1995

MEN WITH LEARNING DISABILITIES WHO SEXUALLY OFFEND AND STAFF ATTRIBUTIONS ABOUT SEXUALLY ABUSIVE BEHAVIOUR

Yates, Caroline

MEN WITH LEARNING DISABILITIES WHO SEXUALLY OFFEND AND STAFF ATTRIBUTIONS ABOUT SEXUALLY ABUSIVE BEHAVIOUR

By

Caroline Yates

A thesis submitted to the University of Plymouth

in partial fulfilment for the degree of

DOCTOR OF CLINICAL PSYCHOLOGY

Department of Psychology

Faculty of Human Sciences

In collaboration with

Cornwall & Isles of Scilly Learning Disabilities NHS Trust, Cornwall County Council

Social Services Department and Plymouth Community Services NHS Trust.

May 1995

Abstract

MEN WITH LEARNING DISABILITIES WHO SEXUALLY OFFEND AND STAFF ATTRIBUTIONS ABOUT SEXUALLY ABUSIVE BEHAVIOUR

By

Caroline Yates

This study was to designed, in two parts, to investigate: 1. Whether the attributions about sexually abusive behaviour, made by staff in learning disabilities services, differed according to whether or not the perpetrator had a learning disability, and if these attributions served to hinder the identification, acknowledgement and reporting of sexually abusive behaviour performed by men with learning disabilities. 2. The number of clients referred to therapists in learning disabilities services, over a two year period, for sexually abusive behaviour, client and offence characteristics, and the referral process. Information was sought regarding therapists' perceived reasons for delayed referrals, and the impact this had on ease of treatment.

A questionnaire employing vignettes was constructed to measure staff attributions, about offenders and their behaviour, on dimensions of impulsivity, level of understanding, sexual motivation, and the extent to which behaviour was influenced by the victim, and other personal and external factors.

Results of the questionnaire were analysed using ANOVA. Significant differences in staff responses were found on all measures. Results suggest that peoples' perceptions of the perpetrator with a learning disability are less likely to invoke attributions of responsibility and blame and thus may serve to hinder the identification, acknowledgement and reporting of abusive behaviour. The results of the survey of therapists indicate that clients referred for sexually abusive behaviours share similar offence characteristics with offenders in the general population in terms of the range of behaviours exhibited, and multiple offending. These results also show that most referrals to therapists are delayed, and that the delay is perceived to be due to staff not considering the behaviour to be 'primarily sexual' in nature, and 'excusing' the behaviour because of the individual's learning disability or 'other' personal characteristics.

Links between the two parts of the study are drawn and these and other findings are discussed in relation to practice and implications for future research.

Contents

	Page
Copyright Statement	1
Title Page	2
Abstract	3
List of Contents	4
List of Tables	5
List of Figures	5
Acknowledgements	6
Author's Declaration	7
Chapter 1. Introduction	8
Chapter 2. Method	44
Chapter 3. Results	58
Chapter 4. Discussion	94
Appendix 1. Letters To Service Managers	120
Appendix 2. The Questionnaire	123
Appendix 3. The Survey	131
Appendix 4. Free Responses To Pilot Vignettes	136
Appendix 5. Letters Of Invitation To Participate And Consent Forms	143
References	145

List of Tables

Table 1. Combined Observed Means for Question 1 62

Table 2. Combined Observed Means for Question 2 63

Table 3. Combined Observed Means for Question 3 64

Table 4. Combined Observed Means for Question 4 66

Table 5. Combined Observed Means for Question 5 67

Table 6. Combined Observed Means for Question 6 68

Table 7. Combined Observed Means for Question 7 70

Table 8a Actions Following First Occurrence of the Behaviour 76

Table 8b Actions Following Subsequent Occurrence of the Behaviour 76

Table 9. Client IQ 79

Table 10. Client Ages at First Offence and First Referral 80

Table 11. Referral as a Consequence of Behaviour 80

Table 12. Victim Categories 81

Table 13. No. of Victim Categories Targeted by Clients 81

Table 14. Type of Abusive Behaviour 82

Table 15. Perceived Reasons for Delayed Referral 83

Table 16. Factors Prompting a Later Referral 84

Table 17. Perceptions of Ease of Treatment 85

List of Figures

1. Figure 1. Actions Following a 'First Occurrence' 77

2. Figure 2. Actions Following a 'Subsequent Occurrence' 78

Acknowledgements

I would like to offer my thanks to my supervisors, Helen Saxby, Kay Hughes, and Paul Robinson for their guidance during this project. Thanks are also due to John Morgan for his enthusiasm and his help.

I am also grateful to Reg Morris for his invaluable advice about statistical issues.

Many thanks go to John for his patience and support.

Finally I would like to thank all those who took part.

Author's Declaration

At no time during the registration for the degree of Doctor of Clinical Psychology has the author been registered for any other University award.

The contents of this bound volume are identical to the volume submitted for examination in temporary binding except for the amendments requested at the examination.

This study was conducted while the author was a Trainee Clinical Psychlogist in the South West Region based in Cornwall & Isles of Scilly Learning Disabilities NHS Trust, and the research was conducted with Cornwall & Isles of Scilly Learning Disabilities NHS Trust, Cornwall County Council Social Services Department and Plymouth Community Services NHS Trust.

Signed.....

Date. 26th July 1995.....

CHAPTER 1 : INTRODUCTION

The juxtaposition of sexual offending with learning disability poses something of a dilemma for services. The sexuality of people with learning disabilities has throughout history been surrounded by myths, stereotypes and prejudice. The denial, and repression of sexual knowledge and expression has been well documented. The implementation of the principles of normalisation and a growing recognition of the rights of those with a learning disability has contributed to growing freedom and acceptance in the general community. This has been accompanied by a growing acceptance of people's rights and opportunities for sexual expression. Indeed, the right to treatment and habilitation have been fought for and upheld in United States courts (Felce and de Kock, 1987) It is therefore understandable if concern exists that a focus on learning disabled people who sexually offend might reawaken some of the fears of previous years, and challenge the hard won liberalising of attitudes. Given the history of institutionalisation, denial of rights and opportunities and increased vulnerability to abuse, clients may be both offenders and victims. However, as the literature reveals, even though learning disability and sexual offending are independent of each other, the nature and prevalence of the offending gives cause for concern. Additionally, there may be particular issues in the recognition and acknowledgement of offending where the perpetrator has a learning disability.

To examine these issues, several areas of context need to be outlined. There is a wide literature regarding sexual offending in the general population but little clarity about how the findings of the studies extrapolate to offenders with learning disabilities. In order to tease out the similarities and differences it seems appropriate to outline each major area for

both the general population and the learning disabled offenders. These areas include the incidence and prevalence of offending, the characteristics and nature of offending and offenders, the development of patterns of offending behaviour and risk factors, and reoffending and recidivism. Finally, issues and influences in the detection, acknowledgement and reporting of offences will be examined. Such issues may be of crucial importance for the identification of offenders with a learning disability, the prevention of offending, and the availability of treatment for both offender and victim.

Definitions

Learning Disability

The distinction between learning disability and normal intellectual functioning is generally regarded as being the arbitrarily defined IQ score of 70, with scores below that level indicating increasing severity of handicap. Some researchers and services also take into account the individual's level of adaptive behaviour when making the distinction. Accordingly, the British Psychological Society (BPS,1991) defines learning disability as,

"A state of arrested or incomplete development of mind which involves severe impairment of intelligence and social functioning"

However, many studies reviewed here are methodologically flawed in that no clear demarcation has occurred, e.g. the intellectual span of people in some studies was IQ 55 -up to 85, thus men with a learning disability as defined by an IQ of 70 or below have been included with men of borderline to low average intellectual ability. Some studies do not

specify their definitions and so the range of intellectual levels is unclear, thus making the interpretation of their results tentative.

Sexual Behaviour

The terms *sexual offence, sexual deviation* and *sexual abuse* are not synonymous, but neither are they mutually exclusive. 'Sexual offence' is a legal concept, referring to behaviour with regard to the law. 'Sexual deviation' is a psychological concept and refers to 'persistent, predominant and unconventional sexual interest' with regard to person, object or activity (Groth & Oliveri 1989). 'Sexual abuse' is generally regarded as a clinical concept reflecting the impact on a victim through involuntary and nonconsensual sexual activity. For example an adult's sexual act toward a child is an offence. If it is mediated by a dominant sexual orientation toward children it also constitutes a deviance, and as the behaviour can be regarded as potentially harmful to the child it can also be considered abusive. Not all sexually abusive acts are a reflection of deviant sexual nature, and deviant behaviour is not necessarily abusive or illegal. In practice, a legal minefield means there is often a lack of certainty about what behaviour actually constitutes an offence.

Legally, unless actually convicted of a sexual offence, a person is not a sex offender. Groth & Oliveri (1989) suggest that this is a crucial factor in whether a client and professionals acknowledge a problem and undertake treatment, or maintain a denial that a problem exists.

Caparulo (1991) takes issue with the reluctance to label, and maintains that if someone acts in a sexually offensive way, they are an offender, regardless of legal status. His view is that the safety of society is more important than the stigma and problems of labelling.

Again, a confusion about terms reflects in some of the studies reviewed, for example some do not offer precise definitions and the terms 'sexual deviance, sexual abuse and sexual offence' may be used interchangeably. Many studies use the term 'offender' to describe an individual receiving treatment for offending even if there has been no conviction. Wyre suggests the use of the term 'illegal sexual behaviour', as deviance, abuse and offending arise from behaviour which leads to sexual gratification for the perpetrator. The *motivation* for the behaviour may not always be sexual but the context implies a sexual content in the process of doing harm to a victim.

Characteristics of Offending and Offenders.

General Population

(I) Incidence and prevalence

Home Office Criminal Statistics (1989) on sex offences for England and Wales show the numbers of sex crimes reported to police rose from 20,222 in 1984, to 29,733 in 1989. Although the overall percentage of reported offences rose by 47% during this period, some offences showed an excessive increase, e.g. gross indecency with a child rose by 170%, rape by 127% and buggery by 89%. These increases may be a reflection of changes in reporting of offences rather than in their actual occurrence. Recent concerns about spousal assault and the publicity surrounding Childline are just two factors which may have influenced reporting rates.

Perkins (1991) has found evidence of under-reporting in many categories of sexual offence including rape and child sexual abuse. However, he also found an increasing willingness to report offences and, a real increase in the prevalence of some sex crimes, particularly those involving violence.

(II) The Offence Process And The Offender

Research on the cognitions of offenders suggest that low self confidence inhibits social functioning. When low self confidence is combined with faulty cognitions and attitudes then the risk of inappropriate behaviour is increased (Marshall & Barbaree, 1990). Faulty cognitions (such as denial), by offenders leads to deviant actions and further convictions. (Samenow 1984).

Research has generally found that immediate antecedents to offending include experiencing negative mood states, e.g. anxiety and insecurity (Abel, Becker, Cunningham-Rathner, Rouleau & Murphy, 1987). The role of deviant arousal in precipitating a sexual offence is unclear. Perkins (1991) argues that systems dealing with offenders, for example the adversarial legal system, may strengthen faulty cognitions such as denial, especially with successive convictions.

Although offenders are almost exclusively male, in all other respects they are noted for their wide diversity. Maletzky (1991), in a study of 5,000 offenders concluded there were no 'definable demographic or personality traits' which distinguished them from the general population, and that a sexual diagnosis could not have been predicted without examining their personal histories.

Offenders who commit different kinds of sex crimes were not distinguished by their personality characteristics, e.g. as measured by the Minnesota Multiphasic Personality Inventory (MMPI) by Valliant & Antonowicz (1992). Although other investigators have found significant profile differences, (e.g. Panton 1978, Baxter, Marshall, Barbaree,

Davidson & Malcom 1984), the differences found were not reliable, for example not all studies found a higher degree of aggression amongst rapists. Reasons for this include the inadequacy of classification systems for the different sex offender categories,(e.g. rapists, who comprise a heterogeneous group with regard to motivation and behaviour), and overly broad sampling.

What is striking, is the number of offences committed by individuals. Marshall and Barbaree (1990), found that on average, an offender would accrue two thousand victims prior to their first conviction. Considering also that there are offenders who are never identified, even a rough estimate of the number of victims over a lifetime emphasises the enormity of the problem.

The offender with a learning disability

(I) Incidence and prevalence

National prevalence rates in the USA in 1983 of sex offenders with a learning disability were estimated as 20,000 (Denkowski, Denkowski & Mabli 1983) .However, no estimate has been found of the proportion of reported offences committed by men with learning disabilities in the UK.

Jupp (1991) reports on a pilot study in the Northwest of England to examine the extent of offending by men with learning disabilities. The study arose because the Clinical Psychology service were concerned about the increasing number of referrals they were receiving. A questionnaire was sent to nineteen health districts in the region. Of the questionnaires distributed to Health Authorities, Social Service Departments, Probation

Services, Police Authorities and Voluntary Organisations the response rate was only 40.7%. Sixteen of the replies were aware of clients with a learning disability within their district who sexually offend, seven had no involvement with the client group and ten had no information.

An analysis of the nature of the offences committed reflected the general pattern of nationally reported sexual offences. Indecent assault constituted nearly 55% of reported cases, indecent exposure nearly 20%, rape 6%, incest 6% and 'other', (which included voyeurism, bestiality and buggery), just over 15%. Of the two most prevalent offences, 9 offences of indecent exposure were against adults, and 6 against minors. 26 indecent assault offences were against adults and 19 against children. An analysis of where learning disabled sex offenders lived revealed that 36% were in the parental home, 26% in their own home, 21% were in supported accommodation, and 8% were in prison.

