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**CHAPTER 24****SEXUAL RELATIONSHIPS AND ADULTS WITH INTELLECTUAL DISABILITIES****GLYNIS MURPHY**

Attitudes to the sexuality of people with intellectual disabilities have changed considerably over the years (Kempton & Kahn, 1991; McCarthy, 1999). At the turn of the 20<sup>th</sup> century, during the eugenics era, as McCarthy (1999, p. 53) says, two contradictory beliefs were held: that society needed protection from the sexuality of people with ID and that people with ID needed protection from sex in society.

Over the last 50 years, however, with the advent of the normalisation and civil rights movements, people with ID have become more accepted within the community, and in most countries are seen as individuals with rights and responsibilities, including sexual rights, like other citizens. Indeed, such rights are included in the 2006 UN Convention on the Rights of Persons with Disabilities (Articles 12, 23 and 25). At the same time, though, it has become clear that sexual abuse is alarmingly prevalent in society and people with ID may be especially vulnerable to sexual abuse, for a number of reasons. In addition, it seems that people with ID may at times perpetrate sexually harmful behaviour, often following sexually abusive behaviour perpetrated against themselves in earlier years.

Clinical psychologists may be involved at a number of levels in work on sexual relationships and people with ID. They may, for example, be advising national governments on legislation, consulting with service providers on sexuality policies, developing self advocacy groups for people with ID on sexual issues, assessing possible

victims of sexual abuse or alleged perpetrators of sexual abuse, for court or for clinical reasons. Both victims with ID and alleged perpetrators with ID may also be referred for treatment following incidents of abuse. In this chapter, a broad overview of research into sexual relationships is given, and issues of sexual abuse against people with ID, and sexually harmful behaviour by people with ID are considered.

## **SEXUAL RELATIONSHIPS AND PARTNERSHIPS FOR PEOPLE WITH ID**

Many people in the general population would say that their most important relationships are with their partners (co-habitees, wives, husbands) whom they love, and with whom they typically have an intimate sexual relationship. Yet for people with intellectual disabilities, such 'partnerships' are rare and not often studied. As Bates et al (in press) has pointed out, according to the census data in England and Wales from 2011, out of approximately 45 million adults (over 16 years of age), around 65% have been in serious relationships (i.e. been married, or lived as a couple, or been in a civil partnership of some kind). In contrast, Emerson et al (2005) found only 4% of the 2898 people with intellectual disabilities they interviewed had a partner of any kind, suggesting that perhaps the prejudices of earlier times about people with intellectual disabilities having relationships have not completely dissipated. Nevertheless, there is emerging research about such relationships, from the viewpoints of people with intellectual disabilities, their parents and families, and their staff.

Recent studies of parents of those with intellectual disabilities found they mostly thought their sons and daughters should receive sex education at school, and few reported feeling confident to talk about such topics themselves (Isler et al, 2009; Evans et al, 2009; Pownall et al, 2012). Parents often balked at the idea of intimate relationships (Evans et al 2009; Pownall et al, 2012), with topics like gay or lesbian relationships (Abbott & Burns, 2007) and parenthood being even more taboo subjects (Cuskelly & Bryde, 2004; Pownall

et al 2012). Staff, on the other hand, while being somewhat more accepting of sexuality in adults with ID, compared to parents, still also said they were often unconfident in talking to people with ID in their care about sexuality (Rushbrooke et al, 2014), especially regarding same-sex relationships (Abbott & Howarth, 2007). They often reported feeling that women with ID in particular should be protected from sexual experiences (Rhea et al, 2012; Gilmore & Chambers, 2010), and they were also cautious about parenthood for people with ID (Gilmore & Chambers, 2010). Frequently staff seemed unsure about people's rights to privacy and intimate relationships (Abbott & Howarth, 2007; Evans et al, 2009) and several studies found both older parents and older staff had more conservative values than younger ones (Cuskelly & Bryde, 2004; Swango-Wilson, 2008; Meaney-Tavares & Gavidia-Payne, 2012). A number of researchers commented on the need for staff training (Meaney-Tavares & Gavidia-Payne, 2012) and clear policy frameworks (see Rushbrooke et al, 2014 for a review).

Most recently, the voices of people with intellectual disabilities themselves have been heard. These research studies tend to be small and qualitative in their methodology but nonetheless very revealing. McCarthy (1999), in one of the earliest studies, interviewed 17 women with intellectual disabilities about their sexual lives and found that most described entirely heterosexual experiences, and only a minority were positive about them. McCarthy (1999), and other researchers since then, have found that women with ID commonly feel a lack of control over what happens to them sexually, often say that money or cigarettes have been used to 'pay' them for sexual favours, and frequently report very high levels of abusive behaviour by the men they were involved with, whether they lived in hospitals or the community (McCarthy, 1999; Fitzgerald and Withers 2011; Bernert, 2011; Bernert & Ogletree, 2013). Very few women reported in any of these studies that sex was pleasurable, and almost all the women reported that it was men who controlled when and how they had sex. Women also said that their sexual lives were controlled by staff or

family members (saying they were 'not allowed' to have sex with boyfriends; or had been told 'only to kiss but that's all', or described having to have a family member sit between them on a date) (Fitzgerald and Withers 2011; Bernert, 2011; Bernert & Ogletree, 2013; Bates et al, in press). Researchers reported that 'the implicit message given by women was that men (with ID) were somehow better and more valuable than women', and more privileged in society than they were (Fitzgerald & Withers, 2011), though an Australian group described how even for men with ID, society considered them only 'conditionally masculine' (Wilson et al, 2013). Indeed, in studies involving men with ID, they also reported having staff and family control their sexual lives, often experiencing very little support when they needed it, for example, for privacy, or to go to a particular venue (Healy et al, 2009; Abbott & Burns, 2007; Bates et al, in press; Dinwoodie, in press).

Strangely, it seems that asking about 'love' has come much later to research in ID, than asking about sex. Those researchers who did ask about love found that people with ID had much to say on the matter. Not surprisingly they saw 'love' as 'caring for somebody' and as reciprocal, saying, for example, 'You cant give all the loving. They've got to give it back, havent they?' (Abbott & Burns, 2007). They emphasised the difference it would make to their quality of life, the joy of seeing each other and the devastation when the other person died (Healy et al, 2009; Abbott & Burns, 2007; Bates et al, in press). As Abbott & Burns commented, this view of love was not dissimilar to the views of people without disabilities, but the differences lay in the barriers the people with ID faced, especially for the lesbian, gay and bisexual individuals. In some studies, people with ID reflected on the way they chose their partners and Bates et al (in press) reported that while physical attractiveness, caring and kindness, and being 'special' to the other person, were certainly important, as for non-disabled people, other attributes such as financial security, social status, education or intelligence were not.

Many people, both men and women, in these studies, seemed to be trying to escape stigmatised identities. For example, they frequently denied their disabilities and distanced themselves from those who were more disabled (Bernert, 2011; Bernert & Ogletree, 2013; Fitzgerald and Withers, 2011; Wilkinson et al, 2015), although occasional people saw themselves as disabled first and gendered second (one woman in Fitzgerald & Withers, for example, saying she was not a 'proper' woman, she was 'handicapped'). It was also common for people to deny any homosexual feelings, perhaps for similar reasons, for example, one man who was struggling against his liking for other men, said 'I didn't want to be anything I'd get bullied for' (Wilkinson et al, 2015). Certainly those who had come out as gay or lesbian, bisexual or trans, had often thought very hard about who they told. They did not tell everyone and, despite this, had experienced extreme prejudice, including from family members (Abbott & Burns, 2007; Dinwoodie, in press). As one person said, in Dinwoodie's (in press) study, ID and LGBT are 'them two things ... what collide together'.

