In all of the school surveys the method for data collection was classroom based, anonymous, self-completion questionnaires in written test conditions.

(10) ESPAD (European School Survey Project on Alcohol and Other drugs) is coordinated by the Swedish Council for Information on Alcohol and Other drugs (CAN). Collaboration between the ESPAD and the EMCDDA started in 1995. ESPAD prevalence figures are taken from published ESPAD reports and may differ sometimes from those reported directly by Member States. The sample sizes given refer to the number of participating 15- to 16-year-old students who filled in the questionnaire.

(11) Caution is required comparing figures due to methodological limitations. For methods and definitions see Methods and definitions: youth and the schools population.

(12) Italy: The most recent general population survey reported by Italy display a wide variation in results compared with the previous surveys which may reflect methodological differences. The data is provided for information, but given the lack of comparability between surveys should be treated with caution.

(13) Netherlands: The most recent general population survey reported by the Netherlands display a wide variation in results compared with 2005 which may reflect methodological differences. The data is provided for information, but given the lack of comparability between surveys should be treated with caution.

(14) United Kingdom: Data for the United Kingdom is for England and Wales only.

According to this survey, 1,42% of the youngsters in school aged between 15 and 16 years old used drugs in 2011.

Beyond the results of this school survey, the “Opinion of the European Economic and Social Committee on The prevention of juvenile delinquency. Ways of dealing with juvenile delinquency and the role of the juvenile justice system in the European Union (2006/C 110/13)”, among the causes of juvenile delinquency listed, under artt. 2.1.6 and 2.1.7, both drug and alcohol abuse, and behavioural disorders caused by the same: “

2.1.6 Abuse of drugs and toxic substances which often causes the addict to commit crimes in order to support his/her addiction. Also, when suffering the effects of these substances or withdrawal symptoms, the usual inhibitions are lowered or removed. Excessive alcohol consumption (even if occasional) should also be mentioned here, as it plays a major role in vandalism and dangerous driving.

2.1.7 Personality and behaviour disorders, either in association with or independently of the factor outlined in the previous point. These usually conspire with other social or environmental factors to make young people act impulsively or unthinkingly, uninfluenced by socially accepted standards of behaviour."

Source: Official Journal of the European Union, 9.5.2006.

The EMCDDA statistical bulletin (http://www.emcdda.europa.eu/stats12) indicates, for the year 2012, the following information (for tables see the following pages):

- TABLE GPS-1. Lifetime prevalence of drug use by age and country, in accordance with the most recent national population survey available (for age 15-24)

- TABLE EYE-9. HBSC school surveys (2009/2010): percentage of lifetime prevalence of cannabis use among students aged 15-16 years old HSBC school surveys (20019/2010)

- TABLE TDI-10. Age distributions and primary drug distributions - EU summary of clients entering treatment, 2010 or most recent year available

- TABLE TDI-25. Age distribution of all clients entering outpatient treatment by primary drug and gender, 2010 or most recent year available

- TABLE TDI-103. All clients entering outpatient treatment by primary drug and age, 2010 or most recent year available.

Table GPS-1. Lifetime prevalence of drug use by age and country, most recent national general population survey available since 2000.

Part (iv) Youth (15 - 24).

Country		Geographical Area	Year	Reference	Age range (15–24)	Sample size (15–24)	Cannabis (%)	Cocaine (%) (1)	Amphetamines (%) (2)	Ecstasy (%) (3)	LSD (%)
Belgium		National	2008	(7)	15–24	1210	21.2	:	:	:	:
Bulgaria		National	2008	(3)	15–24	1087	17.0	3.6	6.1	4.2	0.6
Czech Republic		National	2010	(6)	15–24	270	52.2	0.4	2.2	7.4	3.7
Czech Republic		National	2010	(7)	15–24	271	40.2	1.5	6.6	16.6	5.2
Denmark		National	2010	(6)	16–24	1671	38.0	6.4	7.5	4.6	1.2
Germany		National	2009	(8)	18–24	:	34.6	3.8	4.9	3.7	1.1
Estonia		National	2008	(3)	15–24	243	:	:	:	:	:
Ireland		National	2010–11	(6)	15–24	:	25.9	5.0	3.8	5.7	2.0
Greece		National (except Aegean and Ionian Islands)	2004	(3)	15–24	1785	9.0	0.6	0.2	0.4	0.5
Spain		National	2009	(8)	15–24	:	39.1	9.2	4.7	6.4	:
France		National	2010	(7)	15–24	3430	38.1	4.2	1.6	2.5	1.4
Italy		National	2008	(4)	15–24	3475	34.2	4.9	2.1	2.3	:
Cyprus		National	2009	(2)	15–24	982	14.4	3.1	1.0	3.1	1.8
Latvia		National	2007	(2)	15–24	1855	24.9	4.0	7.0	9.4	2.5
Lithuania		National	2008	(2)	15–24	1165	23.8	0.8	3.4	4.4	0.4
Luxembourg		:	:	:	:	:	:	:	:	:	:
Hungary		National	2007	(3)	18–24	433	25.1	1.9	4.9	6.8	2.7
Malta		National	2001	(1)	18–24	287	4.9	1.1	1.1	1.7	1.6
Netherlands	(4)	National	2009	(4)	15–24	1074	31.1	4.8	3.1	6.0	:
Austria		National	2008	(2)	15–24	2085	23.6	4.0	4.1	5.3	2.5
Poland		National	2006	(2)	15–24	1135	17.3	1.1	4.8	2.3	1.7
Portugal		National	2007	(2)	15–24	2211	15.1	1.4	0.8	2.1	0.6
Romania		National	2010	(3)	15–24	1458	3.0	0.7	0.2	0.9	0.0
Slovenia		National	2007	(1)	15–24	338	:	:	:	:	:
Slovakia		National	2006	(6)	15–24	287	31.3	2.5	3.6	9.9	:
Finland		National	2010	(8)	15–24	411	21.1	0.8	1.9	1.7	1.3
Sweden		National	2008	(5)	15–24	7787	15.3	2.4	3.9	2.1	:
Sweden		National	2010	(12)	16–24	1023	15.2	:	:	:	:
United Kingdom		England and Wales	2010-11	(14)	16–24	3665	34.5	10.1	8.9	9.5	2.6
United Kingdom		Northern Ireland	2008-09	(19)	16–24	286	27.5	6.6	7.8	12.2	3.4
United Kingdom		Scotland	2009-10	(24)	16–24	1157	33.9	12.7	9.1	14.4	3.6
United Kingdom		United Kingdom	2006	(26)	16–24	:	40.1	11.5	11.4	10.7	3.4
Croatia		:	:	:	:	:	:	:	:	:	:
Turkey		:	:	:	:	:	:	:	:	:	:
Norway		National	2009	(3)	15–24	390	18.3	3.1	3.7	1.4	0.2

Table EYE-9. HBSC school surveys (2009/10): percentage lifetime prevalence of cannabis use among students aged 15–16 years old HBSC school surveys (2009/10)

Part (i) All students

Country	Total sample size	Discontinued user	Experimenter	Regular user	Heavy user	Never user
Belgium (Flemish)	1226	4.5	6.9	5.5	1.3	81.8
Belgium (French)	1341	5	5.6	4.9	3.1	81.4
Czech Republic	1522	9.6	11.2	6.2	2.2	70.8
Denmark	1226	4.1	5.5	3.1	1	86.3
Germany	1640	3.1	4.6	2.1	0.8	89.5
Estonia	1398	7.3	8.4	3.9	0.9	79.5
Ireland	1695	2	5.1	3.9	2	86.9
Greece	1648	1.3	2.4	1.6	1	93.7
Spain	2003	4	10.4	7.9	3.5	74.4
France	1906	4.6	9.3	7.6	2.7	75.8
Italy	1546	2.9	6	6.6	1.9	82.7
Latvia	1375	7	10.9	3.7	1.1	77.2
Lithuania	1792	7.6	9	3.4	0.7	79.3
Luxembourg	1382	4.1	5.4	4.9	2.9	82.6
Hungary	1733	4.8	5.6	2.5	0.8	86.3
Netherlands	1457	3.8	6.9	6.2	1.6	81.5
Austria	1820	3.3	4	3.1	1.8	87.9
Poland	1410	4.2	7	4.7	1	83
Portugal	1553	2.4	3.8	2.6	1.1	90
Romania	2002	2.6	3.7	1.3	0.3	92.2
Slovenia	1815	5.7	8.1	4.5	2.9	78.7
Slovakia	1914	4.4	6.9	3.6	0.8	84.3
Finland	2110	1.2	5.3	1.4	0.6	91.5
England	1118	4.7	7.2	5.1	1.9	81
Scotland	2567	3.5	6.6	4.7	2.2	83
Wales	1637	2.4	6.9	5.2	3	82.6
Croatia	2424	3.3	5.6	2.7	1.2	87.2

Table TDI-10. Age distributions and primary drug distributions — EU summary of clients entering treatment, 2010 or most recent year available

Part (i) New outpatient clients, age distribution by primary drug (%)

Substance	<15	15–19	20–24	25–29	30–34	35–39	40–44	45+	Mean age	Age known (base)	Age not known
Opioids	0.1	4.7	17.5	21.7	19.5	15.2	11.2	10.2	32.4	41279	381
Cocaine	0.1	5.1	16.9	23.6	21.1	15.7	9.4	8.1	31.8	30161	1830
Stimulants	0.9	17.5	27.1	20.7	14.4	9.1	5.7	4.6	27.7	6740	47
Hypnotics and sedatives	0.5	7.3	12.5	12.2	12.2	11.3	11.4	32.6	36.0	3029	94
Hallucinogens	1.9	24.3	32.3	21.2	8.6	4.8	3.6	3.3	25.3	690	0
Volatile substances	30.4	40.2	9.2	7.6	4.7	2.9	4.0	1.1	20.1	448	5
Cannabis	4.2	35.3	25.3	15.0	8.7	5.4	3.4	2.8	24.1	54418	965
Other substances	1.9	16.3	13.1	11.1	9.4	11.6	10.2	26.4	33.4	1868	4
Total	1.9	17.8	20.8	19.0	15.0	10.9	7.4	7.2	28.8	138633	3326

Table TDI-25. Age distribution of all clients entering outpatient treatment by primary drug and gender, 2010 or most recent year available

Age group	Opioids		Cocaine		Stimulants		Cannabis	
	Male	Female	Male	Female	Male	Female	Male	Female
<15	0.0%	0.1%	0.1%	0.2%	0.4%	1.0%	3.1%	5.9%
15–19	1.6%	4.1%	3.4%	6.3%	10.2%	17.4%	30.1%	33.8%
20–24	9.8%	17.1%	14.4%	15.8%	24.5%	25.4%	26.5%	22.0%
25–29	19.7%	23.3%	22.0%	22.5%	23.4%	20.9%	17.1%	15.2%
30–34	22.0%	20.2%	22.0%	20.2%	17.3%	14.9%	10.1%	8.7%
35–39	19.4%	14.6%	17.2%	16.1%	11.2%	8.6%	6.1%	5.8%
40–45	14.6%	10.8%	11.3%	10.3%	6.7%	6.3%	3.8%	4.4%
45 +	12.7%	9.9%	9.6%	8.4%	6.3%	5.6%	3.2%	4.1%
Total	136078	39767	48013	8898	11251	4638	82160	15451

Table TDI-103. All clients entering outpatient treatment by primary drug and age, 2010 or most recent year available

Part (i) All opioid outpatient clients by country and age

Country		<15	15-19	20-24	25-29	30-34	35-39	40-44	45+	Age known	Age not known	Total
Belgium	1	0	29	104	188	160	127	91	77	776	9	785
Bulgaria		0	27	173	413	281	47	16	3	960	2	962
Czech Republic		1	26	104	187	254	62	21	27	682	4	686
Denmark		0	18	77	148	259	281	246	419	1448	0	1448
Germany		11	402	2940	5701	6107	4818	3953	3877	27809	122	27931
Estonia	2	0	24	92	260	171	61	12	9	629	0	629
Ireland		1	97	481	763	885	581	232	190	3230	5	3235
Greece		0	50	277	620	741	378	274	305	2645	0	2645
Spain	3	5	84	801	1670	2711	3857	3823	3371	16322	1710	18032
France		3	259	2358	3593	2917	2444	1808	1460	14842	21	14863
Italy	4	12	818	2989	3232	3241	3290	3137	2562	19281	20	19301
Cyprus		0	3	35	74	72	52	26	22	284	0	284
Latvia	5	3	31	120	360	232	100	50	58	954	0	954
Lithuania		:	:	:	:	:	:	:	:	:	:	:
Luxembourg		0	2	10	23	23	15	13	9	95	0	95
Hungary		0	8	35	60	77	58	25	5	268	0	268
Malta	6	0	42	259	383	335	273	132	115	1539	4	1543
Netherlands	7	0	9	61	156	224	318	405	640	1813	0	1813
Austria		3	220	624	509	253	150	90	75	1924	0	1924
Poland	8	2	13	38	103	56	19	10	20	261	0	261
Portugal	9	0	29	208	304	392	477	344	290	2044	0	2044
Romania		0	11	107	208	137	40	8	5	516	13	529
Slovenia		0	12	104	235	233	85	34	19	722	0	722
Slovakia		0	11	37	86	94	42	10	3	283	0	283
Finland		0	17	92	121	77	49	12	11	379	0	379
Sweden		0	12	124	135	125	67	68	93	624	0	624
Uk	10	32	1435	7240	14761	15732	13011	8542	6660	67413	0	67413
Croatia		0	55	452	1385	1811	1161	494	445	5803	0	5803
Turkey		:	:	:	:	:	:	:	:	:	:	:
Norway	11	2	10	96	212	275	265	232	418	1510	0	1510
Total		75	3754	20038	35890	37875	32128	24108	21188	175056	1910	176966

Even if data seem low, the trend in entering drug treatment in Europe under 15 years old is increasing. UK, Italy and Germany report most of the cases.

In US, the NCADD (National Council on Alcoholism and Drug Dependence) indicates that:

"***Juvenile Crime***

Four of every five children and teen arrestees in state juvenile justice systems are under the influence of alcohol or drugs while committing their crimes, test positive for drugs, are arrested for committing an alcohol or drug offense, admit having substance abuse and addiction problems, or share some combination of these characteristics.

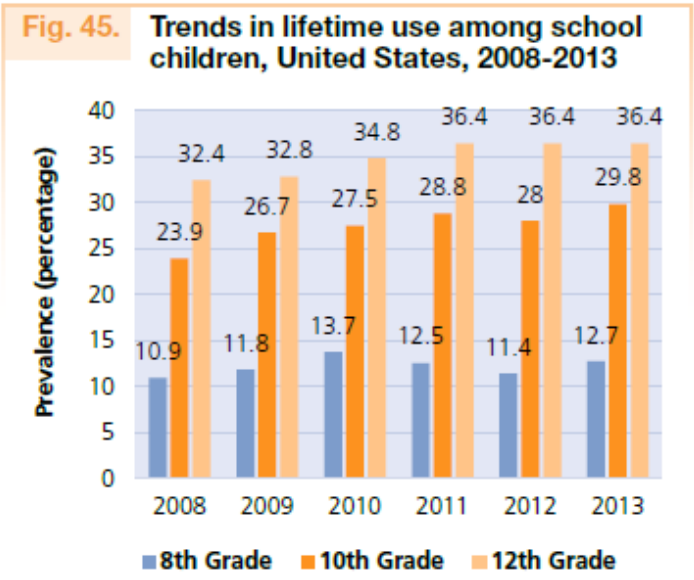
1.9 million of 2.4 million juvenile arrests had substance abuse and addiction involvement, while only 68,600 juveniles received substance abuse treatment.

Alcohol and Violence in College

- Each year, more than 600,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking.
- 95% of all violent crime on college campuses involves the use of alcohol by the assailant, victim or both.
- 90% of acquaintance rape and sexual assault on college campuses involves the use of alcohol by the assailant, victim or both."

source: https://ncadd.org/about-addiction/alcohol-drugs-and-crime

A certain trend with slowly higher rates than in Europe seems to be indicated by another survey, in the US, on the age school children use illicit drugs



Source: Monitoring the Future Survey, United States.

"Initiation and use among youth and young adults is of particular concern due to the established increased risk of harm, such as other drug use and dependent drug use, a risk of heavy dependence, lung problems, memory impairment, psychosocial development problems and mental health problems, and poorer cognitive performance associated with early initiation and persistent use between the early teenage years and adulthood." (World Drug Report 2014, talking about cannabis).

A research by the US Substance Abuse and Mental Health Services Administration has shown initiation of marijuana use before the age of 15 is associated with higher risk of other drug use at 26 or older, and that those who tried marijuana before the age of 15 were six times more likely to be dependent on an illicit drug at 26 or older (relative to those who initiated marijuana at 21 or older ("Initiation of Marijuana Use: Trends, Patterns, and Implications - Joseph C. Gfroerer, Li-Tzy Wu and Michael A. Penne, Rockville, Maryland, 2002).

M. H. Meier and others, "Persistent cannabis users show neuro-psychological decline from childhood to midlife, *Proceedings of the National Academy of Sciences of the United States of America*, vol. 109, No. 40 (October 2012), pp. E2657-E2664.

Signs of drug-crimes among children

"In the Juvenile Justice sector, one of the main problems is the lack of adequate and comprehensive data about children in contact with the law and children at risk. Practitioners starting to plan a children's justice project frequently find, for example, that:

- There is no data about the number or the type of offences committed by children.
- No reliable figures exist for the number of children in prison.
- No figures exist for the children going through the justice system.
- No proper research on issues such as recidivism is available." - p. 20 of the Save the Children Report: "Child Rights and Juvenile Justice" 2016: http://images.savethechildren.it/IT/f/img_pubblicazioni/img287_b.pdf?_ga=1.108760386.170165347.1456316109

Even in this situation where data seem impossible to find, we can assume in the case of drug abuse the same or a very similar age-curve as in the case of general offences.

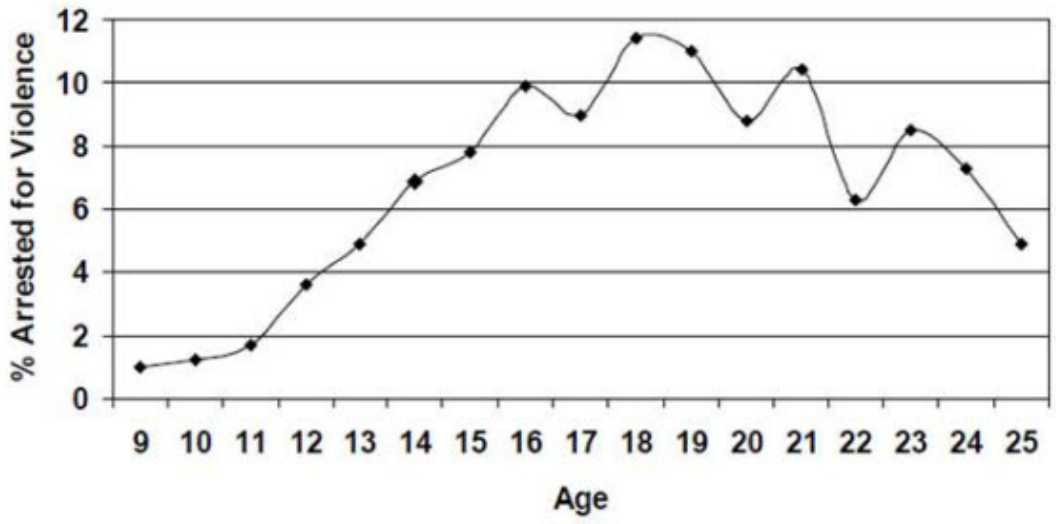


Figure 1: An example of an age-crime curve

Source: Loeber, Rolf, and Rebecca Stallings, "Modeling the Impact of Interventions on Local Indicators of Offending, Victimization, and Incarceration," in Young Homicide Offenders and Victims: Risk Factors, Prediction, and Prevention from Childhood, eds. Rolf Loeber and David P. Farrington, New York: Springer, 2011: 137-152.

For more information on the age-curve issue, please check http://www.nij.gov/topics/crime/Pages/delinquency-to-adult-offending.aspx

In Italy children aged 8 to 10 are involved in drug dealing: from north to south, from Milan to Rome and Naples, children are used by drug dealers in order to survey the street and be the sentinels in case of police actions or controls (source: Italian Drug Observatory:

http://www.osservatoriodroga.it/droga-e-mafia-un-unico-enorme-business/#sthash.EwUAhHva.dpbs)

In UK children are being used as drug mules, sent to surrounding towns and countryside by criminal gangs seeking to expand drug market.
http://www.theguardian.com/society/2014/jan/05/drug-gangs-using-children-as-mules

In France there's been a case of an 11 years old kid trying to sell drugs (cannabis) in the primary school where he was studying: http://www.lefigaro.fr/actualite-france/2013/06/29/01016-20130629ARTFIG00314-un-trafic-de-drogue-demantele-dans-une-ecole-primaire.php

but more cases concern teenagers: drug dealers increased the use of teenagers in their illegal activities and showdowns often concern youngsters aged less than 18. In 2008, in the database of OCRTIS almost 10% of the cannabis dealers in France were under 18 years old; and a third was under 21:
http://www.liberation.fr/societe/2013/05/10/trafic-de-drogue-a-marseille-les-jeunes-en-premiere-ligne_902143

This trend in Europe is also confirmed by other similar behaviours in other parts of the world: http://www.cbsnews.com/news/mexico-drug-gangs-using-more-children-as-mules/

Possible health issues related to drug abuse among children. Precautions?

- Trends in the use of illicit drugs and alcohol are increasing
- HIV, hepatitis, tuberculosis are registering increasing rates (not only out of Europe, but also in the EU)
- Health is an issue when related to drug abuse and prescription drug abuse
- However, the Geneva experiment seems to prove that many health problems are drug related but not drug caused
- Prevention in the families and the need to inform families also about the risks of prescription drug abuse
- Prevention centers

Young people are currently very exposed to drug use because they have access to an increasingly wide range of substances. The trends in the consumption of **illicit drug** use and **alcohol** are increasing. The causes are linked to the willingness to try illicit drugs and the

likelihood of getting drunk - as a social activity and therefore the drug taking behaviour of friends - , but also problems with the family or at school.