Unfortunately details of the questionnaire and how the survey was conducted were not described. It is not possible to ascertain whether the cases were duplicated by different replies, and whether the cases were over a restricted period of time. The term learning disability was not defined and therefore it is not known if the results included people of a wider range of intellectual ability.

With regard to men with learning disabilities it is clear that little is known about the size of the problem, and the characteristics and offence process of the learning disabled individual remains unspecified.

(II) The Offender and Offence Process

Learning disabled sex offenders have been found to have fewer victims, to offend against women less often than non-disabled offenders (50% as opposed to 89%), and display greater social skills deficits (Griffiths Hingsburger, & Christian, 1985). Although somewhat dated now, Gebhard, Gagnon, Pomeroy & Christenson's study (1965) found learning disabled people were over-represented among child sex offenders.

Caparulo et al (1988) argued that the pattern in offending behaviours of learning disabled men were markedly similar to those of the non disabled, and differed only in the degree of sophistication. For example, various cognitive distortions such as victim blaming, stereotypic judgements about women, and minimisation and denial of offences were equally common. Murphy Coleman & Haynes(1983) demonstrated patterns of deviant arousal similar to those in rapists and child molesters of normal intellect. However, this study included participants in the 'retarded' group who were of borderline intellectual ability. In common with men of normal cognitive functioning, aggressive sexual offending is not a result of sexual frustration, but may also be a dysfunctional method of gratifying needs for control and power (Groth, 1979).

Murphy et al (1983) found that intelligence was negatively correlated with 'rape myth acceptance (-.54), sex stereotyping (-.42), adversarial sexual beliefs(-.42), sexual conservatism (-.60) and acceptance of violence against women (-.46). Although methodological information was not available, this superficially lends evidence to the importance of socio-sexual education. However, such tests are highly likely to be

transparent to more intellectually able people, and therefore liable to be contaminated by response bias disfavouring the less able.

In general the evidence points to greater similarities than dissimilarities between learning disabled and non-learning disabled offenders. However, research to illuminate the subtle differences is still in it's early stages and is complicated by methodological difficulties such as the problems of using standardised assessment batteries and the reliability of memory and verbal reports. Ethical issues have also created additional caveats for research with the learning disabled offender e.g. the need to demonstrate that an individual's rights to informed consent are not violated (Noonan & Bickle, 1981).

Demetral (1994) pointed out the importance when working with learning disabled offenders of detecting what Hingsburger, Griffiths & Quinsey (1991) refer to as 'counterfeit deviance'. This term refers to sexual behaviour which whilst appearing deviant, on investigation can be attributed to factors such as poor information about sexuality and expression, experience of sexual victimisation, inadequate social and assertion skills, medication side effects and restricted opportunities to develop more appropriate relationships. Many clients may have adaptive behaviour deficits which are associated with long term institutionalisation. Inappropriate sexual behaviour, it is argued, may thus be attributable to a skills deficit through insufficient and normatively adequate learning opportunities. However, there have been no studies which have aimed to clarify the proportion of offences which might have arisen through 'counterfeit deviance'. Additionally, these same factors also apply to many sex offenders who do not have a learning disability. Marshall (1989), for example, demonstrated that loneliness, and problems with social

competence and intimacy were characteristic of offenders in the general population. This raises two main issues. Firstly, men who have a learning disability may be doubly vulnerable to developing problems through restricted lifestyles and opportunities. Additionally it begs the question of when and how does 'counterfeit 'deviance become 'clinical' deviance and indeed whether such a distinction is feasible. However, this range of contributory explanations of the behaviour have important implications for the classification, prevention and treatment of identified problems.

Problems in addition to learning disability have been found in many offenders. Such problems include impulsivity, aggression, - possibly through poor coping skills, (Murphy, Coleman & Haynes 1983) , social skill deficits, acquiescence and poor assertion skills (Aadland, Afwerke & Schumacher 1988), and poor sense of self worth (Caparulo et al 1988). Additional difficulties may be created when there is a dual or multiple diagnosis. Problems such as organic encepholopathy, schizophrenia and personality disorders may all produce 'symptoms' which include sexual offending behaviours and impulse control difficulties (Gilby, Wolf & Goldberg, 1989). Sex offenders, even within one type of offence, are not a homogenous group, whether or not they have a learning disability. Offending behaviour is the result of a heterogeneous set of background factors, amongst which learning disability is, arguably, just one such factor.

Adolescent Sex Offenders

Evidence suggests that many sex offenders, both with and without a learning disability, begin their offending careers during adolescence, and not infrequently, in childhood. As

this has important implications for recognition, prevention and treatment this area warrants a brief review.

General Population

An apparent rising trend of sexual offences committed by under 18's has been reported . American data shows that 20-30% of rapes and 30-50% of child sexual abuse are committed by adolescents (Davis & Leitenberg 1987, Fehrenbach, Smith, Monastersky 1986). In Canada it is estimated that 25% of sexual offences are perpetrated by adolescents and that one in seven of those imprisoned for offences against children are under the age of 21 (Matthews 1987). However, it is debatable whether there is an real increase in the number of offences perpetrated by adolescents, or whether perpetrators are being identified earlier in their offending careers.

Many adult offenders commenced offending during adolescence. Davis & Leitenberg (1987) found 50 % of adult offenders committed their first offence during adolescence. Hanson & Slater (1988), found 21% of offenders in a study reported abusing from adolescence, although when lie detection procedures were introduced, (polygraph), 71% said they had started abusing during childhood or adolescence.There is evidence that at least 35% of rapists and molesters progress from non-violent to more serious assaults between adolescence and adulthood (Longo & Groth, 1983, in Gilby, Wolf & Goldberg 1989).

Evidence then strongly indicates that offending frequently begins in adolescence, and even during childhood, setting a pattern that continues into adulthood which, for a substantial

proportion of offenders, includes a progression to more serious forms of abusive behaviour. Given the number of victims accrued prior to first conviction, the early identification of offenders becomes a crucial issue.

The Adolescent Sex Offender with a Learning Disability

Gilby, Wolf and Goldberg (1989) conducted a comparative study on learning disabled and non-learning disabled adolescent offenders. The results were congruent with other findings in that there were a high proportion of offences against children, and that offences were often committed from more than one category,(e.g. 'courtship disorders', 'sexual assault' and 'pedophilic offences'). No differences were found, in this respect, between the learning disabled and non-handicapped groups. However, whereas the offenders of average intellect mostly offended against females, both males and females were equally likely to be the victims of the learning disabled offenders. Although 'courtship disorders' were common to both groups, same age or older victims were more common for the learning disabled offender. Victims who were 'not known' to the victim were more common to the learning disabled offender. These findings are interesting considering that many people with learning disabilities have been regarded as, and treated like children yet it is suggested the preference is for same age or older victims. Additionally, the lives of many handicapped adolescents are heavily supervised, and contain few opportunities to meet new people, thus the finding that victims are less likely to be 'known' is surprising.

Marshall (1983) found the learning disabled adolescent sex offender as frequently aggressive toward adults as well as children, and that repeated offences were likely regardless of the consequences for the individual.

The evidence suggests that for many sex offenders, both with and without a learning disability, that their offending careers start during adolescence. A sizeable minority will progress to more serious sexual crimes, and as previously mentioned, each offender may have numerous victims prior to their first conviction, typically not until in their twenties, although the offender with a learning disability is likely to accrue less victims. Clearly, early identification of perpetrators has important ramifications not only for prevention, but also for legal and treatment issues.

Risk of Offending

There have been views expressed for both an increased risk of offending for offenders with a learning disability, (e.g. Berdiansky & Parker 1977, Griffiths et al 1985) , and a lowered risk. Investigations of actual rates of offending are inconsistent. Walker & McCabe (1973) found that over half (59%) of the sexual offences committed by patients subject to Hospital Orders under the 1959 Mental Health Act were performed by men classified as 'subnormal'. Henn, Herjanic and Vanderpearl (1976) found there was a higher incidence of learning disability amongst child molesters. Murphy & Coleman & Haynes (1983) concluded that a majority of reports indicated that 10-15% of those exhibiting sexually deviant behaviour were learning disabled.

These findings were contradicted by Gostason (1985) and Swanson & Garwick (1990) who concluded that men with learning disabilities were no more likely to commit offences than men in the general population. Groth (1978) reported that child molesting (i.e. non-violent sexual offences against children) were no more likely to be committed by men with learning difficulties than by men of normal intellect. Mohr, Turner & Jerry (1964) contended that

only 3-4% of pedophilic and exhibitionistic offences were committed by developmentally disabled people. Verba, Barnard and Holzer (1979) and Wolfe and Baker (1980) found no correlation between intelligence and the type of offence committed. Perdue and Lester (1972) showed that sex offenders were not typically learning disabled although tended to have low intelligence. Thus, it seems, there is no clear evidence for either an increased or decreased risk of offending for learning disabled men.

There are suggestions that the learning disabled man is more likely to be caught offending, thus inflating the incidence rates for this group. Yet, the evidence is that the learning disabled perpetrator is less likely to be referred for prosecution, and therefore be convicted, unless offending is both repeated and severe, (Charman & Clare 1992). In some areas, California for example, men deemed 'incapable' of standing trial are offered community treatment rather than conviction and a custodial sentence, (e.g. Demetral 1994). This suggests that the incidence of offending behaviour of learning disabled men, as determined by convictions, is under-reported, which might explain why several investigators have concluded a lower risk of offending. However, there is evidence to suggest that if a man with learning disabilities is *arrested* for an offence, that offence is most likely to be sexual in nature (e.g. Gross 1985, Landesman-Dwyer and Sulzbacher 1981).

To offend, an individual must overcome several strong social sanctions. Finkelhor (1984) refers to several 'preconditions' for abuse. Firstly, he suggests, the person must be predisposed to abuse. As already discussed there are a wealth of background factors and life experiences which may predispose an individual and that some, such as those with a learning disability may be especially vulnerable. Secondly the person must overcome

internal inhibitions against offending. These internal inhibitions arise from societal sanctions against certain forms of behaviour. The less aware of sanctions an individual is, e.g. through poor learning opportunities, the easier transgressions of sanctions become. Thirdly Finkelhor suggest, external restraints against abusing must be reduced. For many people with a learning disability these restraints may be blurred. For example, compared with their non-handicapped counterparts, they may have had frequent experience of others helping them with more intimate care tasks, and for longer. The boundaries between acceptable and non-acceptable touching then become less easy to define. A fourth precondition is that the victims own restraints and protections must be overcome. As discussed later, there is evidence to suggest that people with a learning disability have fewer restraints and protections making them more vulnerable as victims. It would appear then that for men with a learning disability there may be an increased vulnerability to meeting the preconditions to abuse, thereby increasing the risk of offending.

At present it would appear there is no incontrovertible evidence for either an increased or decreased risk of offending by men with learning disabilities. Studies of apprehended offenders will include a disproportionate number of people who are unskilled in avoiding detection,arrest and prosecution so conclusions based on apprehended populations will always be subject to criticism. Thus, there is a need to attend to full range of problem sexual behaviours in addition to those which lead to apprehension of the offender.

However, Schilling and Schinke (1989) suggest that the life experiences of people with learning disabilities, coupled with the evidence that when arrested it is most likely to be for a sexual offence, may translate into increased risk for certain types of sexual offence. Such

life experiences include poor opportunities for learning about and developing social and sexual relationships, low self esteem, and increased vulnerability to sexual abuse (Walmsely, 1989) As previously noted, these factors relate to the etiology of sexual offending in the ordinary population. Alternatively, there may not be an increased risk of offending, and patterns of illegal sexual behaviours over time may differ from those of sex offenders without a learning disability, even within different sex offender typologies. This has yet to be evaluated. However, the evidence that offences *are* committed is sufficient for learning disability service providers to address the treatment needs of these clients.

Reoffending and Recidivism

General Population

A clear picture of reoffending and recidivism is hard to find. Reoffending, which is the repeat of the original or similar offence, is often not isolated from recidivism, which is the perpetration of any offence not necessarily a sex crime. Figures often include men who have received no treatment along with those who have. Numerous treatment programmes have used different criteria of successful outcome, relapse and reoffending, thus making comparisons difficult. Moreover, as offenders are not an homogenous group, recidivism and reoffending varies between types of offenders, for example men who offended against strangers were found to be five times more likely to fail in a treatment programme than those offending against victims known to them, and those with multiple paraphilias were more likely to reoffend than those with a single diagnosis, (Maletzky, 1991). However, the differential results may be less due to any intrinsic features of the offender, but more to do with how the individual's problem is conceptualised and, the appropriateness and relevance of the treatment. For example, when the focus was changed from dealing with sexual

problems to relationship problems for a group of child molesters, treatment was more effective (Marshall et al, 1990, August).

The Offender with a Learning Disability

Recidivism rates for untreated offenders with a learning disability have been reported to be up to 60% within the first year (Association for Retarded Citizens, Austin 1984). However, the same cautions must be used in interpreting studies of reoffending and recidivism as with offenders in the general population Nevertheless, substantial savings in legal and treatment expenditure and emotional and psychological harm can result from even minimal reductions in recidivism rates (Prentky & Burgess 1990), and so they are an important focus of attention.

To date there have been no studies which have directly contrasted the recidivism or reoffending rates for learning disabled and non-learning disabled men, therefore differential rates may be due to many other factors, including lack of treatment equivalence rather than inferring fundamental 'treatability' differences.