## **SEXUAL ABUSE**

There are a variety of definitions of sexual abuse. The basis for the definitions may be criminological, sociological or clinical but they all share the idea of sexual behaviour perpetrated either without the victim's consent or with a victim who is defined as not able to consent (for example, a child). Definitions of *child* sexual abuse often include the idea of an age differential between the people engaged in sexual behaviour, as an indication of the abusive nature of the act, although as Salter has commented this could result in the exclusion of forced assaults by peers (Salter, 1988). Most definitions include the idea of unwanted sexual fondling, rape and attempted rape (whether vaginal or anal). Examples of definitions are given in Table 24.1.

One of the most important distinctions between different definitions of sexual abuse relates to whether physical contact was made with the victim. Non-contact sexual abuse includes sexual behaviours where the perpetrator makes no physical contact with the victim, such as voyeurism, exhibitionism and stalking. Contact abuse involves physical contact between the perpetrator and victim and includes sexual assaults (such as touching genitalia), frottage, non-consensual oral sex, vaginal rape and anal rape. Most prevalence studies refer to contact abuse.

### **Epidemiology of sexual abuse**

In this section epidemiology of sexual abuse in people with and without ID will be considered.

#### Prevalence of sexual abuse against people without ID

Recent estimates by the Ministry of Justice, Home Office and the Office for National Statistics (2013) suggested that, in England and Wales, judging from the National Crime Surveys of the previous 3 years, on average, about 473,000 adults were victims of sexual offences (around 404,000 females and 72,000 males), *per year*. Of these offences, only a minority were reported to the police, relatively few went to court, and only about 6,000 alleged perpetrators, per year, received a conviction. In the same report, it was recorded that in 2011, over 10,900 prisoners were in jail for a sexual offence, only 103 of these being female (Ministry of Justice, Home Office and the Office for National Statistics, 2013). According to Bourke et al (2014), only about 5-10% of sexual offenders are women, and over 75% of these are thought to have been sexually abused themselves (compared to about 40% for male perpetrators).

Of course, sexual abuse is a crime that often takes place in conditions of secrecy (Salter, 1988) and it is thought that very many victims do not report what happened to anyone. Thus, according to Finkelhor (1994), only 50% of victims of child sexual abuse

ever tell *anyone* about what happened to them. Where they do tell someone, they are likely to tell friends or family members, rather than professionals or the police: only 15% told the police according to recent British Crime Surveys (Ministry of Justice, Home Office and the Office for National Statistics, 2013) and only 6% of victims of adult sexual abuse told the police, according to a study in Ireland (McGee et al., 2002).

Sexual abuse is thus known to be grossly under-reported to the police in most Western countries, probably partly because the victims fear (McElvaney, 2001):

- insensitive questioning by the police
- attitudes of scepticism or disbelief amongst family, friends and authorities
- anxiety about testifying in court, especially about hostile cross examination by defence lawyers
- fear of what actions the alleged perpetrator may take

In addition, victims often feel that they themselves were partly to blame for what happened and they therefore feel too ashamed to report the abuse, especially when it happened in childhood (McGee et al., 2002). Prevalence rates derived from police statistics are therefore gross under-estimates of the true rate and most researchers agree that the best estimates of prevalence come from victim surveys.

Figures for sexual abuse derived from victim surveys vary with the definition of sexual abuse employed, the time period asked about and the interview/questionnaire/case file search methods used (see for example, Salter, 1988, p. 18). It seems that sexual offences may be more common in some countries than in others (though Finkelhor, 1994, points out that this is difficult to establish because of methodological differences between studies) and it is clear from victim surveys that some types of offence are more common than others. Exhibitionism is probably the most prevalent sexual offence: around 50% of women report having been victims of this crime (Di Vasto et al., 1984). Very serious contact offences such as rape (or attempted rape) are less common.



In a very recent study of child sexual abuse, Finkelhor et al (2014) concluded that about 27% of girls and 5% of boys had been sexually abused by the time they were 17 years old (this included penetration in 6% of girls but in very low numbers of boys). In Ireland, McGee et al. (2002) reported that following a telephone interview of over 3000 people, 20% of women and 16% of men reported (contact) sexual abuse before 17 years.

The lifetime prevalence figures of sexual victimisation in the 2001 British Crime Survey of over 22,000 men and women, showed that 24% of women and 5% of men had been sexually victimised, with 5% of women and 1% of men having been raped, at some time in their lives (Walby and Allen, 2004). The lifetime prevalence figures from the study in Ireland reported that 21% of women and 18% of men had experienced contact abuse, with 10% of women and 3% of men experiencing rape.

Most often, for both child and adult sexual victimisation, the perpetrators have been found to be male (over 90% of cases in all known studies). Most studies have reported that the perpetrators were usually known to the victims, though the exact levels of sexual abuse by strangers varies from study to study (for example, the perpetrators were strangers in only 8% of cases in the British Crime Survey 2000, according to Myhill and Allen, 2002, but strangers were responsible for over 20% of child sexual abuse and over 30% of adult sexual abuse in the Irish study, according to McGee et al, 2002). Sexual abuse is often of long duration, particularly where it is familial. Moreover, being a victim of sexual abuse once appears to increase the risk of being re-victimised by a different perpetrator. In the Irish study, for example, 28% of the women and 20% of the men who disclosed abuse were victims of more than one perpetrator (McGee et al., 2002). For both men and women in the Irish study, penetrative sexual abuse during childhood led to a 16-fold increase in the risk of penetrative abuse in adulthood.

### Prevalence of sexual abuse against people with intellectual disabilities

People with ID are often not included or identified in victim surveys and therefore the figures derived from these studies do not apply directly to people with ID.

Nevertheless, people with ID are often the victims of sexual abuse and they have been said to be particularly vulnerable to it, compared to other care groups (Tharinger et al., 1990; Brown & Stein, 1998; Jones et al, 2012; Wissink et al, 2015). According to Jones et al (2012), in a meta-analysis of 8 studies covering over 6000 children of various ages, the prevalence of sexual abuse against children with intellectual disabilities was 15%, and they estimated that such abuse was about 5 times more likely for children with intellectual disabilities than for those without. A similar ratio was reported by Spencer et al, 2005, in a whole population study of approximately 120,000 children over about 2 decades, in the county of Sussex in the UK.

The methodology of the surveys of people with ID, such as the definition used, the period of time covered, the type of sample, the method of ascertaining abuse, all have a major impact on the findings, much as in surveys of abuse against non-disabled people. Some studies, for example, ask about whether sexual abuse has ever occurred (prevalence), such as McCarthy & Thompson (1997), whereas others ask about only new cases (incidence), such as Brown et al. (1995) and Brown & Stein (1998). Incidence figures are clearly likely to be lower. Moreover, surveys that take place in clinics (Chamberlain et al., 1984; McCarthy & Thompson, 1997) tend to produce high prevalence rates because the participants have, of course, been referred as in need of help. In contrast, service level surveys, which examine the number of incidents of sexual abuse reported to social services departments by carers or by day or residential services, tend to produce lower rates than do those which involve the direct interviewing of staff and carers of those with ID (especially as the former often examine incidence and not prevalence). The studies producing the highest rates, however, are those which ask the people with ID

themselves about their experience of abuse (for example, McCarthy, 1999; Briggs et al 2006). Table 23.2 gives the figures from a selection of studies of sexual abuse of people with ID, to illustrate these points.

Victims of sexual abuse in the non-disabled general population are thought to be overwhelmingly female, while the perpetrators are overwhelmingly male, usually known to the victim (see above). Studies of people with ID have suggested considerable similarities:

- Many victims are female, though male victimisation may be more common than in the general population (Wissink et al, 2015). Thus, in surveys of adults with ID, women have made up between 50% and 85% of victims, and men the remainder of victims (Hard & Plumb, 1987; Sobsey, 1994; Buchanen & Wilkins, 1991; Turk & Brown, 1993; Brown et al., 1995).
- Perpetrators are again largely male (all surveys have reported that perpetrators of sexual abuse against people with ID are 90% male – see Buchanen & Wilkins, 1991; Turk & Brown, 1993; Brown et al, 1995; McCarthy & Thompson, 1997).
- Victims with ID usually know the alleged perpetrators: in all, familiar adults were involved in perpetrating 95% of cases in the survey by Turk & Brown, 1993.

