SAVE HANDBOOK

SUPPORT AND TREATMENT OF TRAUMATIZED CHILDREN AFTER VIOLENCE

SAVE

Support and treatment of traumatized children After ViolencE

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INTRODUCTION

The single best predictor of children becoming either perpetrators or victims of domestic violence (DV)[1] later in life is whether or not they grow up in a home where there is domestic violence (1). According to the Council of Europe, one European woman in four experiences domestic violence at some point in her life (2). Every child exposed to violence at home reacts differently, but witnessing violence against their mother is, in all cases, a form of psychological abuse which has potentially severe consequences. It explains why 19% of the patients who seek help from childhood mental health centers in urban areas are witnesses of DV (3).

This handbook is a coordinated response to this severe reality. In addition to this high incidence and serious consequences, some deficiencies are present in our system that aggravate this reality:

LIMITATION OF IDENTIFICATION OF VICTIMS

Domestic violence is often the result of family contexts characterised by conflicts, parental inadequacy, or poor social relations within the local community (4). Additionally, after the violence is perpetrated, families prefer not to report the crime for different reasons (legal, psychological, etc.) and feel a lack of support from the community or are not aware of the help services that can be contacted. In this regard, the report "Behind Closed Doors" (1) acknowledges that the findings of numerous studies on domestic violence are limited by underreporting, both by parents and children.

LIMITATIONS IN AN ACCURATE DIAGNOSIS AND SUPPORT AND CARE OF VICTIMS AND FAMILIES

Some of the children who attend outpatient mental health clinics and paediatric departments in European hospitals are hidden victims or witnesses of IPV but receive a wrong diagnosis, so violence is not tagged in those cases. Symptoms of child traumatic stress could be mistaken for those of attention-deficit/hyperactivity disorder (ADHD). The risk of misdiagnosis is therefore high because there is an overlap between ADHD symptoms and the effects of experiencing trauma (post-traumatic stress disorder-PTSD) unless symptoms are examined closely (5). This makes it very difficult to obtain a correct diagnosis, which can complicate both assessment and treatment: the latter could therefore be oriented without addressing the experienced violence as one of the causes of the symptoms. This is especially true in children exposed to repeated phases of intimate partner violence (IPV) who had greater probability of an ADHD diagnosis.

If children victims of violence do not receive a correct diagnosis, an appropriate support and medical treatment for them cannot be ensured. In fact, nearly one-third of severely maltreated children in domestic environments meet criteria for an ADHD diagnosis (6). The comorbid condition of ADHD and PTSD leads to a greater clinical severity as regards to other psychiatric comorbidities and psychosocial dysfunction (7)

LACK OF COOPERATION BETWEEN HEALTH CARE PROFESSIONALS AND AUTHORITIES

This is often caused by the lack of knowledge of professionals on how to report violence or by the lack of permanent structures or protocols that set rules of cooperation and exchange of information between health care centres and public authorities. Cooperation between health care centres and authorities must be reinforced to ensure reporting and an effective intervention as soon as the domestic violence is detected.

LACK OF KNOWLEDGE ON THE PART OF PROFESSIONALS AND FAMILIES OF EU TOOLS AVAILABLE TO PROTECT CHILDREN VICTIMS AND WITNESSES OF DOMESTIC VIOLENCE

Health professionals often do not have complete knowledge of EU established tools available to protect children victims and witnesses of domestic violence. This prevents them from supporting victims and parents regarding how they can assert their rights and receive legal assistance.

1_Domestic violence or intimate partner violence is a pattern of assaultive and coercive behaviours including physical, sexual, and psychological attacks, as well as economic coercion used by adults or adolescents against their current or former intimate partners.Domestic violence is, in a majority of cases, violence against women conducted by men from their immediate social environment.

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The SAVE (**S**upport and treatment of traumatized children **A**fter **V**iolencE) consortium is made up of 4 centers which work to improve the conditions for early diagnosis, support and care of children and families that are victims of violence detected in health care centres in Europe. The specific expertise of the centers is detailed below:

- Hospital Sant Joan de Déu (HSJD) in Barcelona has been dedicated since 1867 to comprehensive care for women, children, and adolescents. The mental health area includes 5 Outpatient Child Mental Health Centers which have a specific Program of DV and abuse -TEVI program (**T**estigos **V**iolencia—Witnesess of Violence). In 2013, the TEVI Program was recognized as a "Good Practices Program" by the Ministry of Health, Social Services and Equality, Women's Health Observatory, to strengthen the gender focus on care, prevention, health research, and training concerning sexist violence.

- Ospedale Pediatrico Bambino Gesù (OPBG) was established in Rome in 1869 and is the largest pediatric hospital in Europe. The Neuropsychiatry Unit has a section dedicated to children and adolescents who are victims of various forms of violence. OPBG has innovative diagnostic methodologies to identify whether hyperactive children are victims of violence and to treat and support them and their family members.

- Fondazione Fatebenefratelli (FIF) in Rome has been recognized as a provider of health education and professional training by the Italian Ministry of Health for the activities of "Continuous Training in Medicine". Among the activities to support victims of violence, FIF collaborates with hospitals to manage an Anti-violence helpdesk, which offers psychological, social, medical, and legal support to victims of violence, abuse and stalking.

- Barmherzige Brüder Gemeinnützige Krankenhaus GmbH (BBK) (Regensburg, Germany) runs several hospitals and outpatient clinics in the Bavarian Region of Germany. The project "Medical care for underage refugees and migrants" was honoured with the Bavarian Health and Care Award in 2017 for implementing an integrated approach to care for children and families with migrant background.

We want to make the invisible victims and witnesses of domestic violence visible through community partnerships. This handbook offers a common model built by 4 centers working together in 4 specific areas:

1. The basis for detecting and correctly diagnosing children victims and witnesses of DV.

2. The basis of individual, group, and family therapy for witnesses of DV.

3. The protocol to establish a help desk and the key points to increase collaboration between health care centres and public authorities.

4. The tools to break the language barrier, necessary to ensure informed care and facilitate the participation of migrant children and families.

We offer a systematic approach to increase healthcare centre capacity to detect, diagnose, treat, and support children victims of violence and their families.

We offer appropriate tools and information to empower health professionals in understanding when children admitted in outpatient mental health clinics and pediatric hospital settings with post-traumatic symptoms have suffered domestic violence.

Finally, we offer steps to reinforce cooperation between health professionals, families, and public authorities to increase reporting of domestic violence.

During the implementation of the SAVE program, the Covid19 pandemic broke out. All countries took drastic measures of closing schools and workplaces and installed lockdowns. The SAVE team had to react to this pandemic in order to maintain our commitment to vulnerable children and their families in our cities. Our priority during the lockdown was to offer support to children and families isolated in an abusive environment and provide them information material.

Our network approach with local public authorities allowed us to maintain a connected community in order to keep reaching vulnerable children and families. The SAVE team incorporated e-therapy services which allowed us to maintain our therapeutic relationships with our patients and their families.

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CHAPTER 1
DETECTION AND EVALUATION OF DOMESTIC VIOLENCE IN HEALTHCARE CENTRES

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What does exposure to domestic or intimate partner violence mean? The answer to this question has undergone an important evolution. It has gone from thinking that the impact and effects of partner violence on children only occur when children and adolescents are physically present in situations of violence to including other situations in which the child participates in violent events, witnesses them, or encounters the consequences of them. The notion of exposure to violence covers several more inclusive situations (1):

- the child or adolescent may be an eyewitness to the violence;
- the child can hear violent words or acts when s/he is in a nearby room;
- the child is a witness to the consequences of violence, can see his/her mother injured or crying after an assault or the visit of the police.

Abuse by a person s/he loves and on whom s/he depends psychologically implies an enormous suffering for a child. Exposure to violence is a type of abuse. Proof of this is that the health consequences of witnessing domestic violence are practically the same as those caused by direct abuse (2).

Based on this finding, our team began to offer specialized treatment for this type of problem, and in 2005 we created the Witnesses of Domestic Violence Program at our center (*Centre de Salut Mental Infanto-Juvenil de Cornellà del Hospital Sant Joan de Déu, Barcelona*). We call the program TEVÍ ('I saw you' in Spanish, or testigos de violencia), to emphasize the fact that children are aware of DV even though they do not talk spontaneously about it and those around them do not detect it as a problem.

Since the implementation of the TEVÍ program in 2005, we have verified that the detection of exposure to situations of DV in patients improves the diagnosis of their symptoms and allows for more effective treatment. This in turn implies more rational use of resources.

We have implemented universal detection of exposition to violence in all our mental health centers. This means that all caregivers of patients systematically complete a screening questionnaire.

1st PHASE: DETECTION OF VIOLENCE

We ask mothers of all children who attend our centers to complete the *WAST*: Woman Abuse Screening Tool (3). This instrument has a number of advantages over other similar questionnaires: it is validated in several languages and different settings (4,5). It has two versions, one for short screening (WAST-SF) and one for long confirmation; both versions have good psychometric properties and their correction is quick and easy.

WAST SF: Part 1 includes 2 questions:

a) In general, how would you describe your relationship?
- No tension
- Some tension
- A lot of tension

b) Do you and your partner work out arguments with...
- No difficulty
- Some difficulty
- Great difficulty?

If total score:

- 0: Negative result: STOP WAST
- 1-2: positive result. Manage extended version of WAST

WATS- Extended version: Part 2 (includes questions 3-8)

Scoring: Assign one of the following to each question (Likert Scale)

- Never
- Sometimes
- Often

Questions

1. Do arguments ever result in your feeling down or bad about yourself?
2. Do arguments ever result in hitting, kicking, or pushing?
3. Do you ever feel frightened by what your partner says or does?
4. Does your partner ever abuse you physically?
5. Does your partner ever abuse you emotionally?
6. Does your partner ever abuse you sexually?

When the score obtained in the extended version of WAST is in the high-risk range (16-24), the person enters the second phase of the protocol.

2nd PHASE: EVALUATION OF VIOLENCE

- A preferential visit with social workers is scheduled to assess the characteristics of the violence to which the girl or boy has been exposed, and the social and safety situation of the family in the current situation. S/he offers guidance in relation to the social, health, and legal protection circuit of the sector.

- In addition, an assessment is made of the protection and psychosocial support needs that the woman and their children may have. If this is the case, the mother is referred to the mental health care circuits and/or specialized social and legal services in the community. The social worker establishes a coordination plan to try to offer a comprehensive approach to the situation facing the family and to strengthen the links to our program.

WHAT SHOULD THESE ASSESSMENTS INCLUDE?

- Direction of violence
- Type of abuse
- Relation with the agressor
- Length of violence
- Duration of violence
- Last instance of violence
- Complaint
- Restraint order
- Attendance in support services within the community

- Subsequently, clinical evaluation visits are scheduled with an infant and adolescent psychologist or psychiatrist to get an accurate diagnosis. An appropriate treatment plan is established.

WHAT SHOULD THIS ASSESSMENT INCLUDE?

INFORMATION	TOOLS
Psychiatric background of parents	Interview
PTSD symptoms in children and caregivers	UCLA PTSD reaction index DSM-5 (6)
Anxiety symptoms	STAIc (7)
Depressive symptoms	CDI Child depression inventory (8)
Suicide ideation	World Health Organization (9)
Somatic complaints	Somatic Complaint List- SCL (10)
Emotional regulation and conduct problems	SDQ (11)
Mother’s ability to parent	Coding interactive behaviour (12)

Our team has adapted a personal interview called “What I have seen or heard” (13). It is a semi-structured interview adapted to the child and adolescent and designed to explore in a respectful way the situations in which he or she may have been exposed to DV and what his/her reaction was. This interview aims to elicit their experience and provide information and support.

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1. All families argue and have differences of opinion. What happens in yours, when your father and mother (or your father's or mother's partner) disagree?
2. Do they sometimes yell or hit each other?
3. Have you been afraid that your mother would be hurt?
4. Do you remember any situation in which this happened?
5. When was the last time it happened?
6. What has been the worst fight or worst act of violence you have ever seen or heard?
7. What do you do when violence breaks out?
8. Have you ever called the police or tried to intervene?
9. Have you ever been hurt?
10. Have the police ever intervened?
11. Have you ever tried to ask for help?
12. What were you doing at that time?
13. Are there safe places where you can take refuge until you think the danger has passed?
14. Have you been hit or hurt in your home? _______ Have they threatened you?
15. Have other serious things happened to you?
16. Other than your parents, do other people know what's going on?
17. Is it okay for you to talk to your mother/father?

This information allow us to offer psychotherapy add psychopharmacology to those children and families who need it. Treatment for children and families victims of DV can be provided in many different forms: group, dyadic, and individually.

GUIDE FOR HEALTH PROFESSIONALS: CONFINEMENT AND DETECTION OF DOMESTIC VIOLENCE

During the COVID19 pandemic lockdown a guide for mental health professionals was prepared to detect situations of domestic violence.

The period of confinement that we experienced brought with it complicated situations for families: loss of work, financial difficulties, overcrowding, anguish, loss of fundamental

rights, etc. Confinement, therefore, intensified the interaction among children, youth, and adults.

The aggressors can take advantage of circumstance of isolation from the family to intensify the dynamics of abuse, leaving the victims hidden and unprotected. In an attempt to deal with additional stress and anxiety, the abuser may impose stricter and more damaging regimes on their families, increasing control and creating very threatening situations. As a result, abused children and adolescents living in violent homes were now more vulnerable, as their coping and adaptation capacities were diminished. This situation placed them at greater risk of suffering greater mental health problems.

During confinement, the most effective communication with the health professional was by telephone. So this guide aims to detect domestic violence in a confined situation by telephone using a list of key questions. This guide may also be of general applicability—that is, in normal non-confinement situations.

In the period of confinement, the aggressor can control victims more intensely at home. For this reason, the questions raised in the guide pursue two main premises: not to put victims at risk and to increase specificity of the questions that will be single-answer (yes/no) or scaled (0 to 10 from least to most serious). This was to avoid arousing suspicion that the victim was asking help, and therefore to avoid retaliation.

TELEPHONE NUMBER OF INTEREST
EMERGENCIES 112

PROCEDURE TO DETECT DOMESTIC VIOLENCE

Contextualize the call: (give the caller's name)

"I usually start asking families questions about their family life, as this affects their health and safety, and also that of their children. Domestic violence is a very common problem and can be very serious. So I routinely ask a few questions to find out if they experience any form of domestic violence. Remember that everything we are going to talk about is confidential; most of the questions are answered with YES/NO and at any time you want we can stop the interview": P: Professional; A: answer; X: telephone / time according to the service.