Interaction between the care system and behaviour

Etiology And Maintenance Of Sex Offence Behaviour

Associations have been found between offending and various factors. Both paraphilias and offending behaviour have been associated with sexual abuse as a child (Quinsey 1986, Johnson 1984), restrictive and punishing sexual experiences, (Walen 1985), early conditioning to deviant stimuli, (Money 1985), unavailability of, or difficulty maintaining

relationships with appropriate partners, (Berman & Friedman, 1961) family dysfunction, inadequate social skills and sexual knowledge, (Sgroi, 1989), social and vocational isolation (Haaven et al, 1990), patterns of cognitive distortion (Griffiths et al 1989) and a variety of genetic abnormalities. The etiology of offending is still unclear, with an interaction of socio-economic, cognitive, behavioural, emotional and organic variables being implicated.

Many professionals feel that learning disabled sex offenders are created by the systems which are ostensibly devised to care. A majority of rapists and child molesters with a learning disability appear to have been initiated into sexual activity by caregivers or family members. The Seattle Rape Crisis Center statistics (Ryerson 1981), showed that 80% of the sexual offences against learning disabled men were perpetrated by 'professional staff'. Only 1% were perpetrated by strangers. As previously mentioned there are numerous risk factors which may predispose a person to offending, and these factors may be created and maintained by the care systems for people with learning disabilities.

Caparulo (1991) suggests that for many years, professional systems have not known how to deal with the learning disabled sex offender. The consequence has been containment rather than treatment, resulting in the offender having the opportunity to maintain his deviant arousal by 'preying on more vulnerable residents' . He claims that many institutions have thus facilitated the offender, strengthening their offending behaviour, and contributing to the victimisation of persons supposedly accommodated for their own safety.

Summary

Despite somewhat conflicting findings at times, the evidence suggests that men with learning disabilities are at some risk of developing offending behaviours, and that the range and nature of the abusive behaviours will differ little from those perpetrated by the offender in the general population, although the total number of victims is likely to be fewer for the learning disabled offender. Sex offences are considered by the general public to be one of the most serious of all crimes, indeed making sexual advances to young children was ranked as the most serious of all crimes by British citizens (Banister and Pordham, 1994). However, as suggested by the literature there is a reluctance to acknowledge and label men with learning disabilities as offenders. The next section will seek to outline ways in which peoples' opinions, beliefs and attitudes might influence this phenomenon and set the background for this study.

Attitudes toward people with a Learning Disability and Sexuality

At the end of the last century, fears arose that the sexual reproduction of the 'dull' would lead to a lowering of the nation's intelligence. Fired by the Eugenics movement, social policies were introduced which segregated the 'mentally defective' from the rest of society, and widely endorsed sterilisation. Evidence that children with learning disabilities continued to be born, despite these policies, was apparently ignored, e.g. as recently as 1978, 686 sterilisations were performed in Ontario on people who were unable to give their consent, (Evans 1980).

There has been increasing recognition that learning disabled people were 'sexually oppressed' (Kempton, 1977a). The United Nations passed a Bill of Rights (1971), with

regard to people with learning disabilities, which advocated the same rights as available to the general population, and support to facilitate the realisation of those rights.

A wealth of research exploded various myths about the sexuality of learning disabled people, for example that they were asexual, non-sexual or overtly sexual (Abelson & Johnson, 1969). Despite it being shown that there was an overwhelming similarity in sexual response to the general population, information about sexuality continued to be denied, and a higher standard of 'moral behaviour' was expected (Greengross, 1976).

With the widespread adoption of the principles of social role valorisation, the sexual rights of people with learning disabilities have gained greater acceptance. However, sexuality in general is still, in western cultures, largely ignored (Foucault, 1976), and when combined with learning disability and the stereotypes held about it by the general public, then the stigma and taboo may well be increased (Craft, 1987). Indeed, despite the trend toward a liberalising of views, and the fostering of more positive views towards people with learning disabilities, their sexuality remains a sensitive, emotive and controversial area (Johnson 1984) and opportunities to learn about and develop intimate relationships are still not widely endorsed (e.g. Zetlin & Turner 1985). Indeed, where education and opportunities are limited, individuals run the risk of vulnerability to abuse and the development of socially inappropriate behaviours. The extent to which people have been enabled to learn about relationships and sexuality, and take responsibility for their own sexual behaviour, is therefore questionable.

Vulnerability to Abuse

It has recently been acknowledged that people with learning disabilities are more vulnerable to various forms of abuse, including sexual abuse, (e.g.Turk & Brown 1993). Considerable knowledge has been gained about factors which influence vulnerability to sexual abuse, e.g. lack of sexual knowledge, dependency on caregivers, multiple carers, limited communication, behavioural difficulties, a focus on compliance training (Turk & Brown 1993) and also the beliefs which still prevent people from 'thinking the unthinkable' , for example that they are objects of pity and unattractive (Brown & Craft, 1989).

In their British study, Turk and Brown (1993) found that 42% of reported incidents of abuse were perpetrated other learning disabled service users, who were predominantly male. This then constituted the highest group of abusers, with family members responsible for 18% of reported cases, staff/volunteers 14%, other known adults 17% and unknown others 10%. In addition to indicating that learning disabled men formed the largest group of abusers this study also raised several issues in the detection of abuse.

Issues in Detection and Reporting of Offences

Early identification of offenders and recognition and acknowledgement of offences is key to prevention and reduction in the number of , and degree of harm to, victims. The importance of early identification and treatment has been stressed in the recent government report on services for mentally disordered offenders (Reed, 1994).

Again, studies from the general population provide a valuable insight into some of the issues, and although these may also be applicable for offenders and victims with a learning

disability such assumptions are premature. Therefore the two areas need to be reviewed separately.

General Population

The reactions of others can play a significant part in whether a victim reports an offence or maintains a secrecy, and whether the abuse is acknowledged and acted upon. Jehu (1989) reports factors helping maintain nondisclosure as including fear of disbelief or of being blamed, fear of or actual physical violence from the abuser, fear of being taken away from home. In a study of 27 female victims of abuse prior to the age of 17 Jehu (1989) examined the reactions of significant others to disclosures. These included denial of abuse (63% of victims), anger and hostility toward the victim (59%), denial of impact on victim (51%) disbelief of victim (48%), and pressure on victim to withdraw allegations (44%). Similarly negative reactions to disclosures of abuse have been reported where victims are males (Finkelhor, 1984). Other researchers have found more positive reactions from significant others, for example Russell (1986) found comparatively more positive reactions of mothers to their daughters disclosures than Jehu's study.

In 1990, a Working Party set up by the Professional Affairs Board of the British Psychological Society published a report regarding child sexual abuse. They outlined several popular myths and misconceptions about child sexual abuse: -

- 'that children tell lies about their sexual abuse'
- 'that children fantasise the details of abuse'
- 'that some children deliberately provoke adults into sexual acts'
- 'that child abuse is a relatively recent phenomenon'.

Such misconceptions can clearly influence whether disclosures are believed and acted upon, or whether the behavioural and emotional sequelae of abuse are recognised and acknowledged.

The offender with a learning disability

Turk and Brown (1993) found that unless disclosed by a client, (67.9% of cases) sexual abuse of people with learning disabilities often went unrecognised. Only 12% and 6% of cases were identified by residential and day centre staff respectively, with 'other professional ' 2.4% , and 'family member' 3.6%. This raises concerns about the likelihood of abuse being detected and reported where the victim has a learning disability.

As Turk & Brown found then, many instances of abuse go undetected by others. They suggest this is more likely when the behaviour occurs behind closed doors, and when the victim has experienced chronic abuse, and when people around the victim are unaware of the signs and symptoms of abuse. Single cases of abuse are more likely to be discovered than ongoing long term abuse where there may be higher tolerance by victim, or history of not being believed, and greater attention may be paid to the maintenance of secrecy.

Turk & Brown further provide evidence to suggest that reported abuse is merely the 'tip of the iceberg' and describe how cases are progressively filtered out. Firstly, abuse must be **recognised**, and as seen from their results, unless disclosed by the victim, abuse is infrequently recognised. Incidents not known, disbelieved or minimised, will not be reported. The abuse must then be **reported**. However, even if recognised , believed, or acknowledged as significant, the abuse may not be reported for a variety of reasons, (e.g.

fear of scandal, protection of the alleged perpetrator). If reported, then the case then has to be **responded** to, i.e. some form of action taken. If **recording** of the facets of the case does not then occur, further filtering occurs. Finally, **remembering** of cases and their details has to occur. The effect of this filtering can perhaps be demonstrated by the finding that in 48.2% of the cases reported in their study, there was no action taken against the perpetrator

Hard and Plumb (1987) reported a study where 64% and 40% respectively of women and men with learning difficulties had reported their abuse. For a majority of the women these were multiple abuses whereas 80% of the men reported single instances only. However, 55% of the women reported their disclosures were disbelieved, whereas all the men reported that they were believed. These results mirror several personal experiences where female learning disabled clients have reported being sexually assaulted or raped by men with learning disabilities. In these instances the women, despite obvious distress, were either thought to be fabricating their allegations, or to have incited the man to commit the assault. However, in contrast to Hard & Plumbs study, personal experiences also include instances where male clients disclosing abuse have been disbelieved or their experiences have been minimised and various 'justifications' have been found to explain events. Obviously this has serious implications for identifying abusers, as well as acknowledging and treating victims, regardless of their sex.

Even if the signals are picked up, or a disclosure made, they may be interpreted differently if either the offender, and / or victim, has a learning disability because of attitudes and attributions an individual holds about disability the individual, and the situation, including

their knowledge, if any, of the victim. In the absence of clear definitions of abusive behaviour staff and carers may rely on their own idiosyncratic definitions based on their beliefs about sexual behaviour in general, (for example, recent personal experience includes an instance where staff were unable to believe that a woman with learning disabilities had been raped because her clothes had not been torn).

Beliefs about the sexuality of people with learning disabilities may also influence the judgements made by others. For example Sgroi (1989) cites an instant where a man with learning disabilities had repeatedly been found naked, and rubbing the genitals of male and female people with whom he shared a house. Despite the screams and torn clothing of the victims, staff did not report the incidents as they did not believe the behaviour to constitute a sexual assault because the perpetrator was not observed to have had an erection during these incidents.

Failure to recognise or acknowledge abusive behaviour may result from a reluctance to believe that a learning disabled person has sexual feelings or desires. There may still exist a tendency to infantilize, and thereby desexualise, people with learning disabilities. As Sgroi (1991) suggests in her discussion of offenders with learning disabilities, 'the wishful expectation that physically normal adults will not have or act upon sexual feelings or desires can be a covert barrier to recognising sexual offence behaviour when it occurs.'

Other researchers and clinicians have noted how beliefs about disability can interfere with the recognition and acknowledgement of sexually abusive behaviour. Griffiths et al (1989) reported that frequent barriers included carers' beliefs that the person did not understand

what he had done, that learning disabled people act impulsively, and that they act their mental age and so rather than be considered sexually harmful, their behaviour should instead be construed as 'sexually curious or playful'.

How beliefs about the victim might influence judgements are less well illustrated. No studies could be found regarding the influence of victim age and sex and other characteristics on the recognition and acknowledgement of sexual abuse by men with learning disabilities. Again, extrapolation from findings in studies of the general population is problematic, but it provides ideas. The phenomenon of 'victim blaming' for example, demonstrates that a victim who suffers severe consequences is considered as more blameworthy than one who experiences milder consequences. Thus, female rape victims who were either virgins or married were seen as more responsible for their fate than divorcees who were perceived as less respectable and therefore as suffering less serious consequences (Jones and Aronson, 1973). The perceivers belief in a just world is more seriously threatened by the rape of the 'less deserving' victim and so there is an attempt to rationalise the injustice by attributing responsibility to the victim rather than the perpetrator. Victim blaming, however, depends not only on the victim but on the observers' perceptions of the perpetrator and whether the observer identifies with the victim or the perpetrator. Attribution theory elucidates these issues and provides a model for understanding how observer perceptions of the perpetrator may differ according to whether or not he has a learning disability.

Attribution Theory - 'Responsibility' and 'Blame'

Attribution theories suggest that people seek to identify causes of behaviour as causal knowledge enables us to perceive the world as more stable, controllable and predictable (Fincham & Jaspers, 1980). 'Responsibility' for specific actions tends to be attributed when there is an identifiable source for the action (e.g. a person), a belief that the source person could foresee the consequence of the action, the perception that the actions were not justifiable in the situation, and the perception that the actor had a choice. Attributions of 'blameworthiness' are usually reserved for when the causal agent is regarded as subject to censure or punishment and when the event has a negative, rather than positive, consequence. Many studies have used the terms 'responsibility' and 'blameworthiness' interchangeably, although there is some evidence that people perceive them as distinct concepts (Shaver & Drown, 1986). For the purposes of this study it was felt important to maintain the difference between 'responsibility' and 'blame'.

Shaver (1975) suggested that, when making attributions about responsibility, several factors come into play: the contributions of the environment, the actor, and the observer's own personality traits, cognitive sets and motivations.

Considering the actor and the situation, assignment of responsibility will, in part, depend on the degree of perceived intentionality on the behalf of the actor. Jones and Davis (1965) maintain that the imputation of intentionality requires certain minimum assumptions about knowledge of likely consequences, and ability to bring about the action, on the part of the actor. Thus if the actor's knowledge and/or ability was perceived as lacking, then there

outcome was negative. Thus attributions of responsibility presuppose judgements of causality, and blame attributions presuppose judgements of both causality and responsibility. The degree to which an individual is perceived to be responsible, and ultimately blameworthy, depends then on factors such as: perceptions of the actors ability, intention, personal disposition, and the perceived contribution of external, environmental factors such as the influence of the target. These factors will be mediated by the observers own beliefs, attitudes and cognitive sets.