Perpetrators of abuse against people with ID include family members, teachers, other staff, local shopkeepers, clergymen, volunteers, and other service users (Wissink et al 2015). Most studies of adults with ID have found that around one quarter to one fifth of alleged perpetrators are staff, and similar proportions are family members (28% staff and 19% family members in Sobsey & Doe, 1991; 14% staff and 18% family members in Turk & Brown, 1993; 20% staff and 8% family members in Brown et al., 1995). Some studies of childhood sexual abuse have reported higher percentages of family members (around 50% in Sullivan and Knutson, 2000). All studies, including those with children (Briggs, 2006), find a sizable proportion of alleged perpetrators are other service users with ID (44% in Sobsey & Doe, 1991; 42% in Turk & Brown, 1993; 53% in Brown et al., 1995).

According to some studies, the most likely settings for abuse are school, day and residential services, rather than family homes: for example, in Turk & Brown, 1993, only 31% of the victims were abused in the family home and, in Brown et al., 1995, this figure was 25%. Some caution is necessary in interpreting these figures, however, since abuse by family members may more common in childhood, may be easier to keep secret, even in adulthood, and may be less likely to be reported to anyone (Brown et al., 1995).

Most studies have reported that the majority of the victims have mild or moderate ID but it may well be that this is simply because most abuse comes to light through the victim's disclosure (Buchanan & Wilkins, 1991; Turk & Brown, 1993; Brown et al, 1995; Wissink et al, 2015), so that those cases of sexual abuse perpetrated against people with severe disabilities (i.e. people with very limited communication skills) may simply not be being recognised. The type of abuse reported in most studies is serious: over 50% of abuse in Brown et al., 1995 and McCarthy & Thompson, 1997, involved vaginal or anal penetration. Multiple abuse has been reported as common in most studies (for example, 47% of reported abuse in Brown et al., 1995 involved multiple incidents). Of course, with under-reporting it is likely that the more serious incidents and the more frequent incidents get reported, so that it may be that one-off incidents of non-contact abuse are underestimated.

## **VICTIMS AND SURVIVORS WITH ID**

In this section the process of court attendance following abuse, the consequences of sexual abuse for people with and without ID and the treatment of psychological sequelae of abuse will be considered.

## Being a witness in court

Sexually abuse is known to be very under-reported in the general population (see above) and, even once reported to the police, convictions for sexual offences are known to be difficult to obtain in court. Difficulties with evidence often mean that convictions for less serious crimes than were originally contemplated have to be accepted (Grubin, 1998).

In many countries, the police are concerned about under-reporting of sexual crimes in the general population and have been at pains to improve services for victims, so as to encourage people to report sexual crimes. In Ireland, for example, reported sexual offences increased from 18% of indictable crimes against the person in 1988, to 56% in 1997 (McElvaney, 2001). Similarly, the total number of offences recorded as rape by the police in England and Wales was 1,842 in 1985, but rose to 7,809 by 1999 (though conviction rates fell in the same period from 24% to 8%, Myhill & Allen, 2002). The total number of sexual offences against children, reported to the police, has now increased yet again, to 31,000 in one year according to the NSPCC (<http://www.bbc.co.uk/news/uk-33160361>, accessed June 17<sup>th</sup> 2015). Nevertheless, as many researchers have commented, whether this increase in recorded sexual crimes reflects an increased rate of sexual crimes or improved reporting is unclear.

A number of studies of victims of sexual crimes in the general population have shown that the majority of victims do not themselves report the crimes (see under *Prevalence* above). This is even more likely with people with ID, since they may lack the communication skills and the ability to find the police station without support. Most often, they will tell staff or carers and usually they will need staff or carers' support to inform the police. Thus, reports to the police that people with ID have been victims of crimes are frequently made on their behalf, by staff or family carers or by professionals, such as social workers. The police may then interview the victim later.

In a number of jurisdictions, there has been considerable concern that few of these alleged crimes against people with ID, however reported, reach court (Luckasson, 1992; Kebbell & Hatton, 1999). For example, in Brown et al.'s (1995) study of victims of sexual abuse with ID, the police were called in under a half of all recorded cases and only 14% of the alleged incidents of abuse were investigated with a view to prosecution. It is known that part of the problem here is the extent to which staff report crimes to the police when the alleged perpetrator is another person with ID. Lyall et al (1995) found that 60% of the staff in day and residential services in one area of England said they would not necessarily report to the police a major assault by a service user with ID against another service user with ID. Moreover, 10% said they would not necessarily report a rape. A later study by McBrien & Murphy (2006) confirmed the relative reluctance of staff to report such incidents to the police and found that carers tended to think the person (the alleged perpetrator) needed help, rather than the intervention of the law. Carers were also concerned that, if they reported incidents to the police, they risked criticism themselves, suggesting that the ethos in services was that this was not an appropriate action to take. Only 50% of staff said their services had policies in place to guide them in reporting incidents to the police (McBrien & Murphy, 2006).

The low rate of prosecution of crimes of abuse against people with ID may also be attributed to inaction by the police (see the examples in Luckasson, 1992). McBrien & Murphy's study suggested that police assert that they will take alleged suspects with ID to court if they can (McBrien & Murphy, 2006) but the evidence from studies of abuse (eg Brown et al., 1995) is that they tend not to. It may be that in many cases where the victim of a sexual crime has ID, the police are reluctant to proceed because they think the person with ID will be an 'unsafe' witness. For example, in England, the advice to the police in the revised Codes of Practice (2014), associated with the *Police and Criminal Evidence Act*

1984, which dictates how the police should proceed to collect evidence about alleged crimes, is:

*'Although juveniles or people who are mentally disordered or otherwise mentally vulnerable are often capable of providing reliable evidence, they may, without knowing or wishing to do so, be particularly prone in certain circumstances to provide information that may be unreliable, misleading or self-incriminating'*

Nevertheless, very few police have training in interviewing people with ID according to data from a survey of 24 police forces in England, Wales and Northern Ireland (Bailey & Barr, 2000).

The difficulties that people with ID have in communication and memory (Murphy & Clare, 2003) mean that some of these fears about their testimony in the police station when being interviewed as witnesses (or suspects) may be justified. Studies have shown that people with ID sometimes have more difficulty providing eye-witness accounts than non-disabled people (Perlman et al, 1994; Milne et al, 1999) and they have, on average, a higher rate of acquiescence and suggestibility on questioning, than non-disabled people (Clare & Gudjonsson, 1993; Heal & Sigelman, 1995; Finlay & Lyons, 2002). Nevertheless, with the use of careful forms of questioning, avoiding suggestion and leading questions, people with ID may be perfectly good witnesses (Perlman et al, 1994).

However, neither the police nor lawyers may be relied on to use such careful forms of questioning. Witness studies by Kebbell, Hatton & colleagues (Kebbell et al, 2001; Kebbell et al., 2004) found that witnesses with ID were questioned by lawyers in court in just the same way as other witnesses (i.e. no allowance was made for their ID). Moreover, witnesses with ID were more likely than other witnesses to be led by leading questions, especially in cross-examination, compared to witnesses without disabilities (Kebbell et al, 2004), suggesting that people with ID do have a harder time surviving cross examination than do non-disabled people.

