UNIVERSITAT DE BARCELONA

GReVIA
Grup de Recerca en Victimització Infantil i Adolescent

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Children at risk in India:

Knowledge for Indian Children's Safety (KIDS)

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1. Introduction

Child and youth victimization has not been a focus of academic and social interest until very recent times (Finkelhor, 2007). Although the knowledge and social awareness that has come from scientific research and the dissemination of the media has made it possible to visualize and intervene in this phenomenon, childhood and adolescence continue to be especially at risk from violence or consequences of this.

In this context, the project Knowledge for Indian Children's Safety (KIDS) seeks to improve the situation of children who are currently living at residential care centers in India. Considering previous research with this population (e.g., Collin-Vézina, Coleman, Milne, Sell, & Daigeault, 2011; Ellonen & Pösö, 2011; Segura, Pereda, Abad & Guilera, 2015) these children have probably experienced different kinds of victimization during their lifetime. Thus, we will seek to empower the professionals to develop their skills to provide a safe environment that will prevent children for experiencing further violence and that will encourage resilience procedures.

The project is carried out by the Research Group on Child and Adolescent Victimization (GReVIA), from the Department of Clinical Psychology and Psychobiology of the Faculty of Psychology of the University of Barcelona (UB). The members compound an heterogeneous team in regards to their previous experience and training, as they come from different areas of knowledge, such as psychology, criminology and education, which ensures a multidisciplinary approach and keep at the same time the common goal of fighting for the defense of the rights of children and adolescents.

The group carry out studies of social relevance with the highest academic rigor. The team has worked together productively over the years with other national and international organizations such as Save the Children, the Directorate-General for Children and Adolescents (DGAIA) of the Catalan Ministry of Social Welfare and Family, the Vicki Bernadet Foundation, RANA Foundation, or FAPMI. For the current project, the GReVIA team collaborates with the NGO Street Heroes of India (SOI), and with the participation of the University of Loyola, in order to pursue the project goals. The main objective is to find a common line of work based on the social role of research to create new knowledge and proposals to improve the reality of childhood and adolescence.

The current project will have four different stages: 1) Initial assessment; 2) Data analysis and Design of Training Programs; 3) Implementation; 4) Assessment. This report shows the main findings obtained in the execution of the first stage of the project, called "Initial assessment".

2. Objectives and hypothesis

The principal objective of this project is to improve the situation of Indian children who are currently living in residential care facilities, and who might have been victimized during their lifetime. In order to achieve this first and main goal the team will seek to achieve four specific aims.

(1) To analyze the extent of lifetime victimization experiences among children living in residential care centers.

- In order to do so, we will assess the prevalence of victimization and the accumulation of victimization experiences (poly-victimization) among children in those residential care centers collaborating with the NGO SOI.
    - On the basis of the available literature about the topic (e.g., Segura, Pereda, Abad, & Guilera, 2015), the team hypothesizes that children placed in residential facilities in the Southwest region of India will report high levels of victimization, since previous studies have shown that residential care samples report higher prevalence of lifetime and past-year victimization experiences than children from community samples, using a similar methodology (Canada, see Cyr et al., 2012, and Cyr et al., 2013; Spain, see Pereda, Guilera, & Abad, 2014, and Segura et al., 2015). As regards poly-victimization, we expect to find a high number of poly-victims for both time frames, following previous research findings.
- This study will also examine the influence of sex and age on victimization profiles, since previous research has found these to be important variables to take into account when studying victimization in this group of children (e.g., Collin-Vézina et al., 2011; Cyr et al., 2012; Euser et al., 2013; Gavrilovici & Groza, 2007).

(2) To identify the concerns and needs raised by the professionals working at the residential care centers.

- The team will interview different professionals from each center, and will ask them about their needs in relation to children's development, about their knowledge on child victimization, and about the challenges they find in their daily tasks.

(3) To design and develop a training program addressed to professionals working in residential care centers from the Southwestern region of India.

- We will design and develop a training based on previous programs that have already been applied on similar populations. To meet the specific needs of the Indian professionals, the members of the team will integrate the knowledge acquired through the collection of information about children and workers during the first stage of the project (the first stay in India).

(4) To implement and assess the training program aimed to meet the needs of the local professionals and empower them to develop skills in children protection. We hypothesize that some of the program contents can be related to:

- Offer social support to victimized children;
- Promote resilience processes and strategies to prevent future victimization experiences;
- Give guidance to professionals on how to act positively to assist children they have contact with (such as being a tutor of resilience for them) and how to protect them from new experiences of victimization;
- Give advice on the adequate steps to follow if they have the suspicion that one child might have been victimized.

3. Theoretical framework

Victimization is a huge problem that affects children from all around the world. In fact, the rates of children victimization are higher than adult victimization (Finkelhor & Dzuiba-Leatherman, 1994).

It is essential to highlight the importance of using the term *victimization* when studying violence against children. *Victimization* is more accurate than other terms, such as maltreatment, since it encompasses many types of violence against children that sometimes go unnoticed because of lack of social awareness or the social acceptation of violence as a discipline method.

Therefore, the team will work from the *developmental victimology* perspective, proposed by David Finkelhor (2007), which offers a comprehensive look at the children victimization phenomenon.

Developmental victimology differentiates and, at the same time, considers, the different types of violence that children are exposed to. Children and adolescents face common crimes (theft, robbery, threats), violence by their peers, sexual victimization (sexual abuse and aggression), electronic victimization (electronic harassment, online peer victimization) and victimization by caregivers (physical violence, emotional violence and negligence). Whereas some types of victimizations can be experienced both by adults and children, like the conventional crimes, some others, such as neglect, are specific to children or adolescents due to their unique stage of development (Finkelhor, 2007).

In addition, children victimization is not usually an isolated event. For many children, victimization is not an experience but a life condition, since they are victimized in multiple contexts. This is because the experience of victimization increases the risk of experiencing new forms of violence (known as *poly-victimization;* Finkelhor, Ormrod, Turner & Hamby, 2005a; Hamby & Grych, 2013).

At the same time, suffering victimization during childhood can have psychological, neurobiological and social long-term consequences for the victim, such as depression, cardiovascular diseases (Norman et al., 2012) and low rates of employment (Gilbert et al., 2009).

Because of this, in order to keep widening the knowledge on children victimization, it is vital to study the phenomenon in its different contexts. So far, studies have shown that there is, as well, a high prevalence of victimization and poly-victimization in Asian countries.

In a research done in Pakistan with 178 children from 14 to 17 years old, Aziz (2015) found that boys were more prone to be victims of common crimes, while girls were more exposed to sexual victimization (Aziz, 2015). In Vietnam, a recent research, done using the JVQ-R2 questionnaire with 1.606 students, showed that 94% of the participants had suffered at least one type of victimization, while 31% had experienced poly-victimization (more than 10 forms of victimization; Le, Holton, Nguyen, Wolfe, & Fisher, 2016). In China, the investigation done by Chan (2013) using de JVQ with 18.341 teenagers from 15 to 17 years old reported that 71% of the participants had experienced at least one type of victimization, while 24% had experienced poly-victimization (four types of victimization or more; Chan, 2013).

However, most of these studies have targeted community samples, which cannot be compared with samples of children living in residential care centers, since studies have shown that there is a much higher prevalence of victimization and poly-victimization in this specific population (Segura, Pereda, Abad, & Guilera, 2015). In addition, the phenomenon of children victimization and poly-victimization has not yet been studied in India with scientific valid methods (such as de JVQ-R2 questionnaire).