As the clinical literature and personal experience reveals, there are numerous accounts of instances where carers and staff have failed to recognise or acknowledge abusive behaviour, it's sexual nature and it's impact on the victim. Typical attributions, described in the clinical literature, about the abusive sexual behaviour of men with learning disabilities include impulsivity and lack of intention (or lack of harmful intention), and poor understanding. Thus, the failure to recognise and acknowledge abusive sexual behaviour could be explained by the nature of the attributions staff and carers make about learning disability, sexuality, the situation, the individual perpetrator and their behaviour, etc. The attitudes and beliefs that people hold about people with learning disabilities and their sexuality, influences attributions about responsibility and blame, i.e. learning disabled people are less likely to be held responsible or blameworthy. In order to understand the behaviour then, alternative explanations will be sought. These may be, for example, to attribute responsibility to the victim, other predisposing personal or external situational factors, and/or to minimise the importance or sexual nature of the behaviour. As the attribution literature suggests, people's explanations of events can be subject to a range of biases.

In the same way that sex offenders use cognitive distortions such as denial and minimisation to excuse their behaviour (Murphy, 1990), it could also be suggested that staff and carers of people with learning disabilities also employ cognitive biases and distortions, albeit of a different kind, to avoid the recognition and acknowledgement of such an emotive possibility as sexual offending with all the repercussions which that might entail.

Institutions and professionals have been reluctant to accept the fact that sexual offending is a problem for the learning disabled, (Caparulo,1991). Caparulo reports frequently experiencing reluctance on the part of institutions to have people labelled as offenders, usually for benevolent reasons such as preventing further labelling stigma .This is understandable given the changes in attitudes toward learning disabled people and the refutation of the various myths surrounding their sexuality. However, to fail to accept that sexually abusive behaviour occurs is to deny the problem, not just for the abuser, but also his victims. Accepting the problem however, relies on the identification of abusive behaviours and an acknowledgement of their impact. However, as Turk and Brown (1993) pointed out, many factors influence this process with filtering occurring at this identification stage and at subsequent points in the process resulting in the under-reporting of offences. Attribution theory suggests ways in which the identification and acknowledgement of abusive behaviour might be compromised. The frequent outcome is that people, both abuser and victim, are not then provided with treatment opportunities, and the risk of further offending remains high. The recognition of abusive behaviour and an acknowledgement of its impact are therefore crucial in responding to the needs of the offender and victims.

This study therefore sets out to examine two key issues. Firstly, it seeks to explore the ways in which attributions may influence the identification and acknowledgement of abusive behaviour where the perpetrator is a man with a learning disability. Secondly, it attempts to outline the extent and nature of offending behaviour demonstrated by learning disabled men in the Plymouth and Cornwall area, and factors influencing their referral for assessment and treatment, such as perceived reasons for delayed referrals. Thus, the study consists of two parts; a questionnaire regarding attributions and a survey regarding the incidence and nature of offending and the referral process.

PART 1. THE QUESTIONNAIRE

Comparisons between Perpetrators with and without a Learning Disability

As presented above, the attributions made by staff/carers about abusive sexual behaviour demonstrated by men with learning disabilities, may serve to minimise the seriousness or sexual nature of the act and also serve to reduce the degree of responsibility and blame attributed to the individual. This might be through attributing responsibility to other personal, internal, factors, (e.g. low self-esteem), other external factors (e.g. lack of appropriate opportunities), the victim's influence, poor understanding and impulsivity. It might therefore be expected that attributions about the individual and their behaviour might differ from those where the offender does not have a learning disabilities. Additionally, it might be expected that if the attributions serve to minimise or desexualise the behaviour of the learning disabled offender, that this might be reflected in less concern regarding the recurrence of the behaviour when compared with non-learning disabled offenders.

In order to explore these predictions it was decided to employ a series of brief, written vignettes describing an actor behaving toward a victim in a manner which might be construed as sexually abusive. The actor would be described as either having, or not having, a learning disability. Studies employing vignettes have shown them to be a straightforward and economic method, and one which is easy to administer (Hamilton, 1993). Vignettes would be followed by a series of questions regarding possible attributional explanations for the behaviour, (See Appendix 2) The responses to these questions would be measured by a 5 point Lickert type scale where participants indicate their opinion on each continuum. Additional questions would ascertain, from a range of response options, the action that participants might take following the occurrence of the offender's behaviour depending on whether or not the behaviour was the first known occurrence of that behaviour for the actor, or a subsequent occurrence.

Hypotheses

It was hypothesised that:

1. Learning disabled actors would be rated as more impulsive in their behaviour than men without a learning disability.

2. That actors with a learning disability would be rated as having less understanding of the consequences of their behaviour than those without a learning disability.

3. That learning disabled actors would be less likely to have their behaviour rated as due to sexual thoughts and feelings than those without a learning disability.

4. That the learning disabled actors would be more likely to have their behaviour attributed to other personal (internal) factors than those without a learning disability.

5. That learning disabled actors would be more likely to have their behaviour rated as influenced by the other person than those without a learning disability.

6. That actors with a learning disability would be significantly more likely to have their behaviour attributed to other, external, factors, than those without a learning disability.

7. That for the actors with a learning disability there would be significantly 'less concern about the recurrence of the behaviour' than for those without a learning disability.

8. The actions participants would endorse following a 'first occurrence' of a likely sexually abusive act would, where the actor had a learning disability, favour speaking 'directly to the actor', and to' inform/consult from professionals'. The action endorsed for non-learning disabled men would favour informing the police.

9. The actions participants would endorse following 'at least the second occurrence' of the behaviour would, where the actor had a learning disability, still be less likely to be referred to the police than the non-learning disabled actor.

PART 2. THE SURVEY

Evidence suggests that there are more similarities than differences between learning disabled and non-learning disabled men in the patterns of offending, e.g. behaviour starting in adolescence, multiple victims and types of sexual acts, and a trend towards more serious behaviours over time. The survey sets out to provisionally outline the characteristics of learning disabled men referred locally for assessment or treatment regarding these patterns. Additionally, therapists' perceptions of reasons for delayed referral were sought. This information might further clarify the factors which influence the identification and recognition of abusive behaviour and subsequent referral for treatment. This part of the study therefore provides a link with the more experimental approach of the questionnaire. As sexually abusive behaviour may strengthen over time, therapist views regarding ease of treatment in relation to the person's history of offending and referral were sought.

The survey included demographic information about referred clients, e.g. age and age of first known offence, and first referral, and IQ score. Additionally therapists were requested to indicate from a range of response options their perceptions of reasons for referral, and any delay in the referral process. Therapist views on the ease of treatment were also sought.

Hypotheses

From the survey of therapists of learning disabled men referred for the assessment or treatment of sexually abusive behaviour it was hypothesised that:

1. The first known offence was likely to be during adolescence or early twenties.

2. That the first known offence was likely to have occurred at least a year prior to referral to professional services for assessment or treatment.

3. That referrals for assessment /treatment would be more likely to be in response to a 'subsequent' rather than 'first known' abusive act.

4. That more than 25% of referred clients would be likely to have targeted more than one type of victim, e.g. child and adult.

5. Where referral was not prompted by the 'first known' offence, the reasons endorsed by therapists to explain this would most frequently be:- non-detection/reporting of the behaviour, staff/carers not considering the behaviour to be serious in nature, and toleration or minimising of the behaviour, and not considering the behaviour to be primarily sexual in nature, and staff/carers estimating a low risk of recurrence.

6. That the reasons endorsed by therapists to explain a 'later referral' would most frequently be: reoffence, the occurrence of more serious illegal sexual behaviour, and staff/carers considering there to be a high risk of further abusive behaviour.

7. That where referrals were 'later', therapists would endorse statements suggesting that earlier referral would have made treatment 'easier'.

CHAPTER 2 : METHOD

PART 1. THE QUESTIONNAIRE

1. Design

Participants responses to short written vignettes desribing an actor performing a specific behaviour toward a target person were to be assessed. Vignettes were selected as they are convenient to develop and administer and have been shown to produce reliable and valid results (Hamilton, 1993). In order to test the hypotheses, between subjects comparisons would be made between responses to vignettes in which the actor had a learning disability (Condition 1), and those in which he was non-learning disabled (Condition 2). Within each condition, there were two groups of participants, each receiving a vignette for each of 6 victim types. Three of the vignettes would describe a behaviour involving physical contact with the target, and three describe a behaviour which involved no contact with the target. Where participants in one within-condition group would receive 'Contact' vignettes for three of the victim types, participants in the other group would receive the 'Non-Contact' veignettes, and vice versa. This was in order to minimise the problems associated with task transparency and is discussed in more detail below.

2. Materials: The Vignettes

Given that victims are likely to be of both sexes, adults, adults with learning disablities, and children, it was decided to devise six vignettes, one for each category of victim:

- male adult
- female adult
- male adult with a learning disability

- female adult with a learning disability
- male child
- female child

Children with learning disabilities were not included as compromises needed to be made regarding the length of task presented to participants.

It was felt that, if participants received vignettes regarding both types of actor, this would make it easy to guess the purpose of the study which might then produce a response bias. It was therefore decided that the design should be between subjects, with one group of participants receiving only vignettes where the actor had a learning disability and the other group receiving only those where the actor was non-learning disabled.

To enable some comparisons between victim categories, the vignettes needed to be equivalent or identical. It was decided that differing vignettes of equal equivalence in, for example, severity of abuse, would be difficult to devise. Therefore the vignettes for each victim group needed to be identical, thus enabling comparisons.

However, the need for identical vignettes introduced a further problem of task transparency. If each participant were to receive six completely identical vignettes, it was more likely that participants would infer that comparisons were to be made between victims. Again, this might produce a response bias. To overcome this, two different sets of vignettes (Contact and Non-contact) were devised for each victim. One set of vignettes described a behaviour involving direct physical contact with the victim, the other set described a behaviour not involving physical contact. A participant receiving the Contact

version for one victim type, (e.g. male adult), would therefore receive the Non-contact vignette for that victim's counterpart, (e.g. female adult). Thus, each participant would receive one vignette for each victim, with 3 Contact and 3 Non- Contact vignettes.

This meant that within each condition, (Actor Learning Disability and Actor Non-Learning Disability) there were two groups of participants, each receiving a vignette for each victim, but with Contact varying between the groups. The vignettes received by the two groups within each condition then were:-

Male Adult (Contact)	Female Adult (Contact)
Female adult Learning Disabled (LD) (Contact)	Male adult Learning Disabled (LD) (Contact)
Female Child (Contact)	Male Child (Contact)
Female Adult (Non-Contact)	Male Adult (Non-Contact)
Male Adult LD (Non-Contact)	Female Adult LD (Non-Contact)
Male Child (Non-Contact)	Female Child (Non-Contact)

The specific descriptions of behaviour in for the vignettes were chosen for several reasons. During an initial pilot a choice of several vignettes was made available to participants. The two selected for the final questionnaire were considered to be relatively likely to occur, and therefore have face validity, and also to possess a sufficient degree of ambiguity in that a range of alternative explanations might be made for the behaviours.

Additional information about the actors, the situation and the behaviour was to be included in order to improve the face validity of vignettes. However, there is evidence to suggest

that such additional information can have a marked effect on the attributions made about individuals and their behaviour which would reduce the likelihood that individuals were attending to the key points rather than the extraneous information (Shaver, 1975). With these considerations in mind, vignettes contained the following information:-

- Actor's identifying initial and, where applicable, a statement regarding his learning disability
- Situational information, i.e. that the actor approached the target in a secluded place
- A description of the target's characteristics including sex, age range and, where applicable, a statement regarding their learning disability.
- A description of the behaviour performed by the actor.

It was decided to identify actors by an initial rather than a name after a participant commented that associations with certain names might influence responses. The situational information aimed to be neutral in that it did not imply that the actor intentionally followed the target, but indicated that the behaviour occurred in relative privacy. Children's ages were specified, and constant across vignettes. These brief vignettes proved to be acceptable during piloting.

3. The Measures

Questionnaire: Questions 1-7

The items for the questionnaire were derived from the theoretical and clinical literature and from the categories of spontaneous attributions made by the participants during a pilot. The items were;

- The extent to which the behaviour was due to impulsivity

- The extent to which the actor had understanding of the consequences of the behaviour
- The extent to which the behaviour was due to sexual thoughts and feelings
- The extent to which the behaviour was influenced by other personal factors (internal to the actor)
- The extent to which the behaviour was influenced by the other person
- The extent to which the behaviour was due to other factors (external to the actor)
- The degree of concern that the actor might repeat the behaviour

Each item statement was followed by a five point Lickert type scale, (e.g. ranging from highly likely to highly unlikely). Participants were to circle the response option which best suited their view. Responses were scored by substituting values 1-5 for each scale.

Questionnaire: Questions 8 and 9

Two additional questions were added. These were to elicit the actions participants thought they might take if they knew the actor and the behaviour described in the vignette was a) the first and, b) at least the second instance of such behaviour of which they were aware. The same 6 response options were provided for each of the two questions. These were agreed by participants during piloting to cover the principle actions one might take in such circumstances given that options needed to be worded so as not to contain any which might be specific to people with learning disabilities, as this again might introduce task transparency.