There has been concern in several countries over the last few decades that the end result of all these difficulties was that people with ID were not getting equal access to justice (Luckasson, 1992; Sanders et al., 1997). This led, in England, to a campaign for changes to the law (VOICE UK, 1998; Mencap, 1997), as result of which the *Youth Justice and Criminal Evidence Act 1999* was passed. This Act allowed the use of special measures to assist 'vulnerable witnesses' (such as those with ID) to give evidence in court. The special measures included being able to give evidence unsworn, to give evidence by video link, the use of an intermediary and of communication aids in court (Cooke & Davies, 2001). The Guidance associated with the Act, gave suggestions as to how the police should identify people with ID (in order to set up assessments of the need for special measures) and also gave guidance on how to interview people with ID in order to get the best evidence (Home Office, 2000). One study completed since the implementation of the new law has suggested that some vulnerable witnesses have found it an improvement on the previous arrangements (Hamlyn et al., 2004). However, Beckene et al (in press), in a small qualitative study of witnesses with ID in sexual abuse cases, have reported that, despite changes in the law, people with ID find lawyers and judges are often ill-informed and sometimes rude, and they find the court process almost as traumatising as the original abuse.

### **Psychological consequences: victims without ID**

The seriousness of the psychological consequences of abuse have been reported for years (Browne & Finkelhor, 1986; Beitchman et al., 1991; Kendall-Tackett et al., 1993) and there are now many well-controlled studies, both for non-disabled adults and children (see, for example, Ferguson & Mullen, 1999; McLeer et al., 1992; Kendler et al., 2000). Early reports suggested that symptoms included anxiety, sleep problems, eating problems, fears, phobias, depression, guilt, shame, disruptive behaviour, sexualised behaviour, anger, hostility, lack of trust in others, difficulties with social and sexual intimacy and poor



self-esteem (Browne & Finkelhor, 1986; Beitchman et al., 1991). Later studies commented on the similarity of symptoms to those of Post Traumatic Stress Disorder (PTSD) as well. Thus the list of sequelae of sexual abuse expanded to include intrusive thoughts, recollections and 'flashbacks', exaggerated startle response, feelings of self-blame, detachment, estrangement, withdrawal, difficulty concentrating, self-harm, a sense of a foreshortened future. Frequently, victims and survivors of sexual abuse, when being assessed for symptoms, have been interviewed using standardised psychiatric interview schedules or have been asked to report their symptoms using self-report measures (Wilson & Keane, 1997), such as the *Revised Impact of Events Scale* (Horowitz, et al., 1979; Sundin & Horowitz, 2002). The common association of PTSD with depression and anxiety means that measures of these psychological sequelae have often also been employed.

The proportion of the survivors of sexual abuse who suffer serious consequences seems to be very high. It has been estimated that around 70% of sexually abused children have psychiatric symptoms as a consequence (Kendall-Tackett et al, 1993) and about 40-50% have PTSD symptoms (Bernard-Bonnin et al, 2008). The rates may be lower in adults: For example, in the recent Irish study, 30% of women and 20% of men who reported abuse said that the abuse had had a major effect on their lives, with 25% of abused women and 16% of abused men reporting symptoms consistent with a diagnosis of PTSD. Not surprisingly, serious abuse appeared to result in worse sequelae. Thus people who had suffered penetrative sexual abuse were 8 times more likely to have been psychiatric in-patients at some time in their lives than those who had not been abused (McGee et al., 2002). Other studies have reported very similar findings and it seems that violent abuse, long term abuse and abuse by close family members have more deleterious effects than other forms of sexual abuse (Beitchman et al. 1991; Bulik et al., 2001), and although Grubin (1998) asserts that some of these findings may be the result of

dysfunctional family life rather than abuse per se, well-controlled studies (Kendler et al., 2000) show that it is a real effect that cannot be attributed to a generally disturbed family life. Many studies also find that the psychological effects of sexual abuse are very long term. For example, in Kilpatrick's research, 17% of women who were sexually assaulted still had the symptoms of PTSD (see below) 17 years later (Kilpatrick et al. 1987).

### **Psychological consequences: victims with ID**

Relatively few studies of the psychological symptoms of abuse have been conducted in people with ID, although a number of studies have commented anecdotally on the sequelae of sexual abuse or have analysed case notes retrospectively (see Sequeira & Hollins, 2003, for a review). Buchanan and Wilkins (1991), for example, commented that the indicators of sexual abuse included physical symptoms (e.g. vaginal bruising), behavioural symptoms (changes in mood and behaviour, such as sudden withdrawal and depression, or a sudden upsurge in aggression, self-injury, soiling or sexually inappropriate behaviour) and social symptoms (such as poor parental relationships, in cases of incest). In one of the few systematic studies employing standardised measures, albeit of a single case, Davison et al (1994) described the assessment and treatment of a man with ID who had symptoms of PTSD following an alleged rape, perpetrated against him when he was in prison.

There have also been several systematic studies of larger numbers of people with ID. For example, Solyu et al (2013) reported high rates of PTSD (50%), depression (31%) and conduct disorder (11%) in children with ID who had been abused, but these were children referred to a clinic, making the data hard to interpret. In another study, O'Callaghan and colleagues traced 18 people with severe ID who had been abused (outside the family) and whose cases had been reported to the police (O'Callaghan et al, 2003; Murphy et al, 2007; Rowsell et al, 2013). The participant's parents/carers were

interviewed about the person's symptoms following the abuse, using a method similar to that of Howlin and Clements, 1995 (participants themselves could not be interviewed due to their degree of disability and lack of expressive language). Parents/carers were asked to recall the person's skills and disabilities at three time points: before the abuse began, just after the abuse and in the three months before the research interview. Symptoms of PTSD were also considered and a standardised measure of skills and behaviour was completed. It was found that, despite the fact that the abuse had sometimes taken place years before the interviews, very significant changes in people's skills (apparent loss of skills) and challenging behaviours (worsening of behaviours) had occurred following the abuse, with only some recovery in the subsequent years (Murphy et al, 2007). Symptoms of PTSD were extremely common after the abuse, with 58% having severe sleeping problems, 50% of people experiencing frequent dreams and flashbacks, 68% showing extreme distress at cues, 76% showing loss of interest in activities. Again there was only some recovery by the time of the interviews (Rowell et al, 2013). Relatively few people with ID seemed to have been offered consistent treatment. Most families felt extremely traumatised by what had happened and blamed the services for not protecting their son or daughter.

In the third systematic study, Sequeira et al. (2003) compared 54 people with ID who had experienced sexual abuse to 54 people with ID who had not been abused, matching the groups for age, gender, degree of disability and communication skills. Behavioural difficulties, mental health needs and symptoms of PTSD were investigated using standardised measures and it was found that the abused group was showing significantly more challenging behaviour (including self-injury and sexualised behaviour), significantly more mental health symptoms and significantly more PTSD symptoms than the comparison group. As in Murphy et al (2007), much of the abuse had been long term and relatively few people (39%) had received treatment after the abuse from qualified professionals.

**Treatment following sexual abuse**

Considerable advances have been made in the provision of treatment for children and adults in the general population who have been sexually abused and who have developed post traumatic stress disorder or other symptoms. Treatments include self-help manuals, and both individual and group forms of treatment (e.g. Herbert & Wetmore, 1999; Trowell et al., 2002; Hembree & Foa, 2003). According to recent meta-analyses (McDonald et al, 2006; Hetzel-Riggin et al, 2007; Corcoran & Pillai, 2008; Sanchez-Meca et al, 2011), those treated showed considerable improvements, and trauma-focused CBT treatments seemed to be generally superior. Treatment packages for non-disabled survivors of sexual abuse often include psycho-education (i.e. information about the type of trauma and likely effects), as well as a variety of anxiety management techniques (such as relaxation training; mindfulness) and systematic desensitisation or graded exposure or flooding, and cognitive techniques, such as cognitive restructuring. Some of these methods, such as graded exposure, would be widely applicable and suitable for many people with ID, while some (e.g. psycho-educational materials; relaxation training; mindfulness) would need to be carefully tailored, and others (such as cognitive restructuring) would be feasible for many of those with mild ID but more difficult to apply for people with severely limited communication skills. So far only a few studies have appeared that have evaluated aspects of cognitive-behavioural treatment for people with ID who were victims of abuse, including a single case study (Davison et al., 1994), and group treatment (Barber et al, 2000; Peckham et al, 2007). They have demonstrated that psychoeducation, exposure, relaxation training, and support to reprocess trauma can help alleviate the symptoms of PTSD following sexual abuse in people with ID, but clearly far more research is needed to clarify the important elements of treatment.