The current research project is also important because previous studies have shown that children who live in residential care centers are more prone to being re-victimized (Collin-Vézina et al., 2011; Cyr et al., 2012; Gavrilovic & Groza, 2007; Salazar et al., 2013, Segura et al., 2015). Therefore, professionals who work in these settings have to face challenges that, sometimes, can be overwhelming. However, there are programs that can help to develop useful skills. After reviewing several programs, such as the workshop program sessions developed by professionals from EXIL Barcelona working together with the International Catholic Child Bureau (BICE) and implemented in Nepal, and analyzing the collected data from this study, the team will develop a training program addressed to professionals. We strongly believe that the implementation of this program will result in a long-term positive impact for the children living in residential care centers.

Because of this, the team believes that studying victimization and poly-victimization in children living in residential care centers can be crucial for the development of social consciousness and, at the same time, can help to fuel the investment on public policies in order to fight children victimization in India.

4. Research design

4.1 Selection of the sample for each study

Pre-study: Adjusting the questionnaire

Before the beginning of the interviews and the focus groups (*Studies 1 and 2*) the researchers conducted a previous study in order to validate the questionnaire and make sure that the translation was adequate and adapted to the social and cultural context of the geographical area. In order to do so, four students from the University of Loyola who collaborated in the translation and administration of the questionnaire also participated in a focus group.

This focus group was aimed to:

- Translate the questionnaire from English to Malayalam
- Clear out any doubts about the possible different translations of each question
- Help the translators to get familiar with the questionnaire they later were going to apply
- Adequate the questions to the social and cultural context of the geographical area where the study was to be conducted

Study 1: Prevalence of the experiences of victimization among children and youth in residential care

The sample of this study is the children and adolescents living in Trivandrum's Residential Children's and Youth Centers, in the state of Kerala, India.

The inclusion criteria were as follow:

- Children aged between 12 and 17 years old, in consonance with the characteristics of the instruments used to collect information and previous studies in this field.

The exclusion criteria were as follow:

- The child or adolescent presents mental disability or indications of incapacity that do not allow them to understand the questions or explanations of the interviewer.
- The child or adolescent presents a clinical symptomatology that significantly interferes with the evaluation.
- Participants who did not answer 5 or more questions.

Non-probabilistic sampling of consecutive cases has been used in those centers that have agreed to participate in the study.

Study 2: The role of professionals working at the residential care centers in the Southwestern of India

Individual interviews have also been conducted with the directors of the participants' residential care centers, as well as focus groups with the professionals from each center, if possible.

Participants of all studies are summed up in table 1.

Table 1. Centers, number of participants and the method of collecting information.

Center	Type of institution	Individual interview	Focus Group	Application of the questionnaire (JVQ-R2)
1	Residential center for boys and girls	Center's director		8 boys and girls between 13 and 17 years old
2	Residential center for boys	Center's director	3 professionals	15 boys between 12 and 16 years old
3	Residential center for boys	Center's director		14 boys between 13 and 15 years old
4	Residential center for girls		4 professionals	5 girls between 14 and 15 years old
5	Residential center for girls	Center's director		

To get a broad understanding of the child protection topic in India, and in particular in the communities where our studies have taken place (i.e., Kerala and Trivandrum), the Rector of the University of Loyola and chief of the Children's Rights Observatory of Kerala has been interviewed individually.

4.2 Methodology

4.2.1 Sample

The final sample is configured as follows:

a) 41 children and adolescents residing in Kerala children's residency centers (One case was removed due to it did not meet the inclusion criteria);

b) 4 directors of the centers where minors reside;

c) 2 focus groups with the professionals (n = 10) from the residential care centers;

d) 3 social science students from the University of Loyola; and

e) 1 professional from the field of children protection.

The main features of the sample are described below.

Age and gender

As shown in Figure 1, interviewees are between 12 and 17 years old (M = 14.00, SD = 1.05), responding to the selection criteria of the sample, with 87.9% of young people between the ages of 13 and 15.

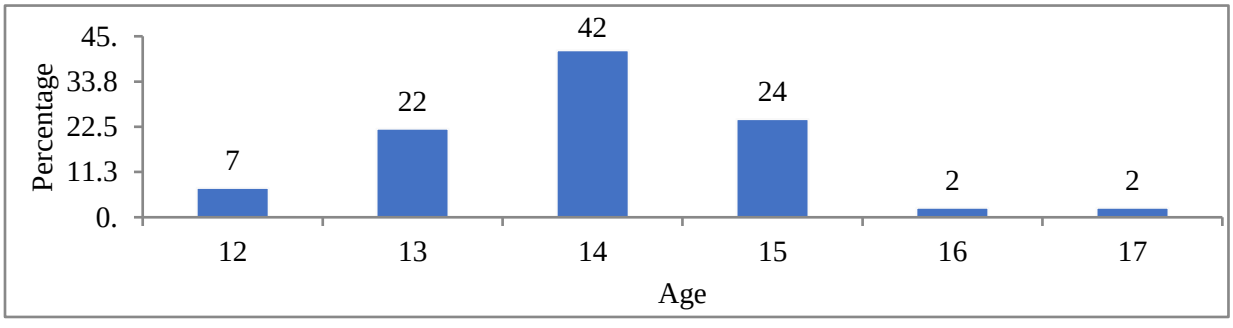

Figure 1. Distribution according to age of respondents

As for sex, 75.6% of the participants in the study are boys while the remaining 24.4% are girls.

Socio-cultural context

To explore the socio-cultural context of the participants, information has been obtained from their place of birth, from the educational level of their parents and from the situation their work. This data is relevant since it gives us more information about the variables that might have an effect in the results, such as the influence of gender in victimization rates.

All the participants were born in India, in different cities, provinces and states. Most of them are in contact with their parents (95.1%) probably due to the characteristics of the centers (see Table 17). The number of brothers ranged between 0 and 4 (M = 1.85, SD = 0.9), with 90.2% of young people between the ages of 1 and 3. Most parents finished secondary school (58.5% for fathers and 56.1% for mothers), while 7.2% and 7.3%, for fathers and mothers respectively finished their bachelor or master degree. The remaining percentage (34.1% for fathers and 36.6% for mothers) are for those who did not know the educational background of their parents. Participants reported their fathers' job as fisherman (43.9%), manual work (12.2%), migrated to the Persian Gulf (7.3%), driver (7.3%), kitchen work (4.9%), and employee in a company (4.9%), among others. They also informed about their mother job as housewife (30.0%), kitchen work (12.5%), did not know (7.5%), rubber tapping (5.0%), fishing (5.0%), housemaid (5.0%), and nurse (5.0%), among others. Besides, 36.4 % of their parents live together, while the remaining percentage showed those who have been divorced or separated or other casualties as one caregiver died, moved out to work, or has run away.

4.2.2 Instruments

The different instruments used to collect information during the investigation vary depending on the participants studied. There are four main objects of study mentioned above: the children, the directors of the center; the professionals that work in the residential care centers; the children; and other staff.

Study 1: We used the JVQ-R2 (Finkelhor et al., 2011) to measure the type and extent of violent experiences that each participant has been through. The JVQ-R2 is a self-report instrument used to assess different types of victimization against children and youth aged 8-17 years. The JVQ original questionnaire consists of series of questions regarding lifetime victimization experiences of children, such as conventional crime; caregiver victimization; peer and sibling victimization; sexual victimization; witnessing and indirect victimization; electronic victimization. The JVQ R2 version provides a comprehensive assessment about children and youth victimization experiences by adding several questions. For each item presence or absence of this victimization, experience was scored as 1 or 0. Since there was no validated and available version of the instrument in the local version, the current JVQ interview version was translated to Malayalam with the permission of its authors. The scale was administered in the context of a personal interview by one of the research team and a translator. The original version of the JVQ has shown good psychometric properties (Finkehlor, Ormrod et al., 2005).

Study 2:

- Centers' directors: We interviewed four directors of the centers (75% males) in order to understand their point of view of the lives of the children who are under their care and to share with the investigation group their expectations and challenges. The methodology used has been a semi-structured interview designed by the research team, based on the available literature and following previous experiences protocols.
- Professionals: We conducted two focus groups with the professionals and the staff working in contact with the children (n = 10, 30% males). The focus group served to collect qualitative data and will include questions about the challenges they face in their every-day task, the potential fears or insecurities, the measures, skills and strategies that they already use and what they would expect from training in order to overcome all these difficulties.