Participants were requested to tick from the given response options the actions they would take, and mark a cross against any they would not take.

4. Piloting.

This pilot study was to gain participants' explanations for behaviour, described in vignettes, under conditions of free response. These explanations were to assist with the construction of measures for the questionnaire.

Participants

Participants were twelve people (n=8 female, n=4 male) who were currently working, or had worked, with adults with learning disabilities. Participants had been employed in various capacities including voluntary, direct care, teaching, professional and managerial roles. Comments regarding the vignettes, wording, relevance of the questions being asked, and layout were requested and taken into account in the final version of the questionnaire (Appendix 2.)

Procedure

Participants were requested to read six short vignettes describing a behaviour, which could be construed as sexually motivated in nature, performed by a male actor toward a victim, (Appendix 4). In three of the vignettes the actor was described as having a learning disability. For each type of actor there were three vignettes, each specifying a different victim. Victims were male adult, female adult, and child (sex unspecified). Participants were then asked open ended questions to elicit their explanations for the actors behaviour. (i.e." Can you give some possible explanations for X's behaviour"). The main content of participants comments about each vignette were recorded (Appendix 4).

The statements for each type of vignette were grouped into broader categories in accordance with the main themes mentioned by participants. These were then used in the development of the measures for the questionnaire. The categories were:

Knowledge *e.g.about sexuality, appropriate social behaviour /relationships, the law*

Understanding *e.g.about the consequences of the behaviour, effects on the other person*

Sexuality *e.g.sexual motivation,sexual deviation*

Control *e.g.impulsivity /control*

Influence Of The Other Person *i.e. relating to the victim's behaviour*

Influence Of Other External Factors *e.g.opportunities for appropriate social and sexual relationships*

Other Internal Factors *e.g.other motivation, mood, self esteem*

Other

Participants free responses will be discussed further in the Results section.

5. Readability of the Questionnaire

A Flesch Reading Ease analysis was performed on the final version of the vignettes and questionnaire items. An average score on this 1-100 scale is 60-70, with lower scores being harder to read. This scale gave readability statistics of 86.6 for the vignettes and an average of 65.5 for the questionnaire questions. Therefore items were of an average-easy level of reading. It was therefore likely that the confounding influence of ability to read and understand written information would be minimised.

6. Administration of the Questionnaire

6.1 Participants

Contact was made with key service managers working in services for people with learning disabilities in Plymouth and Cornwall (Appendix 1). These included managers of Psychology Services, supported domestic homes, day centres and residential treatment units. The nature of the project was described to the managers and examples of questionnaire items, the information letter for prospective participants and the consent form were provided for their consideration. The staff groups to be invited to participate, and the way in which contact would be made with them, were agreed. In most instances, team leaders or managers were sent a letter, again giving an outline of the nature of the project, and stating that approval had been given by service managers. In some instances, participants who knew of the project, but were not currently employed offered to participate.

There were 58 participants, mainly employees of Social Services learning disabilities services in Cornwall, and of Cornwall and Isles of Scilly Learning Disabilities NHS Trust, and Plymouth Community Services, Learning Disabilities Directorate. A majority were direct care staff, although several held qualifications and managerial posts. Participants were approached via the clinical directors and relevant service managers. Of the people approached with an invitation to participate, none declined. Arrangements were made in most instances to see staff as a group, although the administration procedure was carried out on an individual basis where this was not practicable for the service or individuals concerned.

6.2. Procedure

The general purpose of the study was explained to the staff, i.e. that the research was exploring the explanations given by people about different kinds of behaviours. The task, and the length of time it would take was explained. Because of the questionnaire contained statements relating to sexual behaviour, participants were told that their questionnaire may, or may not, contain statements which could be interpreted as sexual. All participants were given a letter explaining the same information as given verbally (Appendix 5). They were requested to sign a consent slip if they agreed to participate and were informed that they could withdraw their consent at any time during the task. It was stressed that all participants would remain completely anonymous and that they could not be identified from their questionnaires.

Participants were assigned to either of the two main conditions at random. For each establishment attended there were an equal number of questionnaires, pertaining to the two conditions, which had been shuffled. These were then given out at random. Participants were asked to read the instructions on the cover, and make any queries, prior to starting. Participants were requested to complete each item in the given order, and to work quickly but carefully without checking back to any previous responses. The task took between 5 and 15 minutes to complete. Several participants made requests for further clarification and these were dealt with on an individual basis.

On piloting it was suggested that, where the actor did not have a learning disability, that this was not made explicit in the vignette. It was contended that to do so would alert participants to the possibility that comparisons would be made between learning disabled

and non-learning disabled actors. However, during the first administration a participant asked if they were to regard the actor as having a learning disability or not. Consequently participants in all administrations were given a verbal instruction, to assume, unless otherwise stated, that all characters described in the vignettes were of 'average intelligence'

Completed questionnaires were collected and shuffled in view of the participants. At the end of the task, time was allocated for participants to make any queries or comments about the task, the focus of the research , or their own experience of the topics raised. The researcher offered to return to give a summary of the results of the project once these became available. This offer was accepted by all the participating groups.

7. Ethical Considerations

Care was taken to ensure, at each stage of the project, that participants understood the content of the research, the voluntary nature and anonymity of participation . The written information and accompanying consent form were designed to reiterate this. Participants were also informed they could withdraw their consent at any time during the task. Time was allocated after task completion for participants to raise or comment on any concerns. The project received ethical approval from Plymouth Local Research Ethics Committee (Trial No 481) and also Cornwall Local Research Ethics Committee (Trial No EC56A.7.94), and all relevant service managers were informed of the nature of the research and were supplied with examples of the questionnaire when considering their approval.

PART 2 : THE SURVEY

1. Construction of the Survey Questionnaire

The survey questionnaire (Appendix 3), was designed with the aim of gathering information regarding:

1. The extent of the problem of sexually abusive behaviour, i.e. number of referrals, within the last two years, to services for people with learning disabilities in Plymouth and Cornwall.
2. The nature of the problem, i.e. the types of behaviour exhibited by referred clients

3.Client characteristics

- the different types of victims targeted by individuals.
- the length of time between the first known occurrence of sexually abusive behaviour and first referral for assessment or treatment.
-the age at which the clients first demonstrated sexually abusive behaviour
-the client's intellectual functioning as measured by IQ

4. The referral process

-whether referral was as a response to the first known incident of sexually abusive behaviour by the client
-factors perceived by respondents as contributing to late or subsequent referral for assessment or treatment

5. The perceived effect of the timing of referral, in relation to the client's history, on ease of treatment.

2. Measures

Items requesting client details such as age were provided with spaces for responses to be entered. The section requesting information regarding victim types and categories of behaviour engaged in by the client was provided with spaces in which code letters, corresponding to designated categories of behaviour, could be entered against the appropriate victim type. Code sheets would be separate from the survey questionnaire. (This is discussed further under Ethical Considerations below). The two questions regarding 'ease of treatment' were provided with 5 point Lickert type scales.

The sections regarding perceived reasons for delayed referral and subsequent referral were both provided with a list of response options. During piloting these were felt to encompass a broad, representative range of options, including several which were neutral (e.g. 'No service to refer to').

3. Administration of the Survey

3.1. Participants

Persons invited to participate in the survey included psychologists, psychiatrists and therapists who had been working in services for people with learning disabilities in Plymouth and Cornwall for two or more years. A total of eight survey questionnaires were sent to named individuals who had been identified by service managers as meeting the inclusion criteria of length of service and relevant client group.

Replies were received from 5 respondents. One non-responder had no cases to report, and another had only been working in the area for a few months and so did not meet the inclusion criteria. As no identification was requested it was not possible to formally identify the number of participants from each professional group who returned the survey sheets.

3.2. Procedure

The questionnaire was initially piloted on a trainee clinical psychologist, an assistant psychologist and an experienced chartered clinical psychologist. Comments were sought regarding the layout, readability and clarity of the questionnaire and the length of time it took to complete. Amendments were made in accordance with suggestions.

Participants were sent a batch of survey questionnaires along with a letter explaining the nature and aims of the research, instructions for completion of the forms, and a separate sheet supplying the categories and codes for the different kinds of sexually abusive behaviour (Appendix 3). All participants were provided with addressed and postage paid envelopes for the return of the questionnaires.

4. Ethical Considerations

All participants were sent a letter along with the questionnaires explaining the nature and purpose of the research and inviting participation in the project should they so wish. Participants were assured that they and their clients would remain anonymous. Given the sensitivity of the information being requested, and that the questionnaire was postal, it was decided to code the categories of abusive behaviour by letters rather than by ticking explicit

descriptions. All envelopes for questionnaires being sent and returned were clearly marked 'private and confidential'.

Participants were asked to identify each client by their initials. This was in order to check for duplications in instances where more than one of the participants was involved with an individual. Alternative means were considered, e.g. health service 'B' notes numbers, but this was deemed to be impractical. Participants were assured that clients' initials were for collation purposes only.

CHAPTER 3: RESULTS

1. Validity and Reliability

1.1 Reliability

There are different forms of reliability. The most relevant will depend on the nature and purpose of the measure employed. For the items on the questionnaire, test-retest reliability was considered relevant.

Test-Retest reliability

This form of reliability provides a measure of the tests stability over time, i.e. the extent to which it will provide the same score on separate occasions. To assess this, 6 participants were asked to complete the questionnaire approximately two weeks after the first administration. All participants agreed to do this, given their questionnaires were identified by a code number only rather than by name. Two of the six vignettes were chosen, at random, for the analysis, with the same vignette being selected for each of the participants and across the two administrations. A Pearson's product-moment correlation coefficient was computed for the scores for each item on the questionnaire, for each vignette. Both analyses showed the scores to be highly reliable, ($r = 0.93$.$n = 41$ $p < 0.00$; $r = 0.94$, $n = 42$ $p < 0.00$)

1.2 Validity

Face Validity

The questionnaire was assumed to have adequate face validity given it's acceptability during piloting. Additionally, several participants commented that the situations presented

in the vignettes resembled issues which had arisen with clients in real life and therefore appeared pertinent to their work. The main criticism that participants had was that in real life there would often be more knowledge about the people concerned and the event on which to base decisions.

Content Validity

Assumptions were also made that the items on the questionnaire had content validity given that the items were primarily derived from the theoretical and clinical literature regarding attitudes toward people with learning disability and attribution theory. Also in support of the assumptions about content validity was that, during piloting, the spontaneous attributions made by participants about the vignettes, reflected the nature and range of content as suggested by the literature. These spontaneous attributions also contributed to the range of items selected for the questionnaire.

Construct Validity

Construct validity was assumed on the basis that the measures and hypotheses were derived from theoretical and clinical literature, and results were consistent with the hypotheses. This lent support to both the validity of the questionnaire and the theory.

Criterion Related Validity

Criterion related validity is the degree of association between the scores on a measure and measurement on some external criteria. With regard to the questionnaire, although it was impracticable to employ external measures from direct observation, inferences were drawn from the results of the survey. The questionnaire was assumed to measure attributions

made about sexually abusive behaviour, including perceptions of impulsivity, sexual motivation and the influence of other personal and environmental factors. As suggested by the results, the attributions made about perpetrators with learning disabilities were likely to result in non-recognition of or the minimising of the offence. This would be predicted to reflect in delayed referral of clients for treatment. The referral process was assessed by the survey part of the study, and indeed, referrals were found to be delayed in a majority of cases. Additionally, therapists perceived the delays to primarily due to staff/carers not recognising or acknowledging the significance of their clients' abusive behaviour. Therefore, although direct correlational methods were not employed, it was inferred that the questionnaire possessed adequate criterion related validity.

2. Group Characteristics

The two groups of participants, i.e. corresponding with the two main conditions, were not matched. It was therefore considered necessary to ascertain if there were any main differences between the two groups which might influence the results.

Two main factors were considered of primary importance in influencing participants responding : a relevant qualification or training, and number of years service. Participants were requested to give information about their qualification status and length of experience working with people with learning disabilities on the 'Instructions' sheet of the questionnaire, (Appendix 2). The two groups were found not to differ in terms of number of staff qualified, unqualified and in training, or in the distribution of years of experience working with people with learning disabilities.

As, for the purposes of analysis, there were two groups within each condition, the above factors were also checked between the groups within each condition. Again, there was an even distribution according to qualification and length of experience. Thus, there were no differences between any of the groups.

3. RESULTS, PART 1: THE QUESTIONNAIRE

Tests of the Main Hypotheses: Comparisons Between Learning Disabled and Non-Learning Disabled Actors on Questions 1-7 of the Questionnaire.

A fully orthogonal analysis of the data was not possible as, within each of the main conditions (Learning Disability and Non-Learning Disability), there were two sub groups of participants, each receiving a different set of vignettes. A fractional factorial analysis (Kirk, 1982) of the data was considered, but because of the unavailability of a customised programme to compute this the adopted procedure was to separately analyse each pair of subgroups between conditions using ANOVA [Actor (between subjects), Target (within subjects)] .SPSS Version 6.0. was employed for the analysis. Thus, the two separate analyses would form a replication of each other in which the effect of the 'Contact' variable was counterbalanced. Thus, within each condition, the two subgroups (Replication 1 and Replication 2) comprised those participants who received the vignettes with the following combinations of victim type and contact:

Replication 1	Replication 2
Male Adult (Contact)	Female Adult (Contact)
Female adult Learning Disabled (LD) (Contact)	Male adult Learning Disabled (LD) (Contact)
Female Child (Contact)	Male Child (Contact)
Female Adult (Non-Contact)	Male Adult (Non-Contact)
Male Adult LD (Non-Contact)	Female Adult LD (Non-Contact)
Male Child (Non-Contact)	Female Child (Non-Contact)

3.1. Question 1: Impulsivity

Hypothesis 1 stated that the behaviour of the actor with a learning disability would be rated as significantly more impulsive than the non-learning disabled actor. The differences between the two conditions were highly significant for Replication 1 ($F(1,27)=27.65$, $p<0.000$), and Replication 2 ($F(1,23)=18.36$, $p<0.000$) . There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table 1 for the means for both analyses).