The majority of the problems related to health is that "more than 1 out of 10 drug users is a problem drug user, suffering from drug use disorders or drug dependence". Drug dependence occurs when you require one or more drugs. It can also be related to some medical conditions such as high blood pressure, chronic pain. Drud dependence becomes a health concern when one person is abusing illegal or prescription drugs. Addiction and dependence are sometimes interchangeable, but it is possible to be dependent without being addicted or the contrary[65].

Almost half of those problem drug users injecting drugs were living with HIV in 2013, but also hepatitis C and tuberculosis. These are the most common virus related to drug abuses and usually the limited access to prevention and treatment increases the risk of contracting blood-borne viruses. In 45 countries, since 2009, HIV prevalence among young people under 25 years old who inject drugs was 5.2%[66]. HIV prevalence is increasing in Asia, in the Pacific area, in Eastern Europe and central Asia. A 2013 analysis show that people who inject drugs have an elevated risk of death, but the mortality rate depends on settings: there is higher mortality in low-and-middle-income countries than in high-income countries. Drug overdose and AIDS-related illness are in any case the primary causes of death[67].

According to the United Nations Office on Drugs and Crime, only one out of every six problem drug users in the world has access to treatment, as many countries have a large shortfall in the provision of services.

Moreover, "the annual number of drug-related deaths (estimated at 187,100 in 2013) has remained relatively unchanged. An unacceptable number of drug users continue to lose their lives prematurely, often as a result of overdose, even though overdose-related deaths are preventable"[68]. This is also linked to the fact that the majority of young people have no access to evidence-informed HIV prevention and treatment services, to information about drugs and their effects. Education is needed. Prevention should be firstly related to the knowledge and the

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[65] http://www.healthline.com/health/drug-dependence#Addictionvs.Dependence2

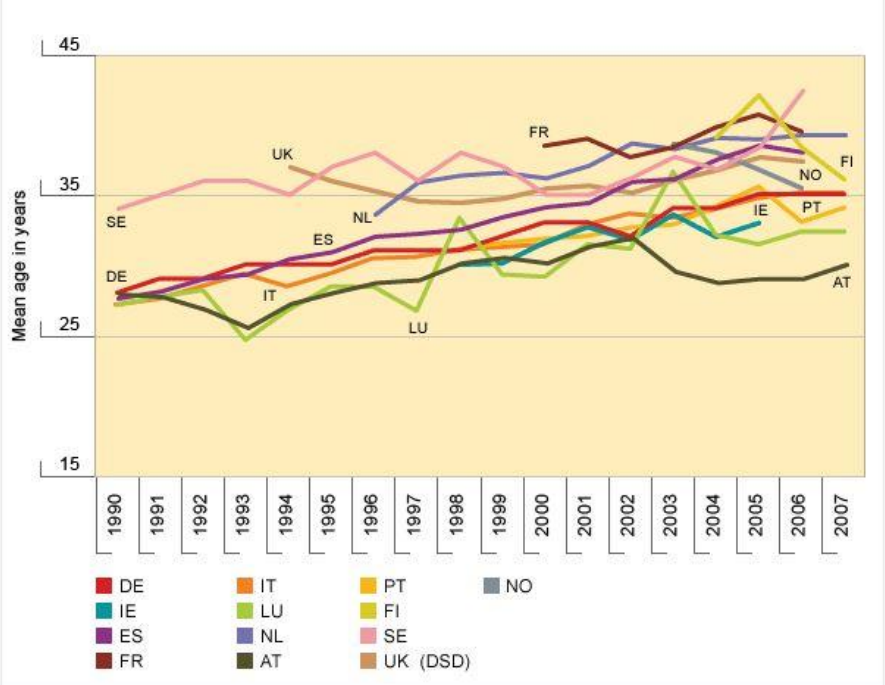
[66] http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

[67] Gap Report, http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf, p. 73-74.

[68] http://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf, p.9

awareness of risks: It is important to get a confidential HIV test; testing is the first step of the medical care and prevention, it can improve health and save lives. Health care providers should, according to the Centers of Disease Control and Prevention, follow current HIV tests and treatment guidelines, educate parents and young people about the risks.

Trends in the mean age of drug-induced deaths in some EU Member state, 1990 to 2007



The figure represents data from countries that reported the mean age of victims for most years during the reporting period. From: Reitox national reports 2008, taken from national mortality registries or special registries (forensic or police), available on http://www.emcdda.europa.eu/html.cfm/index77540EN.html?type=stats&stat_

Drug-related consequences among very young people (from EMCDDA 2007 report - http://www.emcdda.europa.eu/attachements.cfm/att_44741_EN_TDSI07001ENC.pdf):

Only a very small number of under-15s enter treatment because of use of illicit substances. In 2005, 17 EU Member States and Turkey reported around 3 300 clients under 15 years old entering drug treatment, which represents around 1 % of all drug clients (3). In most European countries, less than 1 % of drug clients are under 15 years old and in seven countries the proportion is between 1 % and 2 %. Only Romania has a higher rate, with 3 % of drug clients under 15 years old, but total figures are low in this case.

Even if the figures reported are low, the report itself indicates, among possible explanations, the fact that access to treatment is difficult, especially for marginalized groups. Moreover, the report also indicates that "some children with drug-use problems as well as other concomitant problems might be captured in social services registers although their drug problems remain unrecorded" (idem, p. 11). If to this we add the fact that these data might be under-reported for privacy reasons, the small percentage is no longer a "relief".

A dramatic situation for instance emerges when considering children and in particular categories at risk, such as the "street kids". According to UNICEF, a third of new cases of HIV infection in 2010 was concerning the 15-24 age group ("Blame and Banishment", 2010, UNICEF). In Eastern Europe HIV infection rates are increasing and street children (the so-called thrownaway children) are at risk, especially those using drugs.

Even when considering all categories (not only the ones at risk), in six years (1999 - 2005) the number of under 15 years old entering drug treatment in Europe increased of 330% (from 1000 to 3300, most of the cases being registered in UK).

However, while in 2007

The large majority of under-15s who enter treatment do so for primary cannabis use, and to a lesser extent for use of inhalants; only a very small proportion of young drug clients use opioids or other substances as their primary drug (5). Countries reporting a non-trivial number of clients under 15 years old in treatment for drug use are Germany, Ireland, Spain, France, Italy and the United Kingdom; and Germany, Italy and the United Kingdom report some opioid users among clients under 15 years (6). The gender distribution among drug clients shows a higher proportion of girls in the youngest age group: there are 2.5 boys for every girl among clients under 15 years old, while among clients over 19 years old the gender ratio is 4.1 to 1 (7). This might be related to several factors: the narrowing gap between males and females in social behaviours, including drug use; the fact that young girls may be introduced to drug use by an older male partner; the delayed psychosocial development among boys compared with girls; the role played by psychiatric co-morbidity or preceding disorders earlier in childhood.

(2007 EMCDDA Report), in 2012 the table TDI-10 (see below) reports a completely diverse situation: 30,4% of young drug clients entering treatments use volatile substances as primary drug, while 4,2% use cannabis.

Prevention

a)Prevention in the families

Seen the general framework, prevention is very important and should start from the family: families are the strongest factor in protecting children from drug use. Families should be supported and helped through psychological assistance and programmes, which can give them the strength to support then their children, increasing their skills concerning the problem solving, and increasing their ability in communicating and building trusting relationships.

However, in some cases, it is the same family who - while trying to help own children - risk to wrongly manage the issue. It is the case of some **prescription drug abuse** (one of the most known could be Ritalin - http://ritalinsideeffects.net/ or http://learn.genetics.utah.edu/content/addiction/ritalin/). Being cheap, accessible and being prescription drugs, the common perception is that they are safe safe. However, long term side effects have not been analysed in depth. Moreover, the Ritalin studies show that "ADHD

children are typically taken off of Ritalin when they reach adulthood. Interestingly, these individuals seem to be more prone to cocaine addiction."

b) Prevention centers

Prevention centers

APPROACHING THE VICTIM/OFFENDER

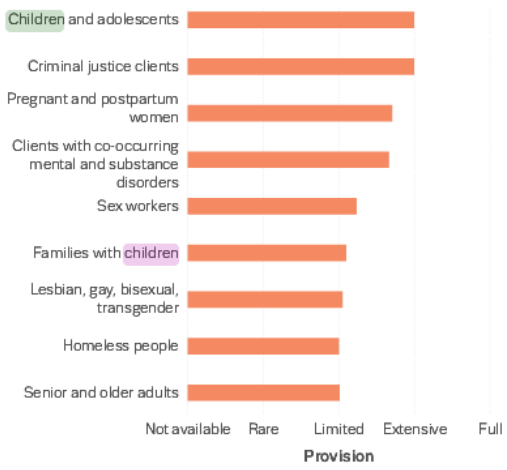
Approaching children engaged in drug abuse can be done trough target interventions, if needed extending them to members of the family dealing with substances abuse.

Responding to diverse needs though targeted interventions

Targeted interventions can facilitate access to treatment and ensure that the needs of different groups are met. The available information suggests that this kind of approach is currently most commonly available to young drug users, those referred from the criminal justice system and pregnant women (Figure 3.8). Targeted programmes for homeless drug users, older drug users and lesbian, gay, bisexual and transgender drug users were less frequently available, despite many countries reporting that there was a need for this kind of provision.

FIGURE 3.8

Availability of drug treatment programmes for target groups in Europe (expert ratings, 2013)



Source:

http://www.emcdda.europa.eu/attachements.cfm/att_239505_EN_TDAT15001ENN.pdf, pag. 69, European Drug Report 2015

Cannabis-specific treatment available in half of countries

The provision of cannabis-specific treatment is increasing in Europe, with half of the countries now reporting its availability. Elsewhere, cannabis treatment is provided within general substance use programmes (Figure 3.9). Services for cannabis users can be diverse, ranging from brief interventions delivered online, to long-term therapeutic engagement in specialist centres. Although most treatment for this group takes place in community or outpatient settings this is not always the case, with around one in five of those entering specialist inpatient drug treatment services now being reported to have a primary cannabis-related problem.

Treatment for cannabis problems utilises psychosocial approaches; family based interventions are often used for adolescents and cognitive-behavioural interventions for adults. The available evidence supports the use of a combination of cognitive-behavioural therapy, motivational interviewing and contingency management approaches. In addition, there is some evidence to support the use of multidimensional family therapy for young cannabis users.

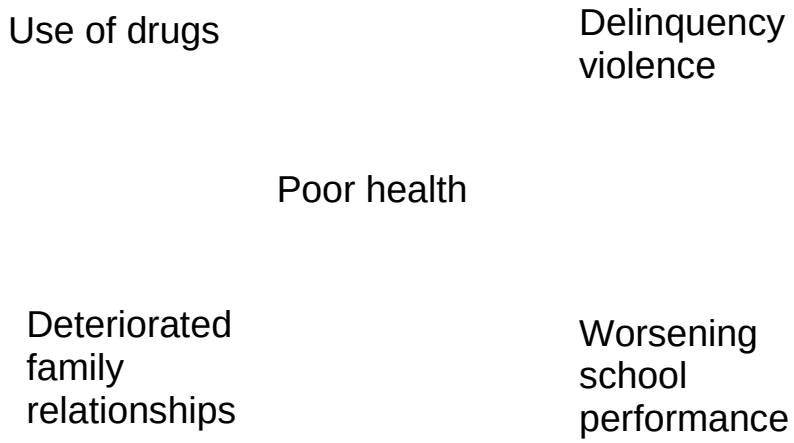
The penalties for crimes committed by minors in Europe depend from country to country and from one type of offense to another: for instance the amount of illegal substance, the actions taken, the type of substance. The majority of minors, however, are charged with possession, sale, and / or intent to distribute.

As stated, penalties for juvenile narcotic crimes range from long-term incarceration to penalties focusing only on the rehabilitation of children/teens having committed the crime. The decision of the judge is generally influenced by the criminal history of the minor, by the nature of the circumstances and, obviously, by the crime committed. Mandatory rehabilitation is often used if the crime has been committed because of a developed addiction.

The most common forms of alternative sentencing are the following:

- supervised or unsupervised probation
- community service
- house arrest
- AA (Alcoholics Anonymous) or NA (Narcotics Anonymous) meetings
- therapy sessions / behavioural management programme

The Drug Crime Cycle:



This is not to say that drug use necessarily leads to violent behaviour or to criminal activity. Moreover, the cycle scheme is not exhaustive, as other factors might incur: social, psychological problems, etc.

In other words, the relationship among juvenile drug use, drug treatment, and crime is complex and chamaleontic and therefore cannot be simplified using arrows taking from one factor to another (i.e. poverty doe snot necessarily bring to drug use; drug use does not necessarily lead to crime; etc.). The general framework is rather the result of various factors influencing all others and creating, upon the base of the initial elements (personality, culture, ethnicity, etc.), a new matrix.

Dealing with such a complex reality obliges policy makers and decision makers, however, to generalize this complex reality in order to create general programmes and common rules.

The approaches leading to better results are those including three elements:

- competency development (for the offender),
- offender accountability (towards the community: a way to repair the "damage"/ to repay the bad action) and
- safety of the community itself (monitoring the behaviour of the juvenile offender).

For more information about this approach: https://www.ncjrs.gov/pdffiles1/nij/186156.pdf

Lipsey's meta-analysis on deterrence programmes and recidivism (1999) combining the results of more than 200 studies on juvenile institutionalized programmes and in community based programmes found that the most promising effects on recidivism occured within programmes incorporating individual counselling, the development of interpersonal skills, multiple services and some behavioural therapy (family, for instance). Jones and Wyant (2007:

765) found the same relationship between programmes helping offenders to build interpersonal skills and a decrease of recidivism rates.

The entire study is available at: http://www.children.gov.on.ca/htdocs/English/topics/youthandthelaw/roots/volume5/preventing05_rehabilitation_strategies.aspx

But here we reported the main finding:

What is Effective:

- Targeting the changeable characteristics of offenders that are directly linked to offending, such as drug use, anti-social attitudes and behaviour, and poor anger management
- Programs that maintain high program integrity through adhering to original program design and monitoring program implementation and offering comprehensive training to staff
- Programs that adhere to the principles of risk, need and responsivity
- Community-based treatment, although this does not preclude success in correctional facilities as well
- Community residential programs for institutionalized offenders
- Teaching family homes within correctional settings
- Treatment that is delivered by service providers other than criminal justice personnel
- Cognitive-behavioural approaches
- Individual counselling, group counselling and guided group therapy
- Family therapy
- Multi-systemic therapy (MST)
- Inter-personal skills training
- Programs that are longer than six months but, at the same time, have reduced contact hours for youth being treated in the community
- Programs that have been well established (i.e., that have been in existence for more than two years)

The role of the family in treating drug addiction

Evidence shows that involving family members in the treatment of their relatives affected by drug addiction is important for at least two reasons: to alleviate the symptoms of stress and their consequences in family members, and to improve the effectiveness of treatment (Orford et al., 2010). Copello and colleagues (2005) identified three main types of family-based interventions, and presented evidence to support the effectiveness of all three types: those aimed at the involvement of the family to promote the entry of the substance user into treatment; interventions which involve the family in the treatment itself; interventions aimed at supporting the family members. Other reviews have shown that family-oriented interventions also decrease behaviours and situations that facilitate substance use, by modifying the emotional environment linked to substance use. A review study in Germany that assessed services aimed at drug-using parents identified a systematic family-oriented approach as an important conceptual element in work with families with addiction problems. Group services (support groups, individual counselling, case counselling, weekend seminars, crisis intervention and parent training courses), public-relations work (awareness of services), administration (planning of resources) and supporting services (childcare while parents take part in activities or family seminars) are also key elements that contribute to the success of the programmes. Initiating contact with help agencies is often difficult for drug-using parents; feelings of embarrassment and shame, and fear of losing their children were identified as major barriers to seeking care. Outreach and referral by other – often non-drug-related – services may help parents overcome these barriers.

http://www.emcdda.europa.eu/system/files/publications/671/TDSI12001ENC_396469.PDF

Most common mistakes in approaching children who abuse drugs or has become addicts, and offenders of drug-crimes

Researches has shown the development of evidence-based treatments and interventions which have evolved during the years and are successful in the management of drug abuse and addiction, as already shown in this paper. However, there are many common mistakes in dealing with children who abuse drugs or has become addicts, and offenders of drug crimes.

Deterrence and abstinence programmes

Deterrence programme has been the basis of studies and jurisprudence for centuries and the idea that fear of punishment motivates and convinces possible offenders to respect law was the main justification of punishments.

The philosopher Jeremy Bentham was one of the first promoter of the idea of deterrence, thinking mankind as rational actors who would calculate the risk of being punished and would whether to commit a crime or not on the basis of potential benefits of the crime itself[69].

Even if the general idea of deterrence as a successful treatment is still spread and politicians still promote strict legislation , some years ago psychological thesis started to challenge this opinion: many authors, such as Loeber and Farrington (1998) noticed that deterrence programmes and drug abstinence programmes are not so effective on recidivism, while Howell (2003) talked about how wilderness programmes are much less effective for serious and violent youth than for other any violent group[70].

The focus of these recent studies is on the influence that norms and sanctions have on who is experiencing drug abuse or drug addiction as well as the idea of the crime, that, in many cases, could widen the drug use and increase a strong sense of oppression and limitation of freedom[71].

[69] L.C. Fentiman, Rethinking Addiction: Drugs, Deterrence, and the Neuroscience Revolution, Pace University School of Law, 2011, http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1785&context=lawfaculty

[70] http://www.children.gov.on.ca/htdocs/English/topics/youthandthelaw/roots/volume5/preventing05_rehabilitation_strategies.aspx

[71] http://www.vittimologia.it/rivista/articolo_bertelli_2011-02.pdf

What Doesn't Work:

- Deterrence-based strategies such as boot camps and Scared Straight
- Incapacitation without treatment
- Early release probation and parole
- Programs that have been implemented poorly
- Mixing high- and low-risk offenders together
- Wilderness challenge programs and other programs that are lacking in theoretical grounding
- Milieu therapy (where the program environment is intended to be therapeutic)
- Vocational training
- Home confinement
- Unstructured or vague individual counselling
- Intensive supervision programs without a treatment component
- Restitution programs without a treatment component
- Transfer to adult court and adult institutions
- Token economies (where chores and good behaviour earn privileges and rewards)
- Drug treatment programs within institutionalized settings
- Employment-related programs among institutionalized youth

http://www.children.gov.on.ca/htdocs/English/topics/youthandthelaw/roots/volume5/preventing05_rehabilitation_strategies.aspx

Drug abuse and addiction as a disease

There are many scholars and researchers who have questioned whether drug use and addiction is or not a disease.

A research from the U.S. National Institute on Drug Abuse has shown that addiction changes the brain and the compulsive behaviours one has when assuming drugs can be similar to behaviours of other mental illness[72].

The "substance use disorder" and "addictive disorders" are still included in the Diagnostic and Statistical Manual of Mental Disorders, in its 5th Edition of 2013. The DSM V is recognised as a universal authority for the psychiatric diagnosis.

Considering child abuser as "diseased" changed the public opinion and the general approach which in past years thought of abuser as immoral and bad persons.

[72] https://www.drugabuse.gov/publications/research-reports/comorbidity-addiction-other-mental-illnesses/drug-addiction-mental-illness

However, treating children who abuse drugs as they have a psychological or mental health disorder could emphasize the fact that treatments are only linked with mental and health care, avoiding social and cultural factors. In fact, often people turn to drug to feel better, because of their depression, anxiety, stress or traumas.

It seems that the disease label justifies health treatment and reduces the willing to understand the real causes of the abuse, addiction or crime. Drug use and addiction is not only linked to health care but it is a mixture of social, cultural and psychological elements that should not be left out. It is also important to analyse the context and the social environment and constructions in which children are living, that could be different in each country.

Moreover, the disease is often a synonym of weakness, but the feeling of weakness is not useful for a child abuser, who has to react and being supported in facing the problem. It could widespread the idea of the stigma.

More information can be found: https://www.psychologytoday.com/blog/the-heart-addiction/201112/is-addiction-really-disease

The role of the family

Families play an important role in approaching and in the recovery of substance abuses[73]. Parents are usually taken as a model of behaviours and for this reason it is necessary that families have a positive influence on their children: the involvement of parents or members of the family in drug abuse, drug crime, sexual abuse are risk factors, as also the absence and lack of supervision of them. In fact, the treatments are usually family-based and aim to increase the involvement and the support of the family[74].