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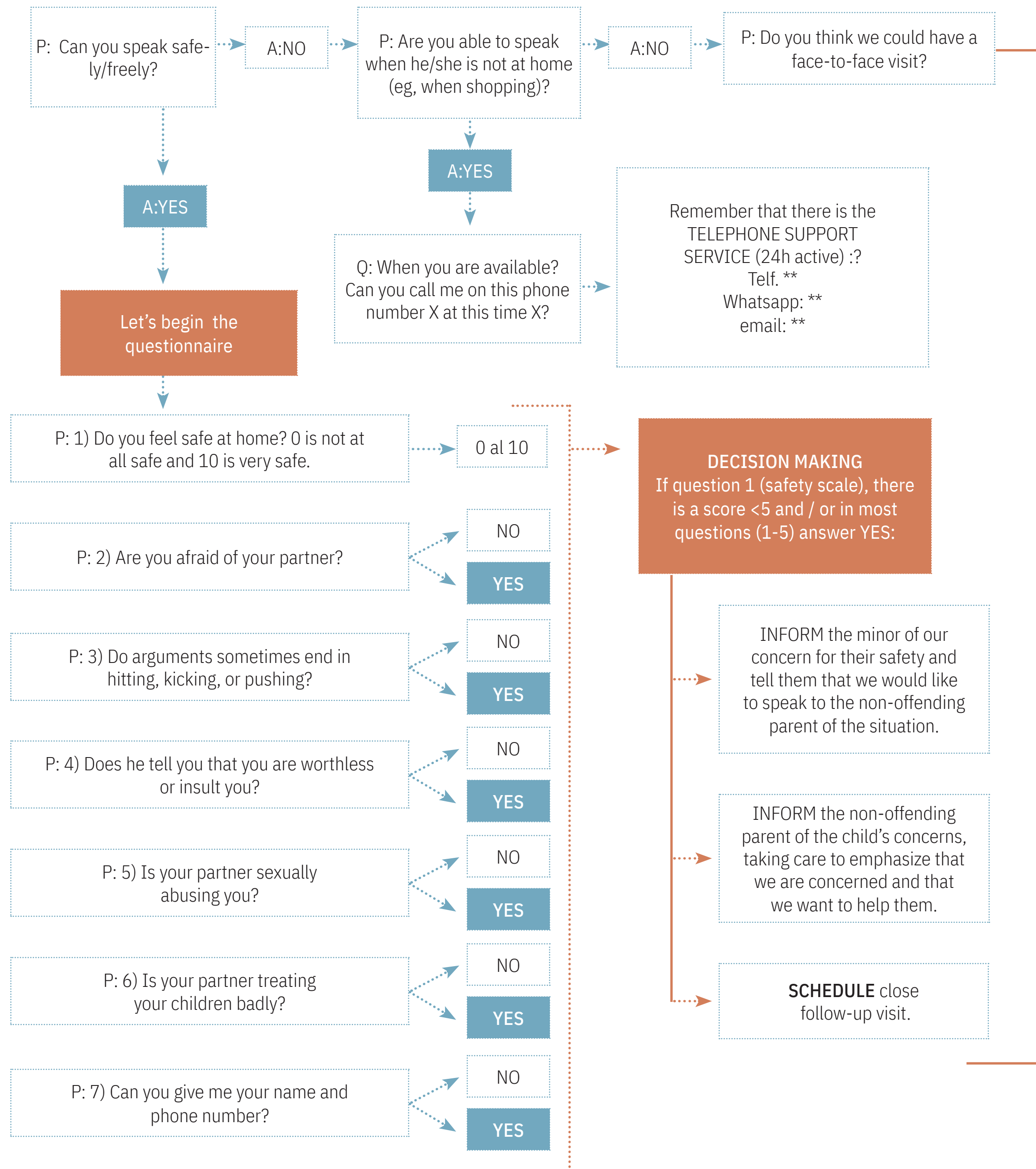
FLOWCHART TO DETECT DOMESTIC VIOLENCE



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CHAPTER 2
DIFFERENTIAL DIAGNOSIS BETWEEN COMPLEX PTDS AND ADHD

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Nowadays we have a greater knowledge of the effects of trauma draws on various branches of study:

- Neuroscience (how the brain supports mental processes)
- Developmental psychopathology (the impact of unfavorable experiences on the development of mind and brain)
- Interpersonal neurobiology (how behavior influences emotions, biology, and mental breakdown of those around us)

STRESS LIFE CYCLE MODEL IN CHILD BRAIN

Every day parents observe the development of the behavioral repertoire of their infants and young children, and the corresponding cognitive and emotional changes. These changes are due to the physiological development of the brain, in particular the development of structures such as the hippocampus, amygdala, and frontal lobes, and the complex circuits that connect these regions (1). Animal and human studies have also shown that during early childhood and old age the brain is particularly sensitive to stress, probably because it undergoes very important changes in its architecture during these periods.

Furthermore, research now links exposure in the early years of life to stress with increased stress reactivity in adulthood, indicating that the effects of stress at different periods of life interact.

Stress triggers the hypothalamus-hypophyse-surrene (HPA) axis, culminating in the production of glucocorticoids by the adrenal glands. The receptors for these steroids are expressed in many areas of the brain and can act as transcription factors, regulating gene expression. Therefore, glucocorticoids can have potentially long-lasting effects on the functioning of brain regions.

Glucocorticoids are important for the brain for normal maturation: they initiate terminal maturation, reshape axons and dendrites, and affect cell survival. But both suppressed and elevated levels of glucocorticoids compromise brain architecture and functioning from the prenatal period. In addition, parent-child interactions and the mother's psychological state also affect the activity of the child's HPA axis. Child behavioural development disorders (both psychological and cognitive) are associated with maternal stress and maternal depression during pregnancy, and with fetal exposure to exogenous glucocorticoids early in pregnancy. These behavioral disorders include impulsive behaviors, attention deficit hyperactivity disorder, sleep disorders, and certain psychiatric disorders, such as depressive symptoms, drug abuse, and anxiety disorders.

Starting at the beginning of the first year, when the child's HPA system is quite labile, good self-emotional-control parents are associated with minor or less prolonged oscillations of HPA axis activations to daily disruptions.(2)

We could talk about a real stress life cycle model. Indeed, the effects of chronic or repeated exposure to stress (or a single exposure to severe stress) at different stages of life depend on the areas of the brain that are developing or declining at the time of exposure. Stress in the prenatal period influences the development of many of the brain regions involved in regulating the HPA axis—i.e., the hippocampus, frontal cortex, and amygdala.

Postnatal stress has different effects: exposure to maternal separation in childhood leads to increased secretion of glucocorticoids, while exposure to severe abuse is associated with reduced levels of glucocorticoids.

Therefore, the production of glucocorticoids in childhood differs according to the environment (differentiation effects). From the prenatal period onwards, all developing brain areas are sensitive to the effects of stress, taking into account that some areas undergo rapid growth during a given period.

From birth to 2 years the hippocampus is developing; it could therefore be the area of the brain most vulnerable to the effects of stress at that time. Conversely, exposure to stress from birth to late childhood could lead to changes in volume of the amygdala, as this region of the brain continues to develop until 20 years of age.

During adolescence, the hippocampus is fully organized, while the amygdala is still developing, with a major increase in frontal volume. As a result, exposure to stress during this period may have important effects on the frontal cortex. Studies show that adolescents are highly vulnerable to stress, perhaps due to a prolonged glucocorticoid response to stress that persists into adulthood.

THE RISK OF MISDIAGNOSIS BETWEEN COMPLEX PTDS AND ADHD

It is therefore evident from this neurobiological introduction how ADHD and complex post-traumatic disorder are linked and at the same time can take on different characteristics. Studies indicate that maltreatment occurring prior to young adulthood is more common among people with ADHD compared to non-ADHD groups, and higher levels of ADHD symptoms are observed among individuals who were exposed to child maltreatment compared to non-exposed individuals (3).

There is a sort of double link between exposure and violence, ADHD, and being the perpetrators of violence. ADHD can be the result of maltreatment in childhood but can also be an early risk factor for experiencing maltreatment and other forms of violence victimization. Behavioral characteristics associated with ADHD, including being impulsive, making careless mistakes, and interrupting or intruding on others, may evoke negative responses from the environment and produce an increase in conflicts.

In the literature children exposed to domestic violence had higher odds of 2.33 for meeting diagnostic criteria for ADHD compared to children who were not exposed; in particular, the risk for being exposed to abuse/neglect was concentrated among children with ADHD and comorbid conduct disorder (3).

Regarding the link between these two diagnostic entities, there is evidence suggesting comorbidity, with prevalence estimates ranging from 12 to 37% (4).

The risk of misdiagnosis is high because there is an overlap between ADHD symptoms and the effects of trauma unless carefully examined (5). This is especially true in children exposed to repeated phases of domestic violence who are more likely to be diagnosed with ADHD (3).

It's true that most of these children who later turn out to be victims of domestic violence arrive or are referred by pediatricians, or more often from the school for behavioral disorders, emotional dysregulation, difficulty in compliance with the rules, and restlessness.

We do not have a point data that expresses the percentage of overlap and confusion between the diagnosis of PTSD complex mistaken for ADHD, but we know that nearly a third of severely maltreated children in the home setting meet the criteria for an ADHD diagnosis(6).

Improving diagnostic tools will likely lead us to reduce the percentage of misdiagnosis; in our clinical experience, only about 5% of child victims of violence have received a diagnosis of ADHD. Furthermore we observed that adopted children show symptoms similar to ADHD with more associated mood symptoms, disruptive behavior, and high levels of hyper-excitation, with a consequently higher risk of misdiagnosis.

The importance of proper functional diagnosis in the child lies in the type of intervention and therefore in the possibilities of therapeutic success and improvement of long-term prognostic effects.

CLINICAL APPROACH TO DIFFERENTIAL DIAGNOSIS BETWEEN COMPLEX PTDS AND ADHD COMPLEX PSTD CRITERIA (7, 8)

The complex PTSD can develop as a result of exposure to an event or a series of events of an extremely threatening or horrific nature, more commonly prolonged or repetitive events from which escape is difficult or impossible (for example, prolonged domestic violence, repeated sexual or physical sexual abuse). All diagnostic requirements for PTSD must be met and at least one of the symptoms must be present in each of the three domains listed:

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1. EMOTION Dysregulation

- Excessive emotional responsiveness
- Explosions of violence
- Reckless or self-destructive behavior
- Tendency to experiment with prolonged dissociative states under stress
- Inability to feel pleasure or positive emotions

2. IDENTITY Dysregulation

- Compromised self-concept
- Devaluation
- Shame
- Low self-esteem
- Guilt

3. INTERPERSONAL Dysregulation

- Persistent difficulty in maintaining relationships
- Difficulty feeling close to others
- Avoidance with little interest in relations and general social disengagement

ADHD CRITERIA (9)

1. Inattention: Six or more of these symptoms must be present for at least 6 months, be inconsistent with the child's developmental level, and have a negative effect on their social and academic activities. To be endorsed, the following must occur:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.

- Often has trouble holding attention on tasks or play activities.

- Often does not seem to listen when spoken to directly.

- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).

- Often has trouble organizing tasks and activities.

- Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).

- Often loses things necessary for tasks and activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

- Is often easily distracted.

- Is often forgetful in daily activities.

2. Hyperactivity: Six or more of these symptoms must be present for at least 6 months, be inconsistent with the child's developmental level, and have a negative effect on their social and academic activities. To be endorsed, the following must occur:

- Often fidgets with or taps hands or feet, or squirms in seat.

- Often leaves seat in situations when remaining seated is expected.

- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).

- Often unable to play or take part in leisure activities quietly.

- Is often 'on the go' acting as if 'driven by a motor'.

- Often talks excessively.

- Often blurts out an answer before a question has been completed.

- Often has trouble waiting their turn.

- Often interrupts or intrudes on others (e.g., butts into conversations or games).

In addition, the following conditions must be met:

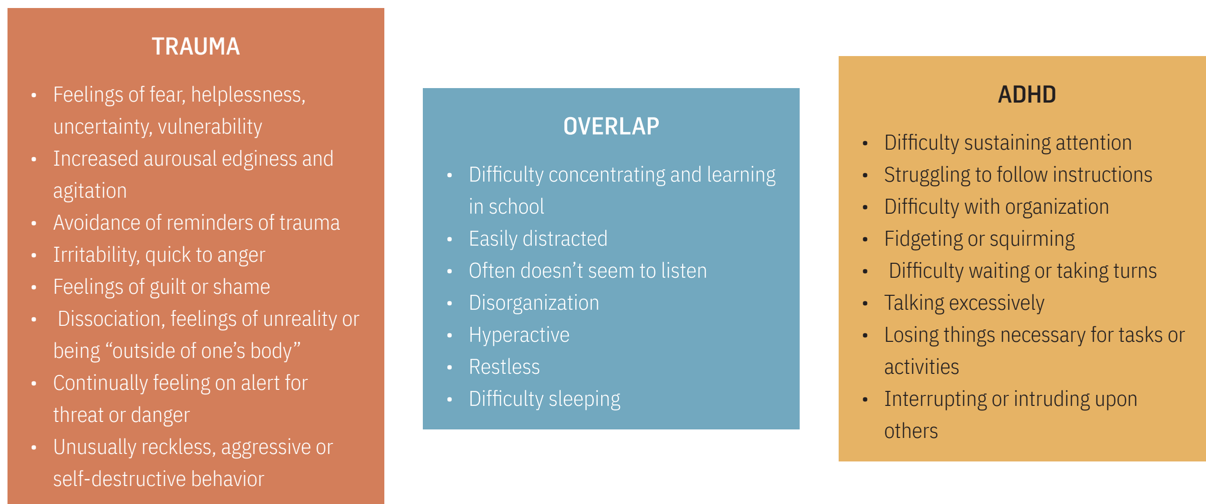
- Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.

- Several symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

- There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.

- The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

The figure below provides a list of some of the common symptoms of child traumatic stress and ADHD. The overlapping area shows some symptoms that are common to both (10).



We have drawn tables to summarize the differences between the two diagnoses in the different areas mentioned **indicating with the + sign present and with the sign – absent.**

EMOTIONAL DYSREGULATION	PTSD COMPLEX	ADHD
Excessive emotional reactivity, both in positive and negative situations	+	+ Deficit in working memory
Explosions of violence	++	-
Imprudent or self-destructive behavior	+	-
Tendency to experience prolonged dissociative states under stress	+	-
Inability to feel pleasure or positive emotions	+	-
Hyperarousal	++	-- Hypo-arousal
Separation anxiety	+++	--

IDENTITY DYSREGULATION	PTSD COMPLEX	ADHD
Self-concept compromised	++	+
Devaluation	+	-
Shame	+	-
Low self-esteem	++	-
Guilt	++	-

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SAVE
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INTERPERSONAL DYSREGULATION	PTSD COMPLEX	ADHD
Persistent difficulty in maintaining relationships	+++	+
Difficulty in feeling close to others	+	-
Avoidance with little interest in relationships and general social disengagement	+	-
Occasionally close or intense relationships, but difficulty in maintaining emotional involvement	+ Uninhibited social commitment disorder	-
No significant relationship with adults	+	-

NEUROCOGNITIVE ABILITIES	PTSD COMPLEX	ADHD
IQ	+/-	+
Visual and verbal memory	+/-	+/-
Working memory	-	-
Attention	Hyper-arousal /numbness	--
Response inhibition	-	-
Recognition of emotions	-	+

BEHAVIOURAL	PTSD COMPLEX	ADHD
Sleep disturbances (difficulties getting to sleep, night dread, and nightmares)	++	+
Avoidance (persistent negative mood, isolation, chronic fatigue, lack of interest)	+	-
Hypervigilance	+	-
Compulsive and repetitive play	+	-
Enuresis	+	+/-
Constantly complaining about physical pains that do not encounter a medical explana-tion (e.g., headaches, stomach aches);	+	-

The neurocognitive profile is less discriminating as it is almost superimposable. Children who are victims of violence learn to suppress their emotions and therefore don't develop the ability to recognize them.They adapt to the environment and do not fall into the biological paradox between the urge to escape from a dangerous environment and the impossibility of being able to do so in behavior. This adaptation mechanism is functional to mental survival in an environment in which danger is felt but cannot escape. ADHD children do not exhibit this type of internal tension, and we do not experience difficulties in recognizing emotions. For the rest, neither ADHD nor PTSD complex is based on neuropsychological profiles.