QUESTION 1					
REPLICATION 1			REPLICATION 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
Male Adult (Contact)	1 2	3.40 1.57	Female Adult (Contact)	1 2	3.36 2.54
Female adult LD (Contact)	1 2	3.33 1.86	Male adult LD (Contact)	1 2	3.14 2.00
Female Child (Contact)	1 2	3.40 1.42	Male Child (Contact)	1 2	3.86 1.91
Female Adult (Non-Contact)	1 2	3.13 1.71	Male Adult (Non-Contact)	1 2	3.78 2.54
Male Adult LD (Non-Contact)	1 2	3.07 1.71	Female Adult LD (Non-Contact)	1 2	3.78 2.00
Male Child (Non-Contact)	1 2	3.27 1.57	Female Child (Non-Contact)	1 2	4.00 1.82

Table 1. Combined Observed Means for Question 1.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

3.2.Question 2: Level of Understanding

Hypothesis 2 stated that the actors with a learning disability would be rated as having significantly less understanding of the consequences of their behaviour than non-learning disabled actors.The differences between the two conditions were highly significant for Replication 1, ($F(1,26)=58.29$, $p<0.000$), and Replication 2, ($F(1,23)=21.90$, $p<0.000$) . There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table2 for the means for both analyses).

QUESTION 2					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
(Contact) Male Adult	1 2	3.66 1.54	Female Adult (Contact)	1 2	3.36 2.45
Female adult LD (Contact)	1 2	3.60 1.69	Male adult LD (Contact)	1 2	3.57 1.82
Female Child (Contact)	1 2	3.73 1.61	Male Child (Contact)	1 2	4.07 2.09
Female Adult (Non-Contact)	1 2	3.40 1.38	Male Adult (Non-Contact)	1 2	3.57 2.27
Male Adult LD (Non-Contact)	1 2	3.27 1.54	Female Adult LD (Non-Contact)	1 2	3.50 1.91
Male Child (Non-Contact)	1 2	3.73 1.23	Female Child (Non-Contact)	1 2	4.14 1.73

Table 2. Combined Observed Means for Question 2.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

There were no effects of target for Replication 1($F(5,130)=1.42$, $p=0.223$) or for Replication 2 ($F(5,115)=1.85$, $p=0.108$). For Replication 2, there was a significant interaction effect of Actor with Target ($F(5,115)=4.05$, $p=0.002$). Scrutiny of the means for this analysis shows there were clear differences in perceptions of the actors understanding of his behaviour according to the target (i.e. victim). The actor with

learning disability was perceived to have noticeably less 'understanding' when the target was a child than when an adult. There was less variation in the scores of the non-learning disabled actors. There were no significant interaction effects for Replication 1 ($F(5,130)=1.56$, $p=0.177$) and as can be seen from the means, the scores within each condition vary little across targets.

3.3. Question 3: Sexual Motivation

Hypothesis 3 stated that the actors with a learning disability would be significantly less likely to have their behaviour rated as due to sexual thoughts and feelings than non-learning disabled actors.The differences between the two conditions were highly significant for Replication 1, ($F(1,28)=13.56$, $p=0.001$), and Replication 2, ($F(1,23)=13.41$, $p=0.001$) . There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table 3 for the means for both analyses).

QUESTION 3					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
(Contact) Male Adult	1 2	2.53 1.33	Female Adult (Contact)	1 2	2.14 1.45
Female adult LD (Contact)	1 2	2.27 1.60	Male adult LD (Contact)	1 2	2.50 1.36
Female Child (Contact)	1 2	2.66 1.53	Male Child (Contact)	1 2	3.21 1.34
Female Adult (Non-Contact)	1 2	2.00 1.27	Male Adult (Non-Contact)	1 2	2.93 1.45
Male Adult LD (Non-Contact)	1 2	2.33 1.60	Female Adult LD (Non-Contact)	1 2	2.36 1.54
Male Child (Non-Contact)	1 2	2.60 1.33	Female Child (Non-Contact)	1 2	1.57 2.64

Table 3. Combined Observed Means for Question 3.
Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

There was no significant effect of Target for Replication 1, however, there was a significant effect for Replication 2 ($F(5,115)=2.30$ $p=0.49$). There was also a significant Actor by Target interaction effect for Replication 2 ($F(5,115)=10.76$, $p<000$. A scan of the means shows that the behaviour of the actor with a learning disability was consistently seen as less 'due to sexual thoughts and feelings' than that of the non-learning disabled actor, except where the target was a female child where the reverse was apparent. However, the Contact variable may have influenced these findings.

3.4. Question 4: Other Personal Factors

Hypothesis 4 stated that the actors with a learning disability would be significantly more likely to have their behaviour attributed to 'other personal factors' than non-learning disabled actors. The differences between the two conditions were highly significant for Replication 1, ($n=30$, $F=10.95$, $p<0.003$), and Replication 2, ($n= 25$, $F=6.01$, $p<0.022$) . There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table 4 for the means for both analyses). For both Replications there was no effect of Target, or Actor by Target interaction effects.

QUESTION 4					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
Male Adult (Contact)	1 2	1.60 2.40	Female Adult (Contact)	1 2	1.93 3.00
Female adult LD (Contact)	1 2	1.87 2.80	Male adult LD (Contact)	1 2	1.78 2.18
Female Child (Contact)	1 2	1.67 2.80	Male Child (Contact)	1 2	1.71 2.45
Female Adult (Non-Contact)	1 2	1.80 2.33	Male Adult (Non-Contact)	1 2	1.71 2.54
Male Adult LD (Non-Contact)	1 2	1.73 3.27	Female Adult LD (Non-Contact)	1 2	1.86 2.09
Male Child (Non-Contact)	1 2	1.67 2.47	Female Child (Non-Contact)	1 2	1.64 2.81

Table 4. Combined Observed Means for Question 4.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

3.5. Question 5: Influence of the Other Person

Hypothesis 5 stated that the actors with a learning disability would be significantly more likely to have their behaviour rated as influenced by the other person in the vignettes than non-learning disabled actors.The differences between the two conditions varied between the two replications. Replication 1 was not significant ($F(1,26)=0.01$, $p=0.923$). Replication 2, however, was significant ($F(1,22)=5.85$, $p<0.024$) . There was thus a significant effect of actor for this replication, in support of the hypothesis. (See Table 5 for the means for both analyses).

QUESTION 5					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
(Contact) Male Adult	1 2	2.43 2.50	Female Adult (Contact)	1 2	2.57 3.10
Female adult LD (Contact)	1 2	2.86 3.21	Male adult LD (Contact)	1 2	3.21 3.80
Female Child (Contact)	1 2	3.78 3.86	Male Child (Contact)	1 2	4.14 4.40
Female Adult (Non-Contact)	1 2	3.28 2.50	Male Adult (Non-Contact)	1 2	2.71 2.40
Male Adult LD (Non-Contact)	1 2	3.21 3.36	Female Adult LD (Non-Contact)	1 2	2.71 4.00
Male Child (Non-Contact)	1 2	3.92 3.92	Female Child (Non-Contact)	1 2	3.93 4.40

Table 5. Combined Observed Means For Question 5.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

However, for both replications there were significant within subjects effect of target, (Replication 1, $F(5,130)=9.26$, $p<0.000$: Replication 2, $F(5,110)=14.69$, $p<.000$). A view of the means for the two replications shows there was less variation in the means for Replication 1 than Replication 2. In Replication 2, there was considerably more influence attributed to adult than child targets (i.e. the means were lower for adults). Whilst there was a similar trend for Replication 1, the scores were within a more restricted range. The fact that this effect occurred for both replications helps to rule out the possibility of the Contact variable as an explanation.

The behaviour of the actor with learning disabilities was consistently perceived as more influenced by the target person than that of the non-learning disabled actor, except in Replication 1 where the victim was a female adult. This victim was seen as having more influence when the actor was a non-learning disabled man. Also in this replication, female adults with learning disabilities, and male adults were seen as influencing the behaviour of

the learning disabled actor more than the other targets. In Replication 2, the target seen to have most influence on the learning disabled actors' behaviour was the female adult, followed by the female adult with learning disabilities and male adults. For the non-learning disabled actor, male and female adult targets were perceived to have most influence. In both replications, for both actors, child targets were perceived to have least influence.

3.6. Question 6: Other Factors, External to the Actor

Hypothesis 6 stated that the actors with a learning disability would be significantly more likely to have their behaviour attributed to 'other factors' than non-learning disabled actors. The differences between the two conditions were highly significant for Replication 1, ($F(1,27)=17.24$, $p<0.000$), and Replication 2, ($F(1,23)=9.88$, $p<0.005$) . There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table 6 for the means for both analyses).There was no within subjects effect of Target, or interaction effects for either replication for question 6.

QUESTION 6					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
(Contact) Male Adult	1 2	1.53 2.93	Female Adult (Contact)	1 2	1.78 2.82
Female adult LD (Contact)	1 2	1.73 2.57	Male adult LD (Contact)	1 2	1.78 2.54
Female Child (Contact)	1 2	1.60 2.93	Male Child (Contact)	1 2	1.64 2.45
Female Adult (Non-Contact)	1 2	1.73 2.78	Male Adult (Non-Contact)	1 2	1.64 2.54
Male Adult LD (Non-Contact)	1 2	1.53 3.14	Female Adult LD (Non-Contact)	1 2	1.57 2.36
Male Child (Non-Contact)	1 2	1.53 2.93	Female Child (Non-Contact)	1 2	1.57 2.64

Table 6. Combined Observed Means For Question 6.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

3.7. Hypothesis 7: Concern Regarding Recurrence of the Behaviour

Hypothesis 7 stated that there would be significantly less concern about the recurrence of the behaviour for actors with a learning disability than there would be for non-learning disabled actors. The differences between the two conditions were highly significant for Replication 1, ($F(1,26)=18.70$, $p<0.000$), and Replication 2, ($F(1,22)=6.19$, $p=0.021$). There was thus a significant effect of Actor and this hypothesis was therefore confirmed for both replications. (See Table 7 for the means for both analyses). Additionally, for both replications there were significant within subjects effects of Target, (Replication 1: $F(5,130)=4.12$, $p=0.002$, Replication 2: $F(5,110)=3.37$, $p=0.007$). In Replication 1 there was also a significant Actor by Target interaction effect ($F(5,130)=3.03$, $p=0.013$).

Scrutiny of the means suggests that in Replication 1, in the Learning Disability condition, there was greatest concern regarding recurrence of the behaviour where the target was a male or female child, with less concern where targets were adults or adults with a learning disability. For those in the Non-Learning Disability condition, however, whilst there was greatest concern where the victim was a male child or a female adult, overall there was a more restricted range of scores. In Replication 2, Learning Disability condition, there were clear differences in the level of concern about recurrence according to target. The greatest concern was for male children, closely followed by female children, with little difference between the adult groups. Within the Non-Learning Disability condition, the greatest concern was where the victim was a female child, closely followed by the male adult. However, the interaction in this replication was not significant and so the interaction effects for this question should not be given too much weight.

QUESTION 7					
REP1			REP 2		
VARIABLE	CONDITION	MEAN	VARIABLE	CONDITION	MEAN
(Contact) Male Adult	1 2	2.73 1.38	Female Adult (Contact)	1 2	2.57 1.80
Female adult LD (Contact)	1 2	2.53 1.77	Male adult LD (Contact)	1 2	2.36 1.40
Female Child (Contact)	1 2	1.73 1.46	Male Child (Contact)	1 2	1.86 1.70
Female Adult (Non-Contact)	1 2	2.53 1.23	Male Adult (Non-Contact)	1 2	2.64 1.70
Male Adult LD (Non-Contact)	1 2	2.53 1.38	Female Adult LD (Non-Contact)	1 2	2.64 1.90
Male Child (Non-Contact)	1 2	1.80 1.23	Female Child (Non-Contact)	1 2	2.28 1.30

Table 7. Combined Observed Means For Question 7.

Key: Condition 1= Actor with Learning Disability, Condition 2= Actor Non-Learning Disability

3.8. Questions 8 and 9: Action In Response To The Behaviour

For these questions respondents were asked to tick or cross the actions they respectively would, or would not, take in response to the behaviour shown by the actor. Response options neither endorsed or vetoed were left blank. The analysis for both questions was to total the number of responses of each type to all action options as given on the questionnaire, subdivided according to the two main conditions: Learning Disability and Non-Learning Disability (Tables 8a & 8b, and Figures 1 & 2). The results were not analysed according to victim or type of contact.

Informing the Police

Following a 'first incident' of the behaviour, (Question 8), the main difference between the two conditions was in response to the 'Inform Police' option, with this being endorsed for a considerably higher number of Non-Learning Disabled actor vignettes (51.9%) than for the Learning Disability group (9.4%). Similarly, being vetoed in 64 % of cases in the Learning disability group compared with 22% for Non-Learning Disability. There was therefore a stronger preference for informing the police when the actor did not have a learning disability. Within the Learning Disability condition, apart from 'Inform no-one', informing the police was the least endorsed option.