According to the Report published by the European Monitoring Centre for Drug Addiction in 2012, Pregnancy, Childcare and the Family: Key issues for Europe's Response to Drugs, drug use is often a burden for the user and for other family members and if a family member is having drug problems, also the ability to rear, protect and care for their children decreases. children have to grew up earlier, assuming responsibilities and tasks to replace their parents' role. Furthermore, the children who are experiencing drug problems in their family

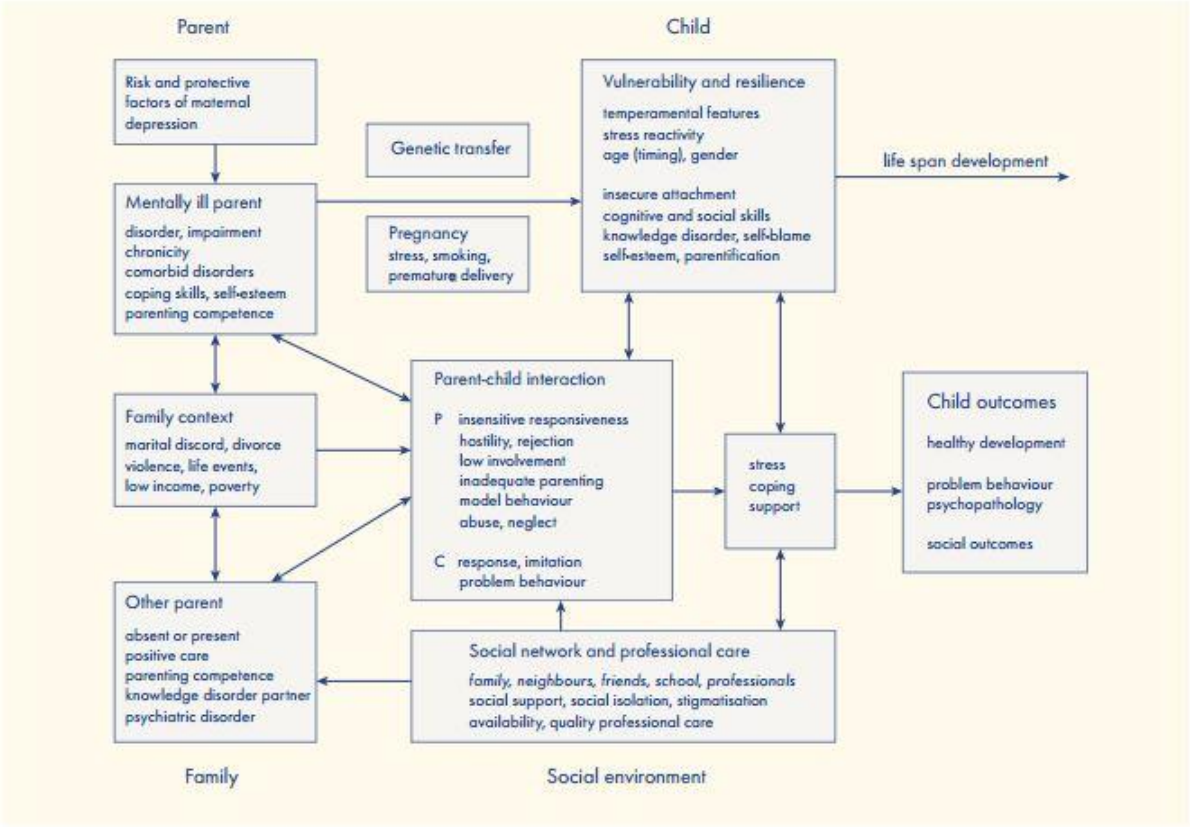
[73] Some countries such as Spain, Ireland, Romania, Norway are implementing prevention programmes also for families at risk, which focus on increasing educational skills and improving parent-child relationships. More info available at: http://www.emcdda.europa.eu/attachements.cfm/att_44741_EN_TDSI07001ENC.pdf

[74] https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/what-are-unique-treatment-needs-juveniles-in-crimin

environment could be more vulnerable, but data show that there are different degrees of vulnerability and capabilities of tackling the situation they have to face.

The model below show the interaction by risk and protective factors:

Figure 3: A developmental model of trans-generational transmission of psychopathology



Source: Adapted from Hosman et al. (2009).

http://www.emcdda.europa.eu/system/files/publications/671/TDSI12001ENC_396469.PDF

For example, an Irish study found out that even if parents disapprove their own drug use and tell their children not to follow their examples, they are usually not successful in transmitting their values; a Danish study demonstrated how a third of children who grew up in a substance use environment had substance use problems later in their life. Also genetic factors could play a role[75].

In the majority of the European countries, children enter treatment in the general drug treatment services for the adult population. However, <direct contact with adult drug users

[75] More details and examples are available here: http://www.emcdda.europa.eu/system/files/publications/671/TDSI12001ENC_396469.PDF

consuming heroin, cocaine and other drugs may have a negative influence on the behaviour of these children. For that reason, several countries have identified a need to establish drug services specifically for very young people>[76].

High-risk family are not only low-income families: some national studies Denmark, the Netherlands, Sweden, the United Kingdom) show that one risk factor is parents' level of knowledge of their children's life out of home and their friends.

Another common mistake is intimidation from parents and educators. This leads to fear, isolation and non-acceptance of reality, increasing the risk of victimisation, while the children should feel confident in asking for help. There should be a positive communication in family and they have to be ready in face the reality. Then, the last thing that children need is <to have unnecessary boundaries and limits imposed on them. These risk stifling their joyous and adventurous spirit.>[77]

Preventing drug crimes and victimization of drugs abuse among children:

An effective prevention of drug use and the reduction of risks would mean promoting health and well being in the society. Giving and assuring access to a continuous prevention and treatment option to people in need, the human and social costs of drug use would consistently decrease: these include the reductions in violence and crimes, as violence (gender-based, sexual and other violence), child abuse, injuries, communicable diseases (HIV, viral hepatitis and tuberculosis) and non-communicable diseases (cancer, cardiovascular diseases) and sexual and reproductive health problems[78].

[76] http://www.emcdda.europa.eu/attachements.cfm/att_44741_EN_TDSI07001ENC.pdf, p.17.

[77] Gorana Hitrec, Teaching children to protect themselves from sexual abuse, http://www.coe.int/t/dg3/children/1in5/Source/PublicationSexualViolence/Hitrec.pdf, p.170

[78] World Health Organisation, Public Health dimension of the world drug problem including in the context of the Special Session of the United Nations General Assembly on the World Drug Problem, to be held in 2016, 15 January 2016, http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_11-en.pdf

Moreover, spending on treatment and prevention, including the empowerment of people to recognize their problem and ask for help and providing access to health care, will bring to a reduction in drug-related crimes[79].

In the Guidelines for the Prevention of Crime, written by the United Nations Economic and Social Council, it is stated that <*there is clear evidence that well-planned crime prevention strategies not only prevent crime and victimization, but also promote community safety and contribute to sustainable development of countries. Effective, responsible crime prevention enhances the quality of life of all citizens. It has long-term benefits in terms of reducing the costs associated with the formal criminal justice system, as well as other social costs that result from crime.*> (Economic and Social Council resolution 2002/13)[80].

According to the last report of the Secretariat of the World Health Organisation, a national drug policy and action plan, supported with a law enforcement against the illicit market, as well as health promotion and prevention programmes, could be more effective than providing just information on the effects of drugs[81]. The necessity of a multi-sectoral and multidisciplinary approach, which conveys pharmacological and psychological support (through an early diagnosis and responding to the individual needs) and social reintegration programmes, is due to the fact that only with an impact at the population level the best treatment outcomes are reached[82].

The responses and approaches used by States are different and there is no single educational and training model or programme that could be suitable for each different national situation[83].

The European Monitoring Centre for drugs and Drugs addiction has collected a series of best practices in drug interventions, which are available on their official website: http://www.emcdda.europa.eu/best-practice .

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[79] <Substance use disorders can be treated and managed cost-effectively, saving lives, improving the health and well-being of affected individuals and their families, and reducing costs to society. The costs of treatment and care are much lower than the indirect costs of drug use disorders and associated health conditions, which include the costs of unemployment and absenteeism, crimes, the criminal justice system and law enforcement, as well as premature mortality and disability>. http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_11-en.pdf

[80] https://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/resolution_2002-13.pdf

[81] http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_11-en.pdf

[82] http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_11-en.pdf

[83] Pompidou Group and Concil of Europe, Education and training on substance use disorders, Recommendations for future national Drug Policies, 2014, http://www.coe.int/T/DG3/Pompidou/Source/Documents/Edu_Training%20Eng%2060s-V3.pdf

Prevention for families

Prevention for school students, which could offer a systematic and efficient way of reaching a large number of young people

Prevention for communities

Note: It is not clear if these types of intervention reduce consumption.

Resilience Theory to prevent adolescent abuse and addiction

In recent years, many studies on resilience linked to researches on drug abuse prevention have been developed. In the social environment, there are a lot of risk factors that include traumatic events, socio-economic disadvantages, family conflicts, violence or social and academic achievements.

Advice for teaching children to protect themselves from sexual victimization/offending

Teaching children to prevent from sexual victimization/offending is also necessary, as children are particularly vulnerable and unaware of dangers, risks, and self-protection.

It is important to have good communication with children and young people, so to give them guidelines and tips on how to ensure their safety. A friendly and supportive environment will also assure a deeper sexual education of the children, even if some societies are not willing to introduce it (some States are also unwilling to introduce it in the educational system, but evidences show a lack of knowledge expose them to victimisation).

The literature on how to teach children to protect themselves from sexual abuse is very wide and a lot of educational programmes on prevention have been developed[84].

[84] Gorana Hitrec, Teaching children to protect themselves from sexual abuse, http://www.coe.int/t/dg3/children/1in5/Source/PublicationSexualViolence/Hitrec.pdf

The role of the family and the school in these programmes are very important. Empowering children to protect themselves and to have the awareness of their rights are the priority tasks of the family. Schools also must be involved in working to prevent sexual abuses, as community programmes or individual actions[85].

The aim is to give children skills, such as:

- facing everyday life and be prepared for it, building up a healthy self-esteem and encouraging children to respect every individuality
- identifying and responding to risks, recognising the right to be safe;
- identifying, preventing and stopping sexual abuses;
- asking for help, expressing needs and feelings[86].

Educational programmes could be also useful in raising public awareness and increasing the public sensibilities on these issues.

Keep in Mind[87] (To Do's)

- Include families into the rehabilitation process if it is appropriate and applicable.
- Ask for help from professionals of other disciplines if necessary.
- Check for if the child needs any medical treatment.
- Create a warm and private environment to facilitate the interview with the child.
- Let the child explain him/her-self with his/her own words
- Do not blame the child for his/her drug addiction problem
- Learn about the general environment that breeds drug abuse.
- Try to identify risk factors for present and future drug abuse.
- Ask for if there is any pregnancy situation.
- Consider that for pregnant women, medications to assist detoxification from stimulants can be used but should be reserved when specific symptoms emerge
- Consider that problem cannabis use can lead to difficulties performing at work and legal problems; cannabis dependence has been associated with adverse psychological and physical consequences.

[85] C. Crosson-Tower, The Role of Educators in Preventing and Responding to Child Abuse and Neglect, U.S. Department of Health and Human Services, 2003, https://www.childwelfare.gov/pubPDFs/educator.pdf

[86] Gorana Hitrec, Teaching children to protect themselves from sexual abuse, http://www.coe.int/t/dg3/children/1in5/Source/PublicationSexualViolence/Hitrec.pdf

[87] based on the data published by The European Monitoring Centre for Drugs and Drug Addiction EMCDDA. Web Page: http://www.emcdda.europa.eu/

- Consider that any behavioural intervention (including cognitive behavioural therapy (CBT), motivational interviewing (MI) and contingency management) can help to reduce use and improve psychosocial functioning, both in adults and adolescents, at least in the short-term (With cannabis users)
- Try to provide drug users with an incentive-based treatment (for example contingency management) together with some employment which helps them to improve their social condition
- Consider that Some of the drugs used to treat depression (fluoxetine and imipramine) can help amphetamine users stay in treatment in the short and medium term (With amphetamine users)
- Consider that multidimensional family therapy helps reduce use cannabis and keep patients in treatment, especially in high-severity young patients
- Consider that psychosocial interventions can help to reduce cocaine use by influencing the mental processes and the behaviours related to the addiction
- Consider that opioid substitution treatment, combined with psychosocial support, helps patients stay in treatment and reduces use and mortality. It also has a positive impact on the mental health of patients
- Consider that methadone and buprenorphine are the recommended pharmacological treatments of opioid addiction. Taking into account clinical practice, methadone is superior to buprenorphine in retaining people in treatment
- Consider that opioid substitution treatment is also strongly recommended for pregnant women dependent on opioids, even more than attempting dexotification.
- Consider that (with dual-diagnosis patients) integrated treatment combining pharmacological and psychological interventions seems to help in cases of psychosis and substance use disorders as well as anxiety and opioid disorders
- Consider that(with dual-diagnosis patients) the therapeutic approach to tackle dual diagnosis, whether pharmacological, psychological or both, must take into account both disorders simultaneously and from the first point of contact in order to choose the best option for each individual
- Consider that infections caused by HIV and Hepatitis C among people who inject opioids can be prevented with opioid substitution treatment and the provision of clean needles and syringes

- Consider that death among drug users is reduced by keeping them in opioid substitution treatment
- Consider that providing drug users with an incentive-based treatment (for example contingency management) together with some employment helps them to improve their social condition
- Consider that residential treatment and therapeutic workplaces associated with contingency management improve work attendance and performance
- Consider that employee assistance programmes help drug users improve work performance
- Consider that Supported employment interventions help drug users with mental problems to get a job
- Consider that opioid substitution treatment has a very strong protective factor against death in prison for opioid-dependent prisoners
- Consider that substitution treatment is also particularly important in prison as it reduces injecting risk behaviours
- Consider that psychosocial treatments reduce the re-incarceration rates in female drug-using offenders
- Consider that for drug-using offenders the use of naltrexone seems to help to reduce their re-incarceration rates
- Consider that pharmacotherapies based on psychostimulants are probably of little value in the treatment of amphetamine dependence
- Consider that Pharmacotherapy for routine treatment of dependent pregnant women is not recommended
- Consider that pharmacotherapies based on antidepressants, anxiolytics and anticonvulsant are probably of little value in the treatment of cannabis dependence
- Consider that Pharmacotherapy for routine treatment of dependent pregnant women is not recommended
- Consider that It is not clear whether antidepressants help reduce the craving for cocaine
- Consider that detoxification under heavy sedation does not work and can actually be harmful (with opioid users)

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Suggested readings

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CHAPTER FOUR ABUSE AND NEGLECT

ABOUT ABUSE AND NEGLECT

In 1999, the Meeting of Consultation of the WHO (World Health Organization) on the Prevention of Child Abuse is defined as the abuse and neglect that the under 18 may suffer, and it includes all types of physical abuse or psychological, sexual abuse, neglect, negligence and commercial exploitation or otherwise causing or likely to cause damage to health, development or dignity of the child, or endanger their survival, in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence also sometimes included among the forms of child abuse.

The Committee on the Rights of the Child United Nations has frequently expressed concern about the extent of different forms of violence against children, including sexual abuse, by having made a General Comment no.13 (2011) on "child's right to be free from any form of violence". This remark affects a number of elements to be incorporated into national coordinating frameworks which include, in particular, the central role of the family in the strategies of care and protection of children and the gender dimension in the violence against children, as well as, sexual abuse and exploitation.

Former legislation at the international level to protect childhood and adolescence

The concept of childhood as a stage of human development with its unique characteristics and own rights constitutes a fact relatively close to our time.

The effects the World War I had on the collective consciousness, from an international perspective, the League of Nations, meeting in the city of Geneva at its V Assembly dated September 24, 1924, approved the first Bill of Children's Rights. The Declaration highlights the need that arises in any abandoned to receive special protection.

Later, after the Second World Ward, the founding states of the United Nations, became aware of the need to protect fundamental human rights that should be granted t all members of the human family. As a result of this international legislative work on the basis of freedom, equality, justice and peace, the Declaration of Human Rights of December 10, 1948, was established. As in the Article 25.2, which decrees "motherhood and childhood are entitled to special care and assistance. All children, whether born in wedlock or out of wedlock, shall enjoy the same social protection".

Similarly, the Declaration of the Children's Rights, November 20, 1959, by the Resolution 1386 (XVI) of the United Nations General Assembly, recognizes in the ten principles it contains, the wide range of rights that children must enjoy without discrimination: name, nationality, food, housing, education, medical services, etc. It also indicates that "the child shall enjoy special protection (…) in order s/he can physically, mentally, morally and

socially develop into healthy and normal manners and in conditions of freedom and dignity" (Principle 2).

The subsequent International **Convention on the Child's Rights** performed by the United Nations General Assembly on November 20, 1989 stands as a legal, political, social and global reference to protect the development and dignity of all under 18 as owners of rights. Therefore, it became the Treaty of Human Rights, most widely ratified of history, affecting the 96% of all children in the world (UNICEF, 1998). Similarly, it created the necessary mechanisms to control that the minors' own rights, in harmony with those of the adults, remained fully guaranteed.

Besides safeguarding the rights announced in the preceding laws, the Convention opposed any kind of discrimination based on race, color, sex, language, religion and/ or any other circumstances as it could be disability (art. 2); and it stresses that all decisions regarding the child, including adoption, should safeguard the "best interests" of the same (art. 3). International adoption is considered as a replacement measure, which has to be controlled by competent authorities, in order to avoid benefits for those investing in its processing (art. 21). In addition to ensuring rights of social, cultural and economic nature (art. 4), the protective effort is extended to civil and political ones by providing a global and integrative perspective and a more rational framework for the promotion and protection of children.

In relation to the "Protection against any kind of violence", it remarks that: "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." (Art. 19).

The mechanism of guarantee that the Convention established to fight for the rights and full protection of childhood corresponds to the Committee of Child's Rights (arts. 43 to 45). In order to achieve it, States Parties undertake to submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have adopted which give effect to the rights recognized herein and on the progress made on the enjoyment of those rights: (a) Within two years of the entry into force of the Convention for the State Party concerned; (b) Thereafter every five years. (art.44.1.). It also states that the Committee, shall submit to the United Nations General Assembly, through the Economic and Social Council, every two years, reports on its activities (art. 44.5).

Convention on the Children's Protection and Cooperation in matters of Intercountry Adoption: The Hague, 1993.

The signatory States of the Convention based on the recognition of the child as a being that, for the harmonious development of his personality, needs to grow in a family environment and in a climate of happiness, love and understanding. Its content takes into account the principles recognized by the international instruments, especially the UN Convention on the Rights of the Child on November 20, 1989. Also, by the United Nations Declaration on Social and Legal Principles, applicable to the protection and welfare of children, considered especially from the angle of the practices in adoption and family placement in the national and international levels (General Assembly Resolution 41/1985, of 3 December 1986).

However, the UE has the exclusive competence in relation to the Convention's regulations affecting the competency, recognition and compliance of legal ruling in matrimonial matters and the parental responsibility ("Brussels II"). Therefore, the EU should make a declaration when signing the Convention, whereby the EU law will remain in force as regards the recognition and enforcement of judgments of the Union issued by a European country on issues related to the Convention.

On 2015, there are 105 signatory countries of the Convention of The Hague.

Another Relevant legislation:

The Convent of the European council about the minors adoption, made in Strasbourg on the 27 of November 2008.

– The Convent of the European Council in relation to the proteccion of children against exploitation and sexual abuse, made in Lanzarote (España) on the 25 of October, 2007.

– The Regulation (CE) no. 2201/2003 of the Council of November 27, 2003 relating to the competence, recognition and enforcement of judicial judjements in matrimonial maters and parental responsibility.

Definition of Abuse and Neglec in Each Country.

In keeping with international standards, the law of each state, clarifies what abuse and neglect means and, accordingly sets out government measures to the protection of childhood and adolescence.

In **Spain** these concepts are regulated by the Law 26/2015 of 28 July, on the Protection of Children and Adolescents, and the Organic Law 8/2015 introducing the necessary changes in areas considered as organic matter to influence the fundamental rights and public freedoms recognized in the articles 14, 15, 16, 17 and 24 EC.

It is considered that an under 18 has suffered neglect or abuse when s/he is in situation of social vulnerability by risk or helplessness:

At risk: characterized by the existence of injury to the individual or social development of the children but not reaching enough seriousness to justify the separation of these from their parents or household and therefore, not requiring the assumption of guardianship by the ministry of law.

The intervention, in any case guaranteeing the child's rights, is limited to try to eliminate, within the family institution, the risk factors and social problems that the child is already in and promoting factors to foster himself and his household by monitoring the evolution of the child in the family.

In helplessness: situation which occur because of failure, or inability or inadequate exercise of the duties of protection established by law for custody of the children, when they are deprived of the necessary moral or material support.

In these situations, in which the seriousness of the facts suggest the separation of the under 18 from the family, the intervention takes the form of the assumption by the government of the guardianship of the child, taking appropriate protective measures and giving notice to the Public Prosecutor.

Portugal: the Portuguese legislation differentiates between "at risk" and "endangered" minors. The main difference between both arises from the danger that the potential risk carries in terms of the children's rights implementation while the plication of the concept of danger is added to the high probability of occurrence.

As it is defined in the Law of Protection of Minors and Youth at risk, "not all the risks for the development of the children legitimize the intervention of the State and society, in their lives, their autonomy and that of their family".

Under this legislation (paragraph 2, article 3, LPCJP[88]) it is considered that the person, child or Young is in danger when any of the following situations occurs:

a) they are abandoned or the family entrust the underage to the social and protection system since they cannot take care of them
b) they are undergoing physical, psychological or sexual abuse;
c) they do not receive adequate attention or affection to their age and personal situation;
d) they are forced into inappropriate labor or work for their age, dignity and personal situation, or are detrimental for their training and development;

[88] Lei de Promoção e Proteção de Crianças e Jovens em Perigo

e) they are obliged directly or indirectly to certain behaviours that seriously affect their safety and emotional balance.
f) they adopt certain behaviours or surrender to consumption activities that seriously affect their health, safety, training and education since their parents do not take appropriate measures to stop this situation.

The State has to intervene when a dangerous situation is identified to eradicate it and keep the minor safe.

In **France**, the definition is given by the Penal Code, Chapter VII (Offences against the exercise of parental authority), Section V (Endangerment of Minors) "Deprivation of food or care to the point of endangering the health of a minor under fifteen years of age, inflicted by an ascendant or by any other person exercising parental authority or having authority over the minor, is punished by seven years' imprisonment and a fine of €100,000 (Spencer, 2005, p. 63).

Italy: Child abuse is defined as "the violation of human or civil rights of an individual, through the act or actions of another person or persons".

Negligence is understood as "a failure to provide the necessary care, help or orientation to the dependent adults or children by their caregivers".

Netherlands: in Netherlands a negligence is considered when a person who is responsible of custody and care of another dependent person does not take care of his/her needs.

Child abuse is defined as any form of violent and threatening behaviour towards minors either physical, psichological or sexual nature. The physical and pshychological negligence understood as the lack of attention to the basic needs of love, warmth, safety and comprehension is also regarded as abuse.

United Kingdom: The National Society for the Protection against Child Cruelty (NSPCC) describes negligence as: "… The continuing failure to meet the basic needs of a child. That is, a hungry child unattended or dirty, without adequate clothing, shelter, security or health care. When the child is in danger or not protected from physical or emotional harm. When the underage does not receive love, care and attention they need from their parents…"

The NSPCC defines child abuse as: "… the attitude another person – either adult or not – that causes significative harm to a minor. It could be physical, sexual or emotional harm, lack of love, care and attention. The negligence, whatever form it takes, can be as harmful for a child as it is the physical abuse.

In Turkey, the right of a child to be protected against torture and other punishments or cruel, unhuman or degrading treatment is guaranteed by the Constitution, the Penal Code[89] and the Right of Criminal Procedure Act[90]. The rights of children in conflict with the law are governed primarily by the law on Juvenile Courts[91] and the regulations of arrest, custody and interrogation[92]. Moreover, children are protected under the law of the public services agency and the protection of childhood[93].