It should also be considered that ADHD has high comorbidity with one or more psychiatric disorders during evolution, 40% to 90% with externalizing disorders and 13% to 50% with internalizing disorders. Symptoms of other types of mental illness—particularly oppositional defiant disorder and conduct disorder—overlap with both child traumatic stress and ADHD. This interference makes the psychopathological picture more complex and increases the difficulty in differential diagnosis (4).

In summary, there are some basic **messages to keep in mind:**

- Do not limit yourself to the presence of criteria for ADHD but take into account the domains for a dimensional diagnosis
- Take into account social functioning, which in PTSD complex is very compromised, especially at the empathic level, in the sense of a strong reduction or an extreme affection and seductiveness, while ADHD children have a tendency to leadership
- The presence of separation anxiety or symptoms of attachment disorder is a propensity for a PTSD complex.
- Mood lability is more present in children with PTSD complex
- PTSD complex is more like an internalizing disorder, with behavioral aspects that suggest emo-tional dysregulation

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CHAPTER 3
POST-TRAUMA SUPPORT PROGRAMMES FOR CHILDREN WITNESSES OF DOMESTIC VIOLENCE: MERITA GROUP THERAPY

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The international guidelines for treatment of patients witnessing domestic violence (DV) recommend that once family safety is established, it is time to offer psychotherapeutic interventions. For minors, recommended interventions include individual, dyadic, and group therapy.

In this chapter special emphasis will be placed on group therapy based on our experience and the elaboration of a structured manual of a specific group therapy designed for witnesses of DV.

INDIVIDUAL THERAPY

Standard treatments in pediatric and youth clinics practiced at mental health centers should include current goals and recommendations in the literature for the clinical treatment of witnesses of domestic violence (1) (2). Objectives of the treatment that are incorporated into the usual therapies are:

a) Develop protection scenarios
- Do not intervene in a violent situation
- Anticipate a security plan.

b) Re-exposure and emotional regulation
- Express emotions
- Reduce anxiety
- Reduce sensitivity to traumatic perceptions
- Minimize avoidance
- Break social isolation

c) Reduce cognitive distortions
- Minimize misconceptions, guilt, and maladaptive beliefs
- Increase understanding of symptoms
- Learn constructive coping strategies

d) Affective bond
- Increase confidence
- Break the victimization cycle
- Work and reintegrate each stage of development

DYADIC THERAPY

The violent scenarios in families in many cases diminish the parental abilities of the mother and the personality and roles of the children, so dysfunctional interactions between them are frequent. These interactions remain after the abusive father is no longer mistreating.

As a consequence, an essential component of the intervention with young witnesses of domestic violence is the priority given to supporting and strengthening the relationship between the minor and the non-abusive parent. For most minors, a strong relationship with one of the parents is a key factor in the good evolution following the traumatic effects of domestic violence (3). Some research observes that the most effective interventions to decrease the externalizing and internalizing symptoms of children are those that combine interventions with children with interventions with mothers and children (4).

The most relevant therapeutic factors of mother-child interventions for improving children's symptomatology are (5):

- The mental health of the mother.

- Specific factors in relation to domestic violence, such as psychoeducation on parenting skills, both in general on psychological principles, and specifically on lived experiences.

- Nonspecific factors, such as empathy, positive outlook, interest, and warmth.

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Based on these findings, we used video-intervention therapy to work on the relationship between mother and child. The video-intervention or video-feedback technique consists of recording two or more people interacting, for example mother-child, parent-child, grandmother-grandchild, etc. depending on the relationship or aspects that you want to address. After recording, the video is viewed (preferably the therapist should have watched and studied it above) and aspects of the observed interaction are discussed.

Video-intervention therapy, normally, is part of a multimodal approach (6), including psychoeducation, individual therapy, family therapy, and other forms of parental support (7).

METHOD OBSERVATION	INTERVENTION
Coding interactive behavior -CIB (8)	Video-intervention (9)

In our experience with video intervention (10) we have found a series of indicators that are modified in this type of dyad. They guide the work with video intervention:

- Validation and praise
- Conversational tone
- Tone and affective range
- Setting limits
- Reciprocity

GROUP THERAPY: MANUAL OF EMOTIONAL REGULATION AND INTERPERSONAL ABILITIES (MERITA)

Group therapy is a therapeutic procedure that is frequently applied in mental health teams because of its effectiveness and cost-effectiveness. In the case of traumatized patients, due to their interpersonal nature, the therapeutic group offers an appropriate climate of security, self-esteem, and intimacy with others. The group provides the opportunity to develop relationships of trust and experience interpersonal security, which helps resolve the isolation and alienation that traumatized children often suffer (11).

There are two types of group treatment for trauma. The first is focused on trauma processing; this usually involves cognitive behavioral guidance and centers on the use of systematic desensitization techniques. The second type of treatment does not focus on trauma; rather, there is an interpersonal approach, often used in clinical contexts. Non-trauma-centered treatments have a lower drop-out rate than those that focus on trauma and are less likely to cause back trauma, by not directly evoking traumatic memories (11).

Given the number of traumatized children being seen in normal clinical practice, the proposal was to design a therapy using an intervention model that would encompass not only the problems of the patients, but would also promote their emotional regulation, ability to cope and relate, and reflexive capacity. Against this background, Group Therapy for Emotional and Interpersonal Regulation Abilities in Child and Adolescent Witnesses to Domestic Violence was formulated and described in the **M**anual of **E**motional **R**egulation and **I**n**T**erpersonal **A**bilities in children and adolescent group therapy (MERITA) (12).

This intervention is based on the original Skills Training in Affective and Interpersonal Regulation (STAIR) therapy (13) (14). STAIR treatment was developed to treat young people hospitalized in mental health units; youth with multiple traumas who had reported stories of physical or sexual abuse and many other traumas, such as domestic or community violence, in New York City, and consisted of 3 group treatment sessions. MERITA adapts the contents of STAIR to our clinical and cultural reality, extends the group sessions from 3 to 12, and proposes new therapeutic proposals.

The formulation and evaluation is based on emerging evidence in the literature on trauma, memory, and development. Previous studies (15) (14) showed that the functional difficulties of patients with a history of sexual abuse and exposure to violence were due not only to the symptoms of posttraumatic stress disorder, but also to emotional regulation difficulties and interpersonal problems. MERITA incorporates an interpersonal psychodynamic approach, strongly supported by attachment theory.

Unlike other treatments for traumatized children and adolescents, which address trauma directly through systematic desensitization behavioral treatment, MERITA treats trauma indirectly. It has been designed to give coherence to the emotional experience, strengthen the capacities of mentalization and emotional regulation, and offer new forms of relationship. This approach improves the symptoms associated with trauma and reinforces the abilities of children and adolescents to address the most painful aspects of trauma on an individual level.

In the MERITA group emphasis is placed on personal relationships as important aspects of life, and on stimulating the ability to give and receive good treatment. The method to achieve these objectives includes establishing a clear

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framework and limits, recognition of emotions in oneself and others, emphasis on the relationship between individual emotions, thoughts, and behavior, and the testing of new skills, verbal communication, and interpersonal conflict resolution.

Therapists seek to insure that the group functions as a 'safe base', in terms of attachment theory, respecting privacy, encouraging the acceptance of the other, encouraging free expression of emotions, accepting protests, etc., so that the mentalizing exploration of the internal and external world is encouraged, as well as an environment for testing new modes of relating.

Exposure to situations of domestic violence affects the core of the child's attachment system, and as a consequence, emotional regulation (16). Violent situations are unpredictable and by their very nature they keep the child in a state of continuous emotional activation. The terrified mother cannot offer protection or comfort. On the contrary, the roles are reversed and the child becomes the protector and responsible for ensuring the attachment relationship. The father, also a figure of attachment and protective potential, is the source of danger and anxiety. The tendency to escape and to attachment towards the same figure puts the child in a state of confusion and terror.

Given that the relationship between the child or adolescent and their attachment figure is profoundly altered in situations of domestic violence and abuse, MERITA is offered as a predictable, coherent, and tolerable emotional experience.

It is a manualized treatment that allows formulating a stable time frame and anticipating the content of the sessions so that the experience is predictable. Therapists offer a positive model of authority, limits are soon defined as to what can and cannot be done, and special care is taken to clarify misunderstandings and to make sense of behaviors, and to offer comprehensible and coherent explanations.

Domestic abuse is conceived as a 'trauma in attachment' (17), a concept that can also be applied to children and adolescents witnessing domestic violence. Research has shown that the ability to mentalize is weakened in most people who have experienced some trauma. The collapse in mentalization entails a loss of awareness of the difference between external and internal realities, similar to that of a 2- or 3-year-old child who has not yet experienced his/her mind as truly representational and assumes that his/her thoughts have a reality equivalent to that of the objects of the physical world.

MERITA group provides elements to reduce these ways of experiencing the psychic reality, such as the container framework, integration between thought and emotion and between the external and internal world, regulation of emotional experience, etc. For example, traumatic experiences, which are lived as dangerous and can cause the possibilities for mentalization to collapse, are not directly addressed; rather, psychoeducation is offered about trauma, in order to provide comprehensibility to experiences and symptoms. It also works on the feelings and emotional experiences of each one, reflected in a group way, so that the risk of the participants working in a simulation mode is reduced, in an 'as if' separate from the external reality.

In addition, the group allows us to observe how each participant has an internal world and how each participant is driven by their own feelings and ideas. The group allows exploration of both the common and the differential aspects of each other.

In addition, MERITA includes an implicit principle in cognitive-behavioral therapy: with practice new ways of acting, feeling, and thinking are possible. Accordingly, MERITA uses role-playing to facilitate learning and behavior change.

Following the appropriate sequence of heightening emotional regulation and interpersonal difficulties, mental conditions are improved so that the child or adolescent can address and integrate traumatic aspects, as well as achieving stabilization of symptoms and the establishment of a good therapeutic alliance.

* **Note:** The following abbreviated version is formulated for 8-12-year-old children. However, in any session specific adaptations for 13-17-year-old teenagers are possible.

THERAPY SESSIONS

BLOCK 1. RECOGNITION AND VERBALIZATION OF EMOTIONS

SESSION 1: PRESENTATION, FRAMING, AND BEGINNING OF IDENTIFICATION AND DENOMINATION OF EMOTIONS

1. Presentation and framing (20 min)

- The therapist can formulate the common link between all participants. For example: "You are all between 8 and 11 years old, you are patients of this center, and you have had difficult situations in the family, so this group can help you to learn new things. But in the group it will not be necessary to speak directly of your problem, if

you don't want to. You can work on these aspects in your individual therapy with your reference therapist."

- The therapist explains the objectives of the group

2. Simple definition of emotions (5 min)

3. Psychoeducation around emotions: Where are they? What are they for? Are they good? (5 min)

- The children are asked where they believe emotions are and where they notice them, and their responses are heard. It is explained to them that emotions are within us, we perceive them inside and sometimes some are seen from outside, and they are like clues that help us know what happens to the person. For example, if a person has tears in his/her eyes, he/she cries, he/she is surely very sad; if a person trembles, they may be nervous, cold, or fearful.

- The therapist asks them what they think the world would be like without feelings.

4. Present and practice how emotions are named: "Learning to recognize your emotions" (30 min)

- Show photos of people from different cultures with different emotional expressions. Ask the group members to write what the people on the sheet may be feeling.

5. Introduction to relaxation (10 min)

The last 10 minutes of several sessions can be dedicated to practicing deep breathing. Group therapists can use their own style to teach deep breathing.

6. Close (5 min)

To end the session, the therapist asks each one to explain how the session was, how they felt, and whether the group experience was as they had imagined and expected it to be. This strengthens the therapeutic alliance, by sharing the positive aspects and adjusting expectations. It is important that all members of the group participate; the most inhibited should be encouraged to participate. Try to ensure that the more 'participatory' members do not occupy the entire space.

SESSION 2: RECOGNITION AND DIFFERENTIATION OF EMOTIONS

1. Reunion and reinforcement of the work alliance (10 min)

2. Exercise of drawing an expressive face and guessing emotion (15 min)

3. Function of negative emotions (10 min)

- We present one appropriate story for the age of the participants in which the main character moves from an emotional state of frustration to one of achievement. Everyone is given a sheet with the written story, except for two blank spaces that must be filled in with the emotion they think is appropriate. This is done individually and then shared.

4. Exercise with emoticons (15 min)

5. Word-mimic exercise (15 min)

- This is a game of interpreting emotions. Cards containing a written emotion are distributed and the children have to represent it with mime; they may not speak. Tell the group that each of them should represent the feeling written on the card and the group has to guess what feeling they are interpreting.

6. Start the SAVE Card (10 min)

- Help each group member write the keys to detect when they feel very bad in the face of a negative emotion (when they feel angry, scared, embarrassed, etc.) and write it on the "My SAVE Card".

7. Close with relaxation (5 min)

• Exercise on good treatment (optional exercise)

When the group is made up of children with behavioral problems who transgress the boundaries with highly acted out aggressive or rivalry reactions, it is advisable to perform this exercise in various sessions. It requires the therapists to be very attentive to these behaviors and intervene at their first manifestations. Throughout the entire treatment, intervene again whenever the opportunity arises, in the face of inappropriate reactions, obstacles, or boycotts. We will talk about group behaviors, and whether they are good for the group or not, and why. With this exercise the insight and the capacity of self-control are worked on.

- Prohibited behaviors. If after warning and providing opportunities for change the participant continues repeating the same action, he/she will visit the director or coor-

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dinator of the center, where reflection, mentalization, and change will be worked on outside of the group.

- The therapist will reflect on the incident that has occurred, and if he/she deems it necessary, s/he will try asking the child to apologize, so that the child can change the behavior in question. In turn, the therapist will reinforce good words and good behaviors.