4.2.3 Procedure

Initial assessment

Literature review: The members of the team will perform a search of the most relevant literature on the topic. In this sense, the members of the team will consider studies published in scientific journals regarding victimization and poly-victimization prevalence in children cared by the child welfare services (e.g., Segura, Pereda, and Guilera, 2015) and in community samples (e.g., Pereda, Guilera, and Abad, 2014). The members of the team will also look for evidence-based training programs or implementation measures that have positive outcomes with this population (e.g., Reavley et al., 2015). This information will be summed up and taken into account for the design the training program.

Field study: As explained above (see 4.2.2. Instruments section), the members of the team will gather empirical data about children living in residential care facilities and workers from these institutions in the Southwestern region of India in August 2018.

The members of the team will overcome the barrier of language by means of native speakers (three students from the University of Loyola) who will translate *in situ* the content of the questions and the participants answer, and who will have been previously trained by the members of the team on children's victimization research and procedures.

The initial assessment will take place from June 2018 to August 2018.

Program development

Data analysis and training design: During this phase, the members of the team will design the training program. This will guarantee that training content and structure will respond to workers' expectations and to the children and professionals' reality. Between October 2018 and August 2020, the members of the team will analyze the gathered information during the first phase. The team will then present the conclusions to SOI in order for them to guide the team during the implementation phase.

Literature Review: During the design of the training, the team will do a second literature review focusing on those materials that are specifically related to the development of social and educational training programs and that match with the results the team has found during the field study.

The design of the training will be done between October 2018 and August 2020.

Implementation of the program

The training program will be intended for those men and women who work or will work in the future in contact with children of residential care centers in the south of India. The training will promote the debate and the discussion between the professionals and the future professionals, and their participation will be crucial for the acquirement of knowledge and the success of the project. The trainings will not seek to lecture professionals on how to do their tasks but, on the contrary, will be focused on the improvement of the professional skills through the dissemination of knowledge and the development of critical views that will allow the participants to keep improving the centers' functioning throughout the years.

During August 2020, the members of the team will go to India to implement the training.

Training assessment

In order to see the impact of the program, its assessment will be done before and after its implementation, in three different stages: just before the implementation of the training (August 2020), one month after the implementation (October 2021) and one year after the implementation of the program (August 2022).

The team will contact the professionals or future professionals and will ask them to complete a survey regarding their knowledge, their professional competences and their self-perception when working or studying. This survey aims to measure the differences between the two periods and observe the changes that the project might have brought to the centers' lives.

The team will organize this information in a final document that will handle in copy to SOI. In this final report, we will also include instruction on how to apply the training, so people in India can keep spreading the word about the content and skills acquired, measuring its effects.

Dissemination of the project

After the assessment of the project, the team will disseminate the results of the project in order to create social consciousness about the risk situation of street children living in care centers in India.

The local professionals of the residential care centers will also participate in different activities in which they will be able to share the changes they have seen inside the care centers and in the children who live there, as well as to propose new measures to improve their work and the situation of the children.

The dissemination of the results can serve as an example for other organizations that are seeking to improve their performance through the study of empirical data and the application of evidence-based programs for their specific needs.

We also aim to publish the results in academic journals and share it in conferences so that the scientific community can replicate the study in other populations or improve the project with their feedback.

Final report

Once the investigation is completed and the assessment of the training programs are done, the team will write a final report and will share it with the interested partners. In this final report, there will be a brief theoretical review introduction, a description of the different stages of the project, the different views of the local professionals, the process of developing the training and the final results of the project.

4.2.4 Chronogram

YEAR	2018			2019	2020		2021	2022			
MONTH	Jun	Jul	Aug			Aug	Oct	Aug	Sep	Oct	Nov
Initial assessment											
Program development											
Implementation of the program											
Training assessment											
Dissemination of the project											
Final report											

4.2.5 Ethical Principles

The members of the team are aware that studying victimization can raise some ethical concerns because of the sensitivity of the topic and the vulnerability of children with adverse life experiences. With this in mind, the members of the team are compromised to work and respect the ethical standards recommended by the Ethical Research Involving Children (ERIC). Thus, children will be individually interviewed by researchers specifically trained to collect data on violence against children (United Nations Children Fund, UNICEF, 2012) and will be treated with the highest standards of respect and consideration.

4.3 Research team

GReVIA is a research group mainly focused on violence against children, in all its aspects, from a scientific perspective. We work based on the theoretical model of Dr. David Finkelhor on the *developmental victimology*. Through Finkelhor's perspective many of studies have found that the majority of children who have experienced one kind of victimization are more likely to experience other forms, in this sense, that victims tend to suffer multiple events of violence which is called poly-victimization, which in turn is a strong predictor for psychopathology.

GReVIA was created and linked to the University of Barcelona (UB). Since it was found in the year 1450, the UB has been a leading center of education, science and critical thinking. The quality of its teaching and research, which have won recognition both in Spain and abroad, complements the UB's commitment to serve the interests of local society and the country as a whole, and combines with a demonstrably dynamic, constructive and humanist character that permeates the daily activities of the institution. As far as international research is concerned, the University has so far secured funding totaling more than 20 million euros for 61 research projects from the European Commission's Horizon 2020 program. GReVIA is a research group at the Department of Clinical Psychology and Psychobiology, UB. Members of the current team (i.e., Marina Bartolomé, Ana Martina Greco, Jessica Oyarzún, Anna Segura and Elizabeth Claudia Suárez) are university professors and research specialists in child and adolescent victimology, the study of protective factors and resilience, and epidemiology and methodology of behavioral sciences. The team has worked together productively over the years, finding a common line of work based on the social role of research.

5. Results

5.1. Quantitative analysis

Lifetime victimization prevalence

All interviewed youths had experienced at least one type of victimization (JVQ-R2) in their lifetime (n = 41), ranging from 4 to 35 experiences of victimization (see the sample victimization distribution in Figure 2). Using the JVQ-R2 version the mean number of lifetime victimization types was 14.66 (SD = 7.94, Mdn = 12.00, IQR = 31).

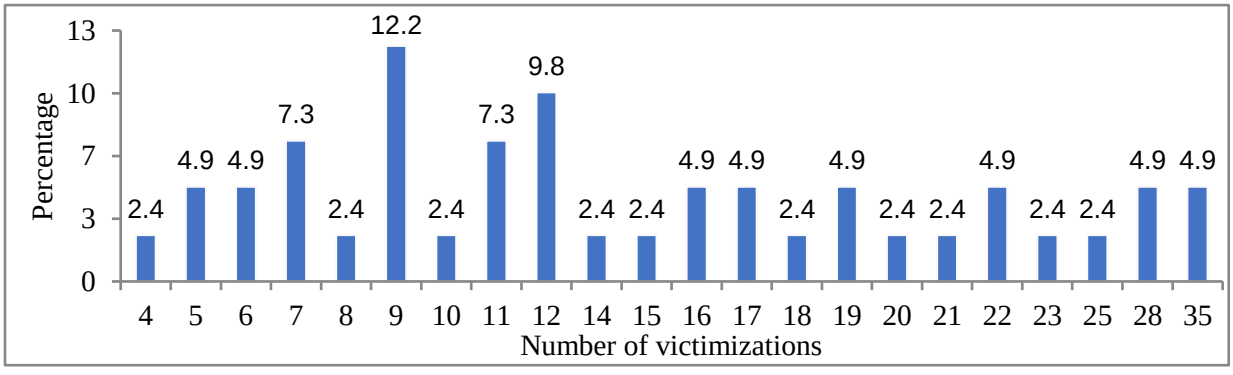

Figure 2. Lifetime victimization distribution (JVQ-R2 version).