Summary:

The consideration of childhood as a stage of the human development with its peculiar characteristics and own rights constitutes a fact relatively close to our time.

The effects the World War I had on the collective consciousness made it possible that, from an international perspective, the League of Nations, meeting in Geneva in the V Assembly the 24th September of 1924, passed the first Declarations of the Children Rights. This declaration highlights the necessity of any abandoned minor to receive especial protection.

The Convention on the Rights the Child in 1989, currently almost universally ratified, points out in regards to the "Protection against any kind of Violence" that: "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child" (Art. 19).

The Convention defines "child" as any person under 18.

Each State internally legislates the realization of protective measures in response to international conventions in the matter.

89 Act No. 765 Criminal Code

90 Act No. 1412 of the criminal proceedings.

91 Act No. 2253 Establishment, duties and and judicial proceeding of the Juvenile Courts.

92 Regulation on arrest, pólice custody, and interrogation of October 1997. Under de law on the Social Services and Child Protection Agency.

93 Act No.2828 on Social Services and Child Protection Agency.

What are the most common types of abuse and neglect that children are exposed to?

According to Fabian Zarate[94] (article: Child Abuse: Approach, Intervention and Prevention in Schools) the various forms of abuse can be classified in a scheme of double entry or two subdivisions: active/passive and physical/emotional.

The ***active abuse*** is due to an intervention of the abuser causing a physical or emotional harm.

The ***passive abuse*** is the one that is produced when you stop meeting the basic needs of children.

Child Abuse		
PHISICAL **- Prenatal Abuse** **- Labour exploitation** **- Begging** **- Corruption** **- Shaken baby syndrome** **- Münchhausen syndrome by proxy**	**Active** - Physical Abuse - Sexual Abuse	**Passive** - Physical neglect or negligence
EMOTIONAL	- Emotional Abuse	- Emotional neglect
OTHER FORMS OF ABUSE	**- INSTITUTIONAL ABUSE** In the field of Public Services In the field of Education In the field of Health In the Judicial field	

Next, we are going to define any of the child abuse aforementioned, referring to the different forms that present, indicators and the possible effects that may occur in children:

1. **Physical Abuse:** it includes acts committed by parents or adult caregivers against children that generates temporary or permanent physical injuries; caused by various objects (belts, electric wires, sticks, cigarettes, various substances, etc.).

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2. **Emotional Abuse:** it involves the attitudes of indifference, insults, offenses and/ or disdain produced by the parents or adult caregivers and that damage their emotional sphere (generating feelings of worthlessness, low self-esteem and personal insecurity).
3. **Sexual Abuse:** it includes the mutual interactions between a child and an adult, in which the child is being used for the sexual gratification of the adult and against which s/he cannot give informed consent. It may include from an exposure of the genitals of the adult to the rape of the child.
4. **Physical neglect:** understood as those situations of omission caused by the parents or adult caregivers in which the basic needs of the child are not met (food, clothing, hygiene, protection, education and health care) even though, they could have.
5. **Emotional neglect:** situations of omission caused by the parents or adult caregivers involving no response from them to the satisfaction of the emotional needs of the children, having been able to respond to them.
6. **Prenatal abuse:** carelessness, by action or omission, to the body of the mother or the self-consumption of substances or drugs that, consciously or unconsciously, harm the fetus that she is carrying.
7. **Labour exploitation:** situation in which certain people assigned the child with continued compulsory work (domestic or not) that exceed the usual limits and that should be performed by adults and which clearly interfere the activities and either social or scholar needs of the child, and that are assigned to the child in order to obtain an economic benefit.
8. **Begging:** activities or actions, performed by a minor, that consist on demands or asks for money in the streets (minor exploitation).
9. **Corruption:** adult behaviours that prevent normal socialization of children and promote patterns of antisocial or deviant behaviour (like rewarding the child for stealing, encourage consumption of drugs and/or alcohol, etc.).
10. **Shaken baby syndrome:** it is produced by a violent shake of the infant body in order to silence his/her crying; it is characterized by retina hemorrhage, cerebral hemorrhage: subdural or subchranoid hemorrhage and the absence of external cranial trauma.
11. **Münchhausen syndrome by proxy:** situations in which the father/mother (mainly) make the child go through continuous medical test, claiming physical pathological symptoms, fictitious or actively generated by the father/mother.
12. **Institutional Abuse:** any legislation, procedure, action or omission from the public authority or derived from an individual professional performance that involves any abuse, neglect; detrimental to the health, security, emotional state, physical well-being, proper

maturation or that violates the basic rights of the child. Indeed, the protagonists of this abuse are the people responsible for the care, protection and education of the child, as well as, the various policies applicable to children.

Kind of Abuse Regarding the Environment in which it is produced

Abuse can be also classified by taking into account the environment in which it occurs, following the report of the independent expert for the study of violence against children, Paulo Sergio Pinheiro, from the United Nations, summited under the resolution 60/231 of the General Assembly[95]**:**

A. Abuse in the domestic environment (home and family).

Eliminating and responding to violence against children is, perhaps, more challenging in the context of the family than in any other since it is considered generally that the more private spheres. However, the right of children to live, survival, development, dignity and physical integrity do not stop at the door of the family home, not even the obligations that the States have to guarantee such rights to the children.

- **Violent methods of discipline.** The violence against children in the family may occur in the context of discipline, under the form of physical, cruel or humiliating punishments[96]. Physical and psychological violence. Injuries, insults, isolation, rejection, threats, emotional indifference and belittling are all forms of violence that may harm the child's physiological development and well-being, especially when these deals come from a respected adult such the father or mother. It is of vital importance to encourage parents to use only non-violent methods of discipline.
- **Carelessness.** For example, not meeting the physical and emotional needs of children, not protecting them from danger or not obtaining medical and other services when needed contributes to mortality and morbidity in young children.
- **Sexual violence at home**. According to various researches realized in 21 countries (mostly developed) between the 7% and the 36% of women and the 3% and the 29% of men said that S/he had been victim of sexual abuse during their childhoods and, according to most of the studies the rate of abuse suffered by girls is 1.5 to 3 times that of men. The majority of abuses occur within the family circle[97].

[95] United Nations A/61/299 Distr.: General 29 August. Original Spanish: English 06-49108 (S) 041006 041006 *0649108* Sixtyfirst Session. Item 62 of the provisional agenda*Promotion and Protection of the rights of children. Ricghts of the child.

[96] Website of the Study of the General Secretary about the Violence against children (*http://www.violencestudy.org/r27*) y J. E. Durrant "Corporal punishment: prevalence, predictors and implications for child behaviour and development", en S. N. Hart (ed.), *Eliminating*

Corporal Punishment (París, UNESCO, 2005), págs. 52 y 53.

[97] D. Finkelhor, "The international epidemiology of child sexual abuse", *Child Abuse & Neglect*, vol. 18, No. 5 (2005), págs. 409 a 417.

- **Gender violence.** The imbalance between boys and girls in some regions in the sex ratio suggest that girls and young women are under a greater risk of suffering **neglect and violence**.
- **Young girls married.** In some countries, the absence of the minimum legal age for the sexual consent and marriage can expose the girls to a violent treatment of their partner. An estimated 82 million girls marry before their 18th Birthday. A significant number are married at much younger ages, frequently coercively, and face a risk of violence, including forced sex.
- **Rejection of children with disabilities**, they are also at a greater risk of neglect. Children with disabilities may be abandoned, a practice that may sometimes be accepted and encouraged[98].
- **Harmful traditional practices** affect children disproportionately and are generally imposed on them by their parents r community leaders at an early stage of their lives. According to the Special Rapporteur on traditional practices affecting the health of women and children, female genital mutilation, according to WHO is carried out on increasingly younger girls, it is prevalent in Africa and also occurs in parts of Asia an in immigrant communities in Europe, Australia, Canada and the United States[99]. Other harmful traditional practices affecting children include, among others, bonds, scratches, burns, marks, violent initiation rites, fattening, forced marriage, so-called crimes of "honor" and related violence dowries, exorcism r "witchcraft".
- **Witnessing domestic violence**: It is estimated that between 133 and 275 millions of children worldwide witness domestic violence each year[100]. Witnessing domestic violence, usually through fights between parents or between a mother and her partner, can seriously affect your well-being, personal development and social interaction in childhood and adulthood[101].

[98] Study of the United Nations Secretary about the Violence against Children, *Regional Desk Review: Violence against Children in West and Central Africa*, 2005

[99] The Subcomision of Promoting and Protecting Human Rights, main subsidiary body of the former Comission on Human Rights, by studying during the last years various thematic issues related to the theme of violene agains children. The Special Rapporteur on tradictional practices affecting the health of women and girls, Halima Embarek Warzazi, has placed speacial emphasis on the elimination of female genital mutilation. See, por example, her ninth and final reporto n the situation of he elimination of traditional practices affecting the health of women and girls (E/CN.4/Sub.2/2005/36).

[100] Estimate based on the UN Population Division data for global population under 18 years for 2000 and domestic violence from 1987 to 2005. Behind Closed Doors: The Impact of Domestic Violence on Children (Londres: UNICEF and The Body Shop International Plc., 2006).

[101] L. A. McClosky, A. J. Figueredo y M. P. Koss, "The effect of systemic family violence on children's mental health", Child Development, vol. 66 (1995), págs. 239 a 1261, citado en Krug, op. cit. en la nota 1, pág. 103; y S. R. Dube y otros, "Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: implications for health and social services", Violence and Victims, vol. 17, No. 1 (2002), págs. 3 a 17

- **The intimate partner violence** also increases the risk of violence against children within the family, studies in China, Colombia, Egypt, Mexico, Philippines and South Africa show that there is a close relationship between violence against women and violence against children. A study from India found that domestic violence doubles the risk against children[102].

B. Violence in Schools and educational institutions

In most countries, children spend more time under the care of adults in public or educational institutions than in any other place, besides their homes. Schools play important role in protecting children against violence. Adults who work in schools and those who oversee them have a duty to provide a safe environment for children and promote their dignity and development.

- **Exposure to violence**. In many cases, educational settings expose children to violence and maybe even teach them to use it.
- **Violence perpetrated by teachers and other school workers,** violence can take the form of corporal punishment, cruel and humiliating psychological punishment, sexual violence or gender-motivated, and bullying. Corporal punishment such as beating and caning is standard practice in schools in many countries. The Convention on the Rights of the Child requires States Parties to take appropriate measures to ensure that school discipline is administered in a manner consistent with the Convention. The Global Initiative to End All Corporal Punishment of Children reports that 102 countries have banned corporal punishment in school, but enforcement of this rule is uneven.[103]
- **Aggression and bullying among students**[104]. In some societies, aggressive behaviour, including fighting, is widely perceived as a minor disciplinary problem. Peer harassment is often linked to discrimination against students from poor families or ethnically marginalized groups, or have special personal characteristics (e.g. Appearance, or a physical disability or gangs and criminal activities related to them especially those having to do with drugs[105].
- **Sexual violence and gender violence.** Mostly this kind of violence is exerted by the teachers and male students against girls and young women.

[102] W. M. Hunter y otros, "Risk factors for severe child discipline practices in rural India", Journal of Paediatric Psychology, vol. 25 (2000), págs. 435 a 447.

[103] Global Summary of the Legal Status of Corporal Punishment of Children, op. cit. at note 9.

[104] D. Olweus, D. Bullying at School: What We Know and What We Can Do (Oxford, Blackwell, The Body Shop International Plc., 2006).

[105] United Nations Secretary General's Study on Violence against Children. Report on the results of the regional consultation for the Caribbean, Port of Spain, March 2005.

- **Homophobia.** In many states and regions violence also attacks increasingly young people as gay, bisexual and transgender. The fact that governments do not enact and enforce laws that explicitly protect students from discrimination, promotes sexual and gender violence.

C. Violence in the Social care systems and judicial systems.

Millions of children, particularly boys, spend substantial periods of their lives under the control and supervision of social care authorities or judicial systems, and institutions such as orphanages, children's homes, shelters, jails, prisons, reformatory centers and juvenile detention. These children are exposed to violence from staff and center authorities who are responsible for their welfare. In most countries corporal punishment in institutions is not explicitly prohibited. Often, there are no effective means of making complaints, mechanisms for monitoring and inspection and appropriated government regulation and supervision. All the perpetrators are held accountable, creating a culture of impunity and tolerance of violence against children. The impact of institutionalization goes beyond the experience of violence with children. Some of the long-term consequences include severe developmental delays, disability, irreversible psychological damage and increased rates of suicide and recidivism.

No less than 8 million children worldwide live in shelters[106]. A relatively small number living in them have no parents, but most do so for other reasons: disability, family breakdown, domestic violence and its social economic conditions including poverty.

- **Violence exerted by the staff of the institutions** with the aim of instilling "discipline" children consist, among others, hit with hands, sticks and hoses; hitting their heads against the Wall, restraining children in cloth sacks, tying them to furniture, locking them in cold storage for days and let them lie in their own screments[107].
- **Abuse in the medical or psychiatric treatment.** Children with disabilities may be subjected to violence in the guise of medical treatment. In some cases, children up to 9 years are subjected to electroshock treatment without the use of anesthesia or muscle relaxants. Sometimes electroshocks are also used as an "aversion treatment" to control children's behaviour. Also, sometimes, drugs are used to control the behaviour of

[106] D. Tolfree, Roofs and Roots: The care of separated children in the developing world (Londres, Save the Children UK, 1995) citado en International Save the Children Alliance. A Last Resort:The Growing Concern about Children in Residential Care (Londres, Save the Children UK,

[107] United Nations Secretary-General's Study on Violence against Children Regional Desk Review: Middle East and North Africa Region (2005), pág. 19; Mental Disability Rights International, Hidden Suffering: Romania's Segregation and Abuse of Infants and Children with Disabilities (Washington, D.C., Mental Disability Rights International, 2006).

children and make them more "compliant" since their ability to defend themselves against violence is reduced[108].

- **Carelessness.** It is another feature of many residential institutions where conditions are so poor that endanger the health and lives of children. In many facilities for children with disabilities, there is no Access to educational programs, leisure, or other reintegration. Often children with disabilities are left in their bed or cribs for long periods without having any human contact r stimulation. This may cause serious physical, mental and psychological damage.
- **Violence among children.** Children living in care are vulnerable to violence from other children, particularly when conditions and staff supervision are poor and older, more aggressive children are not separated from younger or more vulnerable children. Staff may sometimes sanction or encourage abuse among children themselves.
- **Death penalty.** Although the International Covenant on Civil and Political Rights and the Convention on the Rights of the Child prohibit it, some countries still impose the death penalty for certain crimes committed under the age of 18. Currently, at least 31 countries allow corporal punishment as a punishment for crimes committed by children[109].
- **Abuse of the arrest as a disciplinary measure in some institutions.** Although the Article 37 of the Convention on the Rights of Children obliges to ensure that the arrest of children will be the last resource to resort to and for the minimum time necessary, in 1999 it was estimated that 1 million children were private of freedom. Most of them are charged with minor crimes and it is the first time they commit them. Many of them are arrested for truancy, vagrancy or being homeless. In some countries, the majority of children in detention have not been convicted of a crime but are awaiting trial.
- **Attacks by members of the authority during the process of arrest.** Frequently, children who are detained suffer violent treatment by the staff, sometimes as a form of control or punishment, often for minor infractions. At least in 77 countries corporal and other violent punishments are accepted as legal disciplinary measures in penal institutions.
- **Attacks by other adults arrested.** According to the Convention of the Child Rights, the national legislation of most countries requires children in conflict with the law to be

[108] United Nations Secretary General's Study on Violence against Children. Summary report, thematic meeting on violence against disabled children, 28 July 2005 (Nueva York, UNICEF, 2005), page. 18.

[109] Global Summary of the Legal Status of Corporal Punishment of Children, op. cit. at note 6.

in separated facilities in order to prevent abuse and exploitation from the adults. However, in most countries it is normal for children to remain arrested with adults.

- **Self-injury during the arrest.** The detained children are most at risk of self-harm or suicidal behaviour, especially when long or indefinite detention or when they are confined in adult facilities.

D. Violence in the workplace.

The information about violent acts against children in the work place indicates that in most of the cases it is inflicted by the "employers", even though the attackers can be also colleagues, foremen, clients, policemen, criminal gangs and, referring to sexual abuse, procurers.

- **Girls in the domestic/housework.** It is the largest employment category for girls under 16[110], which often takes the form of unregulated labor and exploitation, and sometimes servitude and slavery. Most of the acts of physical and psychological violence against children working in domestic service are committed by women (generally employers), but girls often suffer sexual violence from male members of the family of their employer[111].
- **Child prostitution.** The exploitation of children under 18 in prostitution, child pornography and similar activities are forms of violence[112]... An estimated 1 million children are incorporated into these sectors every year[113]. Many are coerced, kidnapped, sold and deceived into undertaking these activities or are victims of trafficking. In addition to the sexual violence intrinsic to child prostitution, the boys and girls used in prostitution and related areas suffer physical and psychological violence, and neglect. Often they cannot get help[114], and when they do they can be treated as criminals, prisoners and receive little compensation.
- **Bondage.** Children engaged in forced labour or servitude rarely can protect themselves from employers and other workers, and both the studies and the testimonies of children

[110]Child Labour: targeting the Intolerable. Report submitted to the 86th Session of the International Labour Conference (Geneva, International Labour Office, 1998)

[111] J. Blagbrough, "Violence against child domestic workers" (presentation for Anti-Slavery International in a workshop of Save the Children, Thailand, September2003).

[112] For a full definition of the comercial sexual exploitation of children, see the Declarion of the World Congress against the Commercial Sexual Exploitation of Children, Stockholm, June 1996. To view it online: http://www.esecworldcongress.org/sp/index.htm

[113] Profiting from Abuse: An investigation into sexual exploitation of our children (Nueva York, UNICEF, 2001), page. 20

[114] Child Workers in Nepal Concerned Centre, A Situational Analysis of Child Sex Tourism in Nepal (Kathmandu Valley and Pokhara) (2003), pág. 27; International Save the Children Alliance, 10 Essentials Learning Points: Listen and Speak out against Sexual Abuse of girls and Boys. *Presentación global al estudio de las Naciones Unidas sobre la violencia contra los niños (Oslo, Save the Children, Noruega, 2005), pág. 58.*

indicate that all forms of violence are endemic in forced labour and conditions of servitude.

E. Violence in the community.

The community is a source of protection and solidarity for children but it can also be a place of violence, including peer violence, related to guns and other weapons, gang violence, police violence, physical and sexual violence, abductions and trafficking. Violence may also be associated with the media and new information technologies and communications. The older children are more likely to suffer violence in the community, and girls are at an increased risk of sexual and gender violence.

- **Activities alone**. For some children, the way to and from school may be either their first independent exposure to the community, but can also be the first time they are exposed to risks. Others are exposed to violence when carrying out domestic tasks, such as fetching water, fuel, food or fodder for animals. These tasks, which sometimes involve walking considerable distances, are usually assigned to girls in rural areas of the developing world[115].
- **Violence between teenagers**. A sudden, steep is noticeable in the rates of violence (both victimization and perpetration), particularly among boys at around age 15, indicating that a number of factors come together at adolescence to make peer violence more common. Available data indicate that in most parts of the world, homicide rates among boys aged 15 to 17 are at least three times greater than among boys aged 10 to 14. This sudden increase in violence among children older than 15 years occurs even in regions with low overall homicide rates and implies that measures to curtail violent behaviour are critical before they are from 10 to 15 years old[116]. Gender differences in adolescent homicide rates suggest that male socialization and norms of masculinity contribute to violence. In Brazil the rates among boys are four to six times those among girls[117].
- **Youth gangs.** Increased punitive measures, including large-scale detention of supposed gang members, associated with arbitrary, inefficient and violent law enforcement further contributes to the stigmatization of poor youth and the rising violence.

[115] Every Girl Counts, Development, Justice and Gender, Girl Child Report (Ontario, World Vision Canadá, 2001), pág. 17; UNICEF Somalia, From perception to reality: A study on child protection in Somalia (Nairobi, UNICEF, 2003).

[116] Global Estimates of Health Consequences due to Violence against Children, op. cit. en nota 8. Impacto da violência da saúde dos brasileiros (Brasilia, Ministério da Saúde, 2005); Saúde Brasil 2004: una análise da situacão de saúde (Brasilia, Ministério da Saúde, 2004); Firearmrelated violence in Brazil (São Paulo, Núcelo de Estudos da Violência, Universidade de São Paulo, 2004).

[117] Impacto da violência da saúde dos brasileiros (Brasilia, Ministério da Saúde, 2005); Saúde Brasil 2004: una análise da situacão de saúde (Brasilia, Ministério da Saúde, 2004); Firearmrelated violence in Brazil (São Paulo, Núcelo de Estudos da Violência, Universidade de São

Paulo, 2004

- **Sexual violence coming from trusted adults.** Sexual violence is more commonly perpetrated by someone known to the child such as family members or adults in positions of trust (such as sports coaches, clergy, police, teachers and employers).
- **Gender-bases violence within a teenage couple.** Recent research shows that violence is frequently a feature of adolescent relationships. Preliminary results from the ongoing Global School-based Health Survey, conducted among students 13 to 15 years old, shows significant levels of physical violence within dating relationships. Asked if they had been hit, slapped or hurt on purpose by a boyfriend or girlfriend in the past 12 months, 15 per cent of girls and 29 per cent of boys in Jordan responded "yes", as did 9 per cent of girls and 16 per cent of boys in Namibia, 6 per cent of girls and 8 per cent of boys in Swaziland, and 18 per cent of girls and 23 per cent of boys in Zambia[118].
- **Sex tourism.** Accessible and affordable tourism has brought with it sex tourism, which often involves the victimization of children. The Internet and other developments of communication technologies also appear to be associated with an increased risk of sexual exploitation of children, as well as other forms of violence.
- **Refugee and displaced children** suffer significant violence. Many camps lack secure buildings, regular law enforcement, and sanctuary for survivors of attack, and means of reporting and redress[119]. In the cases of forced displacement, especially women and girls can be exposed to protection problems related to their sex, gender issues, including their cultural and socio-economic position, and their legal status, which means that they may be less likely than men and boys to be able to exercise their rights in the same way mean and boys do.
- **Trafficking in human beings.** Trafficking can involve multiple forms of violence: kidnapping or deception by recruiters in their transactions with children, their parents or other cares, sexual violence which affects trafficking victims as they are transferred to their destination[120], and are held captive, frequently accompanied by violence while waiting for a "job" placement. Most victims are trafficked into violent situations: prostitution, forced marriage, and domestic or agricultural work in conditions of slavery, servitude or debt bondage.