SESSION 3: EFFECTS OF TRAUMATIC EXPERIENCES

1. Recall and script of the session (10 min)

2. Provide education on the impact of trauma and stress (25 min)

- Therapist: Explain to the group very simply and briefly that traumatic experiences include witnessing a fight or someone hurting or even shooting another, or being in a serious accident or seeing a seriously injured person. Many people experience trauma throughout their lives.

*** Note to therapists:** Avoid going into details related to the traumatic experiences of patients. This is not the time to process the traumatic event. Let the participants mention something briefly, but stop them before they go into details. If the group is mature you can talk about some of the symptoms of posttraumatic stress. Rather than explaining all the symptoms, it is important that they understand each other.

3. Work with video (30 min)

To introduce the issue of trauma and an approach to emotions that can be unpleasant or traumatic, begin with a pleasant visual stimulus, such as a movie. One proposal is to work with a video of "The Ugly Duckling", which lasts about 5 minutes. Without language and accompanied by music, various emotional states of the characters in the classic story are witnessed. "The Ugly Duckling" can be found at the following link[3]: http://www.youtube.com/watch?v=R_1-F_i8KKI&feature=player_embedded.

- After watching the video, the children are asked what they thought and what emotions they saw in the characters. They then watch it a second time, and this time they must write down the emotions of the characters. Then the emotional attributions that each one has written are shared with the group.

Explain the traumatic reactions of the main character of the film, in the case of teenagers.

4. Close and practice relaxation (5 min)

SESSION 4: EFFECTS OF TRAUMATIC EXPERIENCES II

1. Education reminder on the impact of trauma and stress on emotions (10 min)
2. Intensity of emotions (5 min)

3. Self-regulation of emotions (20 min)

- The participants are asked to think of an experience that has had an impact on them. This exercise will be used to trace emotions: paying attention to the emotion itself, its intensity (how strong it is), what situation it triggers, and what strategy the child uses. Set scales to assess the intensity; for example, 'just a little', 'somewhat', 'a lot'. You can use a scale 0-3 or 0-10 if you prefer.

- It is difficult for children to choose the situation. That is why they can be helped by inviting them to think about a situation in the past week that produced a strong reaction in them, in the family, social, or school environment.

- Then tell them to write the thoughts that accompanied those emotions. Remind them that having emotions and thoughts is normal, and what we do with them is what counts. You may even think: "I'm going to hit this person" or "I'll kill her" or "I'll kill myself." It is OK to have all these thoughts. State that being honest with oneself (and with the group) is difficult. Finally, tell them to write their coping strategies. Examples may include scream at the teacher, slam the door, or go for a walk.

4. Find the emotion in the body (15 min)

5. Reflection on the emotions experienced in the group itself from its beginnings to the present (15 min)

6. Relaxation and closing of the first block (10 min)

- Exercise on good treatment (optional)

3_For teenagers we recommend a piece of the German movie "4 minutes" by director Chris Kraus, from 16-18:30 minutes.

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BLOCK 2. LEARNING TO MANAGE EMOTIONS

SESSION 5: MANAGING UNPLEASANT EMOTIONS, COPING ABILITIES IN BODY, MIND, AND BEHAVIOR

1. Link with previous sessions (5 min)

2. Psychoeducation on the three parts of emotional reactions: the mind, the body, and behavior (25 min)

Through the metaphor of the train and the three cars (body, mind, and conduct), it is taught how emotions can be located in several parts of ourselves. When you have an emotional reaction, there are three parts involved: the body, the mind, and the behavior.

- Examples of each of the cars are asked for and everyone is encouraged to participate by explaining how they think that an emotion can be felt in the body, in the mind, or through behavior.

- "When you do something in one of the cars, you can stop the whole train. You can choose which car you want to focus on. You can stop more than one car if you want, but you don't have to. You are the driver of this train."

3. Poster on 'The train of emotions' (35 min)/Identify and evaluate current coping strategies (30 min)

4. Identify and evaluate current coping strategies (30 min)[4]

5. Review the coping skills and the SAVE Card (5 min)

This session should end with a review of each adolescent's coping skills and a review of the 'My SAVE Card'. Each member should complete the plan with personal strategies to deal with negative and unpleasant emotions.

6. Relaxation and closure (10 min)

SESSION 6: NEW COPING SKILLS, SELF-ESTEEM

1. New coping strategies (20 min)

2. Positive affirmations of oneself: Focus on mental coping strategies (20 min)

- Explain to the group that a very useful strategy is to think or say something positive as soon as you realize that you are thinking or saying something negative about yourself. For example, instead of thinking: "I am useless," a teenager may say, "I do my best."

- Have the group members make several positive statements about themselves and write them on the sheet.

- Explain that self-affirmations and other coping strategies are NOT designed to hide or avoid feelings, but to give adolescents control over their emotions and be able to choose when to tolerate those unpleasant emotions.

3. Recognition of positive aspects in the other group members (25 min)

- Explain that it is difficult not only to see positive things in ourselves, but also to see the positive in others. Sometimes we focus only on the negative in others, because we have suffered harm or rejection from someone, but not all people are equal, and learning to recognize the positive aspects of others can help us make worthwhile friends and no longer lose them. Other people can help us cope with difficulties.

*** Note**: Thinking about positive self-affirmation is difficult for some people. Given the circumstances of life and the messages about themselves, the group may need to be encouraged. Negative ideas about themselves and the world come to mind more easily. Initially, thinking positively may seem silly or impossible for some people. Help each group member to find at least one positive self-affirmation that they can come up with and that they believe about themselves: personal qualities, sports, social, artistic, and cultural skills, etc.

4. Relaxation and closure (10 min)

SESSION 7: NEW COPING SKILLS, SELF-CARE

1. Remember how to stop the train of emotions (10 min)

2. Domestic violence (20 min)

Therapists should ensure that children have an individual session in the days following this group session. This point

4_For teenagers 13-17 years old.

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may contradict the general approach of MERITA, which does not directly deal with situations of domestic violence experienced by the children of the group. Therapists may wish not to clearly address this issue for fear that children will relive the situations of violence suffered. It is essential that therapists carefully evaluate whether the group is prepared after previous sessions to address this issue without the risk of emotional overflow from participants.

Violence between parents is addressed here from the point of view of coping, and of what the children could do.

- The 'Domestic Violence' sheet is used. The therapist distributes the file and reads in a group. Each participant may read a paragraph. An alternative is to view the video on the prevention of domestic violence made by our team. This is a 9-year-old boy who narrates the experience of witnessing this violence; he explains how bad he feels and he offers possible alternatives (https://www.project-save.eu/).

- Allow time after reading for children to give their opinion and comments. Some of the children may evoke personal experiences; be empathetic and encourage them to address these issues in the space of individual therapy.

3. Present relaxation through the 5 senses (25 min)

- Tell the group participants to write something related to each of the 5 senses that reassures them (hearing, smell, taste, sight, and touch). For example, for hearing, listening to music that we like; touch, a massage, etc. Discuss the strategies you have already used to calm down and the situations in which you used them. Reinforce using appropriate strategies to calm down.

4. Relaxation and closure (10 min)

SESSION 8: SKILLS FOR CLEAR COMMUNICATION

Introduction to the group: "You have the right to say 'no' or to ask when in doubt. The best way to do this is to use words rather than actions."

1. Link to previous sessions (5 min)

2. Present the skills for clear communication: giving your point of view and saying what you want (20 min)

- The therapist asks if they know what communication is and if they think they know how to communicate well with their friends, family members, teachers, etc. They are told that there are many children and adults who have difficulties and that today they will be given two key messages for good communication.

• GIVE YOUR VIEWPOINT
• SAY WHAT YOU WANT

3. Role-playing on clear communication (20 min)

Explain that in these groups we will learn ways to deal with similar problems. We are going to focus on how to communicate well with others, and for this the best way is to practice, through role-playing representation, or what for them we will call 'theater'.

- All group members must participate in role-playing. Try to stimulate the most inhibited, recognizing that it may seem difficult the first time, but each time it will take less effort.

- It is also important to highlight non-verbal communication such as gestures, positions, expressions, and everything that is seen even if it is not said. Gestures of interest could be listening, nodding, facial expressions of interest, etc. These are the ones that you can use and add in role-playing.

4. Identify difficult situations and perform a role-play (20 min)

5. Breathing, relaxation, visualization (10 min)

BLOCK 3. RELATING WELL WITH OTHERS

SESSION 9: ASSERTIVENESS AND RECIPROCITY

1. Presentation of the third block (5 min)

2. Knowing how to say "No" and knowing how to listen (15 min)

- Ask the group if anyone has an example of a recent situation in which they would have liked to say "no" but could not. Ask the group to help identify how the person could have said "no" respectfully.

- Explain how important it is to know how to say "no" and to know how to listen to others. Knowing how to listen and being open to what the other person means are essential for good communication, but so is standing firm if one really means "no".

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• For many children who have experienced trauma and/or traumatic situations it can be very difficult to say “no”.

3. Role-playing of assertiveness and reciprocity (30 min)

4. Basic personal rights and duties (10 min)

- Distribute the ‘Basic personal rights’ sheet. Explain that, as a human being, each person has the right to everything on the list, no matter who they are or what they have done (promote dialogue in the group).

- Distribute the ‘Basic personal duties’ sheet. Explain that, in addition to rights, each human being also has duties to guarantee the rights of others. Emphasize the importance of recognizing these duties and their consequences. Do not forget your rights or your duties!

4. Review the coping skills and the SAVE Card (15 min)

SESSION 10: SAVE CARD AND THE GOOD RELATIONS GAME/NEGOTIATION SKILLS

1. Link with previous sessions (5 min)

2. My SAVE Card (25 min)

- This card is written and reviewed individually with the help of the therapist. It is advisable to finish this in session 11 so that in the last session there are only group activities.

3. Joint task: construction of the Game of Good Relations (35 min)/Negotiation and cooperation skills (35 min)

The Game of Good Relations is a MERITA adaptation of the classic goose game[5].

It is a game in which questions on all the subjects treated with role-playing on communication, assertiveness, and negotiation alternate, and it is presented as a review of the therapy. In this session the game is prepared to be carried out in the next session. By using a game that everyone knows, their attention and collaboration are encouraged.

Negotiation and cooperation skills[6]

Negotiation capabilities are necessary in many interpersonal situations. Negotiation often involves combining cooperation and autonomy and requires hard learning. Success in negotiating different individual positions satisfactorily implies that adolescents can contrast their different positions, while maintaining a cooperative relationship; that is, adolescents can maintain a balance between the affirmation of their positions and cooperation and trust.

Group discussion /Viewing (optional, 15 min)

4. Breathing, relaxation, and closure (5 min)

SESSION 11: SOCIAL SKILLS AND CONFIDENCE RECOVERY

1.Reminder that this is the penultimate session (5 min)

The therapist announces that we are in the penultimate session; therefore, the group is coming to a close and this evokes thoughts and emotions in all of us.

***Note to therapists:** The final two sessions are dedicated to strengthening the skills and knowledge developed in the previous sessions. They can include activities scheduled in previous sessions for which there was no time, that ran quickly, or that need to be repeated, in some area that therapists want to explore further.

2. Social skills practice (10 min)

- The therapist invites the children to explain some relationship conflict they have had recently and suggests a role-play.

3. The game of the guide and the blind man (20 min)

4. The importance of being able to trust another person (10 min)

5. Practice in knowing who to trust (10 min)

- The therapist tells a story related to trust, and the

5_The goose game is a classic board game in which each player rolls a die and advances his/her counter on a spiral-shaped board with patterned squares. Depending on the square on which you fall, you go forward or back, and on some squares a punishment is indicated.
6_Negotiation skills will be offered to 13-17 year-olds.

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participants have to identify 3 to 5 personal traits or characteristics that would make a friend reliable and 3 to 5 personal traits or characteristics that indicate that a friend is NOT trustworthy. The contributions of the group are written in two columns ('Reliable' and 'Unreliable') on the board.

6. Finish the SAVE Card (10 min)

In this session it is very important that the participants review and finalize the "My SAVE Card".

7. Close (5 min)

SESSION 12: CONSOLIDATION AND FAREWELL

1. Good Relations Game (40 min)/Farewell party[7]

- The therapist introduces the Good Relations Game. It is a game in which questions on all the previous topics treated with role-play about emotions, communication, assertiveness, negotiation, etc., are presented as a review of group therapy.

- It should be fun and performed in a relaxed environment.

2. Evaluation (25 min)

- The evaluation is carried out with the whole group. The therapist asks the group several questions and encourages everyone to give their opinions openly.
  - How did you feel in the group?
  - What aspects of therapy did you like the most? Try to specify the activities they liked best.
  - What suggestions or proposals do you have to improve therapy? (what aspects would they add /remove, spend more/less time on ...)
  - In what ways has the group helped each one?
  - What areas remain for improvement?
- The therapist gives each child his/her SAVE Card to help them reflect on the improved aspects and those that remain for improvement. This card is taken home as a reminder and reinforcement of the group's purpose.

3. Farewell (10 min)

7_Farewell party is the option for 13-17 year olds. It should be fun and performed in a relaxed atmosphere where prior activities can be repeated.

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SAVE

Support and treatment of traumatized children After ViolencE

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CHAPTER 4
POST-TRAUMA SUPPORT PROGRAM FOR FAMILIES WITH DOMESTIC VIOLENCE

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1. THE CYCLE OF VIOLENCE: WHERE THE RELATIONAL AND THE BIOLOGICAL MEET

It is impossible to imagine the development of a human being independent of relations with other human beings. Starting before birth, the biological, psychological, and relational components interact to guarantee healthy development. The individual is put together as such in a web of relationships, which is why, when those responsible for taking care of a child and nurturing its growth feel they have erred in so doing, development gets detoured and psychopathology appears. Factors such as abuse, neglect, and violence in the family bring about serious psychopathological problems such as posttraumatic stress, and they disrupt evolving systems such as that of attachment. Precocious psychopathology and insecure or disorganised attachment increase the feelings of vulnerability, further encouraging the development of psychopathological problems in the face of subsequent life events (1).

The relational-link matrix, which is the basis of human development, explains the strong generational continuity that exists. The manner in which the current generation cares, or fails to care, will influence how successive generations care or fail to do so with their offspring.

Therapeutic interventions aimed at addressing violence in the family have different formats and involve the implementation of multiple complementary strategies. Individual intervention is required to address the psychopathology and recover personal resources. At the same time, an intervention is needed to modify family relational patterns and provide feedback on violent responses. This should be associated with group strategies aimed at improvement the disturbances that patterns of violence cause in socialization. These strategies can be treated in multiple therapeutic settings. In the case of violent relationships, suffered in the family, a path of family therapy is carried out, if they also occur in relationships with peers, group therapy takes place. Finally, if violent relationships affect emotional regulation and the ability to distinguish social signals, individual therapy is performed.