Considering those items used by the JVQ version (37 items, including S7 as statutory rape), all participants had also experienced at least one type of victimization during their lifetime (n = 41), ranging from 2 to 21 experiences of victimization (see the sample victimization distribution in Figure 3). Using this JVQ version the mean number of lifetime victimization types was 8.76 (SD = 4.93, Mdn = 8.00, IQR = 19, range from 2 to 21).

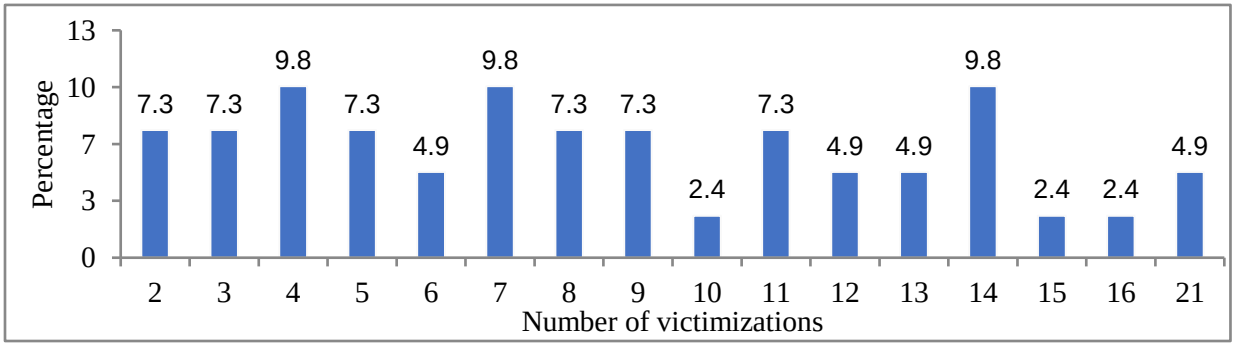

Figure 3. Lifetime victimization distribution (JVQ version).

Victimization modules

Conventional crimes

The majority of the participants (87.8%) had been victims of some conventional crime during their lives, and using the JVQ items (see Figure 4).

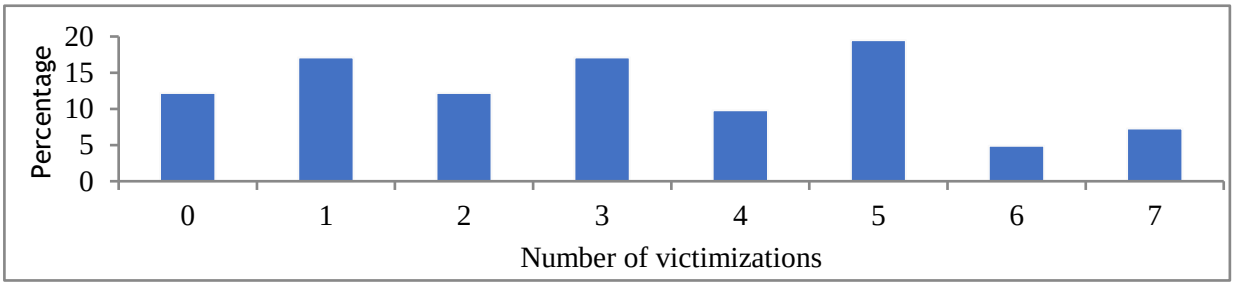

Figure 4. Conventional crimes victimization distribution

For this time frame, crimes against persons (75.6%) were more prevalent (68.3%) than property crimes (see Table 2).

Table 2. Conventional crime victimization experiences during lifetime (JVQ).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
Property victimization	*28*	*75.6*		
C1. Robbery	*11*	*26.8*	*32.3*	*10.0*
C2. Personal theft	*18*	*43.9*	*48.4*	*30.0*
C3. Vandalism	*12*	*29.3*	*22.6*	*50.0*
Crimes against persons	*31*	*68.3*		
C4. Assault with weapon	*23*	***56.1***	*48.4*	*80.0*
C5. Assault without weapon	*20*	*48.8*	*41.9*	*70.0*
C6. Attempted assault	*12*	*29.3*	*35.5*	*10.0*
C7. Threatened assault	*11*	*26.8*	*32.3*	*10.0*

Victimization	Victimized		Gender (%)	
	n	*%*	*M*	*F*
C8. Kidnapping	*3*	*7.3*	*9.7*	*-*
C9. Bias attack	*17*	*41.5*	*35.5*	*60.0*

The most frequent form of conventional crime victimization experiences was being assaulted with a weapon (56.1%). Some participants expressed that the perpetrator was “a friend”, “classmates”, “mother and father”, “brother”, “teacher”, “director/principal” or/and a “nun”. Also, they reported that they had been assaulted at “school”, “at home” or/and “at the center”.

Caregiver victimization

Over three-quarters of participants (78%) had been victims of some caregiver victimization during their lives, and using the JVQ items (see Figure 5).

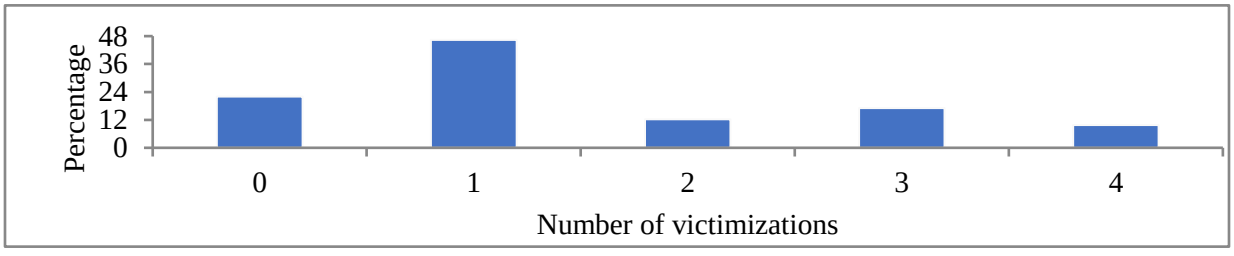

Figure 5. Caregiver victimization distribution

Physical and psychological/emotional abuse are the most frequent forms of caregiver victimization experiences (see Table 3).

Table 3. Caregiver victimization experiences during lifetime (JVQ).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
M1. Physical abuse	*17*	***41.5***	*41.9*	*40.0*
M2. Psychological/emotional abuse	*17*	***41.5***	*51.6*	*10.0*
M3. Neglect	*9*	*22.0*	*12.9*	*50.0*
M4. Custodial interference/ family abduction	*6*	*14.6*	*12.9*	*20.0*

Using the JVQ-R2 supplemental items regarding neglect were assessed, witnessing a parent being verbally threatened by another parent was the most frequent form of this kind of victimization (70.7%) (see Table 4).

Table 4. Supplemental items for neglect (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
M5. Neglect from parental incapacitation	*14*	*34.1*	*35.5*	*30.0*
M6. Neglect from parental absence	*7*	*17.1*	*16.1*	*20.0*
M7. Neglect from inappropriate adults in home	*5*	*12.2*	*12.9*	*10.0*
M8. Neglect from unsafe environment	*13*	***37.1***	*38.7*	*10.0*
M9. Neglect from lack of hygiene supervision	*13*	***37.1***	*32.3*	*30.0*

Peer and sibling victimization

Three-quarters of participants (75.6%) had been victims of some peer and sibling victimization during their lives, and using the JVQ items.