## **PREVENTION OF SEXUAL ABUSE**

The high prevalence and the severe consequences of sexual abuse have led to a variety of initiatives intended to prevent sexual abuse against people with ID. These initiatives have normally taken one of two approaches: the provision of training and information for people with ID (to enhance their self-protection or to increase the likelihood that they will seek help and inform the police if they are abused) and the development of policies and procedures at a service level.

### **Sex education and self-protection**

There is considerable evidence that people with ID have lower levels of sexual knowledge and poorer self-protection skills than people from the general population (Edmonson & Wish, 1975; Timmers et al, 1981; Ousley & Mesibov, 1991; Konstantareas & Lunskey, 1997; McCabe, 1999; McCarthy, 1999; Tang et al., 1999; Murphy et al., 2004). Sex education, whilst widely available to children in the general population has not always been part of the curriculum for children with ID and thus many services for adults with ID now provide sex education and 'keeping safe' programmes for service users, often in day service settings. There are a number of sex education packages available, including slide packages (such as Kempton, 1988), pictorial packs (such as McCarthy & Thompson, 1992; Cambridge, 1997) and videos (for example, South East London Health Promotion Services, 1992; Family Planning Association of New South Wales, 1993). Most programmes also include teaching of 'keeping safe' procedures (recognising abuse, the right to say 'No' and how to report abuse to staff and/or police). However, relatively few sex education/'keeping safe' packs have been evaluated, so it is uncertain how effective they are, although Lindsay et al. (1992) and Caspar & Gliddens (2001) showed that people with ID made gains in knowledge and attitudes following sex education and Murphy et al

(2007) reported that those adults in their study who had had sex education had significantly better sexual knowledge and understanding of abuse than those who had not.

A number of recent studies have argued that improved sexual knowledge does not necessarily generalise and translate into better self-protection skills (Lumley & Miltenberger, 1997), with the implication that programmes often need to employ behavioural training methods, rather than just didactic instruction, and programme evaluations need to include role play of likely scenarios (Haseltine & Miltenberger, 1990; Lumley et al., 1998; Miltenberger et al., 1999). A few studies have hypothesised that one of the crucial skills in abuse self-protection is people's decision-making abilities (Khemka & Hickson, 2000) and some investigation has begun into how to improve decision-making skills in abuse situations (Khemka et al., 2005). Two recent reviews of abuse prevention programmes have shown that they tend to use a combination of behavioural training and cognitive strategies (including problem-solving) but it is too early to say what the most effective components are as yet (Bruder & Kroese, 2005; Doughty & Kane, 2010). Finally, some books have also been developed to assist witnesses with ID to understand the criminal justice system process, so as to support them if they go to the police and to court as witnesses (Hollins et al., 1994).

Whilst it is undoubtedly important to provide sex education, 'keeping safe' programmes and decision-making training, nevertheless some people, particularly those with severe ID, may never know enough about sexuality in general and sexual abuse in particular to be able to keep themselves safe and they may be deemed not to have the capacity to consent to sexual relationships (Sundram & Stavis, 1994; Niederbuhl & Morris, 1993; Murphy et al., 2004). For these individuals policies and procedures adopted at service levels are particularly crucial.

## **Policies and procedures**

McCarthy (1999) has argued that one of the first necessary steps in improving services for people with intellectual disabilities, from the point of view of the prevention of sexual abuse, is the closure of hospital provision, because of the high likelihood of predatory men there (with and without ID) and the relative lack of close supervision (as well as the opportunities provided by large grounds and numerous buildings). Similar points can be made about large residential provision of any kind (McCarthy & Thompson, 1996).

Some researchers and professionals have asked whether mixed services should be provided at all, given that so many perpetrators are men (McCarthy & Thompson, 1996). Yet to cloister all women with intellectual disabilities in all female-staffed services would be an extreme step, which in any case would not protect men with ID from being victims of abuse. Nevertheless, many large service organisations are ensuring that at least some of their services are single-sex and most services are becoming more aware of abuse issues in the design of services, frequently considering the mix of people in each house and adopting gender sensitive policies for personal and intimate care. Staff in many organisations are being more carefully vetted prior to employment and in many countries (including the UK and the US) all staff are supposed to be checked by the police for criminal records prior to employment (Gust et al., 2003).

It has also been argued that staff in services need considerable support and training in order to be able to prevent and deal with sexual abuse. A recent US survey has suggested that most staff do now get at least one-off training in sexual abuse recognition and reporting (88% of organisations provided this) but far fewer provided more frequent training (Gust et al., 2003). Many services also now have sexuality policies (61% of organisations in Gust et al., 2003, have these, compared to only 23% in Mulhern's 1975 survey). Most policies provide guidance to staff with respect to the recognition and

reporting of sexual abuse, but the experience of service users suggests that all too often policies focus on abuse prevention without supporting people in their relationships (Hollomotz & the SpeakUp Committee, 2008). In order to be more than just reactive, policies need to also contain broad advice in relation to how to support service users in their relationships more generally (including in friendships, physical contact, courting, personal hygiene, marriage and co-habitation, parenting, birth control, and sexual relationships issues such as consent and abuse).

### **PERPETRATORS WITH ID: PREVALENCE OF CRIMINAL AND SEXUAL OFFENDING<sup>1</sup>**

During the eugenics era, it used to be thought that men with ID were particularly likely to commit crimes, more likely than men without disabilities. Recent studies have shown, however, that people with ID are mostly not over-represented in prisons compared to non-disabled prisoners, though this depends somewhat on the jurisdiction (see Murphy & Mason, 2014 for a review). Nevertheless, it does seem that men with intellectually disabilities are somewhat over-represented at other stages of the CJS, such as at the police station (Gudjonsson et al., 1993; Lyall et al., 1995) and on probation (Mason and Murphy, 2002) at least in the UK. Whether this is a result of the vulnerabilities of people with ID (for example, being more easy to trace, recognise and detain, and being more susceptible to false confessions), rather than being due to a raised prevalence of criminal offending, is uncertain.

Relatively few research studies of offending and ID have commented directly on the prevalence of *sexual* offending by men with ID, though where they do, the older studies often assert a high prevalence (Murphy, W. et al., 1983; Hawk et al., 1993; Nezu et al., 1998). One of the early influential studies was that of Walker and McCabe (1973), who investigated a 90% sample of all the men with mental disorders detained in hospital,

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<sup>1</sup> Men with ID are often not reported to police or convicted of sexual offences, especially if the victim has ID. Their behaviour is therefore referred to as 'sexually abusive behaviour', rather than 'sexual offending', in this chapter.



following conviction for offences, under the mental health legislation in England. Of the 960 men so detained, about 1/3 had intellectual disabilities and 2/3s had mental health needs and/or personality disorder. It transpired that, of the total number of sexual crimes committed by the cohort, 2/3s were committed by the 1/3 of the cohort that had ID. This has sometimes been interpreted as meaning that men with ID are particularly likely to commit sexual offences. In fact, of course, it means nothing of the kind. For example, it is known that only about 10% of sexual crimes are reported to the police (see above under epidemiology of sexual abuse) and even fewer end in convictions, so that very little is known about the perpetrators of the 'invisible' sexual crimes, with or without disabilities. Moreover, numerous selective filters operate between a crime being notified to the police and the offender being convicted and sent to hospital under mental health legislation (including the police decision about proceeding, the prosecution decision about proceeding, liaison and diversion opportunities, the availability of evidence, the competence of the lawyers, the availability of psychiatric opinions regarding disability for the court, the availability of hospital beds, and so on). It has to be concluded that Walker and McCabe's data cannot be interpreted to mean that men with ID are particularly prone to commit sexual crimes.