Mistreatment is a relational pattern that extends beyond individual, isolated episodes of aggression (2). It is a phenomenon of a relational nature, produced in the core of the relationship. Rather than talking about individuals that are intrinsically abusers, we need to talk about abusive relationships of various kinds and degrees, without regarding any form to be an absolute case (3). If we oversimplify the complexity of mistreatment we limit the possibility of acting upon and resolving the problem (4).

Violence in the family is a structural problem originating in a specific relationship (5), and it must be defined in terms of a sequence of acts and attitudes leading to violence, so as to permit us to carry out comprehensive relational work. We are all capable of changing our system by changing the role that we play in it (5). It is important to avoid restrictive and simplistic definitions, while all changes need to be backed by a dynamic definition of the interaction, with each person responsible for what happens and what may come about from the change (6). Nobody considered a 'victim' can emerge from that condition without first understanding how they participate in it, so as to be able to modify it, and no 'bully' can leave behind that role without first imag-ining that he has the freedom to do so (6).

The interaction of the various participants in relations with abuse generates complexity. Explicitly destructive actions become mixed with other, more subtly destructive ones: cover-ups, omissions, denials, complicity, comparisons, and marginalization, as well as others of an opposing nature such as compensation, repair, consolation, etc. (3).

The first order of business in family work is safe-guarding the children and adolescents. Once sufficient measures have been taken to put a halt to the mistreatment, working with the family becomes viable. When it's possible to involve the perpetrator of violence in family work, it's often found that those who resort to violent attitudes are consumed by feelings of anger and fear, and feel that they have no other means of affirming themselves than through violence. In other words, it shows extreme impotence (7).

Clinical experience and literature highlight the presence of a relationship between abusive behavior and unfavorable childhood experiences. Generation after generation share the experience of growing up in dysfunctional families, victims of sorts of social injustice. Children are born, grow up, and become adults in a society that does little to support them or instruct them on how to treat their children. By the same token, society fails to protect the children from harm as people or help them learn how to be parents in the future. Abused children are the victims of mothers and fathers who had not learned about the job of being parents, just as their progenitors had lacked the opportunity to learn (8). The transfer from one generation to the next of dysfunctional interactive patterns, without the possibility of transforming and correcting them, is an element supporting the transmission of violence and how it can be learned.

The model for treatment of the family includes the idea that the main source of resources for today's parents in treating their children well is the positive experiences that they had with their parents when they were children (9). These childhood resources are activated by making use of maternal and paternal experiences. However, if family treatment isn't sufficient to bring out the positive resources, we will try to bring them out through an individual therapeutic relationship.

Family functioning as a source of resilience involves a family setting with affection, stability, and appropriate, and clear, rules of behavior. Adults with the ability to empathize and care for children, help develop safe and secure attachment bonds (8).

2. RISK FACTORS THAT PROMOTE VIOLENCE

How does the violence start? The beginning of domestic violence episodes may depend on one or more particular negative events. Domestic violence and mistreatment arise and develop through relational feedback chains: this means that violence must be read and experienced as "Pathology of the Relationship" (10) .

Since it is a pathology of the relationship capable of confusing and distorting the emotive experiences, adults that mistreat hardly ever do so with intentionality and lucid determination. Therefore it appears fundamental, when talking about interventions against domestic violence, to protect the most fragile of family dynamics as well as to involve, whenever possible, those who mistreat or are at risk of acting mistreatment, in order to accompany them on a journey of awareness of the damage they inflict on family members.

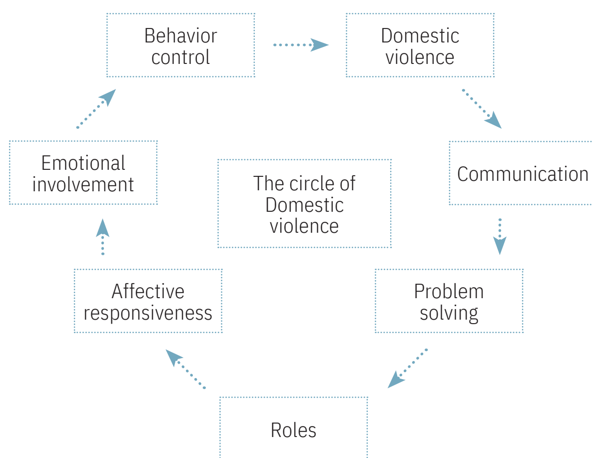
There are multiple risk factors underlying family functioning, which increase the likelihood of developing violent interactive patterns. The main risk factors (11) are identified as:

- poverty
- unemployment
- lack of education
- mistreatment suffered in childhood
- parental dysfunction
- poor family interactions
- neighborhood violence

Socioeconomic strain, marital discord, and parental problems have been studied as risk factors for strict and abusive behavior within the family. It is believed these risk factors negatively influence parents' ability to use positive and effective parenting. The presence of stressful conditions in the family system can increase the hostility and conflict of parents, interfering with the negotiation capacity, assumption of one responsibilities, and recognition of children's needs and care. The strong conflict can be expressed in forms of intra-family violence and involve children by exposing them to aggressive dynamics, making the family neglectful, chaotic, and mistreating (12).

Regardless of the form of violence suffered by the child, fear is an ever-present component since the child is forced to live in a condition of constant terror due to the presence of threatening and intimidating behaviors that determine feelings of inadequacy and helplessness as well as the feeling of being totally defenseless and unable to ask for or receive help.

This has a direct impact on the perception of personal safety by causing unpredictable elements and sources of insecurity inherent in the primary emotional environment. "The presence of a parent is at the same time a protective figure but also a source of neglect and abuse or of which one is afraid, and deeply destabilizes the child and his perceptions with respect to those who are to be considered reliable, present, good and those who frighten, threatens and is bad" (13). When, in addition to witnessing violence, other conditions of risk are established, namely child maltreatment and adverse parenting practices, the probability of a recurrence of violent behavior becomes even higher (14). In these cases "the family environment is characterized by serious dysfunctions that affect the child's ability to self-regulate his emotions, perceptions and expectations towards other which will be characterized, for example, by the inability to establish emotional reciprocity" (15).



The figure illustrates how violence arises and grows within the dimensions of the family that influence each other and each dimension is in turn the cause and effect of the others.

The result is a compromise of dimensions of family functioning, in which the irritability of a member, the lack of communication, the conflicts and the difficulty in recognizing problems can lead to quarrels and to violence. This can turn into a negative cycle in which malfunctioning dimensions provoke violence and violence generates malfunction in an endless spiral.

It is therefore evident that domestic violence and family dysfunction are closely connected to each other. It is important to find ways to interrupt this negative cycle because this helps improve family functioning. In this context, the McMaster model (16) represents an important tool to help understand family functioning. It acts on the negative cycle through analysis of family dimensions and intervention in them. It is a tool that can help therapists deliver effective interventions to families.

3.BREAKING THE CYCLE OF VIOLENCE: FAMILY THERAPY

As professionals, we are committed to our task of navigating the space between understanding and supporting change in family members, and intervening to protect the rights of children and adolescents. The intervention of the law is necessary but not sufficient. It helps expose and establish the limits of behaviours that circumscribe our intervention. Additionally, drawing on the resources that families have, we try to help them reorganize their lives without violence in order to break the cycle of suffering that is passed on from generation to generation.

Family therapy, focusing on violence in the family, aims to improve trusting relationships of children who have been mistreatment or abuse, which in turn can help to prevent the development of personality disorders and criminality, which all too frequently emerge under these conditions (17). A family can function as a unit of understanding and solution to the phenomena of violence, precisely because it is in the family that these possibilities may emerge (6).

In order to maintain a broad perspective that includes all of the actors in the family and the possible situations that may interfere in its functioning, we use elements of the McMaster Model of family therapy, both in the Ospedale Bambino Gesù in Rome and in the Hospital Sant Joan de Déu in Barcelona, to which we add elements that we have developed from our own experience.

4. MODEL OF ASSESSMENT FOR FAMILIES WITH VIOLENT DYNAMICS

The McMaster model is based on the family system, whose structure and organization are important factors for explaining the behavior of family members. The relational patterns

of family system influence the behavior of the members, determining their overall functioning (16). Domestic violence has its own relational pattern that contributes to making it degenerative and dangerous. The McMaster model helps us to identify relational patterns, violence-causing factors, and malfunctioning dimensions.

In our intention to be guided by the theoretical and practical principles of the model, we have never forgotten how fundamental it is first of all to assess the seriousness of domestic violence and when to intervene to protect members before investigating their relational dynamics.

The adoption of the McMaster model contributes to:

- recognition of violent behavior
- recognition of negative effects of violence
- promotion of parental self-efficacy
- improvement in parenting style

The model is based on helping the family to develop understanding and act to solve family difficulties, working with a collaborative therapist who makes patients feel listened to and understood. The therapist helps to develop a meaningful story based on relationships and perceptions of children and the family.

4.1 FUNDAMENTAL PILLARS OF THE MCMASTER MODEL

The McMaster model is based on three fundamental pillars: the effectiveness of relationships, the evaluation of family functioning, and the activation and resolution of problems (16).

- **The effectiveness of relationships** where the therapist is committed to understanding children, parents, and family functioning in which they are set. This effectiveness is built on a collaborative attitude, characterized by empathy and management of difficult emotional expression. Specific attention is paid to consensus, trust, confidentiality, and professional boundaries; patients are helped by the therapist to feel comfortable and manage emotional expression, but it is important to maintain professional boundaries.

  It is fundamental to communicate to the family that the therapist has the aim of trying to remedy the family problems that created difficult situations.

  Example: The therapist says: "I have reason to believe that you are in trouble. I will ask you to complete some tests regarding the nature of your family functioning. Then, I will ask you, at the end of the therapy, to do them again. You will help me. There will be times when I ask your child not to come to discuss something that is much more about your relationship and not his business."

- **The evaluation of family functioning and critical dimensions**. The therapist analyzes and explores perceptions of the different dimensions of the family and to what extent they interfere in the lives of individual members.

  Example: The therapist says: "I will ask you some questions to better understand what kind of family you are and how you act when you are all together. I don't want to judge you about the problem you have. My intention is just to understand how each of you perceives the family problems and what you do to deal with them."

- **The activation and resolution of problems**. 'Activating' parents means understanding the promotion of reflection on a) what led to family dysfunction, and b) what needs to be done to find solutions. 'Activation' describes a change in mental orientation in parents. Troubleshooting is part of this activation process.

  Example: The therapist aims to help the family not repeat same mental pattern and dysfunctional behavior. Achieving something (no matter how small) helps self-esteem and changes interactive patterns.

The McMaster model includes two tools: the FAD (Family Assessment Device), a self-assessment questionnaire designed to assess the family dimensions and based on individuals' impressions of the functioning of their family, and the Mcsiff (McMaster Structured Interview of Family Functioning), a structured interview on the family system on paper (16).

The interviewer's task is to ask, review, and explore in depth each dimension to obtain sufficient information so that a clear and reasonable assessment can be made of the effectiveness of the family in managing the components of each dimension. For these reasons, the McMaster model allows evaluation of a wide range of family functioning factors; among these, one of the main is represented by episodes of domestic violence. In order to take advantage of the model, its management requires knowledge of domestic violence; clinicians must know how domestic violence occurs, how to

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identify it, and how to help parents to understand, manage, and deal with it.

Domestic violence has some peculiar characteristics. Based on our clinical observations we can say that a good percentage of families in which domestic violence occurs present an unstable internal structure, on the relationship and couple levels and in terms of organization. Parents often have unresolved conflicts with their own families. In this kind of family situation children live in a violent climate and are in a position to witness scenes of violence or live in an atmosphere steeped in violence. In such families, parents generally have suffered previous mistreatment or abandonment in childhood or lack of affective guarantees. Chronic dissatisfaction with one's instrumental (practical), emotional, and attentional needs is most often expressed with anger to the point of mistreatment.

During the treatment, we often observe high levels of sudden excitement and feelings of not being understood or listened to by a family member. Moreover, we observe an attitude towards violence that sees it as a tool to solve problems or to achieve one's goals.

The family members present a distortion of affects and relationships, reaching the point of no longer discriminating between violence and normality. The suffering of the first experiences is transformed into adaptation. Very often parents answer "*what have we done wrong?*" with "*even my father did it and I didn't suffer.*" In these kinds of situations families suggest explanations for violent behavior and create their rationales. In this way, the victim and the abuser can 'survive'.

Families present multi-problematic characteristics and multiple cumulative risk factors. Frequently these families are known to the territorial services for deviant behavior, for psychiatric problems, and/or for economic reasons. It is difficult to discern the different forms of abuse, but almost all of them have multiple cross-treatment between parents and between parents and children. They also have negative attitudes towards specialist treatments and they prefer to solve their problems independently. Only in the most urgent of circumstances do violent families contact territorial services.

4.2 EVALUATION OF FAMILY FUNCTIONING AND VIOLENCE

Violence is strictly connected to alterations in family functioning. It is important to remember that the level of this functioning is verified by the therapist through analysis of the McMaster dimensions, which are problem solving, affective responsiveness, behavior control, affective involvement, communication, and roles. As a demonstration of the importance of these dimensions, a study has highlighted how often partners identify communication as a greater problem in the marriage than physical aggression. In addition, they report less constructive communication due to mutual fault and greater avoidance (18).

To understand family functioning, it is important to examine in depth the dimensions and principal characteristics linked to domestic violence episodes:

1. Generally, in violent families there is an inability to face problems for fear of generating conflicts.
2. Often the anger or hostility of a partner, combined with the poor ability to solve problems and discord in relationships, represents a significant predictor of violence.
3. In violent families the control of the other's behavior can degenerate into outbursts of anger and violence for educational purposes towards children and partners.
4. Generally, in violent families the degree of closeness between people can be described by their attachment styles (confident, anxious or contemptuous). Relationships characterized by hostility and detachment have the greatest physical aggression.
5. In violent families there is fear of raising arguments for fear that the other may get angry.
6. Generally, a discrepancy of power in a marriage where a partner is subordinate is a risk factor for violence between husband and wife.
7. The delegitimization of the role by one partner over another can turn into mortification and psychological violence.

When three or more of these characteristics are present and persist over time, it can indicate a family with violent dynamics. It's possible to intercept these characteristics by analyzing the dimensions of family functioning, allowing us to recognize violent behavior in the different dimensions of the family functioning, such as (19):

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4.2.1 Problem solving:

- Family unit doesn't recognize the existence of a problem or its size, and does not have the tools to act.
- Family does not correctly identify the problem. This can trigger projection, displacement or distortion.
- Family is vaguely aware of the problem, but cannot discuss, it precluding its identification.
- Family cannot approach the problem except by generating more conflict.

Example: When the family made a decision, sometimes the son helped make it. However, the father felt himself outvoted.

The therapist says: "I understand that when trying to talk about a problem, someone is in difficulty and you are all worried. Let's find out what the causes are."

4.2.2 Communication:

The family does not communicate but instead there is:

- silence
- chaotic dialogues
- irrelevant dialogues
- messages clearly and directly articulated according to ordinary standards, but some family members don't listen or grasp what has been communicated.