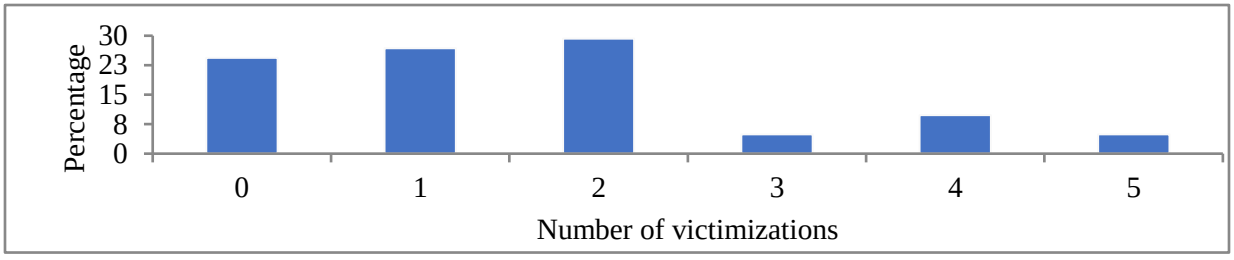

Figure 6. Peer and sibling victimization distribution

Peer or sibling assault was the most common experience of peer and sibling victimization (see Table 5).

Table 5. Peer and sibling victimization experiences during lifetime (JVQ).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
P1. Gang or group assault	*13*	*31.7*	*35.5*	*20.0*
P2. Peer or sibling assault	*20*	***48.8***	*51.6*	*40.0*
P3. Nonsexual genital assault	*2*	*4.9*	*3.2*	*10.0*
P4. Physical intimidation	*8*	*19.5*	*22.6*	*10.0*
P5. Verbal/relational aggression	*19*	*46.3*	*48.4*	*40.0*
P6. Dating violence	*5*	*12.2*	*9.7*	*20.0*

The JVQ-R2 version provides two supplemental items about peer relational aggression, witnessing a parent being verbally threatened by another parent was the most frequent form of this kind of victimization (70.7%) (see Table 6).

Table 6. Supplemental items for peer relational aggression during lifetime (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
P7. Social discrediting by peers	*17*	***41,5***	*35.5*	*60.0*
P8. Social exclusion by peers	*13*	*31,7*	*29.0*	*40.0*

Sexual victimization

Around 1 in 7 participants (14.6%) of the sample had been victims of some form of sexual victimization during their lives, and using the JVQ items.

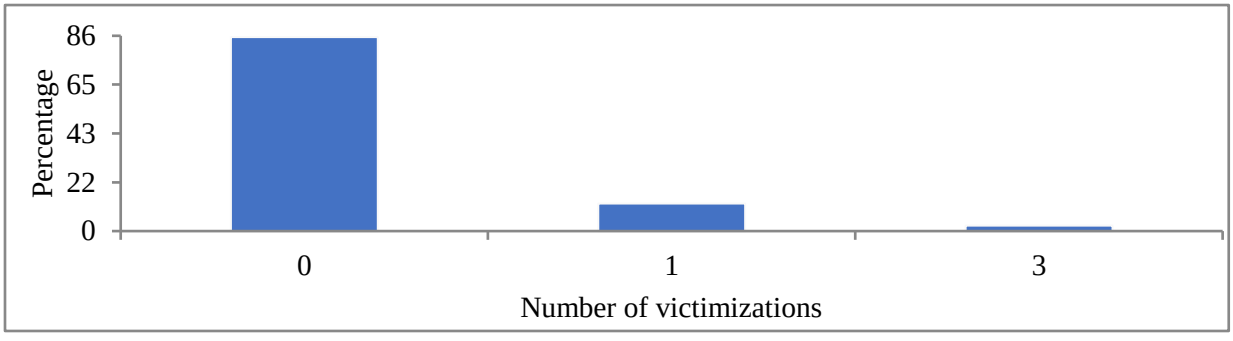

Figure 7. Sexual victimization distribution

Sexual victimization without physical contact was more prevalent (12.2%) those with sexual contact, being verbal sexual harassment the most frequent experience (see Table 7).

Table 7. Sexual victimization experiences during lifetime (JVQ).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
With physical contact				
S1. Sexual abuse/assault by known adult	*-*	*0.0*	*0.0*	*0.0*

Victimization	Victimized		Gender (%)	
	n	*%*	*M*	*F*
S2. Sexual abuse/assault by unknown adult	*1*	*2,4*	*3.2*	*0.0*
S3. Sexual abuse/assault by peer/sibling	*1*	*2,4*	*3.2*	*0.0*
S4. Forced sex (including attempts)	*1*	*2,4*	*3.2*	*0.0*
Without physical contact				
S5. Flashing/Sexual exposure	*-*	*0.0*	*0.0*	*0.0*
S6. Verbal sexual harassment	*5*	***12.2***	*12.9*	*10.0*
S7. Statutory Rape and Sexual Misconduct	*-*	*0.0*	*0.0*	*0.0*

Witnessing and indirect victimization

All the participants (100.0%) had witnessed some kind of victimization or had experienced it indirectly during their lives, and using the JVQ items.

Figure 8. Witnessing and indirect victimization distribution

For this timeframe, crimes against persons (75.6%) were more prevalent (68.3%) than property crimes (see Table 8).

Table 8. Witnessing and indirect victimization experiences during lifetime (JVQ).

Victimization	*Victimized*		*Gender (%)*	
	n	*%*	*M*	*F*
Family violence				
W1. Witness to domestic violence	*29*	***70.7***	*64.5*	*90.0*
W2. Witness to parent assault to sibling	*17*	*41.5*	*41.9*	*40.0*
Community violence				
W3. Witness to assault with weapon	*13*	*31.7*	*32.3*	*30.0*
W4. Witness to assault without a weapon	*29*	***70.7***	*74.2*	*60.0*
W5. Burglary of family household	*10*	*24.4*	*25.8*	*20.0*
W6. Murder of family member or friend	*3*	*7.3*	*6.5*	*10.0*
W7. Witness to murder	*2*	*4.9*	*6.5*	*0.0*
W8. Exposure to random shootings, terrorism or riots	*4*	*9.8*	*12.9*	*0.0*
W9. Exposure to war or ethnic conflict	*-*	*0.0*	*0.0*	*0.0*

Using the JVQ-R2 supplemental items regarding the exposure to family violence, witnessing a parent being verbally threatened by another parent was the most frequent form of this kind of victimization (70.7%) (see Table 9).

Table 9. Supplemental items for exposure family violence (Witnessing and indirect victimization) experiences during lifetime (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
EF1. Parent verbally threatened	*29*	***70.7***	*67.7*	*80.0*
EF2. Parental displaced aggression	*20*	*48.8*	*45.2*	*60.0*
EF3. Parent pushed	*18*	*43.9*	*45.2*	*40.0*
EF4. Parent hit or slapped	*27*	*65.9*	*71.0*	*50.0*
EF5. Parent severely physically assaulted	*1*	*2.4*	*35.5*	*11.1*
EF6. Other family violence exposure	*9*	*22.0*	*19.4*	*30.0*

Otherwise, supplemental items from the JVQ-R2 version report information about school violence and threat, witnessing a parent being verbally threatened by another parent was the most frequent form of this kind of victimization (70.7%) (see Table 10).

Table 10. Supplemental items for school violence and threat (Witnessing and indirect victimization) experiences during lifetime (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
SC1. School threat of bomb or attack	*1*	*2.4*	*3.2*	*0.0*
SC2. School Vandalism	*12*	***29.3***	*35.5*	*10.0*

Finally, the JVQ-R2 version adds supplemental items in order to better assess the exposure to community violence, witnessing a parent being verbally threatened by another parent was the most frequent form of this kind of victimization (70.7%) (see Table 11).

Table 11. Supplemental items for exposure community violence (Witnessing and indirect victimization) experiences during lifetime (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
ECV1. Exposure to sexual assault	*3*	*7.3*	*0.0*	*30.0*
ECV2. Exposure to robbery	*11*	***26.8***	*25.8*	*30.0*
ECV3. Exposure to threatened assault with weapon	*6*	*14.6*	*16.1*	*10.0*

Electronic victimization

Only one participant (2.4%) of the sample had been victim of electronic victimization, in particular he/she was harassed via internet (see Table 12, and for electronic victimization supplemental items see Table 13).