Other studies have also drawn conclusions about the prevalence of sexual offending by men with ID from samples that were highly selected, such as those in hospital or those referred for special pre-trial evaluation (Hawk et al., 1993) and while many assert that large numbers of men with ID commit sexual offences, there are also studies that suggest they are only as likely as other men to do so. Hayes (1991), for example, showed that men with disabilities in prison in Australia were as likely to be there due to conviction following a sexual offence as were men without intellectual disabilities (4% of both groups had committed sexual offences). In the absence of good total population studies it has to be concluded that the prevalence of sexual offending in men with ID is uncertain.

### **Characteristics of non-disabled men with sexually abusive behaviour**

A considerable amount is known about non-disabled convicted men who commit sexual offences, as a result of decades of research. Non-disabled male sex offenders often come from dysfunctional families where violence is common, the parents have a poor relationship and fathers are frequently rejecting (Rada, 1978; Langevin et al., 1984; Williams & Finkelhor, 1990). The sex offenders may have been abused themselves as children (Groth & Burgess, 1979; Langevin et al., 1985) and frequently have abnormal sexual interests as adolescents (Abel & Rouleau, 1990). They are commonly reported to have low self-esteem, to be socially isolated, emotionally lonely and/or lacking in the social skills required for intimate relationships (Knight et al., 1983; Awad & Saunders, 1991; Garlick et al., 1996; Seidman et al., 1994; Fisher et al., 1999). Sex offenders have been found to show reduced empathy for their victims, though they do not normally show reduced empathy generally (Scully, 1988; Beckett et al., 1994; Fernandez et al., 1999; Fisher et al. 1999), and they seem to be susceptible to cognitive distortions that deny and minimise their offences and blame their victims (Abel et al., 1984; Murphy, 1990; Happel & Auffrey, 1995). Some sex offenders may have very large numbers of victims, target more than one age group and have multiple paraphilias (Abel & Rouleau, 1990). Frequently sex offenders spend a great deal of time grooming their victims prior to offences, often this may involve elaborate planning and preparation.

### **Characteristics of men with intellectual disabilities and sexually abusive behaviour**

Far less is known about the characteristics of men with ID who engage in sexually abusive behaviour. Evidence from the studies that there are, many of which involve men detained or living informally in clinical settings (who may be a biased sample of all such men) and few of which include comparison groups, suggest that men with ID and sexually

abusive behaviour are similar in many respects to non-disabled sex offenders, although relatively few of them are ever convicted of sexual offences in the courts (Thompson, 1997). They tend to come from chaotic, violent and neglectful families who often have criminal histories themselves (Gilby et al. 1989; Day, 1994), they frequently show other challenging behaviours, such as aggression and may have other non-sexual convictions (Gilby et al., 1989; Day, 1994; Lindsay et al., 2002) and often have a history of mental health problems (Day, 1994; Lindsay et al., 2002). They have an increased likelihood of a history of sexual abuse as victims themselves (Gilby et al., 1989; Lindsay et al., 2001; SOTSEC-ID, 2010) and they commit the full range of sexual offences (Day, 1994; Thompson, 1997; Lindsay et al., 2002), usually knowing their victims (Gilby et al., 1989) and frequently re-offending if not treated (Gilby et al., 1989; Day, 1994; Klimecki et al., 1994). There is good evidence that men with ID who engage in sexually abusive behaviour also show cognitive distortions (Lindsay et al., 1998a, b, c; Lindsay et al., 2000; SOTSEC-ID, 2010) and have little empathy for their victims (SOTSEC-ID, 2010). Where they differ from non-disabled sex offenders is that the men with ID more often have adult victims (usually other people with ID) and more frequently target male victims (Gilby et al., 1989; Murrey et al., 1992). There is some suggestion that they may be less likely to be violent during their sexual offences than non-disabled men, and less likely to commit penetrative offences (Murrey et al., 1992) but the latter at least may be a function of their more supervised lives (so that more minor sexually abusive behaviour is easier to detect). Men with ID and sexually abusive behaviour are rarely reported to the police, especially if the victim is another person with ID: Thompson (1997), for example, found over 70% of offences against children by men with ID were reported to the police but only 11% of offences against another adult with ID. The men are very rarely convicted, even after being reported to the police (for the reasons discussed in the sections on victims, above) and the consequences of their behaviour are often minimal (Thompson, 1997). According to some

reports, men with ID and sexually abusive behaviour have less specific victim patterns than non-disabled sex offenders (i.e. may have some male victims, some female, some children) but this has sometimes been disputed, especially since the data from Abel & Rouleau's (1990) study on non-disabled men's sexual preferences and victim types.

## **TREATMENT FOR ALLEGED PERPETRATORS**

### **Treatment of Non-disabled Perpetrators**

Researchers have tried to develop theories of sexual offending to account for the characteristics of sex offenders and to allow treatment programmes to be developed to reduce the likelihood of re-offending. All of the theories have been based on what is known about convicted non-disabled male sex offenders. Early theories tended to be based on the idea that abnormal sexual arousal underlay deviant sexual responding, as a result of early conditioning. Paedophiles were reported to be more aroused to images of children than adults (Quinsey & Chaplin, 1988) and rapists more aroused to violent sexual scenes than to consenting sex (Quinsey et al., 1981). Treatment programmes at the time were either medicinal (involving anti-androgens, such as in Bancroft et al., 1974, and Cooper, 1981) or were behavioural. Behavioural programmes focused on correcting abnormal arousal either by punishment, such as in aversive conditioning (Quinsey et al., 1980) and covert sensitisation (Maletzky, 1980) or by reinforcement, such as in orgasmic reconditioning (Marquis, 1970). However, it gradually became clear that sexual preferences, especially as measured by phallometry, were not good predictors of sexual offending and many of the related treatments proved unsatisfactory when properly designed evaluations of their effectiveness were undertaken (see Marshall et al., 1999, chapter 8 for a review of the evidence). Moreover, Marshall et al. (1999) argued that many of these behavioural treatment programmes were unethical, as they provided treatment

that was often punitive for sexual behaviours that were not illegal (such as homosexuality, fetishism and transvestism).

During the 1980s and the next few decades, a number of very influential theories appeared, which attempted to explain the sexual offending of non-disabled men, in terms of cognitive and emotional pre-cursors and components. Three of the most successful have been those of Wolf (1981), Finkelhor (1984, 1986), and Marshall et al. (1999). Wolf (1981) proposed a model of the cycle of offending that attempted to explain how child sex offenders came to repeat their offences. His hypothesis was that sexual offenders began with poor self-esteem and personal problems, which when the problems worsened, led to a retreat into self-reinforcing fantasies, including sexual fantasies. These then led the offender on to targeting a victim, getting to know him/her and planning how to offend. At this stage it was hypothesised that the offender would begin to engage in cognitive distortions (such as 'it is only a bit of fun'), so as to excuse himself from his actions. The offence itself would follow, with a brief period of sexual satisfaction, but quickly guilt and further lowering of self esteem would ensue, only for the offender to repeat the whole cycle when further events threatened his well-being.

Finkelhor's theory (1984, 1986) reinforced Wolf's model and expanded on some aspects of the behaviour of sex offenders. Finklehor proposed that in order to commit child sexual abuse, four pre-conditions had to be present:

- the sexual offender had to be motivated to offend
- he must overcome his internal inhibitions to offend (through cognitive distortions, such as denial of harm, minimisation of intended actions and victim blaming)
- he must overcome external obstacles (through planning how to make contact with victims)
- he must overcome the victim's resistance (through grooming and befriending the victims)

There is considerable evidence of cognitive distortions and of planning, grooming and befriending of victims from numerous studies of non-disabled men (Abel et al., 1984; Murphy, 1990) that support Finkelhor's theory.