Example: The son doesn't want to voice his concerns regarding himself, the mother, or what happens at home. When he does, the mother and her partner blame him for making excuse. So, the family is not able to communicate clearly and in a direct way.

The therapist says: "I'd be interested to know what the mechanisms through which you try to diminish yourself are. I want you to talk one at a time, until you are able to talk each other without attack."

4.2.3 Roles:

- Difficulties in providing materially for the family
- Conflicts in the distribution of household chores
- Role reversal: parentalized children
- Granting of power: symmetry or rigid complementarity

Example: The father has a serious conflict with one of the children, who, in his eyes, fails to do as he is told; the children feel they are not taken into account with the changing and confusing demands of the father. The therapist asks: "Do you feel that the household tasks are assigned fairly? If someone fails to do his chores is it because he can't, or doesn't have time, or has an attitude?

4.2.4 Affective Responsiveness:

- strict restriction of the range of emotions
- constant overproduction of emotions
- confusion in taking responsibility for one's emotions
- frequent episodes of mood swing

Example: The partner come home and asked the mother why she hadn't prepared dinner, and if this was intentional. The mother answered that she hadn't had time and he insults her.

In families where interaction degenerates into verbal and/or physical violence during the treatment, interaction between family members must be discouraged. Instead, the family is encouraged to reason (18). Members are invited to be specific in their speech, using concreteness of detail as an antidote to breaking emotions. The therapist says "Don't tell me how you feel, tell me what you think."

4.2.5 Affective involvement:

- No involvement: no interest or involvement is shown or experienced, or there is cognitive involvement only, without affect.
- Narcissistic involvement: interest in the other only if it benefits oneself.
- Over-involvement and intrusiveness.

Example: The father feels excluded when the mother speaks with the son and becomes angry with the mother because she claims to know everything and to decide everything. The therapist asks, "When he feels excluded, does he move away or stay there? In both cases, what does he think?"

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4.2.6 Behavioural control:

- Behavior of family members carries physical risks for themselves or for others.
- Family members show bizarre, anti-social, or excessive patterns in the areas of eating, sleeping, detoxing, sexuality, and aggression, e.g., alcoholism, drug abuse, incest, sexual perversion or promiscuity, anorexia nervosa, abuse of a child or partner.
- Behaviors of family members reveal their lack of respect for others.
- Family members do not agree with each other on the behavioral rules to be followed.

Example: The partner tastes the soup and asks his wife about the ingredients. He doesn't like it and is convinced that his wife has cooked 'without love'. He reacts exaggeratedly and starts slapping her.

In this dimension, we investigate how each member treats the other and what each expects from the other.

The therapist asks "When you come home after work, what do you expect your wife and children to do? Are there any situations that get you angry?"

It is easy to meet families whose members have lost trust in each other and there is a constant search for attention to the point of using violence. Example: "I didn't want to hurt her. She doesn't listen to me."

The table below summarises the objectives of each McMaster dimension of family functioning and the differences in effectiveness of each of them.

5. FAMILY TREATMENT: PROBLEM-CENTERED SYSTEM THERAPY OF THE FAMILY (PCSTF)

Following evaluation, the therapist switches to family treatment, which will work on the level of underlying structure by investigating where family violence arose, how emotional reactions come from violence, and working on the management of aggression, fear and depression, while sharing parenting responsibilities.

The McMaster model provides for the involvement of all family members when possible or alternatively the victim parent and children.

Overall, the evaluation and treatment interventions consist of 14 sessions of 1 hour each, once a week: 2 evaluation sessions, 11 therapeutic sessions, and 1 final session. The number of sessions may be reduced to 8 if the treatment focus allows, or an additional session may be added, if needed.

	OBJECTIVE	GREATER EFFECTIVENESS	LESSER EFFECTIVENESS
Solution to problem	To successfully complete basic tasks, development and crisis	Ability to identify the problem, talk about it with the right person, imagine alternatives, make a decision about what to do, put the plan in motion, see how it develops, and determine whether the problem has been solved	Denial or inability to recognise the problem, no communication with the right person about the problem, repetition of unworkable solutions, inability to carry out actions to bring the problem to a close, no assessment of whether the problem has been solved
Communicaction	Mutual understanding	Clear and direct	Confused and evasive
Roles	Assumption of the role	Necessary family functions carried out: provision of resources, support, and growth	Family functions are not properly distributed or are not carried out. Reversal of roles, with members overlooked
Affective response	Emotional management	There is a wide range of affective responses quantitatively and qualitatively appropriate to the stimuli that elicit them.	There is a narrow range of affective responses that are either exaggerated or incoherent in relation to the context
Affective involvement	Achieve security and autonomy	Empathy	Symbiosis, narcissistic, lack of attachment
Behavioural control	Adaptation and maintenance	Democratic style	Chaotic style, laissez faire or excessively rigid

SESSIONS	PHASE	OBJECTIVES
2	ASSESSMENT	Recognise violent behaviour Understand the problem, needs, and strengths of the family
11	TREATMENT	Establish objectives and conditions Work with modified dimensions Assign between-session tasks
1	CLOSING	Summary of treatment Reflection on how the problems have been solved Encourage trust in resources Reflection on how the problems have been solved

The treatment of the family takes place through the PCSTF (Problem-centered System Therapy of the Family) which operates on the assumption that changing the systemic process within the family can change individual behavior (16). During treatment, the therapist and family members identify, negotiate, and implement strategies to change those behaviors that have been identified as contributing to the onset of problems.

Example: To propose to carry out 'problem solving' activities. Often the parents don't talk for fear of arguing to the point that they no longer go out and see friends and families. The 10-year-old daughter, through obsessive symptoms, keeps them united and engaged, forcing them to repetitive behaviors under her control. The therapist urges parents to reflect on how much 'not talking to avoid the crisis' increases discomfort rather than solving it. The strategy is to make the parents understand that the solution they have put in place to solve their problems actually worsens the situation by increasing the vicious circle. The therapist helps them think about how bad they are not to mention. The therapist asks them, "Will keeping quiet make you feel better?" and both respond "No, we are worse off."

Verbal, physical, and psychological violence occurs when visual circles are triggered and aren't corrected. The treatment tries to help resolve the negative relative circuits and members are encouraged to recognize the discomfort signs and an imminent loss of control.

The goal is to produce behavioral change in the family, identifying and setting the activities they will work on during the sessions. These new behaviors are often practiced in sessions repeatedly before families attempt to perform them at home. Often with the therapist, the activities are carried out with the aim of providing help to family members, and following the progress of the activity together (21).

At the conclusion of treatment, the members of the family are asked to summarise what occurred during the treatment and to state what they have learned, emphasizing what the therapist has seen. They are asked what they would do if the problems that they have worked on recurred, emphasizing the notion that family functioning is an ongoing process and encouraging confidence in the members of the family that they are now equipped to move forward on their own thanks to what they have learned in therapy, reinforcing their capabilities and enriching their resources.

5.1 GENERAL PRINCIPLES OF PCSTF

1. The therapist's task is to **help all family members to understand their situation** as clearly and objectively as possible, so they can decide what they want to do about it.

2. **Therapy focuses on the needs of the family**. Families sometimes choose to pursue changes that seem insignificant to the therapist. When this is the situation, the therapist explores the pros and cons of pursuing this path with the family and supports the family along the way. A further problem that is sometimes encountered during therapy is the emergence of sensations such as anguish or tension, and the therapist may want to resolve the family discomfort. In this case, the therapist is advised to let the discomfort express itself as it is fundamental to helping the family understand the experience.

3. **Families have the ability to adapt and change.** Families are adaptable, self-organized systems that can change with changing circumstances. During the meetings, the therapist recognizes the strengths and resources that families bring to therapy and helps the family to use them to better manage challenges and problems. At the same time, the therapist also recognizes that the family's ability to change may be compromised by intrinsic limitations or circumstantial situations. This tends to favor the maximum circulation of information among members of the family system in order to reconstruct the communication bridges that have long been interrupted.

4. **Families must want to change and be active in the process of change.** The task of the therapist is helping family members to identify and understand their problems. In addition, if the therapist finds reluctance to work towards change, he or she reviews the agreed tasks by encouraging the family to decide on a course of action.

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5 **The therapy process serves as a model for effective problem solving.** The way in which therapy is structured and organized acts as a model for the family on how to deal with and solve problems. In fact, families can learn a lot by observing how the therapist addresses problems and by experiencing the benefits of effective problem solving together (22).

To work with families with domestic violence experience the recognition of the negative effects of violence is essential. It should be remembered that those who carry out abuse in the family don't immediately admit their behavior. Very often even those who suffer violence at home are reluctant to talk about it and to describe violent behavior. In these cases, the therapist is empathetic and tries to get results from understanding what the family is experiencing, maintaining a neutral position and acting as facilitator.

In the literature, the term parental self-efficacy is used to describe parents' sense of trust or assessment of their ability to be successful parents, including judgment on the ability to play the role of parent. The literature also stresses the importance of these concepts as an intrapersonal resource, necessary for the positive health and developmental outcomes of parents and children. PCSTF therefore contributes to improving parental self-efficacy.

PCSTF also helps improve parenting style. Through treatment, the therapist helps parents understand how the child could be exposed to violence and the consequences of these actions on their lives; the therapist helps parents learn to control anger, and helps them understand the child's angry feelings, and how to control them. The attitude to violent behavior is examined by the therapist through analysis of the dimension of 'behavioral control', while parental stress is analyzed in terms of 'affective response'.

The intervention in families helps raise the consciousness of adults concerning their own actions, which is an essential component of good self-management and effective responsibility in the needs of their children. The techniques provided by the McMaster Model and family therapy encourage the mentalising process that allows individuals to think about and reflect upon their own mental states, their needs, their feelings, and the feelings of others, all of which are essential parts of putting an end to violence in the family (23.

CONCLUSION

The McMaster Model offers a series of advantages over other approaches to the treatment of families in which there is violence. From the first session the dimensions offer the clinician a clear picture of what the difficulties in the family are. More detailed assessment with FAD and McSiff permit the family to begin to reflect on things that they had not considered before, and even to contemplate changes before the intervention phase has begun. The model allows for recognition of violent behavior as well as the negative effects that it has. By focusing on strengths more than weaknesses it reduces the sense of guilt and anxiety of family members, and it implicitly transmits the message that the therapist trusts in the family to achieve effective change. Emphasis on the here and now entails an active orientation and permits the objectives of the treatment to be more clearly seen. The format is flexible, so that it may continue after the fourteen sessions if, for example, the therapist feels this is in order, or if there is a desire to work on other problems. Alternatively, the number of sessions may be reduced for more narrowly focused work. Finally, the favourable cost-benefit ratio that McMaster family therapy carries makes it ideal in the public health system, where effective therapy with a reduced number of sessions is the order of the day.

With the Mcmaster and our clinical experience we are able to confront violence in the family in a specific, operative manner. One mustn't forget that facing a problem of this kind requires a complex, global approach, with a multifaceted intervention and solid teamwork. One must never let down their guard nor think that they know it all. In families of the kind treated with this approach there is a tendency for abuse and violence to continue. When we witness persistent violence dynamics, the feeling of failure and impotence can lead to paralysis. For these reasons we mustn't fall into the trap of simplification or masking complexity.

Nevertheless, we must not forget that every family has hidden strengths, protective factors, and transformational resources: sensitivity, attention, and patterns of behavior that can bring about the well-being of the child and his or her future development.

It was in that grief
That love came to me and
In a harmonious voice said:
Keep on living!
I am life!
Your heaven is in my eyes!
You're not alone!
I collect all your tears
I walk with you and hold you up,
Smile and hope! I am love!

(Aria *La mamma morta* ('They killed my mother') from Act III of the opera *Andrea Chénier*, 1896, by Umberto Giordano)

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CHAPTER 5
IMPLEMENTATION OF HELP-DESK: THE EXPERIENCE OF A.P.E. CENTER

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INTRODUCTION

The A.P.E. center (Accoglienza Persone Esposte) (Reception of vulnerable people) was born in November 2011 and is aimed at offering psychological, social, medical, and legal support for adults victims of violence, abuse, and stalking.

This resource is based on the European recommendations of Council of Europe Convention on preventing and combating violence against women and domestic violence of 11/05/2011 (1).

The team is structured as follows:

- Three doctors from the Fatebenefratelli Hospital. The commitment required is to carry out the clinical evaluation and participate in the monthly team meeting.
- Two psychologists: one psychologist from Fatebenefratelli Hospital and one consultant from Fatebenefratelli Foundation.
- Two social workers from Fatebenefratelli Hospital.
- Two consultant attorneys: a civil and marriage lawyer, and a criminal lawyer.
- Coordinator of the center: a social worker from Fatebenefratelli Hospital.

The team intervenes on two levels:

- 1st level: Cure and care area. The aim of welcoming, supporting, and providing support to people who are victims of violence, with individual and group multidisciplinary interventions offered in coordination with local services. In addition, the ability to recognize what kind of violence leads to calls is fundamental.
- 2nd level: Training area aimed at raising awareness, training, and preventing violent behaviors and cultures with various initiatives, both inside and outside the hospital, aimed at A.P.E. users and health and social services operators, but also the students of the schools.

INTERVENTION LEVELS

'Cure and care' is mainly achieved through:

a) Hospitality (personal, telephone, telematics) performed by psychologist or social worker. The main goals are to: listen to people who make a request for help related to violence, understand their situation having empathy towards them, offer support, and make an appointment to activate a specific assessment of the case.

b) Multidimensional and multi-professional evaluation which requires the intervention of doctors, psychologists, and social workers. This evaluation is focused on physical, psychological, and social aspects of the person.

c) The construction of a customized path that includes individual and group interventions. The A.P.E. team considers the group path a priority work tool, as it offers people the opportunity to reflect on and confront their emotions and difficulties, and develop strategies

to face the repercussions of violence. It activates the resources and stimulates interpersonal skills. The A.P.E. center does not carry out psychotherapy;, if necessary, the team refers users to the UOPC (Unit Operative Clinical Psychology) of Fatebenefratelli Hospital.

d) Understanding the phenomenon of violence by developing an adequate capacity to recognize it. Violence is "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (2). Violence is transversal; it can affect anyone regardless of age, social status, or economic situation.

There are different types of violence:

- ***Physical violence*** is any form of violence against the body, affections, and properties of the person. It includes every physical act aimed at damaging the other person: when someone pushes, tugs, hits, punches, slaps, or kicks, or when someone hits with an object, tries to strangle, pulls by the hair, or blocks by force, thereby not allowing the other to move. It includes destroying objects, documents, photos, and other things especially dear to the other person.

- ***Psychological violence*** is the most difficult type of violence to recognize. Many people do not perceive it as violence, even though it causes a great loss of security, self-esteem, and serenity to the point of serious pathological effects. This is why it should not be underestimated and we must learn to recognize it. It includes a series of attitudes and behaviors that creep into the relationship in a gradual way, to the point that the person no longer realizes how harmful they are for psychological health. That is, when someone insults, threatens, torments, criticizes constantly, humiliates or ridicules.