Where the incident was 'at least the second' occurrence of the behaviour (Question 9), the differences between the two conditions were maintained with informing the police being endorsed more for the Non-Learning Disabled group (68%) than the Learning

Disability group (20%) with 38% and 8.6% vetoes for the Learning Disability and Non-Learning Disability group respectively.

These results suggest that where the actor has a learning disability there is an increased tendency to favour informing the police where the behaviour is at least the second known occurrence than when the first instance, but that the learning disabled person is still considerably less likely to be referred to the police than a man without a learning disability.

Inform the Actors Family

Following a 'first' occurrence of the behaviour (Question 8), in both conditions, there were more vetoes than endorsements for this action. However, there were marginally more endorsements for the Learning Disability (19%) group than for the Non-Learning Disability group (12%). In both conditions there was an increase in the number of endorsements when the behaviour was 'at least the second' occurrence but remained a more favoured option where the actor had a learning disability (26%) than for those without (16%). The biggest contrast was in the vetoes, which whilst reduced for both groups, were considerably higher (51%) where the actor did not have a learning disability, compared with only 6.7% where the actor had a learning disability. This suggests that informing the offender's family was a more favoured option when that offender had a learning disability, although this was still only endorsed in about a quarter of instances even where it was at least the second known incident of the behaviour.

Speaking Directly To The Actor

Following a 'first incident' of the behaviour (Question 8), this action received more endorsements for the Learning Disability group (81%) than the Non-Learning Disability group (55%). Less than 5% of responses vetoed this option where the actor had a learning disability, compared with 33% for the Non-Learning Disability group.

Following a subsequent occurrence of the behaviour, there was a marginal decrease in endorsements for both groups. There were no vetoes for the Learning Disability group, and 24% vetoed the option for the Non-Learning Disability group.

The evidence suggests that speaking directly to the offender is a more favoured option where that person has a learning disability, than when he does not. Indeed, for the Learning Disability group, this was the most favoured option following a 'first' incident, although very closely followed by 'inform/consult professionals'. Where it was a subsequent instance of the behaviour, this most the second most favoured option with 'inform /consult professionals', receiving the most endorsements.

Informing The Victims Family

Following a first instance of the behaviour, this option was again endorsed more often where the actor had a learning disability (30%), although this option was vetoed in an equal number of cases. In the Non-Learning Disability group there were more vetoes (36%) than endorsements (21%).

Following a subsequent instance however, the endorsements remained the same for the Learning Disability group and vetoes were reduced, but the endorsements doubled (43%) for the other group.

These findings suggest that when the behaviour is the first known instance, informing the victim's family is a more favoured option when the actor has a learning disability, but that when the behaviour has occurred at least once before, it is a more favoured option when the actor is non-learning disabled.

Inform No-one

Following a first instance of the behaviour, endorsements comprised only 5.6% of responses where the actor had a learning disability, and 4.6% where the actor did not have a learning disability. There were 58% and 53% vetoing the action in the respective groups. This option received even fewer endorsements for both groups where the behaviour was a subsequent incident whilst vetoes remained little changed.
These results suggest that irrespective of whether the offender has a learning disability or not, most people would prefer to inform, rather than not inform, someone of the behaviour.

Inform/Consult Professionals

Where the behaviour was a 'first' instance, there were around 80% endorsements for this action for both groups, with no vetoes for either. Endorsements rose slightly for both groups where the behaviour was 'at least the second' instance - again with no vetoes.

Where the actor did not have a learning disability this was the most favoured option regardless of whether it was the first, or a subsequent instance of the behaviour. Where the actor was learning disabled and it was the first instance, this option was favoured second to speaking directly to the actor, but only by a mere 1% . Where it was a subsequent instance of the behaviour, to 'inform/consult professionals' was the most favoured option .

Overall, the most favoured actions where the actor had a learning disability were to speak directly to the actor and to inform/consult with professionals. With the exception of 'informing no-one', informing the police was the least favoured option. In contrast, where the actor did not have a learning disability, informing the police was a highly favoured option, particularly where the behaviour was known to have occurred on at least two occasions. Again, 'inform no-one' was the least favoured option whether or not the behaviour had occurred more than once.

Table 8a. Actions Following 'First Occurrence'

Question 8

Option	Total Responses								Percentage Responses			
	L D				NLD				LD	NLD	LD	NLD
	Yes	No	NR	Tot	Yes	No	NR	Tot	%Yes	%Yes	%No	%No
Inform Police	17	116	41	180	89	38	41	174	9.44	51.15	64.44	21.84
Inform Actors Family	34	54	85	180	21	95	49	174	18.89	12.07	30.00	54.60
Speak Directly to Actor	146	8	26	180	96	58	20	174	81.11	55.17	4.44	33.33
Inform Victims Family	54	54	72	180	36	62	76	174	30.00	20.69	30.00	35.63
Inform No one	10	104	66	180	8	92	74	174	5.56	4.60	57.78	52.87
Inform/Consult Professiona	144	0	36	180	140	0	34	174	80.00	80.46	0.00	0.00

Table 8b. Actions Following 'Subsequent Occurrence'

Question 9

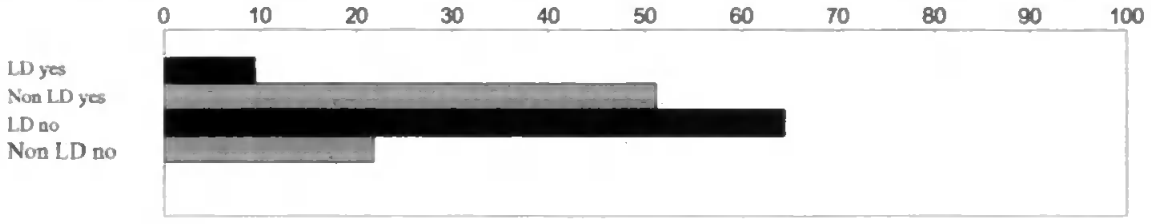
Option	Total Responses								Percentage Responses			
	LD				NLD				LD	NLD	LD	NLD
	Yes	No	NR	Tot	Yes	No	NR	Tot	%Yes	%Yes	%No	%No
Inform Police	36	68	70	180	118	15	34	174	20.00	67.82	37.78	8.62
Inform Actors Family	47	12	114	180	27	88	49	174	26.11	15.52	6.67	50.57
Speak Directly to Actor	136	0	44	180	92	42	40	174	75.56	52.87	0.00	24.14
Inform Victims Family	54	24	102	180	74	44	56	174	30.00	42.53	13.33	25.29
Inform No one	2	96	82	180	4	104	66	174	1.11	2.30	53.33	59.77
Inform/Consult Professiona	160	0	20	180	152	0	22	174	88.89	87.36	0.00	0.00

Key
LD = Actor Learning Disability
NLD = Actor Non Learning Disablity
Yes = Endorsed
No = Vetoed
NR = No Response

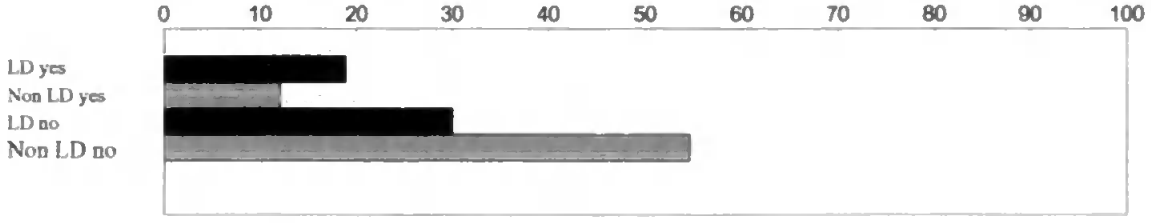
Figure 1. Actions Following a 'First Occurrence'

Question 8 - INFORM POLICE

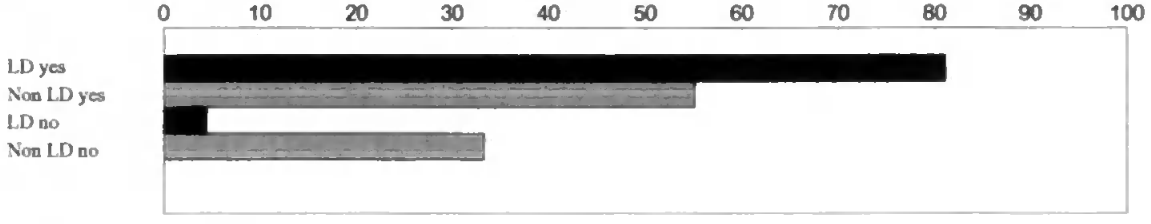
Percentage Responses



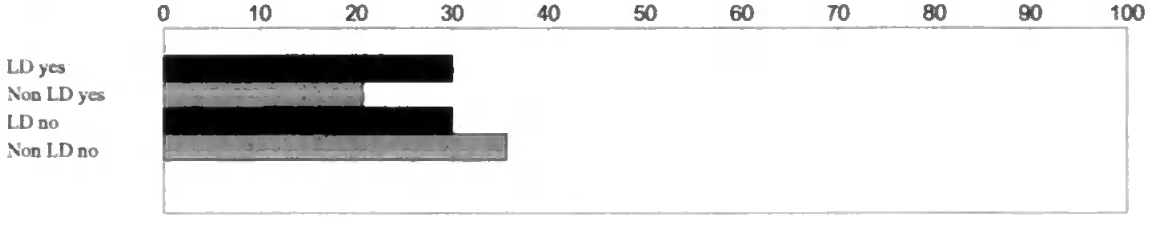
Question 8 - INFORM ACTORS FAMILY



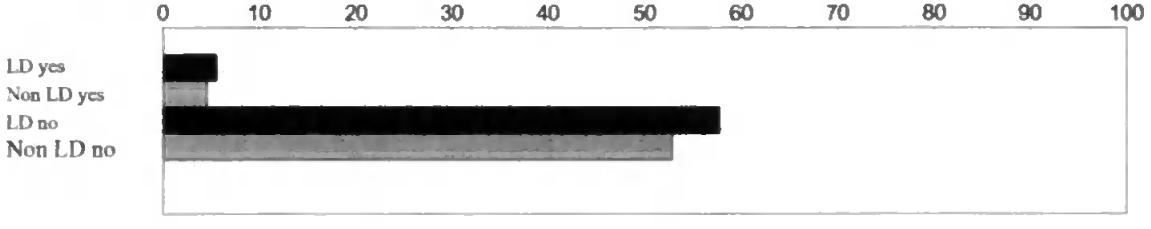
Question 8 - SPEAK DIRECTLY TO ACTOR



Question 8 - INFORM VICTIMS FAMILY



Question 8 - INFORM NO ONE



Question 8 - INFORM/ CONSULT PROFESSIONALS

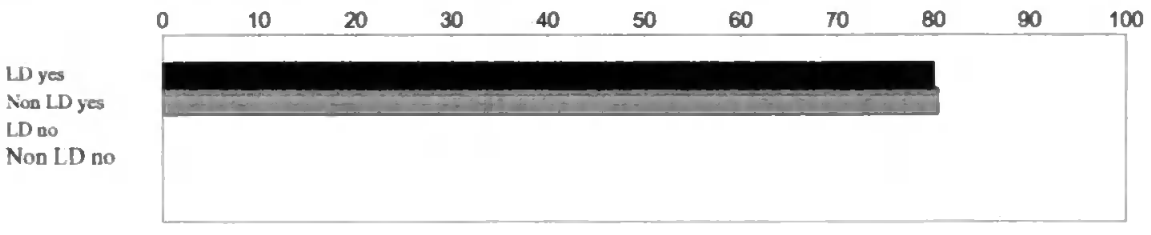
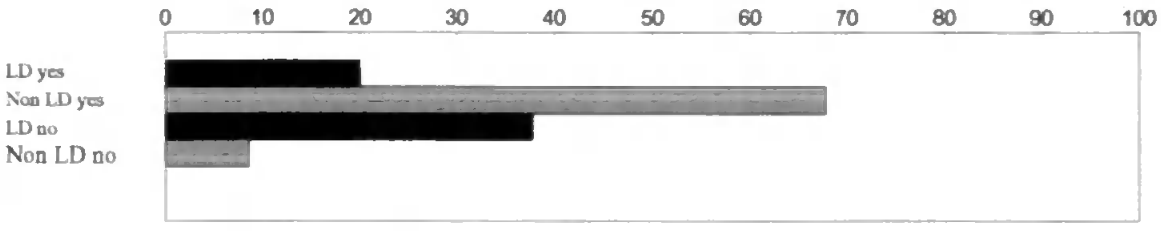
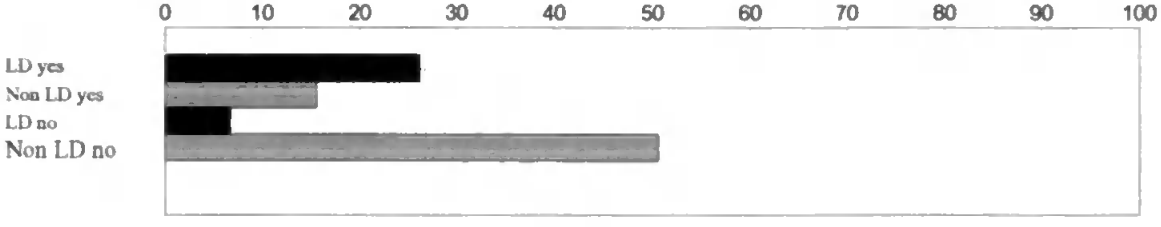