Finally, Marshall and colleagues' model attempted to explain the social isolation and loneliness in sex offenders, the presence of attachment deficits, and the role of empathy (Marshall, 1990; Marshall et al., 1999). They proposed that male sex offenders had insecure attachments to their parents as young boys, leading to either fearful or avoidant attitudes to social intimacy with peers (according to whether parents had been inconsistent or detached/unresponsive, respectively), and thus loneliness followed. Marshall and colleagues proposed that during puberty, because of their social relationships difficulties, boys with insecure attachments began to seek intimate experiences through sexual acts, particularly when transitory personal factors (such as anger, depression, resentment) or situational factors (such as alcohol) were operating (Marshall, 1990; Marshall et al, 1999, pages 27-31). The proposed intimacy deficits and the increased loneliness of sex offenders were confirmed by Seidman et al (1994) and Bumby & Hansen (1997).

Hudson & Ward later attempted to extend Marshall's theory, using Bartholomew & Horowitz's (1991) 4 category model of social attachment. Bartholomew & Horowitz proposed that there were really 4 attachment styles: secure (in which a person's view of him/herself and others was positive), preoccupied (in which a person viewed others positively but him/herself negatively), fearful (in which a person viewed both him/herself and others negatively) and dismissing (in which a person viewed him/herself positively but others negatively). Ward et al (1996) predicted that child molesters would have a preoccupied or fearful attachment style, while rapists would be more likely to have a dismissing style and their data supported this prediction. Nevertheless, there was no clear differentiation between offender types in a later study, suggesting that the relationship between attachment style and offender type is not clear cut (Hudson & Ward, 1997).

Since the 1990s, a number of other theories of sexual offending have been proposed and Ward and Hudson (1998a) have tried to provide a meta-theoretical framework to classify them: level I theories being multi-factorial, level II theories being single factor and level III being micro-level or offence process theories. They have suggested that the eventual goal is to have a global theory and that this is likely to be achieved by 'theory knitting' (Ward et al, 2006, p. 14).

In line with the more sophisticated theories of sexual offending proposed during the 1980s and 1990s, treatment for non-disabled men who had committed sex offences became better targeted at the cognitive and affective reasons for sexual offending (Marshall, 1996) or, as some researchers have termed them, the men's 'criminogenic needs' (Andrews & Bonta, 2003). Increasingly, cognitive behaviour therapy (CBT) became the treatment of choice and recent large meta-analyses have demonstrated that such treatment approximately halves re-offending rates, the re-conviction rate for untreated men averaging 17% while treated men average 10% over about a 4 year period (Hanson et al., 2002). Similar findings were reported in a later meta-analysis of 23 studies by Hanson et al (2009), in which the untreated recidivism rate was 19% and the treated rate was 10%. According to Hanson et al (2009), the most successful programmes were those based on the three principles of risk (i.e. degree of risk of reoffending), need (criminogenic needs) and responsivity (likelihood of men responding to treatment).

These days, CBT is usually provided to groups of sex offenders, partly to allow some support to be offered by the men to other men within the group but also partly to enhance the challenging of cognitive distortions by group members. The content of CBT programmes, which are usually run by one male and one female therapist, vary somewhat, but most programmes (see for example, Marshall, 1999) last about one year and include modules on:

- Enhancing self-esteem

- Improving social skills, usually focused on relationship skills
- Enhancing victim empathy
- The role of fantasy and sexual preferences
- The cognitive model and challenging of cognitive distortions
- Relapse prevention

Increasingly, the programmes are beginning to include a consideration of the Good Lives Model (Ward and Stewart, 2003) and will adopt some strategies to address how the men can attain good lives, as well as how they can cease offending. In the UK, treatment programmes are mandatory for men convicted of sexual offences, whether they are serving sentences in prison or in the community (depending on the length of their sentence).

### **Treatment of Perpetrators with ID**

While there has been considerable debate and enormous research effort put into discovering the causes of sexual offending amongst non-disabled men, research into the causes of sexual offending amongst men with intellectual disabilities is only just beginning. Some evidence suggests that there are many similarities between men without disabilities who commit sexually offences and men with intellectual disabilities who engage in similar behaviours (see above, under *Characteristics*). Treatment for men with ID has usually followed that developed for non-disabled men. In the early years, therefore, treatment tended to be medicinal, with anti-libidinal drugs (Clarke, 1989; Cooper, 1995) or to focus on behavioural methods (Murphy, W. et al., 1983; Foxx et al., 1986), often with sex education and social skills training components (Griffiths et al, 1989; Haaven et al., 1990; Swanson & Garwick, 1990; Charman & Clare, 1992; Lund, 1992; O'Connor, 1996). Latterly, group CBT has become more likely to be the treatment of choice and there are now some treatment manuals and training courses available for therapists: for example,



the ASOTP programme used in a number of prisons and hospital settings in the UK for men with ID (Rogers & Fairbanks, 2003; Williams et al, 2007), recently re-named the New Me programme, and the Sex Offender Treatment Services Collaborative (SOTSEC-ID) model used in the community and in hospital settings in the UK (Sinclair et al., 2002; SOTSEC-ID, 2010; Heaton & Murphy, 2013). Frequently these programmes are similar to, but somewhat simplified versions of, the kind of group CBT for non-disabled sex offenders. They almost always include an additional component on sex education, however, as men with ID tend to have lower sexual knowledge than non-disabled men (Murphy & O'Callaghan, in press), though it is not known for certain whether this has any real link to sexually abusive behaviour.

The feasibility of CBT, generally, for some people with ID is beginning to be widely accepted and a few randomised controlled studies of the effectiveness of CBT have appeared (Willner et al, 2002; Willner et al, 2014), though none of these as yet have been for men with sexually abusive behaviour. Nevertheless, in an uncontrolled study, Rose et al. (2002) demonstrated that a closed group intervention lasting 16 weeks (for 2 hours per week), for a group of 5 men, focussing on sex education, identifying feelings and enhancing empathy, considering sexual fantasies, offending cycles and planning how not to re-offend, had some (non-significant) effect in improving empathy and cognitive distortions, in some men. A similar programme lasting a year, for more than 40 men, also showed significant improvements in sexual knowledge and empathy, and significant reductions in cognitive distortions (Murphy et al, 2007; SOTSEC-ID, 2010). Moreover, Lindsay and colleagues, in a series of studies, have shown that group CBT, involving some victim empathy work, challenging of cognitive distortions about responsibility, intent, harm done to the victim, and including relapse prevention (see Lindsay, 2007), resulted in reduced cognitive distortions and reoffending, with 2 years of treatment producing better results than one year of treatment (Lindsay & Smith, 1998). Heaton & Murphy (2013) have

shown that the effects of this form of CBT are well maintained over periods of about 4 years, at least in terms of the changes in sexual knowledge, empathy and cognitive distortions, for men with ID and sexually abusive behaviour. Meanwhile, Lindsay and colleagues have also demonstrated significant reductions in harm in repeat sex offenders over a period of 12 years (Lindsay et al, 2006).

## **PREVENTION OF SEXUAL OFFENDING**

### **Non-disabled men**

For men without disabilities, relapse prevention is an important part of cognitive-behavioural treatment programmes (Pithers, 1990; Eccles & Marshall, 1999). The method chosen to promote relapse prevention for sex offenders came originally from Marlatt's work with people who had addictive behaviours (Marlatt, 1982). The model proposed that there was a chain of events from seemingly unimportant decisions (or SUDs, such as to walk to the shops past the school, at a time when children are in the playground), to lapses (such as engaging in deviant fantasies), to full blown relapses, as a result of an abstinence violation effect (AVE). During treatment, non-disabled sex offenders were taught to recognise the stages that led to relapse and to avoid the slide from SUDs to lapse, to AVE, to full relapse. Recent reviews have suggested that relatively few non-disabled men re-offend following treatment (10% approximately, according to Hanson et al., 2002 and Hanson et al 2009). Nevertheless, a recent study which tested out the added effectiveness of the relapse prevention (RP) module suggested it had little effect and a study comparing those treated with RP to those treated using the Good Lives Model suggested the GLM approach was somewhat superior (Barnett et al, 2013). In any case, a 10% recidivism rate is too large and so invariably, in addition to treatment for non-disabled men, standardised measures of risk are used to predict who will re-offend (Hanson & Thornton, 2000) and increased supervision is provided for high risk men, in order to reduce the risks.