Table 12. Electronic victimization experiences during lifetime (JVQ).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
INT1. Internet harassment	*1*	***2.4***	*3.2*	*0.0*
INT2. Unwanted internet sexual messages	*-*	*0.0*	*0.0*	*0.0*

Table 13. Supplemental items for electronic victimization experiences during lifetime (JVQ-R2).

	Victimized		*Gender (%)*	
Victimization	*n*	*%*	*M*	*F*
INT1B. Cell phone harassment	*1*	*2.4*	*3.2*	*0.0*

5.2. Qualitative analysis

Interviews with directors

We perform four interviews with the directors of four different centers. Two of them were women and two of them were men.

General structure

Each center seems to be specialized in a particular type of profile. Table 17 showed the characteristics of each center.

Table 17. General structure of each center.

Center	Kids' profiles	Number of kids	Staff	Ratio (adult/child)	Religious
3	Boys from poor families	94	5 = A director, a cooker and 2 or 3 counselors	1/11	Yes
5	Girls in risk for abuse	52	9 = Four religious women, three graduated or professors, two male cookers	1/11	Yes
1	Children victims of sexual traffic, with VIH, offenders or from broken families	12	4 = Director, one caregiver, one teacher, one cooker	1/2	No
2	Teenage boys from poor families	60	5 = Three religious men, two female cookers	1/12	Yes

Note: Centers match with those described in Table 1.

Routines

All centers had similar routines, although religious centers would begin earlier (around 5 or 6am) to pray. At 8am all children have breakfast and go to school. They come back around 4pm, when they have an hour of free time and a tea break. Then, they study until around 8pm when they dinner. They go to sleep around 10pm. In the center number 3 they perform sharing sessions before going to bed, around 9pm, so children can share what was their day like.

External resources

Centers relied on different external resources in terms of providing counseling to children under their care. Center number 1 said that NGOs and a program called "Inspiring" would provide for this service. In center number 2 there was one of the sisters who also had some counseling knowledge and therefore, she also filled in this role. Center number 3 was very much in touch with the government since they were involved in LGBT laws improvements. They also relied on the services provided by the national Child Line and Child Welfare Community. Center number 4 reported to communicate with an external psychologist or counselor and a doctor. The director also said they were in touch with school professionals and the association of parents from school.

Violence

When asked about their views on violence, how would they define this concept, most directors mentioned violence among kids or committed by them:

Sometimes kids get into fights and we try to consider both sides. People outside our center do commit violence; they fight and they torture.

Juvenile that are involved in delinquency or violent acts.

Only the director from center 3 seemed to acknowledge that kids not only perform but also suffer violence:

There are different types of violence: psychological, physical… (…). It can be hit, scream or not allowing them to play with other kids, isolate them, not giving them food, free time to have fun… All of these are forms of power, ways to exercise control over kids. Also, not letting them going to bed on time, not giving them enough attention or care when they need it. In normal children homes there is also violence… .

In sum, most directors have no specific idea of violence or they associate it more with the violence committed by children rather than the one suffered by them. When asked specifically about children's violent experiences, answers were quite similar

*Girls tend to fight against each othe*r.

There is no violence in the center, only fights, discussions… Sometimes they steal things from each other. Parents become violent and get mad [with the residential center's staff], and they might be aggressive with the workers of the centers.

Nothing happen here (...) [Violent experiences] outside the center is normal, violence is low in Kerala, they do not have any cases. They do not make children starve. I have heard about people hitting children, disciplinary. When they get angry they can get physically aggressive, they call nicknames or tease.

Once more, only the director from center number 3 seem to be more aware of children's experiences

Most children have been through some type of violence. In school, teacher beat the children, in every school. Most of the school teachers do that.

When asked about how they deal with violence inside the centers (i.e., whether if they have any protocols or steps to follow), answers also reflected this concept in the same three participants:

We can take them to the child welfare community. If sometimes I see a sad boy, I ask him what is wrong or I go talk to him. But there is nothing serious, I do not want to go to higher levels for regular everyday problems. If there is a very bad boy, we kick him out.

When we see girls fighting we separate them, we isolate them and we make them think. We refer them to counseling when we suspect something [more serious] or with any problems.

Nothing has happened. [In our seminars] we give proper guidance, formation, personal development [to our staff].

The question was then asked in conditional (i.e., what would they do if they would find out that one of the kids under their care was being a victim of some type of violence?). The answers we got also denied the possibility of being victim of an adult:

[When they are violent] against themselves, we talk to them, explain what is wrong, explain to them, [make them] realize these things should not happen. Then they talk to parents or relatives, and make them realize that "everybody is caring for me and loving I should not do this" [Interviewer]:- And when the perpetrator is an adult? – [Answer]:- No possibility for the child to face this kind of violence here. But, in case of a suspicion he will refer to the superior bishop.

Call them and try to solve this problem. [We tell the kids to] Inform us. Try to realize the wrong part, what make them feel angry to attack or assault the others. To know better about the reactions of children would improve and decrease violence.

Only the director of center number 3 had a different perspective and reported how the system fail to response correctly to this type of cases.

In India every person who has a sexual contact with a girl is a crime also for the marriages. The state will take the child away, and the government will set the child to a government center. But there are problems in trials with children because they do not really tell about the abuse, and the procedure is really slow. When they are taken away, they lose their families, friends, schools, neighbors, and they feel like being in a jail (even the cell phones ae not allowed). They take them from the school to the center. These centers tend to be collapsed; they have too many children, more than what they can handle and facilities are not enough.

"With peanuts you will get only monkeys" the payments is very less, for that reason who work with these kids, who with what school education, and maybe very moral, what these children will get from them, maybe these children can be abused. The girls try to escape from these homes, and when the police catch them, they took them back to the center. So, the system is not good. The situation is really complex, and the resources are very limited.

We also asked about the challenges they found when dealing with violence. All participants agreed that the lack of financial resources was the main problem, as reflected in these answers.

Financial resourcers, workers here are not satisfied with their salary and it is just a job for them. They do not really get involved. We cannot keep people working on voluntary basis, everything is expensive in Kerapa and we get less funds tan other centers because they say we convert.

Lack of resource to provide kids with psychological therapy. When there is a good pay, the good people will come. We have problems. We have not enough funds, not good infrastructure. We are training the volunteers and they work with the kids, and then after a period of time, they leave.

During the stage in India, news broke about a center that abused children under their care. Participants were asked about these news and how did they feel about it. Interestingly, centers that included girls among the children under their care thought this was pretty common:

In India, this is very frequent. Nobody looks at caretakers' criminal records, nor his/her education and orphan kids are the most unprotected.

This news were not a surprise. Charity is based in the idea that someone gives something to some other ones, but this interferes with this latter person's freedom and we expect this person to obey. We establish power-based relationships when the caregiver has a charity relationship with the kid. We think there is exploitation because this is a way of thinking, even though they might be good people. [In our case] we do not think like that, we think we are the chosen person (by the government or by ourselves) to give them but in equality terms, because the kid is entitled to receive. It is not charity. When you see it from this point of view, exploitation options are reduced… .

On the other hand, the directors of centers dedicated to boys said these were isolated cases:

This cases are not common; we cannot generalize.

I only read it on the newspaper. In Kerala there are more than 300 centers for children, maybe it happen in one or two.

Risk factors

Participants were asked about the risk factors they recall at individual, family and cultural level. In Figure 9, answers are organized by each level. As it can be seen, most participants identified risk factors related with the family or cultural background, rather than on the individual.