[118] Analysis provided to the Study by the Global School-based Health Survey: The World Health Organization, op. cit. at note 9.

[119] USAID, Project – Linking Gender-based Violence Research to Practice in East, Central andSouthern Africa: A Review of Risk Factors and Promising Interventions. The Policy Project, 2006.

[120] Trafficking for sexual exploitation and other exploitative practices (Florencia, Centro de Investigaciones Innocenti del UNICEF, 2005).

- **Exposure to violence in the mass media**. The mass media sometimes portray as normal or glorify violence, including violence against children, in print and visual media including television programmes, films and video games[121]. The Internet has also stimulated the production, distribution and use of materials depicting sexual violence against children.
    - **Cyberbullying**. The Internet has been used to ask for online sexual relationships or to obtain the child confidence in order to draw them into a situation where s/he may be harmed. It also exposes children to violent or pornographic materials, as well as harassment and intimidation by adults and other children[122]. Surveys carried out in Canada and the United Kingdom suggest that large numbers of schoolchildren have been harassed, bullied or victimized through e-mail or mobile phones, or have had someone publish misleading information about them online[123].

  Other violent acts in the community:

    - Child begging
    - Child prostitution
    - Child soldiers
    - Abduction and murder of minors
    - Prenatal violence

Hate related offenses

The **hate related offenses** take place when one person attacks another and the latter one has been chosen because of the social group s/he belongs to, the age, the gender, the religión, the gender identity, the nacionality, the ideology or the political affiliation, disability or sexual orientation.

The hate related offenses is a violent behaviour caused by prejudices, and its production and reproudction seems to be typical of human societies throughout history. This definition of the hate related offenses raised by María Mercedes Gómez in the paper "Los usos jerárquicos y excluyentes de la violencia" [124] can be understood as a violence form against people pelonging to a specific group, being this a social, racial or ethnic group or against people having a sexual or religious tendency classified as “different.”

[121] United Nations Secretary-General’s Study on Violence against Children, Regional Desk Review North America (2005)

[122] ECPAT, Violence against Children in Cyberspace. Informe de recurs(2005).

[123] T. Beran y Li Q, “Cyber-Harassment: A Study of a New Method for an Old Behaviour”, Journal of Educational Computing Research, vol. 32, No. 3 (2005), págs. 265 a 277.

[124] *The University de Los Andes (Colombia), language and sociocultural studies. Faculty Member.*

The way predjudices are set depends on the social context and the stereotypes created by the society itself. Such predjudices and the violence that they produces in general, are caused by "the need of clearly address the differences between hegemonic and non-hegemonic communities because of the fear the first ones have of losing their privileges. The unification and repetition of the predjudices created bu the society are a way of legitimize the violent acts carried out by some specific groups.

Now, we are going to explain the concepts used for each tipology of hate related offenses, according to the classification of the Interior Ministry of the Spanish government:

- RACISM/XENOPHOBIA: Any incient perceived as racist or xenophobic by the victim, or any other person, including the pólice officer or any toher witness, although the victim does not agree, as well as the act of hatred, violence, discrimination, phobia and rejection against foreigners or people from different groups, due to their racial, ethnic, national, cultural or religious orignis. The origin of this definition lies in the suggestion made by ECRI (European Commission against Racism and Intolerance.)
- SEXUAL ORIENTATION OR IDENTITY: Facts motivated by sexual differences (gay, lesbian, heterosexual.)
- RELIGIOUS BELIEFS OR PRACTICES: Facts motivated by contrary feelings to specific religions (Jews, Catholics, Jeovah's witnesses, Muslims, and others.)
- DISABILITY: Any act against the victim done by taking advantage of her/his disability, whichever it is (physic, psychological, dotage...)
- PENIAPHOBIA: Hate or rejection to the por one. It includes those intolerant expression and behaviours related to hatred, Recoge aquellas expresiones y conductas de intolerancia referidas al odio, aversión or hostility against poor, powerless people and unemployees.
- ANTISEMITISM: Any act of hate, violence, discrimination, phobia and rejection against Jews or Israeli people.

  One of the most important isses that includes this evaluation is that, although the victim does not recognize his/herself as a discriminated person, any other person, including the police officer or other witness can recognize a person as a victim, even if the victim does not agree with the other person. The origin of this definition lies in the suggestion made by ECRI (European Commission against Racism and Intolerance) and means a great progress in the visibility of this discriminatory behaviours within the society.

Summary Chart

Classification of forms of physical abuse according to, Fabian Zarate[125] (article: "Maltrato Infantil: Abordaje, Intervención y Prevención en las Escuelas")

CHILD ABUSE		
PHYSICAL - Prenatal abuse - Labour exploitation - Begging - Corruption - Shaken baby syndrome - Münchhausen syndrome by proxy	**Active** - Physical abuse - Sexual abuse	**Passive** - Physical neglect or negligence
EMOTIONAL	- Emotional abuse	- Emotional neglect
OTHER FORMS OF ABUSE	**- Institutional abuse** In the field of Public Services In the field of education In the field of health In the judicial field	

TYPE OF ABUSE IN RELATION TO THE ENVIROMENT IN WHICH IT IS PRODUCED, according to the report of the independent expert for the research on child abuse, Paulo Sérgio Pinheiro, submitted in accordance to the General Assembly resolution 60/231[126]**:**

A. ABUSE IN THE DOMESTIC ENVIROMENT (FAMILY AND HOME)	• Violent methods of discipline • Carelessness • Sexual violence • Gender violence • Young girls married • Rejection of children with disabilities • Harmful traditional practices (female genital mutilation) • Domestic violence

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clementezarate@hotmail.com. Higher University of san Andrés. First cycle of seminars and workshops of teacher updating of primary level Nuestra señora de la Paz. Bolivia. From the 21 to the 22 May.

[126] United Nations A/61/299 Distr.: General 29 August. Original Spanish: English 06-49108 (S) 041006 041006 *0649108* Sixtyfirst Session. Item 62 of the provisional agenda*Promotion and Protection of the rights of children. Ricghts of the child.

B. VIOLENCE IN SCHOOLS AND	• Exposure to violence. • Violence perpetrated by teachers and other school workers • Aggression and bullying among students • Sexual violence and gender violence • Homophobia
C. LA VIOLENCIA EN LOS SISTEMAS DE ATENCIÓN SOCIAL Y EN LOS SISTEMAS	• Violence exerted by the staff of the institutions • Abuse in the medical or psychiatric treatment • Carelessness • Violence among children • Death penalty • Abuse of the arrest as a disciplinary measure • Attacks by members of the authority during the process of arrest. • Attacks by other adults arrested • Self-injury during the arrest
D. VIOLENCE IN THE	• Girls in the domestic/housework • Child prostitution • Bondage
E. VIOLENCE IN THE COMMUNITY	• Activities alone. • Violence between teenagers • Youth gangs. • Sexual violence coming from trusted adults • Gender-bases violence within a teenage couple • Sex tourism • Refugee and displaced children • Trafficking in human beings. • Exposure to violence in the mass media • Cyberbullying • Child begging • Child prostitution • Child soldiers • Abduction and murder of minors • Prenatal violence

The hate related offenses take place when one person attacks another and the latter one has been chosen because of the social group s/he belongs to, the age, the gender, the religión, the gender identity, the nacionality, the ideology or the political affiliation, disability or sexual orientation.

ABUSE/NEGLECT AND CHILDREN AS VICTIMS

Although the child abuse is anuniversal problema that exits since ancient times, until the twentieth century was not considere as crime and a problem of profound psychological, social, ethnic, legal and medical consequences, with the Declaration of the Rights of the Child (UN 1959.)

The American doctor, Henry Kempe[127] ("Niños maltratados", Ruth S. Kempe, 1985, p. 22) says that the shaken-baby syndrome was first described in 1868 by *Ambroise Tardieu*[128], profesor of Legal Medicine in Paris, by drawing on findings obtain through autopsies of children.

In 1953, Kempe y Silverman found out a phenomena that they called "Battered child syndrome", addressing the fractures y hematomas caused to the children by their parents. En 1962, Kempe described the battered child syndrome in an exhaustive way from the paediatric, psychiatric, radiological and legak point of views, as well as the first incidence figures corresponding to The United States[129].

Kempe's papers had a significant impact worldwide because they enabled that the child abuse become a social phenomenon accepted. From this moment, the number of cientific publications that dealt with the theme multiplied and also began to define another forms of child abuse like carelessness or negligence and sexual abuse. Later on, several associations were created to protect children victims of mistreatment.

[127] Dr. C. Henry Kempe (birth name Karl Heinz Kempe, b. 1922, Breslau, Germany (now Wrocław, Poland) - d. 1984, Hanauma Bay, Hawaii) was a pediatrician and the first in the medical community to identify and recognize child abuse.
In 1962, Dr. Kempe and Dr. Brandt F. Steele published the paper, "The Battered Child Syndrome." Publishing this paper led to the identification and recognition by the medical community of child abuse.
Dr. Kempe received two nominations for the Nobel Prize. The first nomination was for his work in developing a safer smallpox vaccine. The second nomination was recognition for his contribution to the prevention and treatment of child abuse. Due to the efforts of Dr. Kempe, abuse reporting laws exist in all 50 states. His efforts also led to the passage of the 1972 Colorado law requiring legal counsel for the child in all cases of suspected abuse.
128 Auguste Ambroise Tardieu (Paris, 1818 - Paris, 1879), was a french medical examiner of thenineteeth century. He was president of the Académie nationale de médecine, as well as dean of the Medical School and professor of Forensic Medicine in the University of Paris.
129 Kempe, C. H., "The Battered Child Syndrome" en Journal of the American Medical Association, 1962, 181, 17

Origin of the Problems: Attachment.

What's the first alered thing in an abused child, in some cases even before being born?: the bond with the parents, the attachment. This produce s the lack of basic trust of the abused children (in the rest, self-confidence and in the future; the so-called "depressive triad".)

The first stage of the social development identified by Eriksson, which comprehends from the 18 months more or less, is the basic trust versus basic mistrust. In these first months, the babies develop a sense of trust in people and objects of their world. They need to develop a balance between the trust (which aloows them to established close relationships) and the mistrust (which allows them to protect themselves.) If the trust prevails, as it should be, the children develop the virtue of the hope: the belief that they can satisfy their needs and get what they wish for (Eriksson, 1982.) The key element to develop this trust is a sensitive, warm and consistent care.

What prevails in abused children is mistrust, because of this they believe that the world es unfriendly and unpredictable, so they will have problems to establishes relationships. As well they will have serious difficulties for developing a solid personal identity, the basis of the personality.

Both the role of the mother and the role of the mother involve affective commitments and taking part in the care and the raising of their children (Engle and Breaux, 1998.) As Lailable and Thompson (1995) establish, if the attachment is positive, it is more likely that the children feel safe and self-confidence, value themselves positevily and feel competent.

Mueller and Silverman (1990) come to the conclusión that the principal consequence of the abuse in little children is the attachment insecurity, which led to the difficulty to establish bonds.

In 2012, UNICEF published its report "Hidden in plain sight: a statistical analysis of violence against children" presenting the earliest stadistical data on the violence against children, based on information related to 195 countries. This report points out that "regardless of the economic, social, cultural, religious and ethnic circumtances of the children, the violence is still a part of their lives, so real, in the whole world. Freguently, the children development, who have suffered serious abuses o carelessness, is inappropriate; and the child has difficulties with learning and school performance. They also may have low levels of self-steem and suffer from depression, and if the worst-case scenario, this can led high-risky and autodestructive behaviours."

Personality Traits of Abused Minors

The research in the children's personality has been developed by many authors during the last decades with the same results in most cases. "The abuse in all of tis forms is devastating for the management of the development tasks which are setting attachment bonds, self-development, symbolic representation, peer relationships and communicative behavior" (Mª Victoria Trianes, p. 85.)

A Mexican research carried out with children living in reception centres (Romo, N., & cols. 2007) shown that the most recurrents and protrudings traits of the personality of childrens victims of their parent's violence were: **insecurity, shyness, withdrawn and aggressiveness.**

A similar research in Spain (Moreno, J. & García-Baamonde, E., 2006) concluded that children living in reception centres shown raits such as **heightened anxiety, insecurity, introversion and low self-steem.** They also confirmed the characteristic of the personality change according to the child abuse form and the age of the child. The result were the following:

- The child who suffered psychological and sexual abuse show more introversion than the ones who were abandoned and physically abused.
- The ones who were abandoned and physically abused show more anxiety than the rest.
- The children who were physically abused show self-disapproval, frustration, pessimism and insecurity. They tend to be individualistic, critic with the rest, irritable and disdainful. (Prino y Pierrot, 1994; Levendosky, Okun y Parker, 1995). They show dissociative imbalance, negativ thoughts and mechanisms for detachment from reality (Carlson, 1998). Sometimes they show feelings of helplessness, so they tend to be manipulative and destructive as a way to get the control of the environment. Other times, they show a hypervigilance behavior with what surrounds them.
- The children psychologically abused get hihg scores in part of "cunning."
- The best characteristics to define the minors abandones is the independence or "thick skin" hard sensitivity. They score high in self/supporting and affective imbalance (Barudy, 1998.)
- The children who suffered sexual abuse are reticent, inecure and withdrawn in regard to personal contacts. For them, it's hard to balance intense emotions. They avoid the threat and the excess of social stimulation via introversion and distance.They have feelings of guilty and subjective disturbance (Wurtele & Millar-Perrin, 1992.)
- The children victims of negligence and physical abuse gradually develop inferiority feeling, low self-steem, unsuitability feeling, as well as sadness and chronic anxiety (Cantwell, 1980; Garbarino, 1980.) They show a deep feeling of failure and shame of

their learning difficulties too; and they are very insecure and easily frustrated (Sullivan & Spacer, 1977)

Summing, the characteristics we are higlighting in the emotional field are:

- **Distort and negative self-concept and low self-steem:** they feel unsatisfied with themselves. The think they are bad, unpleasant and stupid (Kempe, 1979, p. 74.)

The mechanism within would be "my parents don't love me, so I don't deserve being loved, I'm not good enough, I'n not a good person." The children consider themselves bad, impupolars and distracteds (Kaufman y Ciccheti, 1989.) They deeply believe they are incapable.

- **High difficulty to acnkowledge their own feelings and to spak of themselves,** especially of their oriantations and sympathies, solitude, anguish and tastes (Kempe, p.74)
- **Hypervigilance, "frozen watchfulness"** (Ounsted, cited by Kempe): children that are constanly whatching and have a notable memory of what physic environment that surrounds them; they are constaly on guard to avoid upsets or try to please.

  Hypervigilance is synthom of post-traumatic stress disorder, which is include in DSM-V.
- **Sadness, anxiety**
- **Withdrawn,** mood swing, difficulty to feel.

Child abused **behave** as follows:

- Immoderate **aggressivness** or outbreaks of aggressivness unexplainable, or due to little stimulus.
- **"Evil" symptoms:** Kempe (1979) called that way some of the abused children he worked with because they were negative, aggressive and frequently hyperactive. "They arechildren extremely difficult to dealt with. […], they are constanly attacking other children. They only attention they seem to want is a negative one. Sometimes, their hyperactivity seems severe enough to be treat with medicines." It is curious the similiraty of this description to the modern and frequent ADHD (Attention deficit hyperactivity disorder.) It would be interesting researching the relation between this disorder and the negligence and/or emotional deficiencies experiences of the minors.

  In the same line, Bowlby (1984) stresses the tendency of abused children to attack or threaten adults with typical aggressive behaviours called "annoyance."
- **Limited social skills:** we will see this aspect insightfully in the social interacctions section.

- **Isolation, withdrawn, passivity:** is like "the other side of the coin" of the aggressiveness. The researches show that abused children may become overtly aggressive or isolated (Dubowitz, 1999; Shonk & Cichetti, 2001.)

Summary Chart

The origin of the psychological problems of abused children:

lack of a sensitive, affective and consistent care

absence of bond child-parents. Insecure attachment

lack of trust (in the rest, in the future)

difficulty for a good development of the personal identity

- PERSONALITY TRAITS of abused children:

Emotional field:

- Distort and negative self-concept and low self-steem
- High difficulty to acnkowledge their own feelings and to spak of themselves
- Hypervigilance, "frozen watchfulness"
- Sadness, anxiety
- Withdrawn, mood swing, difficulty to feel.

Behaviour:

- Aggressivness
- "Evil" symptoms,nehaviour "annoyance", hyperactive children, hard to manage
- Limited social skills
- Isolation, withdrawn, passivity

Social Interactions between Abused and Neglected Children and Others

One of the main consequences of abuse is the difficulty in relationships with adults and equals due to the lack of trust, which is a consequence of the lack of secure attachment in the relationship between the child and the parents.The attachment is decisive in children's social relationships, because of this the Reactive attachment disorder is included in the diagnostic manuals of WHO and the American Psychiatric Association (APA). This disorder is characterized by development disorders and inappropriate forms of social relationships in most circumstances. It is included in the last edition of the diagnostic and statistical manual of mental

disorders of the American Psyquiatric Association (DSM V) [130], together with another category within the disorders related with traumas and stress factors:

- **Reactive attachment disorder:** inability to start and answer to most of social interactions in an appropriate manner for development.
- **Uninhibited social relationships disorder:** random sociability, excessive familiarity with strangers

Parental Interaction

"The mistreatment is a disease of the parents that suffer the children" (Dr. Baño, of the Hospital "Niño Jesús" of Madrid)

Kempe says that "mistreatment of children has survived until the current era virtually unmodified due to two persistant beliefs. The first one consists of considering the children as a property by their parents and it is also assumed that the latter have the full right of dealing with them according to what they though is convenient. In the other hand, the children fell under the responsability of the parents; and during many centuries, the strict treatment was justified by the belief that de physical punishments were required in order to maintain the discipline, teach educational decisions, and expel the evil spirits" (1985, p. 22.)

From few decades ago, due to the persistance of this beliefs, there is work in favor of "prioritizing the children's rights over the ones of the parents" (or best interest of the child.)

In the recommendation on 28th February 1984, of the Committee of Ministers of the Council of Europe, "the parents' authority" isn't mentioned but "the parents' responsibility." The latter is the only expression used in the UN International Convention for the rights of the children (Boucaud, 1991)

- **Anxious-ambivalent attachment, reactive attachment disorder**
- **Total submission to the wishes of the parents**: is "the best way many children have to obtain food, attention and cares within a hostile environment" (Kempe, p. 67.) Barudy speaks of children who become "clear" (extremely obedient, passice and undermanding) in order to go unnoticed, avoiding any risk of confrontation. This characteristic of submission and excessive desire of please may extend in the children interactions with another authority figures too.
- **Misbehaviour**, playing the figure of "tha bad child" to justify the mistreatment the child suffer (especially in cases of physical abuse.)
- **"Family plays"**: from the viewpoint of the systemic therapy, Cirillo and Di Blasio (1989), make an interesting approach to mistreatments abuse paying attention to the structured and

[130] http://www.dsm5.org/Pages/Default.aspx

complex familiar dynamics that are related to violence more than in the individual problems. They discover how plays of abusive families are; in many aspects, they are similar to the plays in the psychotic families plays carried out by Mara Selvini Palazzoli and others (1988.)
These authors distinguish between two categories of plays: the *incapability of the parents as message,* and the *mistreatment of the scapegoating.*
Interaction with Equal Status

They do not developed social skills and tend to be reject by pairs[131]., because they did not have early positive social ineractions. The little children who suffer physical abuse tend to be fearful, non-cooperative, and less able to answer accurately to friendly actions, and as a result they are unpopular. [132].

There is a tendency to solitude and isolation in the age where the children are expected to have more relation with their parents, specially playing. They have such difficulty to play; they can't; and, they are not able to play. It is hard for them to have fun, only in a few cases they allow themselves to enjoy.

Bullying and domestic abuse: the bullying phenomenon (intimidation, harassment and abuse with equal status) is more and more present worldwide in the classrooms of primary and secondary educational institutions. Although it is not appropriate pause on this research here, it is interesting to ask ourselves how this is related to the mistreatment children suffer from their family. It is assumed that the children who were physically abused are the susceptible ones to become stalkers and bullies in the classrooms. This phenomenon is frequently in the child protection centres too.

The Mexian NGO "Educadores sin Fronteras" published a research on school coexistence (2013), interviewing 6180 students of primary and secondary from 8 Mexican states on the forms of violence they suffer from, both at school and home. The 38% recognized being punished by their family by hits. The 43% of these are assailants or victims of their pairs at school. The roles, assailant and victim, are frequently exchanged. The research conclude saying that family violence is a triggering factor of violence of bullying. "Many times they are people systematically reproducing the violence in which they learnt to interact," explains Úrsula Zurita, researcher of the Latin American Social Sciences Institute.

[131] Bologer & Patterson, 2001; Price, 1996

[132] Coie & Dodge, 1998; Haskett & Kistner, 1991; Sazinher & collaborations., 1993.

In spain, a research on the exposure's influence of violence in behaviours of aggression in cyberbullying show the existence of strong link between being involved in cyberbullying behaviours as aggressor and being exposed to violent situations within the family unit. Precisely, being the witness of domestic violence a factor with a more explanatory power of the aggression in cyberbullying than having suffered from family violence in the first person.

Interaction with Other Adults:

As well as in the aspect of withdrawn and aggression, the relationships move between 2 poles here: suspicion and mistrust; or, over-reliance and complacency.

Apprently, the child unjustifiedly fears the adults; the child also fear adults who are affective with him/her or with a positic characteristic (g.e. the friendly and affective teacher gest close to see what happens to the child and s/he shows rejection, mistrust and suspicion to the teacher.) In the other hand, there is also an overwhelming ease to adapt to unkown people or to those s/he does not trust in: children so adapted and complacent with unkown adults.

Barudy[133](1998) explains this as "the relational model of dependency-mistrust" (this is mostly in children victims of negliegence or carelessness.) The child cab be extremely dependant to the attachment of the adults. This way, s/he can be friendly to any adult without discriminating or exposing him/herself to situations of risky (sexual abuse) or rejection. Once the child has worried the adult, this dependence can be turned into a withdrawal so as to protect him/herself from the possibility of a new frustration. The children emotionally isolate themselves, refusing to take part in long-term affective relationships.