- S***exual violence:*** all forms of involvement in sexual activities without the full consent of the other person. In the couple, when a partner imposes sexual relations on him/her without his/her consent, or presses by blackmailing or threatening negative consequences, forces the other to look at or use pornographic material, or to have sex with other people without full consent of the partner.

- Out-of-couple relationship: when someone is forced by a person to have sexual relations with one or more people, or when a relative, an acquaintance or a friend does not accept that the person says no.

- ***Economic violence:*** This refers to those attitudes aimed at forcing and maintaining a position of economic dependence on the person, in order to exercise total control.

- ***Domestic violence:*** This occurs in the family when a child sees physical, verbal, psychological, sexual, or economic violence perpetrated on adults or minors who are important to him/her. There is a series of behaviors aimed at controlling and limiting the freedom of the person, sometimes implemented by the partner or former partner and taking on real forms of persecution. Such behaviors can become obsessive and persecutory if continued over time, producing fear and terror in the victime and destabilizing his or her emotional balance.

- ***Stalking*** consists of a series of behaviors aimed at controlling and limiting the freedom of the person, sometimes implemented by the partner or former partner and assuming real forms of persecution (3).

Training area

Training is focused on recognition and prevention of risky situations through information and explanation. One of the central points of this work is the importance of understanding the relation between the violence and false stereotypes linked to it. The most common stereotypes about violence are:

- ***Domestic violence is present exclusively in culturally and economically poor family contexts.*** Mistreatment affects women all over the world regardless of religion, social, and cultural status. The rich classes tend to denounce less out of shame or difficulty in being believed.

- ***Violence is caused by occasional and sporadic loss of control.*** Most episodes of violence are premeditated, they are not irrational acts. They tend to establish a climate of control over women within a relationship.

- ***Violence is caused by drug and alcohol use.*** Alcoholism and drug addiction are never the direct causes of violence. Most violent men are neither alcoholics nor drug addicts.

Male identity is full of stereotypes that contribute to the cycle of violence. Sometimes it is not easy to recognize them, because historically they are present in the depths of our knowledge (examples: men do not cry; a man must first think about work and success; a man must be strong; a man must earn more than his woman; a man doesn't need to talk; a man must provide for his woman).

Stereotypes oblige people to conform to what must be done to be a 'normal man'. This can sometimes make men feel inadequate, not man enough, and therefore cause suffering. It is often very easy to think that the suffering experienced is caused by the partner, or by the family that are identified as the main obstacle to feeling 'a real man'.

Violence in affective relationships is, very often, a behavior that man acts as a reaction to the pain that he feels as a result of confrontation with these stereotypes, replacing suffering inflicted by the partner and family.

A first great achievement is to recognize how much these stereotypes affect our attitude, and the way we experience our relationship as a couple. The path to change passes through the awareness that every man can be a man in his own way, free from stereotypes. There is a need for a deep change, modifying a system of relationship that must start to work in a substantially different way.

It would be desirable to:

- develop a good relationship ecology.
- not be afraid of the differences between men and women.
- understand that there must be comparison, trust, respect and sharing.

HELPDESK IMPLEMENTATION

A helpdesk is a service that offers victims of violence a listening ear and hospitality, along with psychological, social, medical, and legal advice. Steps to developing an aid services for victims of violence are:

- Telephone reception, in which a specialist worker, psychologist, or social worker responds to the caller. Often the first contact happens by telephone, which helps to overcome the sense of shame connected to the violence suffered.
- Host interviews, in which a specialist worker, psychologist, or social worker analyses the situation of the person who is the victim of violence andtheir personal needs, and then sets up a multidimensional assessment path, only after the user has signed the informed consent.
- Multidimensional evaluation, with a doctor, psychologist, and social worker individually evaluating the person victim of violence, and, after comparing, defining an individual project by structuring an exit path from the violence.
- Information and legal advice with lawyers working with the centre.
- Interventions of a periodical psycho-social nature, with a series of interviews, periodically and of varying duration, according to the needs of the person.
- Interviews of psychological support or referral for psychotherapy, if deemed necessary, to professionals who collaborate with the center.
- Support and self-help groups.
- Support in the search for a housing solution.
- Accompaniment in the search for a job placement; help in job search and training.
- Support in the use of services; administrative and bureaucratic procedures.
- Support in the judicial process.

The most difficult points encountered in implementing the helpdesk may be summarised in three areas:

1) Communication: The different languages used by the many professionals (doctors, psychologists, social workers, and lawyers) have sometimes confused information on the cases. In order to avoid this, a monthly meeting with all the professionals present and each situation discussed is very useful.

2) Disinformation: Often the basis of the few complaints made by victims of violence is a lack of awareness and information of the people who receive them. To remedy this, we constantly train health, educational,

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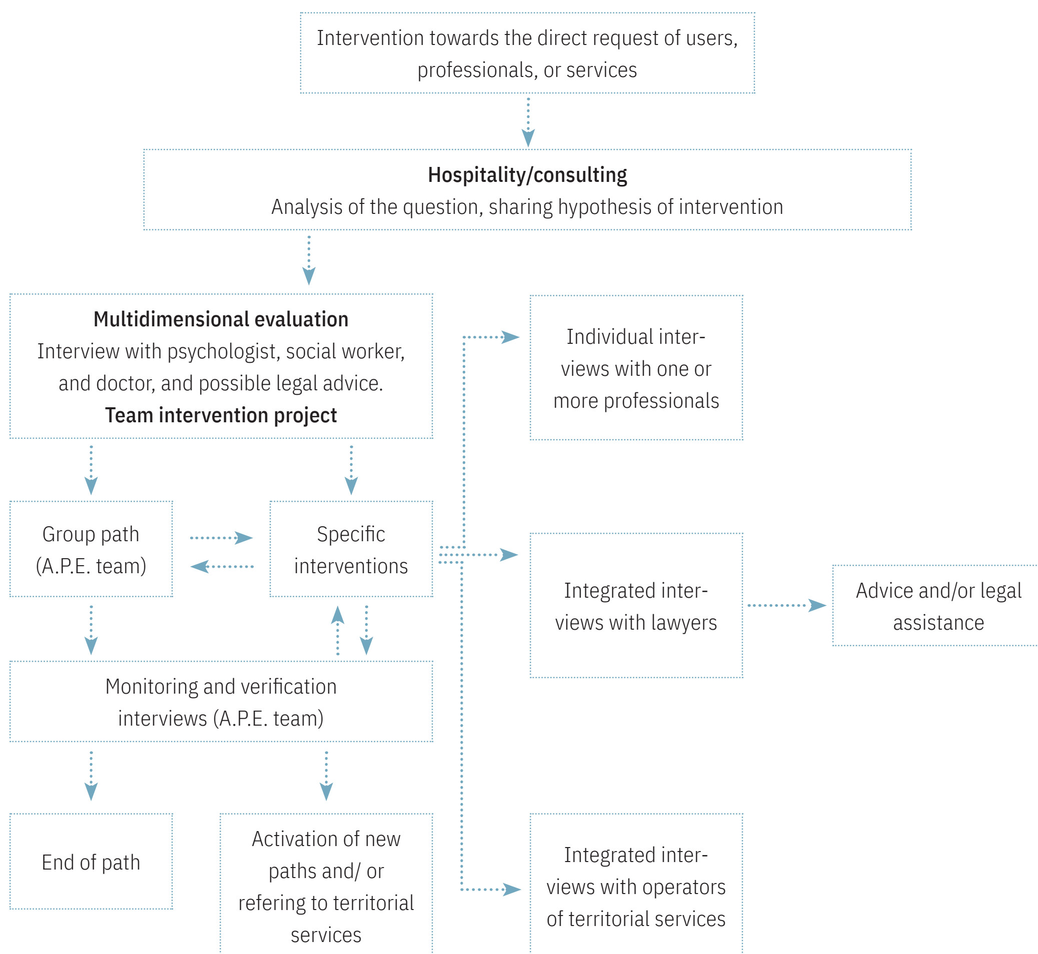
and social professionals to ensure that they are able to recognize situations of violence and to direct the person who is the victim to the request to help avoid any kind of downsizing of the gravity of the situation.

3) Isolation of aid services: Fundamental in working with victims of violence is the constant stimulation and care of network work with the various territorial services that often tend to act individually, creating fragmentation. In order to avoid this, it is essential to develop a network that allows efficient cooperation among the various territorial services by encouraging the integration of the different interventions oriented to the person.

The A.P.E. center provides direct access on Mondays and Thursdays from 9.00 am to 3.00 pm and indirect access on all other days by email at: centroape@fatebenefratelli-isolatiberina.it.

Tel. 06.68370440 - Website: www.fatebenefratelli-isolatiberina.it.

SUMMARY OF THE USER'S PATH TO THE A.P.E.



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SAVE
Support and treatment of traumatized children After ViolencE

CHAPTER 6
COOPERATION PROTOCOL BETWEEN HEALTHCARE CENTERS AND PUBLIC AUTHORITIES

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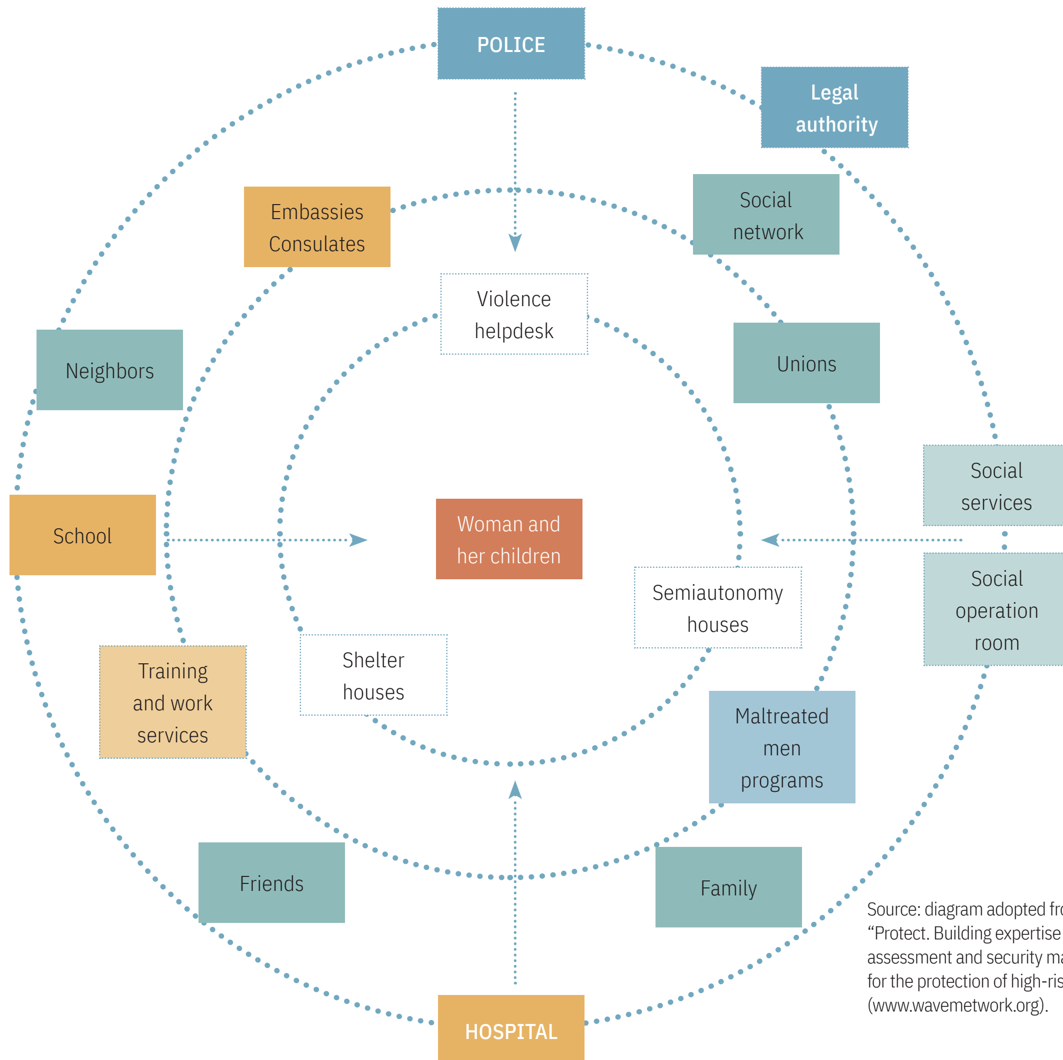
PREMISE

In general, knowledge of human relations between citizens who in various capacities ask for help from the services of their territory allows the operators themselves to begin integrated care and support paths more adequately and inclusively. This method of intervention is equally useful (if not strategic) for all those who, in various capacities, care for minors that are victims of violence and try to protect them, creating and feeding a widespread territorial network made up of public services, private realities and a third sector made up of schools and law enforcement agencies, voluntary workers, and others.

FUNDAMENTAL NETWORK FOR COOPERATION BETWEEN INSTITUTIONS

From a network perspective, it is not possible to separate the person from his or her living environment. However in these circumstances it may be necessary to implement interventions for the safety of people who are victims of violence through a service network capable of developing substantial units over time which, by activating, reinforce the same network.

ROME´S ANTIVIOLENCE NETWORK



Source: diagram adopted from "Protect. Building expertise in risk assessment and security management for the protection of high-risk victims". (www.wavemetwork.org).

BUILDING A PROTOCOL AND KEEPING IT ACTIVE AND EFFECTIVE OVER TIME

(The experience of the San Giovanni di Dio HOSPITAL - Fatebenefratelli Isola Tiberina).

The objective of the European guidelines (1) and the national guidelines (2) is to provide adequate and integrated intervention in the treatment of the physical and psychological consequences that male violence has on women's health.

The path for women who are subjected to violence must ensure a timely and adequate management starting from triage to their accompaniment/orientation if consenting, to the dedicated public and private services present in the reference territory. It guarantess to prepare a personalized project of support and listening with them for the escape from the experience of violence suffered, according to Directive 2012/29/EU (3) of the European Parliament and of the Council of 25 October 2012 that establish minimum stand-

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ards on the rights, support, and protection of victims of crime (2012). The following are show the services dedicated to the protection of women who suffer violence:

- Health services of the national, hospital, and territorial health service
- Territorial social and health services
- Anti-violence centers and shelters
- Law enforcement and local police forces
- Public prosecutor's office at the ordinary court and at the juvenile court
- Court (civil-criminal for minors)
- Territorial bodies (Regions, Provinces, Metropolitan areas, Municipalities)

ACCESS TO THE EMERGENCY ROOM AND FREE TRIAGE

The triage nursing staff, with adequate professional training, proceeds to the timely recognition of any sign of violence, even when not declared. For this purpose, nursing staff may use information relating to any previous access to the emergency room made by the woman.