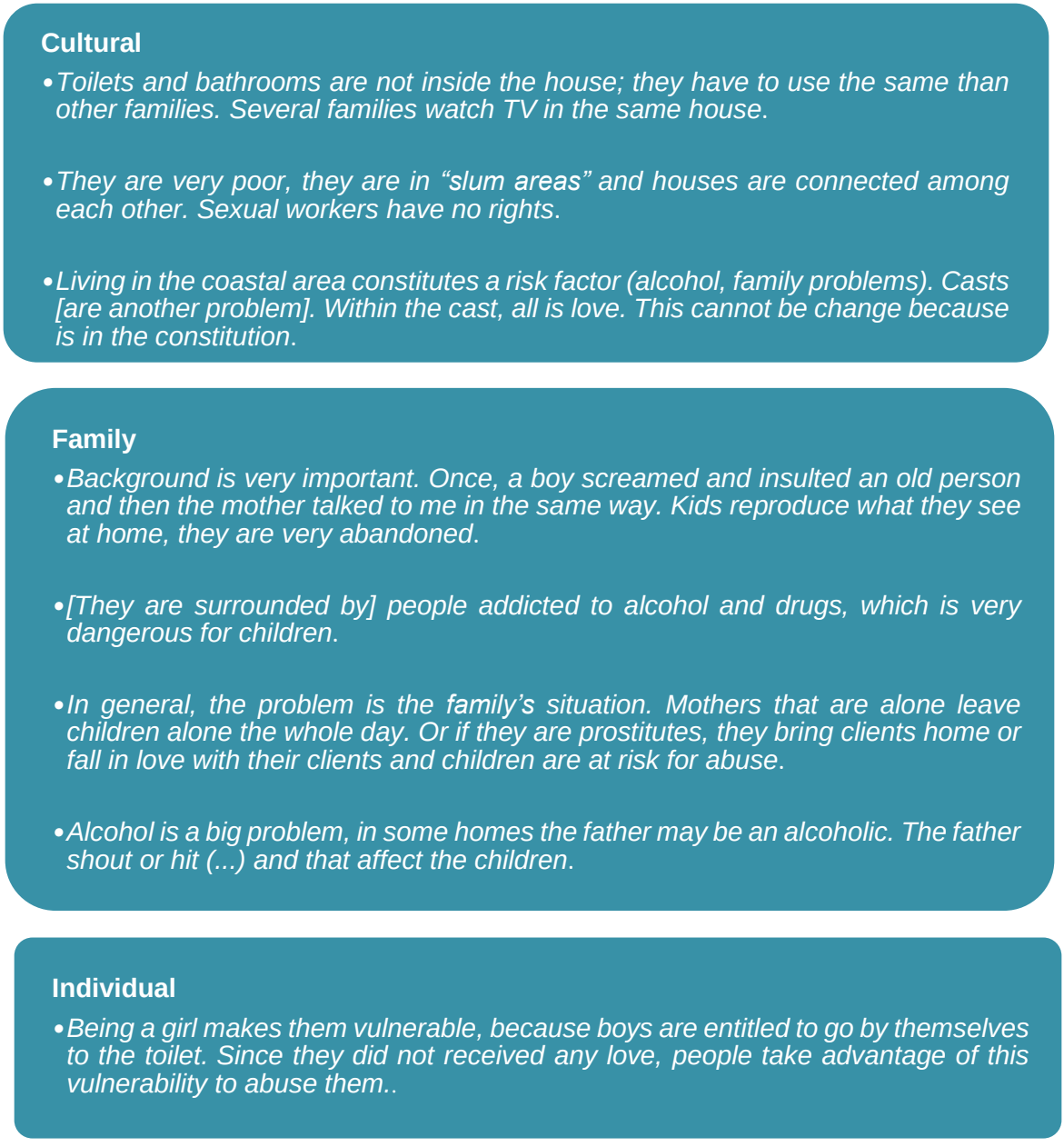

Figure 9. Risk factors identified by participants according to their level

Rapport

When asked about their views on daily work with the kids, how would they describe the relation their have with the children of the center, most directors mentioned that they had a positive relationship with the children:

We are like a family, we don't want to be an institution.

Good relationship between professionals and children, as family members. Those who are working here, they know why are here, they know the background of the children. The man in orange was here before and now he has a family and is working here helping the boys.

Rules/Limits/Manners

Participants were asked about the disciplinary methods that they regularly use with children. As it can be seen, most participants identified corporal punishment as the most used disciplinary method in behavioral management.

I have a stick to give them fear, misbehaving is not allowed. Call the child, the educator warns the children the first time they make mistakes, and they explain why he has done it wrong. When the child returns to do 4 or 5 times, they hit him. Because the child has to learn, time of learning, learn properly. When they do a mistake (for example if his reading is not properly, or when a bad smell comes, or for a misbehavior) the other remember this, they make fun of afterward.

If there is a very serious case, the girls are beaten with a stick. And in front of the group.

Only the director of center number 3 had a different perspective, pointing out other methods of discipline:

Basically when children have bad behavior, we remind them of some of their privileges or give them jobs they do not like (for example, they have to go to buy milk or we can punish children by leaving them without playing football).

Challenges

We also asked about the challenges, insecurities and difficulties do they have in order to establish rapport or to relate to children.

All participants agreed that the main issue is, as children come from different realities, there are problems of adaptation to the rules of the center, as reflected in these answers.

Girls have a hard time adapting to life in the center coming from backgrounds so different, because here they are under their responsibility and if something happens to them it will be their fault, they must be careful).

I feel overwhelmed, I work 24 hours, the boys and the staff discuss among themselves, all come from very low strata. Parents always want more things, even if they give them everything.

Improvements

When asked about their views on improvements in the rapport with those kids (training, resources, better networks), most directors mentioned training and economic resources:

We believe that to the girls a training program, it would help them to classify the personal development on how to act, to develop more their dreams, their ambitions).

All the students also, have meetings. Find out, observations with them, just generally talk about thing they observe. And talk if they feel some problems and ask them suggestions, they also feel that they are cared.

Resilience and support

We also asked about what would help they to improve the support you bring to the children when they face problems (training, resources, better networks, system).

Participants mentioned to provide methodology and strategies for support for coping with current and future crisis situations:

Resources

The two brothers got formation during 10 years, they are public figures also, they know how to handle these students/them. The parents (mostly their mothers) or relatives come to visit them, they want to take them out (they can), Sundays and all holidays they can come.

They do a cultural program with the students. The meeting helps (staff). Family gather - feeling or being as a family. Seminars with the other associations affiliated with the government.

Call him and talk with a boy that needs help, make him feel that I am there. I will send him to the counselor.

I am part of a university committee where they evaluate the violence that occurs in these institutions (they decide what to do, Interventions). In this committee, there are people from the university and external, like me and another from the police. And in return they have students who come to the center to work as volunteers.

On the other hand, some directors of the centers mentioned some isolated actions and strategies used to strengthen the children:

Only one sister who gives counseling and some workshops have had.

I take care of them, I listen to them, they can always tell me what happens inside them. There is a help line in which children can complain about the center.

Challenges

We also asked about the challenges, insecurities and difficulties do they have regarding children health (detection) and social problems or how to support these children. Some answers were:

Children have a lot of stress. Sometimes it is because they are not given enough attention and they are not up to date at school, they need additional help. They may have been abused or have suffered violence and this trauma will be present in their lives. These people have not been taught to choose someone at the time of falling in love. The mother does not have enough skills when choosing a couple and this person who chooses can later be their aggressor. He has problems to relate, to understand who is good or bad. Children with HIV positive no longer accept them. We realized that it is not good for them to have them in a group because they spread diseases among themselves and were vulnerable to all diseases.

One child that they background is so poor, their parents are separated, and this is the only boy that they have, that affects the child very badly. Thinking also, he has some kind of fear, if he sees me, he would not speak to me, the way he stand the way he look at me, he feels kind of inferiority. Little problems about the studies, they always prefer playing out unless studying, they can sit for an hour or half an hour. They are selected here by 10, before coming here they have to learn how to read and write and when they come here they realize that some of them they don't know how to do it.