Repetitive Cycle of Abuse: from Victims to Offender/Persecutors?

"The most frequent trait in the family stories which abuse of the children, from one generation to another, is the repetition of the pattern of the violent acts" (Kempe, p. 35)

- The scientific literature on the *abused-abusing intergerational cycle* is the most extensive one. It confirms the consolidated opinion that says the abuse is a repetive phenomenon that develops from one generation to another (Cichetti, Rizley, 1981; Main, Goldwyn, 1984). This is precisely why it is necessary to interrupt it (Cirillo, Di Blasio, 1988).

Barudy refers to the abusive parents as "abusers who abuse" because they grew up in social and familiar systems that were violent and abusive, this explain the transgenerational character of these phenomena. "The drama of these adults lies in the fact that their afflictions, product of the violence and the abuse the lived being children, weren't verbalized, listened and/or acknowledge. So, these afflictions are subsequently expessed thourgh the situations of

[133] Family neuropsychiatry, child psychiatry, psychotherapist and therapist. *Recognised fomer by EFTA (European Family Therapy Association)*

family violence" (p.22.) They use thir children as a reparation source, since they do not find compensatory experiencies for their lacks within their own community.

The social learning theory points out that people, who lived violent experiences in their childhood, are more likely to be abusive parents or violent partners via direct imitation of the most significant adults they know: their parents.

Summary Chart

- REACTIVE ATTACHMENT DISORDER y UNINHIBITED SOCIAL RELATIONSHIPS DISORDER (DSM V).

PARENTAL INTERACTION:

Two mistaken beliefs that continues the possibility of abusive parents:

1- The children are property of the parents
2- The parents have to make use of discipline and authoriry as they conveniently estimate

Nowadays: it has change from "parents' authority" to "parents' responsability".

Characteristics of the intereactions between abused child and the parents (or authority figures):

- Anxious-ambivalent attachment, reactive attachment disorder
- Total submission, excessive desire of please
- Misbehaviour

Systematic therapy: "family plays" of abusive families are similar to the ones of psychotic families.

INTERACTION WITH EQUAL STATUS:

- Lack of social skills
- Tendency to be rejected
- Tendency to solitude and isolation
- Difficulty top lay and enjoy
- Tendency to take part in bullying actions (abuse between equals), as aggressors (especially in case of physical abuse) or as victims, frequently exhanging the roles.

INTERACTION WITH OTHER ADULTS: "relational model of dependency-mistrust":

SUSPICION AND MISTRUST

OVER-RELIANCE AND COMPLACENCY

REPETITIVE CYCLO OF ABUSE: FROM VICTIMS TO OFFENDER/PERSECUTORS?

The abused children tend to be abusive parents due to:

- Direct imitation of the known model (social learning)
- Identification with the aggressor
- Mechanisms of compensation of their lacks and traumas and form of expressing their affliction.

Signs of sexual offending & victimization

The sexual abuse of children is a form of child abuse which infringes the right of the child to his/her physical integrity and human dignity, which is recognized in the article 19 of the Convention of the Rights of the Child, impeding a full development.

In accordance with the Committee of the Rights of the Child, in its Recommendation no.13 "sexual abuse is every sexual activity imposed by an adult to a child of which the latter has right of protection from de criminal law. It is also considered abuse the sexual activities perpetrated by a child to other, if the first one is significantly older than the victim or uses the force, threats or other ways of pressure. The sexual activities between children are not considered sexual abuse when children do not surpass the age limit established by the state for consenting relationships.

Sexual abuse is also:

- The incitement or coercion so as to make a child work on any ilegal sexual activity or psychologically harmful.
- The use of a child with the aim of comercial sexual exploitation.
- The use of a child to produce images or sound recording of sexual abuse of children.
- Child prostitution, sexual slavery, sexual exploitation in turims.

Cooperating with the eradication of ***children abuse and exploitation***, between the varios states, results in the ***Council of Europe Conventio of 2007*** on the protection of the minors against sexual abuses and sexual exploitation (***Convention of Lnazarote***) by resorting coercion, force or threats; by abusing of recognized position of trust, authority or influence over the child, even within the family; and/or, by abusing of a vulnerable situation of the child, especially physical or psychic disability or a dependence situation.

Regarding to ***child prosititution***: **"**shall mean the fact of using a child for sexual activities where money or any other form of remuneration or consideration is given or promised as payment, regardless if this payment, promise or consideration is made to the child or to a third person."

On the concept of sexual abuses, the following categories can be pointed out:

- ***Sexual abuse:*** any kind of physical contact with or without defilement; with or without physical contact carried out without violence or intimidation and without consent. It may involves: vaginal, oral and anal penetracuón, digital penetration, caresses or explicit verbal propoaitions.
- ***Sexual assault:*** any physic contact with or without defilement with violence or intimidation and without consent.

- ***Exhibitionism***.It is a category of sexual abuse without physical contact.
- ***Sexual exploitation of children:*** A category of sexual abuse of children where there exists sexual abuse and economic exploitation of children. From one hand, the client has sexual relationships with the child; on the other hand, the exploiter, who may be or not the same person as the cient, obstains economic benefits of such sexual relationships. This phenomenon involves prostitution and chil pronohraphy, as well as the sexual trafficking and the sexual tourism of children as ways of achieving the acces to the victim of the sexual exploitation of children. The sexual esxploitation is usually compared to sex trade of children.
- ***Gromming*** is a form of online sexual harassment of children, but not the on ly one. We may consider *grooming* when a sexual assault is produced, where previously has been a strategy of approachment or cajolery, aming to get the trust of the child so as to obtain the force element to start the blackmail.

The Offender or Persecutor

The offenders are not a homogeneous group. For instance, a pedophilemay be heterosexual, or being married. However, the abuse of both girls and boys. An incestuous biological father can abuse of his own children and of unkwon children at the same time, and also violate adult women[134]. There is not a unique profile that involves all offenders, nor common characteristics.

According to the article called the Sexual offender[135], the **general characteristics** of children offenders are: married and familiar men (around 87%) or close relatives of the child, so they have a previous relationship of trust with the child (only from the 15% to 35% of the sexual offenders are completely strangers to the child.) They perpetrade the abuse in the average lifetime (from 30 to 50 years), although half of them show behaviours with tendency to abuse before 16 *from 20% to 30% of sexual assaults of children are perpetrated by other children.) The women offender are usually mature women who abuse of teenagers.

The sexual offender is a person of appearance, clever and an ordinary life. They usually show traits of neuroticism and introversion, as well as immaturity (e.g. childishness). Nonetheless, the pedophilia usually appear together with another paraphilia (e.g. exhibitionism) and are related with other disorders, such as alcoholism or antisocial personality. It is frequent a link between pedophilia and obsessive personality.

[134] Prendergast, William. «Treating sex offenders in correctional institutions and outpatient clinics,». New York, Haworth Press, 1991, ISBN 978-1-56024-207-9

[135] Original Spanish: *Agresor sexual [135]: https://es.wikipedia.org/wiki/Agresor_sexual*

According to a survey[136], half of them did not receive affective expression during their childhood and adolescence. They have problems with the alcohol consumption but do not have lack of social skills, although they do not feel empathy towards their victims, denying the crime (this traits do not necessarily combined in every individual.)

It has also been pointed out that the personality of the offender, who would enjoy submitting and famaging a child, is included in the so-called "perverse psychological structure[137]"

We can distinguish between **two main types of offenders:** the primary ones and the secondary ones or situationals.

- **The primary ones** show a sexual orientation which is almost exlusive to children and their compulsive behaviour is not bound to their personal status. Clinically, they are "pedophiles", in the accurate sense of the world, who present specific cognitive distorsions: they consider their sexual behavior as accurate (they do not feel guilty or ashamed), plan their actions, may attribute their behavior by saying it is a result of the seduction of the child or may justify their behavior as a form of sexual education for the child.

In addition, they may contribute to specific problems of psychological or social origing, as alcohol or drug misuse, the depressed mood, lack of self-control, and even in some cases, metal retardation[138].

- Regarding **the secondary or situational ones,** they are characterized by a behavior that results from a feeling of loneliness or stress: the abuse is a way of compensate their low self-steem or release themselves of certain hostility. They are not strictly pedophiles with people they usually have problematic relationships (occasional impotence, stress within the couple…) because their natural orientation is adult people. They only turn to children exceptionally in a compulsive way, noticing their behavior as anomalous and feeling guilty and shame afterwards.

When they are discovered, many of them deny their actions; and even, they deny them to hilseves. Another frequent actitud is relativization of the acts' significance (they strongly believe in the impossibility of causing problems to the chil or refer to a crush to justify the sexual actions) or addressing the responsibility to the child, who is the one that mesmerized him to commit the abuses[139].

[136] *See BENEYTO ARROJO, María José: «Intervención con hombres...», pages. 141-142.*
[137] *See DÍAZ LÓPEZ, Enrique: «La estructura perversa», in the website Geomundos*
[138] *See OLIVERIO-FERRARIS, Anna; & GRAZIOSI, Bárbara: ¿Qué es...?, page. 100.*
[139] *See OLIVERIO-FERRARIS, Anna; & GRAZIOSI, Bárbara: ¿Qué es...?, page. 99.*

The doctor **Irene Intebi,** specialist in sexual abuse,[140] explains:

> "One more time, against of what we want to believe, the international statistic take us by surprise because the point the biological fathers as the main responsibles of the domestic abuses. We would like to say that corresponds to other cultres, other ydiosyncrasies, and other upbringing forms. We resort to the research carried out in Buenos Aires from 1989 to 1992 on138 cases. The dara are insdisputable: the 42, 5% of the offenders are the biological fathers. In second place, the close relatives (uncles, granfathers, brothers, cousins, etc.) which are the 23, 7%. The third place, with the 17,5%, belongs to acquaintances who are not familiar. *In the las place, there are the ones more identificated by the general opinion as the most freguently offenders: stepfathers, responsible of this actions in the 13,8% of the cases*[29]

The Victim

Consequences of sexual abuse in minors

In general, the short-term consequencies of sexual abuse are desvastating for the psychological functionof the victim, especially when the offender is a member of the child's family. The long-term consequences are uncertain. There is correlation between the sexual abuse suffered during childhood and the appearance of emotional disturbations or maldaptive sexual behaviours during the adult life. It is significant that the 25% of children sexually abused become offenders when they are adults[141]

Short-term effects

From 70% to 80& of the victims remain emotionally disturbed after an aggression (short-term effects). The girls usually show anxious and depressive reactions (very serious in teenagers) and the boys show problems of learning breakdown and socialization, being more susceptible to present behavioral disturbations as sexual aggressions and violent behaviours.

From a theoretical point of view, the "model of post-traumatic stress disorder" considers that the consequences are the typical of any "trauma": intrusive thoughts, rejection of stimulus related to aggression, sleep disturbance, irritability, concentration difficulties, fear, anxiety, depression, guilty feelings, etc. (effect that may physically materialize into symptoms such as stomach pain, headache, nightmares…)

Meanwhile, another theoretical model, the "traumatogenic", focuses on four variables as main causes of trauma:

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[140] *Entrevista a Irene Intebi, experta internacional en prevención del abuso sexual infantil, in the website Inventario 22.*
[141] *Conf. FREYD, Jennifer J.: Abusos sexuales..., page. 43.*

- **Traumatic sexualization:** sexual abuse is an interference in the normal sexual development of the child because they experience a distorted experience of sexuality (especially when the aggression occurred at home)
- **Loss of confidence:** not only with the aggressor but with the ramaining people who were unable to prevent the abuse.
- **Helplessness:** having suffered abuse takes the victim to consider him/herself unable to defend against the vicisitudes of life, causing him/her passive and withdrawal actitudes.
- **Stigmatization:** guilty, shame, etc. Undermining their self-steem.

Long-term effects

Although the effects are comparatively less frequent tan the shor-term ones, in long term, the trauma is does no resolve and often moves from one symptomatology to another. However, it is not possible o identify a characteristic syndrome of adults who were sexually abused in childhood or adolescence. There are many determinants of the persistence of long-term effects, such as, the existence of the abuse of other problems in the life of the child (abuse, parental divorce, etc.) and even, in many cases the effects caused by negative circumstances appear in adulthood (marital problems, work, etc.)

The most refgular phenomena are alterations in the sexual field, as erotic inhibition, sexual dysfunction and decreased ability to enjoy, depression, lack of control over anger, hypervigilance if having children or adopting behaviours of abuse or consenting it; and characteristic symptoms of any post-traumatic stress disorder.

In more detail, the followings can be identifies as log-term effects: the abused may experience syptoms such as flashbacks (vivid memories that imposed itself against the victim's will) emotionally lability, sleep disorders, hyperactivity and constant alert. Moreover, isolation, emotional numbness (emotional petrification), memory and concentration disorders, phobias, depression and self-destructive behavior can be produced.

There are also proves of people tan can forget the sexual buses (as wel as other traumatic events of their life). People who has sufferes traumas may have invasive memories of an event, or at the same time, they are able of remember images (or vice versa), or can remember the feelings lived during the abuse but not the excat events that caused them.

Traditional clinical experience has shown that there are three fundamental reasons to repress memories: avoid pain, avoid being overwhelmed and avoid unacceptable desires. Recently, it has added the " avoidance of information that threatens a necessary link ' as a cause, and perhaps the most important , in line with a specialist who had already pointed out that one

reason for the unconsciousness of memories is" the preservation of another's love" (MJ Horowitz) [142]

Amnesia as a consequence of the abuse

A report from 1994 of the American Psychological Association (APA) estaqblioshed gouw basic ideas related to the delayed memories of abused children:[143]

- Most people who suffered sexual abuse in their childhood remember everything or part of the event;
- A sexual aggression forgotten during a long time, may be remember (it is unknown how);
- The pseudo-memories of events that did not happen are posible (it is unknown how);
- There is insufficient knowledge of the process that brinbs an exact or inexact memory of the sexual abuse during childhood.

However, the oblivion phenomenon of sexual aggressions is much extended and well recorded but its causes and mechanisms are not understood. In the other hand, there is also a theory saying that there are "fake memories" or fabricated memories (especially, with a persuasive individual present with an authoritative position: therapist, progenitor, etc.). Many victims express great doubts about the reality of their own memories of the aggression, indepently of the frequemcy of their memories[144]. This theory, supported by some people, does not appear in DSM-V, nor in ICD-10 and is also rejected by the academic community. [145]

International Rights

In the international field, instruments have been also developed that emphasize in the attention against sexual abuses, within the general protection of children.

- **American Convention on Human Rights** Article 19. Every minor child has the right to the measures of protection required by his condition as a minor on the part of his family, society, and the state.[146]
- **Ibero-American Convention on Youth Rights** Article 11. The States Parties shall take such measures as may be necessary to prevent from exploitation, abuse or sexual tourism or any other kind of violence or mistreatment of young people and shall promote the physical, psychological and economic recovery of victims.[147]

[142] Charles Whitfield, Joyanna Silberg & Paul Jay (2001). *Misinformation Concerning Child Sexual Abuse and Adult Survivors* (en inglés). New York : Haworth Maltreatment & Trauma Press. Consulte don 13 March 2014

[143] FREYD, Jennifer J.: *Abusos sexuales...* (page. 15).

[144] *See FREYD, Jennifer J.: Abusos sexuales..., page. 72-73.*

[145] *See FREYD, Jennifer J.: Abusos sexuales..., page. 65.*

[146] *Convención Americana sobre Derechos Humanos, or Pacto de San José de Costa Rica.*

[147] *Convención Iberoamericana de Derechos de la Juventud.*

- **Convention on the Rights of the Child** (UN)[148]. Article19 1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Article 34. States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

1. The inducement or coercion of a child to engage in any unlawful sexual activity;
2. The exploitative use of children in prostitution or other unlawful sexual practices;
3. The exploitative use of children in pornographic performances and materials.

Article 36: States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Summary Chart

The sexual abuse of children is a form of child abuse which infringes the right of the child to his/her physical integrity and human dignity, which is recognized in the article 19 of the Convention of the Rights of the Child, impeding a full development.

Cooperating with the eradication of ***children abuse and exploitation***, between the varios states, results in the ***Council of Europe Conventio of 2007*** on the protection of the minors against sexual abuses and sexual exploitation (***Convention of Lnazarote.***)

The offenders are not a homogeneous group but the general characteristics of the sexual offenders of children are:

- They are mainly men, close relatives; they commit abuse between the ages of 30 and 50 years.
- Appearance, cleverness and ordinary life.
- Traits of neuroticism, introversion e immaturity.

The primary offenders show a sexual orientation which is almost exlusive to children and their compulsive behaviour is not bound to their personal status; while the secondary offenders **,** they are characterized by a behavior that results from specific situations.

[148] *Convención sobre los Derechos del Niño (UN Assembly).*

In general, the short-term consequencies of sexual abuse are desvastating for the psychological functionof the victim, especially when the offender is a member of the child's family. The long-term consequences are uncertain. There is correlation between the sexual abuse suffered during childhood and the appearance of emotional disturbations or maldaptive sexual behaviours during the adult life

In the international field, instruments have been also developed that emphasize in the attention against sexual abuses, within the general protection of children.

- American Convention on Human Rights Article 19
- Ibero-American Convention on Youth Rights Article 11
- Convention on the Rights of the Child (UN). Article19 1, 34 and 36.

Possible health issues related to abused and neglected children. Precautions?

There is no certainty about the percentage of abused children becoming offenders, criminals or mentally ill, but many investigations conclude that abuse increase the possibility of it happening (Dodge, Bates & Petit, 1990; NRC, 1993; Widom, 1989; Dubowitz, 1999)

There is a wide variety of symptoms appearing in abused children. Bal, Crombez, Van Oost y De Bourdeauhuij (2003) make an interesting distinction between 2 types of problems: "internalized" (such as anxiety, depression, dissociative symptoms or those related to post traumatic stress) and "externalized" (such as sexual problems, aggressivity or anti-social behaviour).

The prevalence of one symptom or the others, magnitude, severity and chronicity in the aftermath depend on:

- Type and severity of the abuse.
- The child´s subjective assessment of the abuse (specially to what extent he/she considers him/herself responsible)
- The age at the start of the abuse episodes
- Relationship with the abuser
- Family support to the child victim
- Access and skillfulness of the social, medical and psychological services (Branett, Manly…..

Main Health Related Problems Detected

Neurological and physical problems

- Inadequate brain development in children with deficient nutrition, especially in babies and small children.
- Low weight and short stature
- "Growth deficit" with no evident physical reason, so-called "non organic" (Dubowtiz, 1999).
- Psychosomatic response: headaches, stomachaches…
- Repeated psychosomatic illnesses.
- Sphincter control disorder: enuresis; encopresis.
- The child suffers frequent accidents.

Cognitive and learning problems

- Lower I.Q.
- Slow language development (Coster, Gesteen, Beeghy y Cichetti, 1989), due to lack of stimulation.

- Low academic performance. They tend to repeat grades, to get lower scores, and to have behaviour problems (Duwobitz….)
- Lack of enthusiasm and creativity (Egeland, Sroufe & Eriksson, 1993). Lack of interest, and low motivation for learning.
- Difficulties to keep attention and focus.

Behaviour disorders

ADHD (Attention Deficit Hyperactivity Disorder), aggressive behaviour

Anxiety:

It usually appears as anguish, intense psychological discomfort. Lopez Soler,C et al (2012), as part of a study on emotional disorders in abused minors, that there was a high sensitivity to anguish but a lower level of anxiety symptoms.

Depression:

Barudy (1989) indicates that his experiences with children victims of belgience and abandonment confirmed what Blumberg (1981) had already stated: one of the main sources of child depression is affective deprivation. This depression might remain masked by other behaviour disorders.

A large number of investigations have confirmed the link between depression and abuse within the family (deblinger et al., 1990; mcleer et al., 1988, Lehman, 1997; Sternberg et al., 1993). In a similar way, the aforementioned investigation from Lopez Soler (2012), confirmed the presence of depressive symptomatology, mainly dysphoric symptoms.

DSM-V describes three kinds of depressive symptoms, related to post-traumatic stress disorder and applicable to child abuse situations:

- persistent negative emotional state (e.g. fear, terror, anger, guilt or shame)
- persistent negative beliefs or expectations about oneself, the others or “the world” (e.g. “i feel bad”, “i cannot trust anyone”, “the world is very dangerous”)
- persistent disability to feel positive emotions (e.g. happiness, satisfaction or loving feelings)

- Self-destructive or self-mutilation behaviour:

They are more frequent in physically abused children than in those victims of negligence, although more frequent in these than in normal population (Green, 1978). They also appear in cases of sexual abuse.

Suicidal ideation or tendency:

It is striking to find suicidal thoughts in 9 or 10 years old children.

Joiner (2005) considers physical abuse as a facilitating circumstance to the suicidal event under serious emotional disturbance and suicide contemplation. On this same conception, Kokoulina, e. & Fernández, r. (2014) confirmed that abuse during childhood increases the probability of suicide consideration but only physical abuse was linked to the suicidal behaviour report.

Identity dissociative disorder:

Dissociative disorder is a self-defence psychological mechanism leading to a split between identity, memory, ideas, feelings or perceptions and conscious knowledge and cannot be recovered or experimented voluntarily.

It can be found as isolated episodes or as part of a psychotic disorder. It appears as a consequence of a high level traumatic impact, because the child cannot bear the intensity of suffering, coincidentally with the episode or later. They are frequent in cases of sexual abuse.

Psychosis:

Damage to the personal identity and personality development of the abused child, makes it evident that child abuse has a big impact in further development of psychotic disorders.

Many investigations have focused on confirming this evidence. Filipo Varese et al. (2013) did a meta-analysis of 41 investigations selected from a search from January 1980 to November 2011 in MEDLINE, EMBASE, PsychINFO y WEB of Science (UK). The outcome of this review was that adversity and trauma during childhood increase substantially the risk of psychosis. All kinds of adversity were linked to high risk of psychosis, noting that adverse experiences exposure, generally, increases the risk of psychosis, regardless of the specific nature of the exposure.