Regions are recommended to adapt company and regional information systems (4). The triage area must include information (paper and/or multimedia) that is visible and understandable even to foreign women, relating to:

- types of violence
- effects of violence on the health of women and girls
- reference legislation
- logistic indications on dedicated public and private services in the area

Assigned an emergency code (red or yellow), the woman must be recognized with a relative urgency code, yellow code or equivalent,- so as to guarantee a timely medical examination (usually waiting time maximum 20 minutes) and minimize the risk of after second thoughts or voluntary removals. The woman in question must be assured of the assistance and protection required by the specific case. The assignment of the yellow code or equivalent determines the activation of the path for women who suffer violence. In addition to the triage code, a routing ID is assigned within the context of the organization of the emergency department which contributes to determining the activation of the routing itself. In the event the woman has entered the emergency room with underage children, they should remain with the mother and be involved in the same path.

The woman is informed of the possibility of making a complaint, by contacting the police.

The discharge report must be completed with diagnosis and prognosis, reporting the diagnostic codes (main or secondary) ICD9-cm:

- 995.50 minor abuse/mistreatment
- 995.53 minor sexual abuse
- 995.80 adult abuse/mistreatment
- 995.83 adult sexual abuse
- 995.51 psychological violence against minors

In the absence of possible immediate solutions, and if provided for by agreements with the reference health department, the operator/health worker offers to woman the possibility of remaining in brief intensive observation (OBI) or in any case in a hospital environment for not more than 36/72 hours, in order to guarantee protection and safety. Color code attributed for reported violence is always of RED or YELLOW priority.

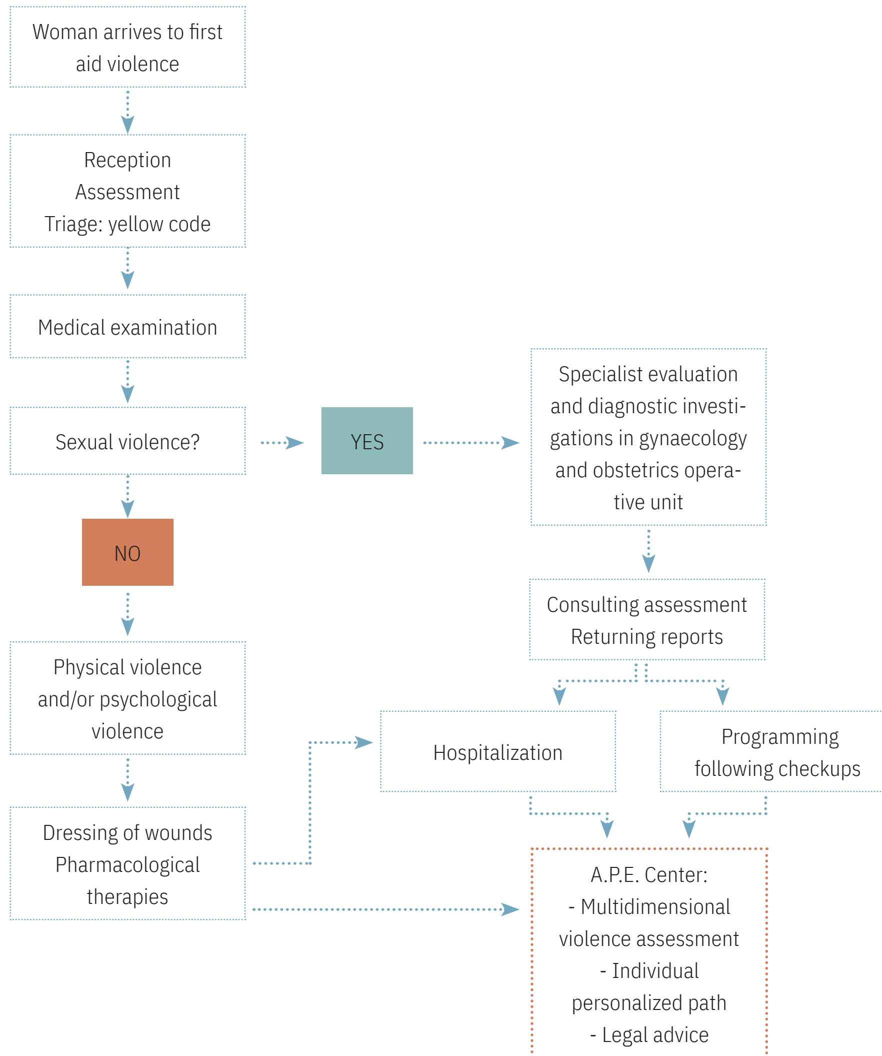
THE EXPERIENCE OF THE S. GIOVANNI CALIBITA HOSPITAL

In relation to the emergency room the normative references of the decree shall be used, with the contribution of internal consultants to the hospital: psychologists, social workers, and doctors, and the contribution of the A.P.E. team which, in part, corresponds to the staff mentioned above.

Operating models

"3.6.8 The doctor may also request psychiatric consultation and proceed to report to the APE center with the patient's consent. If the request for support from the APE center takes place during the night shift or during holidays, the medical/nursing staff will indicate the association's telephone number in the PS folder" (5).

THE EXPERIENCE OF THE FATEBENEFRATELLI HOSPITAL AND THE A.P.E. CENTER



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CHAPTER 7
CHILD PROTECTION IN ACUTE CARE HOSPITALS

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MANUAL ON CHILD PROTECTION

The number of cases in which child endangerment is suspected or confirmed has increased worldwide in recent years due to an overall enhanced awareness of child protection. Legislators reacted accordingly and adjusted the laws and legal framework. Therefore, concepts of child protection are becoming increasingly important in inpatient care. These concepts are already an integral part of the daily work of the staff in several children's hospitals. In the long term, they should be established extensively.

The procedure in case of suspected child endangerment presented in this manual implies a guideline-oriented concept developed by the child protection group ("Kinderschutzgruppe") of the KUNO Klinik St. Hedwig Regensburg—Krankenhaus Barmherzige Brüder. It is based essentially on common guidelines of child protection and complies with the interdisciplinary approach that is required by legislation.

OBJECTIVES OF THE PROCEDURE WHEN CHILD ENDANGERMENT IS SUSPECTED

- Protecting children and adolescents is the top priority and at the same time the most important goal of the procedure when child endangerment is suspected.
- In order to achieve this goal, interdisciplinary and multi-professional responsibilities and procedures are defined based on guidelines.
- Due to the standardized practice, professional groups can act appropriately in this sensitive area.
- An important aspect is networking between hospitals and non-clinical organizations such as youth welfare offices, 'early help' entities, facilities for social-medical aftercare in general and registered doctors in private practice, to establish required structures and networks.

SCOPE OF THE PROCEDURE WHEN CHILD ENDANGERMENT IS SUSPECTED

- The process for suspected child endangerment includes case-specific interdisciplinary care for minors (in the areas of paediatric and adolescent medicine, paediatric surgery, paediatric urology, paediatric anaesthesia, paediatric radiology, obstetrics and gynaecology).
- Professional and sensitive treatment of contact persons of the affected child/adolescent and family is elementary.
- In cooperation with internal social services and lawyers, forms and documents are created and reviewed, contact is made with the youth welfare office, the domestic (paediatrician) physician and, if necessary, the (criminal) po-

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lice and family court. Moreover, all necessary information is passed on to the above mentioned institutions.

GUIDELINE – PROCEDURE AFTER ANNOUNCE-MENT OR ARRIVAL OF A CHILD/ ADOLESCENT IN CASE OF SUSPECTED CHILD ENDANGERMENT

In the following, the procedure after announcement and/or arrival of a child/adolescent in the hospital with suspected child endangerment is explained step by step. The chronology should be considered more as a suggested framework than as a rigid guideline.

Step 1:

In a suspected case, the medical service answers the telephone call of the registered (paediatrician) physician, the youth welfare office, or the police. The medical service informs the responsible senior physician and documents the case comprehensively, including contact persons and telephone numbers in order to call back.

Step 2:

After a detailed medical history of the presenting problems and the course of injury by the medical service, it has to be proved from a legal point of view whether there is a sufficient legal basis for carrying out a medical examination. If, from a clinical point of view, the suspicion of child endangerment is confirmed, a detailed clinical examination is carried out in the presence of a nurse or other doctor as witness in order to avoid inconsistencies in the medical history (four-eye principle). In addition, external injuries are protocolled by standardized photo documentation.

Step 3:

On the part of the nursing service, the nursing admission is carried out and documented in order to save the clothing worn, to determine abnormalities in appearance and genital area and to record the patient's social behaviour towards the accompanying person and the caregiver, as well as to confirm the presence of the accompanying person.

Step 4:

The medical service determines in case of suspected sexual offenses whether there is an indication for an immediate forensic (gynaecological) emergency examination. Moreover, it has to be decided what type of monitoring is required, e.g., central monitoring or intensive care surveillance, or whether the care can be continued on an outpatient basis. The internal social service should be consulted as an important interface and support.

In addition, the police and/or youth welfare office are contacted promptly if there is an immediate danger to the patient, siblings and/or other family members (for example in case of a risk of suspected repeat offenses) or if an involved person is suicidal. The same applies for 'freshly bleeding' injuries.

Step 5:

Inpatient and outpatient cases with forensically unclear injuries are discussed retrospectively and the further proceeding is coordinated with the responsible forensic institute. If nec-essary, interdisciplinary conferences of the child protection group take place regularly in order to review the cases. The first discussion with the parents of the child/adolescent is used to speak about the further course of action and diagnos-tics in case of unclear injury patterns, or in case they are not plausible for the described medical history. The final interpre-tation of the case is carried out progressively after completing the clinical reports and excluding differential diagnoses.

Step 6:

The internal social service conducts the social anamnesis and family situation in cooperation with the case management. If necessary, the youth welfare office is notified as part of the guarantor position.

The affected child/adolescent is discharged if the question of responsibility (social plan phase) has been clarified and the subsequent care can be ensured in close cooperation with the resident (paediatrician) physicians and facilities for social-medical aftercare.

CONCLUSION

The interdisciplinary approach and close cooperation of the individual professional groups as well as involvement of a legal adviser are essential to ensure holistic and comprehensive assessment and the subsequent targeted treatment of a sus-pected or justified case of child endangerment. A standardized procedure with clearly defined responsibilities provides employees with the necessary security when dealing with the patient and offers the patient the greatest possible protection.

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CHAPTER 8
MEDICAL CARE FOR UNDERAGE REFUGEES AND MIGRANTS IN ACUTE CARE HOSPITALS

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MANUAL ON MEDICAL CARE FOR UNDERAGE REFUGEES AND MIGRANTS

In 2015, a large number of refugees came to Europe. Many people sought help. They came with little property and the idea of a safer and better life, but did not know much about the country in which they arrived or its people. Many of the refugees were unable to communicate in the local language. Therefore, a project for medical treatment and care for refugees and migrants was started in the KUNO Klinik St. Hedwig Regensburg—Krankenhaus Barmherzige Brüder.

AIMS OF THE PROJECT

The primary goal is to improve (acute) care of underage refugees and migrants in acute care hospitals. This includes the following aspects:

- Improving medical treatment and care for underage refugees and migrants
- Ensuring high quality, coordinated and reliable medical care for underage refugees and migrants
- Minimizing the risk of infection for other patients
- Clarifica-tion of necessary vaccinations
- Developing special medical services for underage refugees and migrants
- Enabling communication and information
- Integration of refugees and migrants in care training

GUIDELINE – PROCEDURE FOR MEDICAL TREAT-MENT AND CARE OF UNDERAGE REFUGEES AND MIGRANTS

In order to improve and facilitate the acute care of under-age refugees and migrants, a guideline has been established at the KUNO Klinik St. Hedwig Regensburg—Krankenhaus Barmherzige Brüder, which covers the entire way of the patients and their relatives during the hospital stay. Important aspects include the first contact point at patient admission, communication and information, coordination of care prior and after the inpatient stay, providing contacts with supporting institutions and re-porting to responsible authorities.

Patient admission

Upon arrival of the patient, identification papers, proof of residence status, and proof of health insurance are required. If the origin of the family is unclear, it is possible to find out which language is spoken by the patients and their families using the illustration of various national flags as well as showing country names in the respective national language and writing.

Communication and information

An important aspect of the treatment of underage refugees and migrants is communication in order to understand the

patients, to explain treatment options and thus to create trust. Consequently, a number of instruments has been developed to simplify communication and information during the hospital stay.

To clarify simple topics related to the treatment process, books with pictograms are used. These are relevant, for example, to answer questions about the experience of pain and its localisation and make it easier to communicate, especially with very young patients. In addition to this, electronic tablets with translation apps are available.

Difficult specific medical conversations can be conducted using the help of certified webbased video interpreters. For daily conversations, a register is available in which the knowledge of foreign languages of the hospital's staff is recorded. Moreover, children's books explaining the hospital stay and other material with child-oriented information can be used in different languages for young patients.

Translated patient information, such as menus or processes that are valid in the ward, promotes communication and conveys hospitality and security to patients. Pictograms and pictures of the main ingredients can also be used to facilitate ordering food.

During the inpatient stay, there is an important focus on measures to promote hygiene. Therefore, a flyer in different languages explaining and visualizing hygienic behaviour is used. Targeted information and education concerning hygiene risks as well as internal hygienic measures can often prevent the spread of infections. Flyers providing information to patients on infectious diseases that are widespread in their country of origin or in countries they passed through during their flight, as well as information on possible vaccinations, are also used.

The current COVID-19 pandemic is an important example of how necessary it is to raise awareness of hygiene support measures. Helpful information such as visitor, distance, and hygiene rules are available to foreign patients in various languages, both in paper based and digital form.

Furthermore, educational and information materials in various languages for the time after discharge from the hospital can be helpful. These include, for example, brochures for initial orientation for asylum seekers, health advice for refugee parents and asylum seekers, information and contact details for important aid organisations and authorities (e. g., social welfare office and youth welfare office), as well as the intermediation of contact addresses for of unaccompanied minor refugees and migrants.

Coordination of the care prior to and after the inpatient stay

Prior to the hospital stay, the internal case management undertakes the planning and coordination of the inpatient stay by organising outpatient and inpatient examinations, medication, food, medical aid, and more. Moreover, the case management plans the organisation of post-discharge care (nursing service, home care). Volunteers additionally support the families during the entire hospital stay.

Arranging contacts and reporting to responsible authorities

If necessary, families in need of protection are reported to social services, for example to the youth welfare office. If an increased need for help is identified, contacts can be established with social counselling centres, outpatient services, and other aid services.

CONCLUSION

In order to improve and facilitate the hospital stay for underage refugees and migrants and their families, it is important to provide them with all necessary information in their native language and to use various communication tools. It is recommended to have available a selection of information material for different ages and to use both paper based and digital communication options. In addition, the intermediation to and information about post-stay aid organisations is an important measure.

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