Prevention

We interviewed them about what they would do to prevent violence against children.

Measures

We use mediation methods for what has happened from all perspectives when there is a fight. Sometimes I use the stick because it is a way of showing what will happen if they misbehave.

They are conscious that violence is not allowed. Make them do realize the bad side of violence, personal development, what kind of persons what will become, making them think. Ask them since you have do wrong, which kind of punishment do they think they deserve, they (the Father) ask them to suggest a punishment.

Effectiveness

Some directors mentioned examples of disciplinary methods that they considered were effective:

When we punished a boy for example, without letting him do anything, it worked much better. It is also effective to throw them out, because we do not have the obligation to keep having it.

If they commit a mistake, we are going to understand why he should not do that and he has done a mistake. To make them more responsible. It is necessary for our lives to become good persons. If they want to be a good player and they make a mistake against to any value, if they not respect the values they cannot be a good player. And they think and become responsible.

Improvements

Another question was what else would help them to improve the protection and care of these children. Some participants agreed that the lack of financial resources and government support were the main problem, as reflected in these answers.

I wish they would close this center because it is very frustrating. The government does not support us and the parents are violent and very demanding.

The main problem is the lack money, accommodation, facilities and develop the infrastructures, extra-curricular activities, extra tuition or classes (rather than the school education), more professionals who give classes to the children.

6. Conclusions and implications

The current pilot research study has shown that children placed in residential care centers experience high rates of victimization experiences according to previous research with this population (e.g., Collin-Vézina, Coleman, Milne, Sell, & Daigeault, 2011; Ellonen & Pösö, 2011; Segura, Pereda, Abad & Guilera, 2015). In this regard, all interviewed youths had experienced at least one type of victimization in their lifetime, ranging from 4 to 35 experiences of victimization, which is similar to previous studies, e.g., in Spain (Segura et al., 2015), even though the sample characteristics were slightly different.

The most common victimization experience reported by the participants was witnessing or indirect victimization. All girls and boys of the current sample have experienced this kind of victimization, which referred not only to community violence but also to domestic violence. Risk factors from micro and macro-systems, for example alcohol abuse or overcrowding in housing, should be taken into account, and their contribution to this type of victimization should be analyzed.

Almost 9 out of 10 (87.8%) participants also reported conventional crime experiences, related to property victimization such as personal theft or vandalism, but also to crimes against persons, e.g., assaults or bias attack. Besides, three quarters of the sample (75.6%) experienced peer and/or sibling victimization, mostly peer or sibling assault, verbal or relational aggression and some of them reported dating violence. Children can experience all these adversities at home, at streets, at school but also, while they live at residential care centers. In consequence, each center should promote a safety and respectful environment to make children comfortable where they live (e.g., to have their own belongings without having to worry about them, having their own spaces), and allow them to trust adults we in case they need to report an adversity.

Caregiver victimization experiences were reported for 78% of the current participants, meaning that at some point almost 8 out of 10 children have experienced physical or emotional abuse, neglect or family abduction. Results are consistent with previous studies with child welfare system samples (e.g., Segura et al., 2015). However, children of the current sample were not always placed at residential care centers for maltreatment reasons but for poverty. Differences between child welfare systems should be acknowledged and analyzed when researchers aim to understand this data. Another relevant aspect is that even though corporal punishment was not asked, children reported these kind of experiences at the hands of those working at residential care centers. In this regard, future studies should assess and explore children's corporal punishment experiences.

Sexual victimization was reported for 14.6% of participants, showing lower rates than on previous research with child welfare system samples (e.g., Cyr et al., 2012, Segura et al., 2015). Researchers should analyzed whether cultural differences or the translation have had an impact on this outcomes.

Otherwise, only 2.4% of the participants reported electronic victimization. Most of them informed they did not have access to electronic devices. Again having a deep knowledge of the population would allow researchers to understand the difference between this rate and the ones obtained in other similar studies.

Based on the qualitative data, researchers have identified several misunderstoods between children and caregiver or professionals working at the residential care centers. For example, most of the times when professionals are asked about violence against children, they tend to think that it mostly happens between them, meaning that one kid verbal or physically assault another. However they do not recognize that violence from adults toward children can occur. This phenomena could prevent them to identify risk factors or extremely dangerous situations for children. In this regard, training programs should be designed and developed in order to sensitize those professionals working with children at residential care centers, to allow them to better understand children's victimological trajectories, their distress and behavior, and how to protect them or the resources or strategies to use.

In line with quantitative results, risk factors coming from the macro system seem to have an enormous influence in the violence children experience in this context. Shared toilets, living in the coast area, belonging to a specific cast can increase the risk of experience victimization. The children themselves cannot change these variables, so ways of developing resilience for kids with higher risks are needed. The lack of financial resources and the legal frame have also been brought up in the interviews. Policy makers and other stakeholders may want to consider these findings as they can be key in changing this children's realities.

Finally, all the current results showed that interpersonal violence is a relevant problem for boys and girls living in residential care centers at the southwestern region of India, Trivandrum. The current research team would like to continue with the purpose to create a training for Child Welfare System workers. Working together and learning from each other would let us protect children.

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8. References

Aziz, A. (2015). The Epidemiology of Poly-Victimization in Pakistan. *Journal of Behavioural Sciences*, 25(1), 108.

Chan, K. L. (2013). Victimization and poly-victimization among school-aged Chinese adolescents: prevalence and associations with health. *Preventive medicine*, *56*(3-4), 207-210.

Cyr, K., Chamberland, C., Clément, M. E., Lessard, G., Wemmers, J. A., Collin-Vézina, D., ... Damant, D. (2012). Polyvictimization in a child welfare sample of children and youths. Psychology of Violence, 2(4), 385-400. doi: 10.1037/a0028040

Cyr, K., Chamberland, C., Clément, M. E., Lessard, G., Wemmers, J. A., Collin-Vézina, D., ... Damant, D. (2013). Polyvictimization and victimization of children and youth: Results from a populational survey. Child Abuse & Neglect, 37, 814-820. doi: 10.1016/j.chiabu.2013.03.009

Finkelhor, D., & Dzuiba-Leatherman, J. (1994). Victimization of children. *American Psychologist*, *49*(3), 173.

Finkelhor, D. (2007). Developmental victimology: The comprehensive study of childhood victimization. En R.C. Davis, A.J. Luirigio y S. Herman (Eds). *Victims of crime*. Thousand Oaks, CA: SAGE Publications.

Finkelhor, D., Hamby, S., Turner, H., & Ormrod, R. (2011). *The Juvenile Victimization Questionnaire: 2nd Revision (JVQ-R2).* Durham, NH: Crimes Against Children Research Center.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, *373*, 68-81.

Le, M. T., Holton, S., Nguyen, H. T., Wolfe, R., & Fisher, J. (2016). Poly-victimisation and health risk behaviours, symptoms of mental health problems and suicidal thoughts and plans among adolescents in Vietnam. *International journal of mental health systems*, *10*(1), 66.

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLOS Medicine*, *9*(11), 1-31.

Pereda, N., Guilera, G., & Abad, J. (2014). Victimization and polyvictimization of Spanish children and youth: Results from a community sample. Child Abuse & Neglect, 38(4), 640-649. doi: 10.1016/j.chiabu.2014.01.019

Segura, A., Pereda, N., Abad, J., & Guilera, G. (2015). Victimization and polyvictimization among Spanish youth protected by the child welfare system. Children and Youth Services Review, 59, 105-112. doi:10.1016/j.childyouth.2015.10.011

Reavley, N., Bassilios, B., Ryan, S., Schlichthorst, M., & Nicholas, A. (2015). Interventions to build resilience among young people.