Another interesting review was based on the National Comorbidity Survey (US population´s epidemiological survey in 1990 y 1992). Data was used to calculate the link between physical abuse (including sexual abuse) and psychosis. Results show that child physical abuse were a prognostic factor in psychosis and a significant cumulative relation was established between trauma and psychosis such that the number of different traumas suffered increased the probability of psychosis. Besides, a significant interaction with sex was noticed, as long as rape was the most significant predictive factor for psychosis in males.

Drug consumption:

With a double intention: to move away from his/her reality/life experience; for the anti-social behavior components it entails.

Criminal behaviour:

In a longitudinal investigation of 411 children (West y Farrington, 1973), with tracing from 8 years old, it was observed that, with 18 years old, 27 had been sentenced for violent crimes

and 98 for non-violent crimes. In the violent group, 62% had received an extremely severe parental discipline, compared with 33% in the non-violent group. This study links physical abuse with violent criminal behavior.

Specific Consequences:

- ***Of SEXUAL ABUSE*:** besides the aforementioned, it might lead to an early sexual behavior, inappropriate seduction, adult age problems to perform satisfactory sexual relations, reduction in the feeling capacity for emotions linked to intimacy, physical contact and sexuality (Barudy, pg. 249).
- ***Of PHYSICAL ABUSE*:** shifty eyes, defensive gestures, skin marking and signs, etc.

Precautions:

- Global intervention in the child´s familiar and social environment. Creation of social support nets for the family. Look at the family as a system, treat the family, not only the child.
- Work systematically on trauma expression and exteriorization with the children, once they are assisted by the child protection system. Avoid beliefs such as: "it´s gone, better not to remember…", "now he has different parents, now he is ok…" Perform interventions specifically focused on reducing abuse consequences.
- Routinely explore (psychologist and psychiatrist) adverse events during childhood in psychotic patients (schizophrenia or similar diagnosis) to develop integral proposals and treatment plans. Likewise, work on depressive patient´s possible weaknesses and depravities during childhood (in addition to medication).
- Create processes and platforms (from school, Social Services, etc.) that can convey child´s inputs about abuse (within the family, bullying, gender violence, etc.). Invisibility extends abuse ("if no one talks about it, it does not exist").

Dsm-5 Categories of Related Disorders for Trauma and Stress Factors:

Trastorno de apego reactivo 313.89 (F94.1)

A. Steady pattern of inhibid behaviour, emotionally withdrawn to adult caregivers, which is shown by the two following characteristics:

1. The child rarely or seldom looks for comfort when feeling discomfort.
2. The child rarely or seldom allow others to confort him/her when s/he feels discomfort.

B. Lingering social and emotional disturbance characterized by two or more of the following symptoms:

1. Minimal social and emotional reaction to the remaining ones
2. Limitless positive affection.
3. Irritability episodes, sadness or unexplained fair that can be avoid even during non-threaten interactions with adult caregivers.

C. The child has lived an extreme patter of unsufficient care as it is stated by one or more of the following characteristics:

1. Negligence or social lack detected by the continuous lack of meeting the basic emotional needs to obtain welfare, stimulus and affection from the adult caregivers.
2. Repetitive changes in the primary caregivers that reduces the opportunity of creating a steady attachment (e.g. frequent changes of custody.)
3. Education in unusual contexts that reduces substantialy the opportunity to establish a selective attachment (e.g. institutions with a high number of children assigned to one caregiver)

D. It is supposed that the care factor from the Approach C is the responsible of the disturbance of the behavior of Approach A (e.g. the disturbances of Approach A begin when there is a lack of accurate care of the Approach C.)

E. The approaches to Autism Spectrum Disorders do not meet the approaches.

F. The disorder is obvious before the age of 5 years.

El The child has an age development of 9 months at least.

Unhibited social relationships disorder 313.89 (F94.2)

A. Behavioural patter in which the child actively interacts with strange adults and presents two or more of the following characteristics:

1. Reduction or lack of reluctance to interact with strange adults.

2. Oral or physical behavior too familiar (which does not match with what is culturally accepted and with the appropriate social limits of the age.)
3. The child resorts rarely or seldom to the adult caregiver after a risky output, even in strange contexts.
4. The child is willing to go with a strange with little or no hesitation.

B. The behaviours of Approach A are not limitted to impulsivity (as in the attention deficit hyperactivity disorder) but involve the unhibited social behavior.

C. The child has lived an extreme patter of unsufficient care as it is stated by one or more of the following characteristics:

1. Negligence or social lack detected by the continuous lack of meeting the basic emotional needs to obtain welfare, stimulus and affection from the adult caregivers.
2. Repetitive changes in the primary caregivers that reduces the opportunity of creating a steady attachment (e.g. frequent changes of custody.)
3. Education in unusual contexts that reduces substantialy the opportunity to establish a selective attachment (e.g. institutions with a high number of children assigned to one caregiver)

D. It is supposed that the care factor from the Approach C is the responsible of the disturbance of the behavior of Approach A (e.g. the disturbances of Approach A begin when there is a lack of accurate care of the Approach C.)

E. The child has an age development of 9 months at least.

Post-traumatic stress disorder 309.81 (F43.10)

Summary Chart

Possible health problems related with abused and abandoned children:

Depends on different factos:

- Type and gravity of the abuse.
- Subjective assessment from the child to him/herself
- The age of the child at the beginning of the episodes.
- Relation between the child and the **offender**.
- Dosmetic and social support to the victim

Types of problems that we can find:

Neurological and physical problems:

- Inadequate brain development, low weight and short stature. Growth deficit, non organic.
- Psychosomatic responses.
- Repeated psychosomatic illnesses.
- The child suffers frequent accidents.
- Sphincter control disorder: enuresis; encopresis.

Problemas cognitivos y de aprendizaje:

- Lower I.Q.
- Slow language development
- Low academic performance.
- Lack of enthusiasm and creativity
- Difficulties to keep attention and focus.

Behaviour disorders: aggressivness, hyperactivity.

Anxiety

Depression: it is especially related to the affective lack (negligence and abandoned)

Self-destructive or self-mutilation behaviour: especially in cases of physical and sexual abuse

Suicidal ideation or tendency: suicidal thoughts in every abuse type. Suicidal behaviour is specially related ith physical abuse.

Identity dissociative disorder: mechanisms of reality. They are frequent in cases of sexual abuse.

Psychosis: child mistreatment grows significantly the risk of developing a psychotic disorder (many researches with the same conclussion.)

Drug comsumption

Criminal behaviour

Specific consequences:

- ***Of SEXUAL ABUSE:*** premature sexual behaviour, inappropiate seduction, sexual problems during adulthood.
- ***Of PHYSICAL ABUSE:*** shifty eyes, defensive gestures, skin marking and signs.

APPROACHING THE VICTIM/OFFENDER

Expressions of Abused Minors

Aiming to illustrate this section we have choosen reflecting the expressions of abused minors throughout an exhibitions of drawings carried out by themselves.

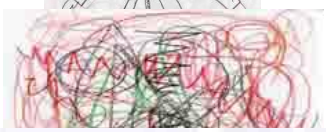
These are the drawings from the exhibitioms *"Els monstres de ca meva",* which was organized in Palma on October 2010 and was accompanied by some workshop conferences on child mistreatment. The sample is formed by 18 drawings perdormed by children and teenagers from 5 to 15 years, who at some point in their lives have been unprotected. The names of the children are fictional so as to keep their anonymity.

Therapists, psychologists and educators make use of the drawing to help te child explain what has happened to him/her or how the child feels before a case of mistreatment, abuse or negligence. The drawing represents the speech with which the child communicates with us, explains the exceptional event that has motivated the therapeutic intervention and also how s/he sees her/himself and how s/he sees the offender.

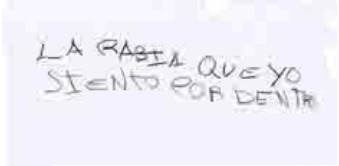
The drawings of the exhibition has been transferred by the *Servei d'Infancia I Familia del Institut Mallorquí d'Afers Socials*, the Institute of Legal Medicine of the Balearic Islands, and the boys and girls from the Treatment Unit of the *Conselleria d'Afers Socials, Promoció I Immigració* of the Balearic isles Government in Spain.

» Andreu, 8 years

Abused by his stepfather since 4 years, he draws himself with a fearful face and remarking the shirt buttons and the zipper of the jeans. Below, in the following picture, he expresses his anger with colors.

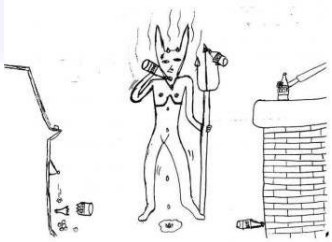


Andreu expresses his anger with colors and traces.



Andreu writes here how he feels and cuts the edges with scicssors.

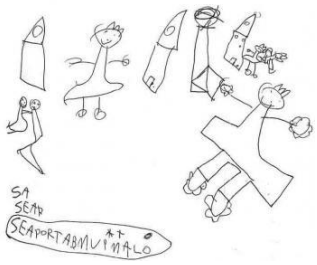
» Fernando, 13 years



For years, he was physically and psychologically abused by his father. Now, he lives with his mother, who has rebuild her life away from the father. The child is fine, but he had a season when he was constanly fighting with his teachers and partners from the school.

He draws his father as a devil. He is in a bar, alone, because the remaining people fears him. He drinks beers, is drunk and smells to alcohol. He also plays slot machines. Fernando feels anger towards him, "he's wicked."

» Elena, 6 years



She was abused and mistreated by his father. Now, she is currently living with her grandmother, as foster children.

The drawing represents her father. She draws him very small and having sexual relationships with her. Elena writes: “he has behaved very badly.” The big smilling figure represents her foster grandmother with whom she feels protected.

» Sergio, 15 years

He was psychologically abused by his father since childhood.At the beginning of the adolescene the sexual abuses also started.

In the drawing, he draws himself immobilized in a cross, unable of escaping the aggressions of his father, who is represented as fierce with claws at the top. Sergio draws the moment he decided to say he was suffering abuses. This moment is represented by the green hole of hope, where a black trace, from there to the lover part, symbolizing the difficulties (guilty, solitude, hopelessness, getaway from home.) The drawing finishes with straight sword, which represents the discovering of his strength and the desire of fighting to improver his life quality.

» Miriam, 9 years

She has suffered physical and emotional mistreatments, and negligence. Her mother is immigrant, ho arrived to Spain when she was 15 and pregnant of Miriam.

She draws her family without reference adults. She and her family belongs to an ethnic minority, but she does not represent it in the drawing. The figures does have nothing in coomon ith the real ones, ethnically speaking. Dibuja su familia sin ningún adulto de referencia. She has been insulted by her partners due to his ethnicity. On the left at the lower margin she says she feels ver lonely, although she crosses it out because she does not want people to know it.

» David, 8 years

He was sexually abused. He draws his ofender with burning eyes, remarking the sexual organs, Next to his offender, David writes words related to the abuse he suffered. He describes the drawing: “the one who damage me and I have finally said that it is true he did so.”

» Javier, 6 years

He was declared at risk since he was 4 years old and lives in a probation centre since a few mothns. His parents are separated and have serious disputes between them. The father served 1 year of imprisonment for gender violence against the mother. The mother takes methadone and is being treated of mental health problems. The parents have finger-pointed each other and have reported each other for having sexually abused of the child in the home of the other one.

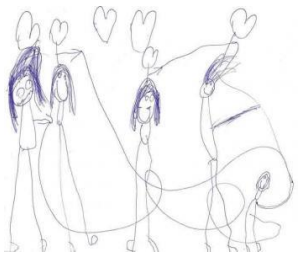
The child draws himself in a rainy day. He draws a car, drived by his parents, that seems to be running over him. Next to the car, he draws a house without windows where he tells that his father, his mother and him live.

» Isabel, 8 years

He suffered sexual abuse within the family circle.

At the right botton of the drawing, Isabel draws her ofender abusing of her. She expliains he lifted her to a chair so as to be at the same heigh and penetrate her from behind. At the left botton, she draws her little brother, who was at the door watching all that was happening.

» Irene, 5 years



She and her siblings suffered emotional abandoned and negligence.

In his drawing, Irene expresses the chaotic affectiv relationships that existed between the members of her family. The first two figures (the sister, 10 years old, and the mother) maintains a bad relationship because the mother delegates to the sister the responsability of looking after the children. In this family, there are suspicious of sexual abuse of the older daughter.

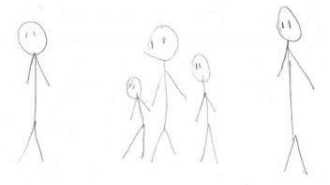
» Joan, 8 years

He has suffered sexual abuse.

He draws his ofender in cage, closed with a locker. The key is at the right top protected by thorns, so the offender can not take it.

» Dani, 12 years

His parents have separated. Dani explains what the drawing represents: “We are in the middle of a fight between my parents, which has not finished. The war sword is straight.”



The father was condemned for gener violence crime agains the mother and has a restraining order. Dani is the one looking after his younger siblings at this moment, he protects them.

» Marina, 5 years

Her father abused of her, since she was 4 years old.

She draws the pornographic films she watched with his father. Marina tells that the characters she saw “were naked and did messy things.” The circular line is the television frame.

» Marcos, 9 years

He has been repetitively physically and sexually abused by a school partner. In this drawing he represents his offender with small head, big hands and details in the clothes, especially in the jeans zipper, which he remembers being forced to unzip during the episode of abuse.

» Elisa, 7 years

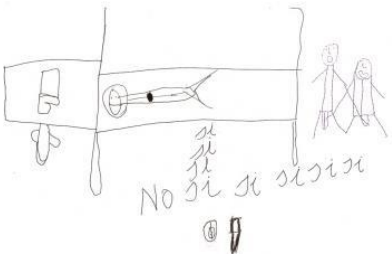
She suffered sexual abuse within the family circle.

The psychologist ask her to draw how she feels regarding to the abuses. She draws herself screaming, without body and with opened eyes and mouth, expressing the fear she felt while being abused.

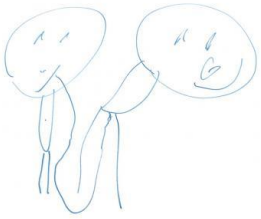
» Andrea, 10 years

She suffered sexual abuse within the family circle.

She draws where the ofender touched hew and how she had to touch him. Andrea is ashamed because she has to talk about what happened to her. They come to an agreement: she does not speak but she answeres the questions by writing “yes” or “no” in the paper.



» Víctor, 7 years



He was abused by his father when he was 4. Now he is tutorial.

In the blackboard, he draws what his father asked him to do, in this case, a fellatio. The line that comes from the genital area represents the tongue.

Intervention.

The psichological assessment of case of abuse is fundamentally carried out by an interview of the psichologist with the minor and the observation. Basically, these are the two types of interviews planned with the victim: on the one hand, those which are thought to investigate what has hapenned; in the other hand, those oriented to the intervention on the child as victim of abuse.

The immediate effect that results from the first contacts with the victim is if the therapeutical intervention is necessary or convenient. Normally, certain individual characteristics of the minor and od his/her social/family contexts may be enough reasons to protect the minor from the negative impact of abuse.

There are four basic criteria that suggest a major urgence of intervention in an abuse case.[149] the cohabitation of the ofender with the child after the abuse; the passive actitud or the neglect towards the child on the part of the family; the severity of the abuse, the lack of monitoring the case which may avoid new abuses.

There are also two broad phases, with their correspondent technics, in the process of intervention on the victim of sexual abuses[150]: first, the educative phase; and the second phase which is specifically therapeutical.

The educative phase expects the minor to understand his/her own sexuality as wll as the one of the offender via subjective way adjusted to the child’s level. The aim is informing the minor and achieving s/he understandas what sexual abuses are and how to anticipate them. The

[149] See FREYD, Jennifer J.: *Abusos sexuales*..., page. 65
[150] See FREYD, Jennifer J.: *Abusos sexuales*..., page. 66 and followings.

goal is to guarantee the child's safeness in the future; and especially, increasing his/her self-steem by giving him control mechanisms over the related aspects to sexuality.

The therapuetical phase[151] deals with the situation of the child after being abused and implements certain techniques to overcome the trauma and avoid relapses in adulthood. Among the techniques:

- Emotional relief of the minor, aimimng to break down the secret, and the feeling of isolation, which sometimes leds to the creation of a mistaken defense by the child.
- The cognitive appreciation to avoid dissociation or denial of the experience, so that the child recognizes his/her feelings as right and usual after the experience s/he has been through.
- Techniques that allow changing the cognitive, affective, sexual and behavioural disturbances (social skills and assertiveness; relaxation training and anger control, self-examination…)
- Therapies based on the "dramatic play" (to imagine situations and characters who allow the minor to go back to the disturbing event from and analictic, external, controller viewpoint), the children's stories (to explain and analyze the events metaphorically), drawing (with diagnostic and therapeutical function at once)

[151] For a presentation of the main therapeutical interventions about the minor, see chapter 5. («*Efectos del abuso y posibles intervenciones*») by Anna OLIVERIO-FERRARIS & Bárbara GRAZIOSI: *¿Qué es la pedofilia?*

Most common mistakes in approaching abused and neglected

Miyths and Beliefs Related To Child Abuse

According to Mario Zarate[152] thys mtyhs or beliefs related to child abuse are base don the consideration which says that:

- ***The child abuse cases are few and are not a serious problem.*** This is uncertain. Around 50% of the families suffer some type of violence.
- ***The child abuse is more frequent in needy families in comparision to the number of cases in which the ofender is thebiological father and/or mother.***
- ***The number of cases in which the offender is the stepfather or the stepmother is greater in comparision to the number of the cases in which the offender is ht e biological father and/or mother.***
- ***The mothers and/or fathers who abuse of her children are people suffering serious psychological or psychiatrics symptoms.*** It is known that the rate of psychologicals problem is vero low and it should be conceptualize as social illness.
- ***The coexistence between love and abuse within a family is not posible.***
- ***The story will repeat more times, in other words, any child victim of abuse, will have abusive behaviors with his/her children.*** But some children are called "resilent" by the world bibliography. These children have characteristics that allows them to overcome this obstacule.
- ***The child abuse is more frequent in large families that live in small spaces.***
- ***The violence is innate.*** This not true. It is a behaviour learnt from family and social models taken as a way of solving situations.

Violence against Childhood: Concealed, Non-Reported and Badly-Registered

We know the existence of cruel and humniliating punishments from a log time ago: female genial mutilation, carelessness, sexual abuse, murder and other vilence forms against children. However, the gravity and urgence of this worldwide problem has not been revealed until quite recentlyl[153].

The myths and beliegs regardinf child abuse makes difficult the progress of problem solving because their deconstruction is a hard task for the community that supports them. Thus, making more difficult the creation of actions which tend to modify the baseline situation.

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clementezarate@hotmail.com. Higher University of san Andrés. First cycle of seminars and workshops of teacher updating of primary level Nuestra señora de la Paz. Bolivia.

[153] *A. Reza, J. A. Mercy & E. Krug, "Epidemiology of violent deaths in the world", Injury Prevention, vol. 7 (2002), pages. 104 to 111; Krug, op. cit. At the note 1, pages. 59 to 86.*

According to the independent expert of the reasearch on violence against children of the UN[154], **the main mistakes on detecting the depth of abusive situation are:**

Non-Denouncing or Recordering Abusive Situations.

In many places of the world there are not systems in charge of rerecordering and studying the reports of violence against children.

There some reasons why there is this lack of denounce.

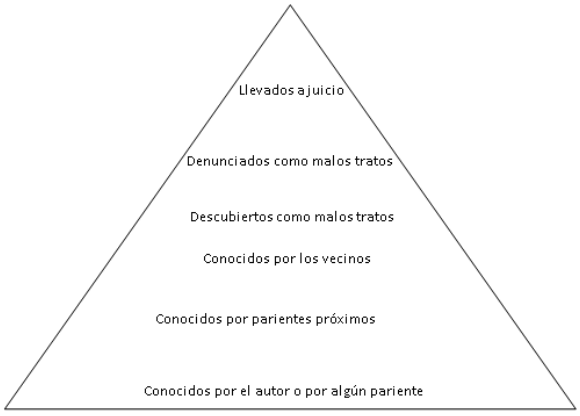
- The smallest children, who suffer violence at home, are not able to denounce
- Many children are afraid to report incidents of violence against them because of the fear of suffering reprisals; or not to make thinks worse due to de intervention of authorities.
- In many cases, the parents, who should protect their children, keep in silence if the ofender is the partner, or other family member, or power member of the society, such as an employer, police office or a community leader. The fear is closely related to the stigma frecuently linked to the report of violence.
- In the societies in which the patriarcal ideas of the family "honor" are more valued that the human rights and the welfare of the children, an event of rape or sexual abuse may led to victim ostracism, more violence, evento until the deatch of the victim at the hands of the family.
- Many governments lack of registration systems of birth, so the smalles babies and children lack a official identity putting them at risky situation.
- In additon, many of them also lack of a system of research and record of the children's deatch.
- Although millions of girls are married before 18, the anbsence of registration system makes difficult to track the problem.
- Few states systematically register and report the children who are put in protection or detention institutions, and even less do they gather information on the violence against the ones in such situations.

In this regard, Rostad shows the following scheme related to the hiding of the cases, draw from the graphic called **iceberg effect.**

Even today, child mistreatment is still a problem produce in the private environment that is now in the public domain and the proper decision were not made to solve it.

ICEBERG EFFECT OF CHILD MISTREATMENT

[154] This report is base don the study of Paulo Sérgio Pinheiro, independent expert appointed by the Secretary-General *according to the General Assembly resolution 57/90 of 2002.*



The Rostad's iceberg clearly shows in its base, which correspond to the grater number, the cases known by the victim, the offender or even other family member, although this cases are not reported. The tip of the iceberg corresponds to the number of cases that are judicially reported, which is smaller number.

In the other hand, there are also some **limitations** that inclfuence the answer that the educative field can deliver to the problem of child mistreatment. This limitations could be cope with considerinf the following aspects:

- A specific regulation is required to deal with the problema of child mistreatment by clearly indicating the role that the school sector must assumed.
- Such regulation should include coverage for asoects related to privacu or anonymity when the situation requires it.
- Spreading the specific education and training of everybody who performs educational tasks.
- Establish each person responsabilities: teacher or professor, director, particular teachers, school support team.
- Having appropiate instruments for the collection of data, protocols for reports, questionaires, interviews for the first detection and diagnostic.
- Guiding and supporting teachers in critical situations which led not to report the detected mistreatment cases: a) fear of facing aggressive or violent parents; b) insecurity in regard to the support of the educative systema;c) doubs when making an accurate diagnostic; d) fear to legal consequences; e) ignorance of what will happened after submitting the report, etc.