## Men with ID

CBT programmes for men with intellectual disabilities also include relapse prevention components, though the importance of this part of the programme has yet to be ascertained. It seems likely that the baseline relapse rate for men with ID who commit sexual offences may be higher than that for men without disabilities: Klimecki et al. (1994), for example, found a recidivism rate of 31% amongst men with ID who had not had treatment and who had been convicted of sexual offences in one part of Australia. Results from Lindsay & Smith (1998), Lindsay et al (2010), SOTSEC-ID (2010) and Heaton and Murphy (2013) suggested that treatment reduces this rate considerably, but nevertheless re-offending does sometimes occur.

Of course, many men with ID who have sexually abusive behaviours are not yet being offered treatment. In the majority of cases, their behaviours are managed through clinical risk assessment and risk management: a recent survey in the US of 240 service providers indicated that 74% of services managed sexually abusive men through close supervision (Ward et al., 2001). This has advantages but also disadvantages for the men themselves. Many men are reluctant to go through a treatment programme for a whole year that will force them to confront their attitudes and behaviour, but they may do so in order to be able to be less constrained and supervised in the future; on the other hand, if they are simply closely supervised without treatment, there is no logical reason to stop such supervision, when the risks they pose unsupervised have not necessarily lessened. Standardised risk assessment measures are only just beginning to be used for men with ID (Johnston, 2002; Boer et al, 2010) and only one has been specifically designed for men with ID and sexually abusive behaviour (the ARMIDILIO-S, Boer et al, 2012). It is, as yet, too early to tell whether such measures will help to contribute to reductions in risk through targeted increased supervision.

Providing treatment and risk management for men who have been sexually abusive is only one form of prevention, of course. It would be preferable to prevent men from offending in the first place. We are as yet a very long way from knowing how to do this. Feminists argue that one important issue is the way that society generally (and men in particular) tolerate attitudes and behaviours associated with sexual offending, as indicated by the widespread availability of pornography, of use of prostitutes and of hostile attitudes to women (McCarthy, 1999, pp. 35-40). Furthermore, the social inequalities inherent in most societies make it more likely that some families will struggle to create harmonious and nurturing family relationships, thus creating some of the insecure attachment and other pre-conditions thought to be important in the development of sexually abusive behaviour. In addition, in services for people with intellectual disabilities there is often an unjustified toleration of inappropriate sexual behaviour, with insufficient notification of the police and a tendency to simply move men who sexually abuse to another residential setting. The criminal justice system, when involved, also frequently fails the victim with intellectual disabilities, making it more likely that perpetrators will re-offend.

## **SUMMARY**

There is a growing recognition of the rights of people with ID to the same kinds of close relationships that the rest of the population enjoy, but there remain many barriers for them in exerting such rights. At the same time, it is known that people with ID are very vulnerable to sexual abuse, with rates of abuse against people with disabilities being considerably higher than those against non-disabled individuals. There is widespread recognition of this now, however, and there are many sex education and abuse prevention programmes available. Meanwhile, it is acknowledged that a considerable proportion of the abuse against people with ID has been perpetrated by men who themselves have ID. There is an increasing recognition of this and several treatment programmes are now

available both in prisons, hospitals and in the community that seem to lower the risk of reoffending.

## EXERCISE

Work in groups of 4. Imagine you have been asked to set up project to treat adolescents with intellectual disabilities who have persistently behaved in a sexually inappropriate way. What practical steps would you take to organize the project ? What key elements would you include in the programme? How would you network the programme in with other important services and relationships in clients lives? When you have reached a decision on each of these questions, summarize these and read them to the class.

## FURTHER READING FOR CLINICIANS

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Table 24.1 Definitions of sexual abuse (examples)

Source	Definition
British Crime Survey (Myhill and Allen, 2002).	The British Crime Survey of 2000 asked women and men the following question about sexual victimisation: <i>'Since the age of 16, has someone, either a stranger or someone you know, used violence, threats or intimidation to force you to do sexual things against your will?'</i> Further questions went on to ask victims about attempted rape and actual rape.
Baker & Duncan (1985) in their survey of over 2000 people	<i>'A child (anyone under 16 years) is sexually abused when another person, who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal. This might involve intercourse, touching, exposure of the sexual organs, showing pornographic material or talking about sexual things in an erotic way.'</i>
Turk & Brown's (1993) definition, used in their work with people with intellectual disabilities.	<i>'Sexual abuse occurs when a perpetrator exposes his/her genitals or looks at or touches certain parts of a victim's body (breasts, buttocks, thighs, mouth, genital or anal areas) or requires the victim to perform sexual acts, for the purpose of gratifying or satisfying the needs of the first person and when one or more of the following apply:</i> <ol style="list-style-type: none"> <li data-bbox="499 1189 1437 1223">1. <i>The second person withholds their consent</i></li> <li data-bbox="499 1227 1437 1361">2. <i>The second person is unable to give their consent because the severity or nature of their intellectual disability severely affects their understanding of the basic elements of sexual behaviour</i></li> <li data-bbox="499 1366 1437 1619">3. <i>Some other barrier to consent is present for the victim, which means that they are unduly pressured in this particular situation (including the presence of a parental, familial, caretaking or other authority relationship between the persons involved; the use of force, a weapon or the threat of injury or punishment by the first person; the abuse of a power relationship which precludes consent by the weaker person).'</i></li> </ol>



**Table 24. 2. Selected surveys of sexual abuse of people with ID**

Authors	Definitions	Method	Rates
Chamberlain et al., 1984	Completed or attempted intercourse (penetration)	Case notes study only of the clinic notes on 87 female adolescents with intellectual disability, attending an adolescent clinic	25% had been sexually abused (clinic-based but case notes only)
Hard & Plumb, 1987, quoted in Turk & Brown, 1993	Not known	Face to face interviews with 65 people with ID attending a day centre	58% reported having been sexually abused
Buchanan & Wilkins, 1991	Proven or strongly suspected 'sexual exploitation'	Survey of 37 day & residential workers in one county in UK, regarding cases of known sexual abuse of people with ID.	25 cases of sexual abuse identified. Prevalence rate 8%
Turk & Brown, 1993 and Brown et al., 1995	See text	In 1st survey: All statutory providers in one health region in England asked to provide data on all new incidents of sexual abuse of adults with ID over a 2year period. 2 <sup>nd</sup> survey: similar	1st survey: 60 new cases/year in general pop. of 3.6 million. 2 <sup>nd</sup> survey: Similar.  Estimated 1400 new cases of sexual abuse per year in England
McCarthy & Thompson, 1997	Sexual abuse as defined in law & other (see article)	185 people referred to a sex education team; all individuals interviewed face-to-face	61% of women & 25% of men had been sexually abused
Brown & Stein, 1998	New cases of poss. abuse reported to & recorded by Social Services	Abuse alerts (physical, sexual, financial, etc) across all care groups in Social Services dept.s in 2 counties in England	14-26 alerts per 100,000 general population; 34% of alerts for people with ID; one third of these sexual abuse
Spencer et al, 2005	Child Protection Register definitions	Merging of health records and Social Services abuse records for almost 120,000 children	Children with ID were 8 times more likely to be sexually abused (6 times more likely once eg SES taken into account)
Briggs et al, 2006		Interviews and questionnaires with n=161 special education students aged 11-17yrs	32% of girls and similar rate for boys