Certainly, the reasons why the violence phenomenon is hidden are **myths** and **limitations** interliked reharding this topic.

Social Acceptance of Violence

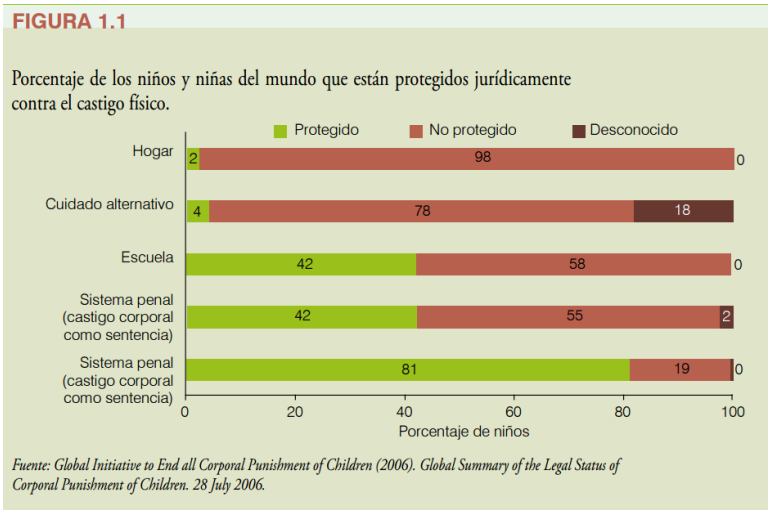
The lingering social accepatnce of some violence forms against children is a signifcant factor that contributes to its continuation in almost every state.

- Children, offenders and the public in general may accept the psychological, physical and sexual vioence as inevitable part of childhood.
- Most laws of the states still accept the physical punishment as "fair" or "legal" and reflect the violence approval of the society when the violence is disguised as "discipline."

- The pusical punishment and other forms of cruel and degrading punishment, intimidation (bullying), sexual abuse and various violent traditional practices may be seen as usual, especially when the result is not an evident and lasting physical damage.
- According to the Global Initiative to End All Corporal Punishment of Children, at leas 106 countries forbid the use corporal punishment at school, 147 countries do not forbid it in shelter institutions, and only 16 countries have forbidden it at home until now[155].
- The violence also goes unnoticed because there are not safe and reliable ways to report violence. In some places of the world, people do not trust in the police, social services or other authorities. In toher placesm, especially in rural areas, there are no accessible authority to which one can report.[156]. Where data are collected they are not always recorded in a complete, consistent or transparent way. In particular, little data are available about violence within care and detention institutions in most parts of the world because, although incidents may be documented, most institutions are not required to register and disclose this information, even to the parents of the children concerned.

The Fact of Not Having Reliable Data

No country can measure progress towards eliminating violence against children without regular surveys.



Studies, wich research on the use of violence by the progenitor or other adults, the violent experiences during childhood, the current healtd situation and the children's behaviours and the adults who put at risk their healt are required to calculate the magnitude and nature of the non-fatal violence against children with precision. The fatal violence against children can only be measured with precision via registrations systems of death, investigation and report.

Summary Chart:

[155] Global Initiative to End All Corporal Punishment of Children, *Summary o the Legal Status of Corporal Punishment of Children (28 June 2006).*

[156] *Multi-country Study on Women's Health and Somestic Vioence against Women (Geneva, WHO, 2005).*

According to Zarate, the main mistaken myths and beliefs in the field of child abuse are the followinglos principales mitos y creencias erróneas en el ámbito de la violencia de menores son:

- The child abuse cases are few and are not a serious problem.
- The child abuse is more frequent in needy families.
- The number of cases in which the offender is the stepfather or the stepmother is greater.
- The mothers and/or fathers who abuse of her children are people suffering serious psychological or psychiatrics symptoms. The coexistence between love and abuse within a family is not possible.
- Any child victim of abuse, will have abusive behaviors with his/her children.
- The child abuse is more frequent in large families that live in small spaces.
- The violence is innate

The UN IDENTIFIES three main mistakes that block the accomplishment of effective programs on the elimination of violence:

- **Non-denouncing or recordering abusive situations.** Rostad shows the scheme related to the hiding of the cases, draw from the graphic called **iceberg effect,** by clearly showing in its base, which correspond to the greater number, the cases known by the victim, the offender or even other family member, although this cases are not reported. The tip of the iceberg corresponds to the number of cases that are judicially reported, which is smaller number.
- The lingering **social accepatnce** of some violence forms against children is a signifcant factor that contributes to its continuation in almost every state.
- **No disponer de datos fiables.** Studies, wich research on the use of violence by the progenitor or other adults, the violent experiences during childhood, the current healtd situation and the children's behaviours and the adults who put at risk their healt are required to calculate the magnitude and nature of the non-fatal violence against children with precision. The fatal violence against children can only be measured with precision via registrations systems of death, investigation and report.

Preventing abuse and neglect against children

Prevention programs, for being effective, need to consider as target population not only children, but parents, teachers, all the professional who have contact ith children in the field of health, education, social services, labour, and all the population in general. The programs should not alarm but minimize the risks either.

The prevention must take action over ***information, attitudes and behaviours*** so as to detect risky situations, change fake beliefs, facilitate the disclosure; to know how one should proceed and where are the professionals who deal with such situations.

Primary Prevention:

The primary prevention intends to eliminate or decrease the number of mistreatment cases. The society should be educated about the ilgelatility of using violence to educate children. The knowledge of the children needs has to be improved, as well as the risks childhood may be taking. In addition, the sensitivity of the population has to be aware of significant issues such as child abuse.

Some posible actions addressing this aim would be:

- Addressed to society: limiting the violence in the televisión and toys; recognized the rights of the child; budget for education…
- Addressed to family: informing about health related aspects, characteristics of the child, family protection measures
- Addressed to teachers: knowing the reality of mistreatment, the awareness of the mass media, encourage team work with various professionals

- Secondary prevention:

Efforts addresses to high-risk population or those families where there is already a violence form. The detection of high-risk situations such as parental or maternal backgrounds of mistreatment by master indicators…

- Tertiary prevention:

This would be the intervention after identificating and valuing the cases of mistreatment. Actions are planned to restore the deterioration due to the situation, re-educate the offenders with programs tending toreduce tension duting the transition to parenthood. Training the parents to face the children care and education is necessary. This can be achieved discovering their skills and providing them with abilities to perform when there is a family conflict; working with the child victim of mistreatment; preventing the child of veing a victim again…

It is advisable to incorpórate the educative programs on prevention within the activities of effective and sexual education so as to allow a global approach to sexuality in a context of health education, and welfare and personal development.

Who's response.

The OMS, in collaboration with several partners:

- Offers technique and regulated orientation base don scientific data in order to prevent chilhood mistreatment;
- Promotes the increasement of support to the child abuse prevention in scientific data and inernational investments in this field;
- Provides technical support to prevention programs of childhood mistreatment in scientific data of varioues countris with low and high incomes.

Effective preventine measures:

The significance of the parental training in positive upbringing

Accoring to the ***World Health Organisation***,[157] the prevention program more efficient are the one which offer support to the parents, and provides them with positive knowledge and techniques to upbring their children, among them:

1. Home vistis of nurses to offer support, training and information;
2. The parental training in froups so as to improve their aptitudes to upbring their children, their knowledhe of child development, and encourage them to perform positive strategies in their relationships ith their children;
3. Intervention with multiples ítems that generally involve parental support and their training, pre-primary education and attention for the child.
4. ***The ones addressed to prevent head trauma due to mistreatment*** (known also as shaken baby síndrome, battered child síndrome or brain injury for traumatism.) Generally, hospital programs in which the new parents are informed of the risks of shaken small children and ho to face the children with inconsolable crying.

The significance of preventing sexual abuse of children.

They are generally carried out at schools and children are taught the following:

- Their body property;
- Differences between usual contacts and indecent molestation;
- How to recognize abusive situations;

[157] OMS. Children abuse Breafing note No. 150. December 2014

- How to say “no”;
- How to reveal the abuse to a reliable adult.

These programs work improving protection factors against sexual abuse during childhood (e.g. the knowledge of sexual abuse and protective behaviours). There are not other tests which reduce other abuse forms.

The sooner these intervention take place in the child life, the greater are the benefits that may influence the child (e.g. cognitive development, behavioral and social skills, educational achievements), and the society (e.g. crime reduction.)

In addition, the early recognition of cases and the continuous support of the victims and their relativesmay help to reduce the repetition of the abuse and also ease the consequences.

Ohter effective actions

- ***Training professionals in education and health to carry out social, educative and therapeutic interventions.***
- ***Carrying out prevention and treatment programs for offenders*** because they always need help due to their high rate of repetition. They have to assumed the problem, accept their values, work on their empathy, learn to put themselves in someone else’s position; training in self-control.
- ***Set a coordinated attention service for the child*** throughout the integration and coordination of the vaiours instutions related to child abuse.
- ***Report it****, since this allows justice to protect the child,* avoid the offender abuses of other children, force the offender to follow a therapeutical treatment, reduce the occurrence of the incidence.

Protective Factors

Zarate[158] has clustered various specific conditions called protective factors that decrease the probability of mistreatment incidents, modify the influence of the risk factor and reduce the child vulnerability.

Certainly, the human being builds builds its personality and créate strategies to face reality throughout a contant interaction with environment since its birth.The balance of its future life, the sociability and the adaptability to the environmental and stressful conditions depends

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on the quality of the social environment. Children will learn to loce, tolerate and understand, if they feel loved, understood or tolerated.

<table>
<tr><th colspan="4">SOCIO-INTERACTIVE MODEL (Adapted from Moreno 2002)</th></tr>
<tr><td>Ontogenic development (GIRL/BOY))</td><td>Microsystem (FAMILY)</td><td>Exosystem (SOCIETY)</td><td>Macrosystem (CULTURE)</td></tr>
<tr><td rowspan="2">Easy temperament
Good self-steem
Good will for social interaction
Facility to adopt accurate views and skills during the processing of social information.
Tendency to pro-sociality and cooperation.
Absence of evolutional difficulties.
Good student.</td><td rowspan="2">FATHTHER/MOTHER
Accurate attachment figures.
Democratic style of education.
Inductive discipline.
Sensitive to the child needs.
Absence of stressful events.
Appropiate mental health.
Appreciation and steem of the child.
8. Good network of social support.</td><td>RELATIONSHIPS
- Famnily knows and keeps a close relationship with the teachers and friends of their son/daughter.</td><td rowspan="2">1. Good economic, political and social situation.

2. Appreciation of the tolerance, solidarity and protection of the weakest and poorest ones.

3. Sensitivity towards the rights and the needs of childhood.</td></tr>
<tr><td>VALUES
- Family system of values similar to the equals group and the one which prevails in the school environment.</td></tr>
<tr><td rowspan="2"></td><td>FRIENDS
Has good, solid and mutual friends.
Beloved by his/her partners.</td><td></td><td rowspan="2"></td></tr>
</table>

	Stable history of acceptance.		
	SCHOOL Proper adjustment to the school context. Good academic performance. Good skills in some extra-curricular activities (plays, sports, theatre, music, etc.)		

Protocol for detecting children at risk situations[159]

Child's name:

Age:

Address:

Father's name:

Mother's name:

Educational unit:

Grade:

1. **Never**
2. **Sometimes**
3. **Often**

Item	A. **PHYSICAL ASPECTS**	1	2	3
1	Has bruises or signs of beats			
2	Has wounds with unusual froms			
3	Has burns			
4	Has fractures			
5	The hygienic conditions are deficient			
6	Wears always the same clothes or inappropiate clothes			
7	Absence of personal higiene or none			
8	Realeses unpleant smells			
9	Does not bring the breakfast to class			
10	Ask for food to his/her partners and eats with many hunger			
11	Attends to class with sleep and symptoms of fatigue			
12	A delayed physical develpment			
13	Pees on his/helself at school			
14	Poops on his/herself at school			
	B. SOCIAL ASPECTS	1	2	3

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15	Truancy			
16	Arrives late or escapes			
17	Wants to stay at school after finishing the timetable			
18	Does not talk about himself and/or his/her family			
19	Shows aggressiveness to the partners and with the school material			
20	Do not coolaborate in group activities			
21	Isolates himself and is not expressive			
22	Focuses the friendship on one partner			
23	Has mood swings			
24	Looks for the teacher's protection			
25	Show rejection towars adults or tries to pleased them			
26	Show pre-criminal behaviours			
27	Wants to be the centre of attention all the time			
28	Cries with no reason			
29	Self-harm			
30	There is no relation between the family and the educational unit or this relation is occasional			
	C. SCHOOL ASPECTS	**1**	**2**	**3**
31	An academic performance with sudden changes			
32	Does not finish, does not or does bad the homework			
33	Is not constante in the schoolar activities			
34	No lleva a clase todo el material escolar			
35	Has the school materials and the books messy and untidy			
	D. FAMILY ASPECTS	**1**	**2**	**3**
36	The parents don't attend to the school meetings			
37	The parents refuse to talk about the problems of the child.			
38	The parents blame or hate the child			
39	The parents demans too much from the child			

40	The parents usually consume drugs and alcohol			

Summary Chart:

- Prevention programs, for being effective, need to consider as target population not only children, but parents, teachers, all the professional who have contact ith children and teenagers.
- The prevention must take action over ***information, attitudes and behaviours*** so as to detect risky situations, change fake beliefs, facilitate the disclosure; to know how one should proceed and where are the professionals who deal with such situations.
- There are different levels to implement thiese prevention measures:
    - ***Primary prevention,*** addressed to the social avareness of the society of the ilegality of using violence to educate children.
    - ***Secondary prevention*****:** addressed to high-risk population or those families where there is already a violence form.
    - **Tertiary preevention:** after identificating and valuing the cases of mistreatment. Actions are planned to restore the deterioration due to the situation, re-educate the offenders with programs tending toreduce tension duting the transition to parenthood.
- General effective preventine measures:
    - Training the children to face warning situations.
- Training professionals in education and health to carry out social, educative and therapeutic interventions.
    - Carrying out prevention and treatment programs for offenders
    - Set a coordinated attention service for the child
    - Report child abuse
- Preventing measures addressed to progenitors:
    - Home vistis of nurses to offer support, training and information
    - Training in positive parenthood
    - Multitasking training programs: parents, educators and minnors
- Programs of specific prevention:
    - Hospital programs to prevent head trauma.
    - Schoolar programs for the education and the defense of the minor facing possible sexual abuses.

- Socio-interactive model of Zarate[160]. has clustered various specific conditions called protective factors that decrease the probability of mistreatment incidents, modify the influence of the risk factor and reduce the child vulnerability

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Privacy issues? Principles in sharing information about children with other parties?

Legislation

Information obtain from newsletter of Spanish Agency of Data Protection

At **European level** data protection is framed as a fundamental right of citizens. The main rule in this field is the Directive 95 / 46 on European Union. But before, already in 1981, the council of Europe had adopted the Convention 108on the protection of persons, which is the only binding international instrument on data protection.

Both texts are undergoing revision processes aimed at updating to take into account the consequences of technological developments, the globalization of trade data and, in the case of the directive, the legal and institutional changes which resulted in the entry into force in 2009 of the Lisbon treaty.

Current EU legislation was drafted back in 1995 and needs updating to keep pace with technological change. The European Commission proposed in 2012 a new regulation on a single set of rules for all data collected online to ensure it is kept safe and also to provide businesses with a clear framework for processing them.

Negotiations between Parliament, the European Commission and the national governments reprsented by the Council started in June and a provisional agreement was reached on 15 December. Parliament's civil liberties committee backed the deal on 17 December and it will now needs to be endorsed by MEPs during a plenary session and by the Council.

The prominent position of data protection in Europe, reflected in its consideration as a fundamental right and the existence of numerous regulations that regulate both broadly as in specific sectors, is also reflected in the diversity and importance of agencies, structures and cooperation clusters.

Protection of data in the world

The geographical distribution of countries with specific rules of data protection and with authorities responsible for ensuring their application is mixed. Europe is a continent where the protection of data has achieved a higher level and in almost all European countries can be found some of these elements and often both. North America is also a region where data protection, or more precisely, privacy, has achieved a high level of development. In recent years there have been significant progress in legislation and institutionalization in the field of data protection in Ibero-america and the Pacific and in some regions of Africa.

Countries with data protection authority

Normally, the existence of laws governing the processing of personal data is accompanied by the establishment of supervisory authorities responsible for the enforcement

of those laws. In the european environment, the independence of these data protection authorities is considered an indispensable feature for an effective performance of their functions, but in other geographical areas that independence can be assessed or be implemented in different ways as happens in europe.

Europe: Albania, Germany, Andorra, Austria, Belgium, Bosnia-Herzegovina, Bulgaria, Cyprus, Croatia, Dennmark, Slovakia, Slovenia, Spain, Estonia, former Yugoslav Republic of Macedonia, Finland, France, Greece, Hungry, Ireland, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxemburg, Malta, Moldavia, Monaco, Norway, Neetherlands, Poland, Portugal, Unite Kingdom, Czech Republic, Romania, Serbia, Sweden, Switzerland
Africa: Burkina Faso, Moroco, Mauritius, Senegal, Tunisia.
America: Argentina, Canada, Colombia, Costa Rica, UU.EE., Mexico, Peru, Uruguay.
Asia: Hong Kong, Israel, South Korea
Oceania: Australia, New Zealand.

Here available a list of all countries of the world with the data protection authority recognised as such by the international conference of commissioners of data protection and Privacy. The status of member of the conference required the authorities a number of requirements, including independence in the exercise of its functions and the monitoring of specific rules of data protection. In some countries there are also subnational authorities territorial or sector. Similarly, a small number of countries have legislation but have not given the control of their application to specific authorities.

Countries with adequate level of protection

The concept of adequate level of protection or "adequacy" relates to data protection in the European Union. Directive 95 / 46 prohibits the transfer of data to countries that do not have an adequate level of data protection and establishes a procedure for determining formally if a country provides that level of protection. In short, the decision rests with the commission, after consulting the group of article 29 and to a committee of representatives of the member states, which cherishes a number of elements such as the existence of data protection laws, the content of these laws and the practical operation of the system of protection of data. The group of article 29 Authorities adopted an Opinion those adequacy finding criteria.

The main consequence of a country is declared is appropriate for data may be transferred from the member states of the European union without any type of formality or special leave. To date, have been regarded as offering adequate protection: Andorra, Argentina, Canada

(private sector), Switzerland, Faroes, Guernsey, Israel, Isle of Man, Jersey, New Zealanda and Uruguay.

Processing of data of minors, the example of Spain[161]:

Data processing of minors requieres particular vigilance, because greater rigor is required by the Spanish Data Protection Agency (AEDP) when consent is obtained from a minor, since the child addresses to a person who is not training yet.

- Where is the age borderline on who can give such consent? The article 13.2 of the Regulation of the (LOPD) points out:
- *Data pertaining to data subjects over fourteen years of age may be processed with their consent, except in those cases where the law requires the assistance of parents or guardians in the provision of such data. The consent of parents or guardians shall be required for children under fourteen years old.*
- *When processing refers to the data of minors, the information aimed at them shall be expressed in easily understandable language, with express indication of the provisions of this Article.*
- In regard to data that can be obtained, the article 13.2 of the Regulation points out:
- *En ningún caso podrán recabarse del menor datos que permitan obtener información sobre los demás miembros del grupo familiar, o sobre las características del mismo, como los datos relativos a la actividad profesional de los progenitores, información económica, datos sociológicos o cualesquiera otros, sin el consentimiento de los titulares de tales datos.*
- This prohibition has only one exception with the aim of allowing the minor capacity to consent be completed, and pints out the last section of the article 13.2. of the Regulation: "The aforesaid notwithstanding, data regarding the identity and address of the father, mother or guardian may be collected for the sole purpose of obtaining the authorisation set out in the previous subsection."

Keep in Mind

<u>To prevent:</u>

- Multidisciplinary interventions, which usually include support and training for parents, early childhood education and care to the child.

[161] *Published byr* Jesús Pérez Serna *Monday, 19th April 2010*

- Child school education programs for identification and defence against possible sexual abuse.
- Training in Positive Parenting: usually in groups, to improve their skills for raising children, improve their knowledge about child development and encourage them to adopt positive strategies in their relationships with their children.
- Hospital programs on prevention of head injuries, providing information to new parents on the dangers of shaking little children and how to deal with the problem of children with non-stop crying.

<u>To take action in cases of child abuse.</u>

- To implement a detection protocol for risk situations in childhood that includes physical, social, school and family aspects.

- To report abuse because it allows justice to protect the child, avoids that the offender abuses other minors, impose the aggressor to continue therapeutic treatment and decreases the incidence.
- To facilitate self-revelation and the emotional relief of the child, with the aim of breaking the secrecy and the corresponding feeling of isolation and guilt. Allow the child to tell about it.
- Cognitive re-evalutation in such a way that the child recognizes that his or her feelings are normal and legitimate after the experience like the one that he or she has lived.
- Therapies based on "Dramatic play" of children's stories and drawing.
- Using techniques of social skills, assertiveness, self-control,… that allows changing the alterations caused by experiences of abuse.

Not To Do's

- Do not report or not register the situations of abuse.
- Accept forms of violence by tradition, culture or false right to protect intimacy.
- Accept that physical, sexual and psychological violence is an inevitable part of childhood.
- To approve "reasonable" corporal punishment when it is described or is disguised as "discipline".
- To perceive as normal those forms of violence which do not result in physical damage visible or long lasting such as sexual harassment or intimidation (bullying).

- Let yourself go by false beliefs that makes believe that the cases of violence are isolated and linked to poverty, non-biological parents or mental illness. Since the research studies show that violence against children is greater in cases of biological parents and all social strata.
- Not availability of reliable data to estimate the magnitude and nature of non-lethal violence against children.
- To blame directly or indirectly the child as responsible for the violence suffered.
- Not taking action wrongly assuming that the child has enough resilience mechanisms.
- Contribute to the stigmatization of the child with proceedings that do not respect his or her own privacy and personal data.
-

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