Figure 2. Actions Following a 'Subsequent Occurrence'

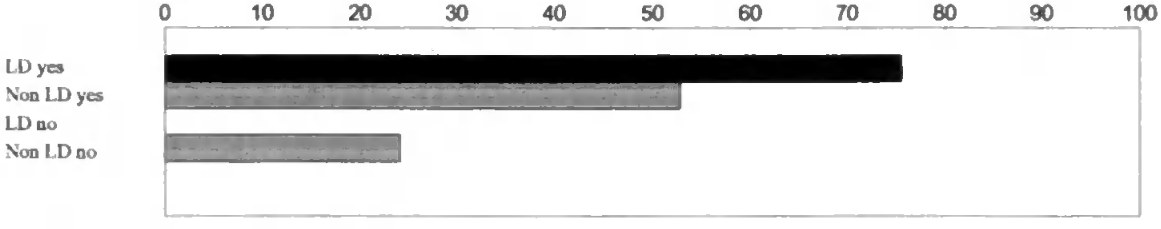
Question 9 - INFORM POLICE



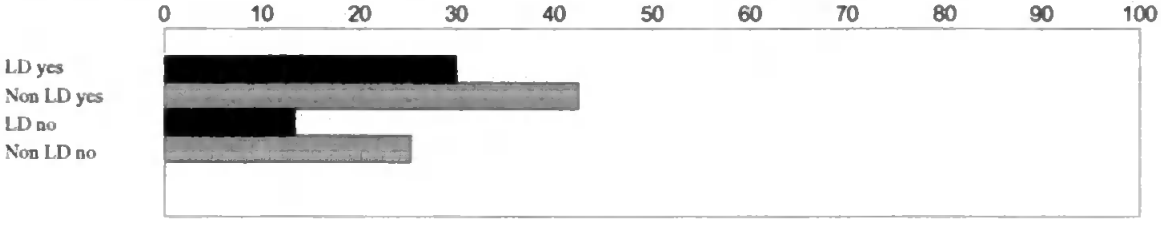
Question 9 - INFORM ACTORS FAMILY



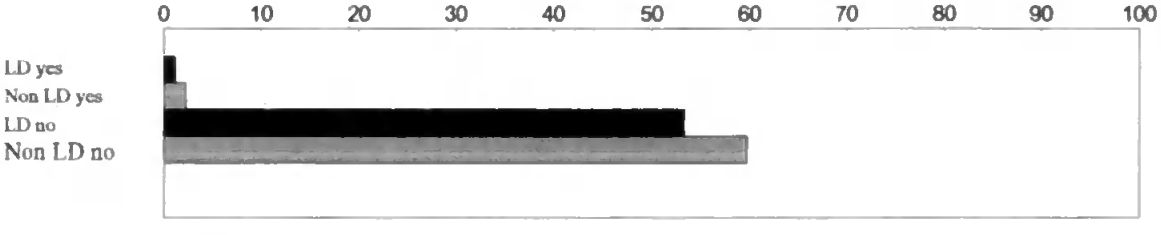
Question 9 - SPEAK DIRECTLY TO ACTOR



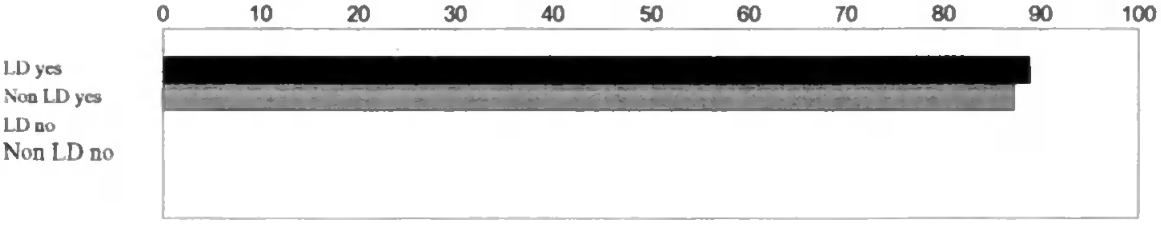
Question 9 - INFORM VICTIMS FAMILY



Question 9 - INFORM NO ONE



Question 9 - INFORM / CONSULT PROFESSIONALS



4. RESULTS PART, 2: THE SURVEY

Survey Of Males With A Learning Disability In Plymouth & Cornwall Referred For Assessment Or Treatment For Sexually Abusive Behaviour.

A total of 5 participants returned data. Survey sheets for a total of 24 clients referred for assessment or treatment in the last two years were completed. Duplications in the data, i.e. in instances where more than one professional had been involved with a client, were checked for using client initials and current age. There were no duplications and therefore a total of 24 clients details available for analysis.

4.1. Client IQ

Information about client's full scale WAIS (Wechsler Adult Intelligence Scale) scores was provided for 14 of the 24 clients. A majority of the clients scored in the ranges from 51-80. There were none in the 41-50 range and only one person scoring 40 or below.

	FULL SCALE WAIS-R SCORE RANGE				
	40 OR LESS	41-50	51-60	61-70	71-80
NO. OF CLIENTS	1	0	5	4	4
				n=14	

Table 9. Client IQ Scores.

4.2. Client Age

The current ages of clients reported by respondents ranged from 14 years to 40 years old, with the mean current age 28.8 years. **Hypothesis 1** stated that the first known offence was likely to be during adolescence or early twenties. A mean 'first offence' age of 23 yrs 3months somewhat supports this hypothesis. Hypothesis **2** stated that there would be at

least a year between the mean age at the first known offence and the mean age for first referral to professional services for assessment or treatment of abusive sexual behaviour. The results show there was only a nine month difference between ages, and therefore this hypothesis was not supported, (Table 10). However, a majority of respondents supplied ages in years only, omitting months, thereby making a distinction difficult.

	AGE RANGE	MEAN AGE n=19
AGE AT FIRST KNOWN OCCURRENCE OF ABUSIVE SEXUAL BEHAVIOUR	3yrs 4m - 43yrs	23yrs 3m
AGE AT FIRST KNOWN REFERRAL TO PROFESSIONAL SERVICE FOR ASSESSMENT/TREATMENT OF ABUSIVE SEXUAL BEHAVIOUR	5yrs 2m - 43yrs	24yrs 0m

Table 10. Client Ages at 'First Offence' and 'First Referral'.

4.3. Referral

Hypothesis 3 stated that most referrals would be the consequence of subsequent, rather than the first known, occurrence of sexually abusive behaviour. Only six of the 24 referrals were made as a consequence of the first known instance of abusive sexual behaviour by the client. 18 referrals (i.e. two thirds) were the result of subsequent abusive behaviour (Table 11). This hypothesis was therefore supported.

	REFERRAL A DIRECT CONSEQUENCE OF FIRST KNOWN OFFENCE	REFERRAL A CONSEQUENCE OF SUBSEQUENT ABUSIVE BEHAVIOUR
NO OF CLIENTS n=24	6	18

Table 11. Referral as a Consequence of Behaviour.

4.4. Victim Characteristics

All three 'Female' groups were more commonly targeted as victims than any of the three 'Male' groups, (Table 12). More clients were known to have targeted female children

(n=10 clients), than other victim groups, with female adults and female adults with a learning disability being slightly less targeted (n=9 and n=8 clients respectively). The male victim group targeted by the most clients was male adults with a learning disability (n=5).

	VICTIM CATEGORY					
	MALE ADULT	FEMALE ADULT	MALE ADULT LEARNING DISABILITY	FEMALE ADULT LEARNING DISABILITY	MALE CHILD	FEMALE CHILD
No. of Clients targeting victim category	3	9	5	8	4	10

Table 12. Victim Categories.

Hypothesis 4 predicted that more than 25% of referred clients would be likely to have targeted more than one type of victim. Of the 24 clients referred, a total of 11 (48.5%) were known to have demonstrated abusive sexual behaviour to more than one victim category, thus supporting the hypothesis. A total of 13 clients (54.2%) were reported as targeting a single victim type.

	No OF VICTIM CATEGORIES TARGETED					
	1	2	3	4	5	6
No OF CLIENTS n=24	13	8	1	2	0	0
% OF CLIENTS	54.2	33.3	4.16	8.33	0	0

Table 13. Number of Victim Categories Targeted by Clients.

4.5. Categories of Abusive Sexual Behaviour

A large majority of the 24 clients (a total of 18) engaged in more than one type of abusive behaviour. Only 6 clients were described as demonstrating a single type of abusive behaviour, although for 3 of these clients respondents noted that they were not aware of the full details of the range of behaviours demonstrated by their clients. For clients who

were abusive to more than one victim type the behaviours sometimes differed according to the victim.

The commonest behaviour demonstrated was making explicit sexual statements, requests or demands (54.16% of clients). Exposure of genitals was the next most frequent behaviour (50%). Manual contact with genitals was noted for 45.8% of clients, and touching the body for 37.5%. 33.3% of clients engaged in genital-genital contact with victims, with 29.16% attempting or achieving penetration. 29% of clients were reported as engaging in masturbation with the victim. Oral contact with body or genitals was the least engaged in behaviour, being reported for only 20.83% of clients.

TYPE OF BEHAVIOUR ENGAGED IN BY CLIENT OR CLIENT ENGAGES VICTIM TO PERFORM	No OF CLIENTS ENGAGING IN BEHAVIOUR	% OF CLIENTS ENGAGING IN BEHAVIOUR
Make explicit sexual statements, requests or demands	13	54.16
Expose genitals	12	50
Masturbate self or other person	7	29.16
Touching body, over or under clothing e.g. breasts, buttocks, thighs	9	37.5
Touching genitals under or over clothing with hands	11	45.83
Touching genitals over or under clothing with genitals	8	33.33
Oral contact with body or genitals	5	20.83
Penetration or attempted penetration (vaginal or anal)	7	29.16

Table 14. Type of Abusive Behaviour.

4.6. Delayed Referrals

Hypothesis 5 stated that the reasons endorsed by therapists to explain delayed referrals would most frequently be 'non-detection/reporting' 'staff not considering the behaviour to be serious in nature' and 'tolerating/minimising' the behaviour. Data for this analysis was reported for 14 clients. For 2 clients, participants did not complete this section as they felt they had insufficient information to comment. Of those reporting reasons for delayed referral, for 2 clients (14.28%) this was attributed to staff/ carers not knowing to whom

they could refer (Table 15). Only one case reported a delayed referral due to the client moving area or establishment. For 3 clients delayed referral was attributed to staff /carers not recognising the behaviour as significant. In 5 cases the behaviour was not reported by the victim, but in three cases, abusive behaviour was either detected by others or reported by the victim but was not considered serious. In 4 instances (28.5%) the behaviour being detected or reported it was either tolerated or minimised by staff/carers. Where the behaviour was detected or reported *and* considered serious there were no cases of delayed referral. For six clients (42.8%) delayed referral was attributed to staff/carers not considering the behaviour to be primarily sexual in nature whilst for 10 clients (71.43%) the behaviour was seen as being excused because of the client's learning disability or other personal factors. For 57% of clients, staff/carers devised their own interventions to deal with the abusive behaviour. In only one instance was delayed referral attributed to staff/carers considering there to be a low risk of the behaviour recurring.

SURVEY ITEM	No of Clients	% of Clients
No service to refer to	0	0
Staff/carer did not know who to refer to	2	14.28
Client moved area or establishment attended	1	7.14
The behaviour was not recognised as significant by staff/carers of this client	3	21.43
The behaviour was not reported by the victim	5	35.7
The behaviour was detected or reported by the victim and considered potentially serious but a referral for assessment/treatment was not made or pursued	0	0
The behaviour was detected/reported by the victim but was not considered serious	3	21.43
The behaviour was detected/reported by the victim but was tolerated or minimised by staff/carers	4	28.57
The behaviour was not considered to be primarily sexual in nature, e.g. was primarily attributed to social skills/knowledge deficit of appropriate opportunities	6	42.86
The behaviour was excused because of this client's learning disability or other personal characteristics	10	71.43
Staff /carers of this client devised own interventions to deal with the behaviour	8	57.14
Staff/carers thought there was a low risk of the behaviour recurring	1	7.14
	n=14	

Table 15.Perceived Reasons for Delayed Referral.

Therefore, the three main reasons, as perceived by professionals, for a referral to *not* directly follow an instance of abusive sexual behaviour were: the behaviour being excused ,or not be considered to be primarily sexual in nature, and staff/carers devising their own ways to manage the behaviour. Thus, the hypothesis was only partially supported in that the main perceived reason for delayed referral was that the behaviour was 'excused because of the individual's learning disability or other personal characteristics.

4.7. Factors Prompting a later Referral

Again, this information was provided for 14 clients (Table 16). One reason stands out as being the main prompter of a referral - that the same or similar behaviour recurred (n=10). For 2 clients it was a more serious behaviour which was perceived as the motivation to refer. Although in the previous section it was reported that, for 8 clients, referral was delayed through staff/carers devising their own interventions to deal with the behaviour, for 6 clients these interventions were not successful and were seen to prompt referral.

SURVEY ITEM	No of Clients (n=14)	% of Clients (n=14)
The same or similar behaviour recurred	10	71.43
The behaviour was not detected or reported by the victim until some time after it occurred	0	0
More serious abusive sexual behaviour occurred	2	14.28
Staff/care interventions did not reduce or eliminate the behaviour	6	42.86
The client requested referral for assessment/ treatment	0	0
Staff/carer/other involved person requested referral for assessment /treatment	5	35.71
Staff/carers thought there was an increased risk of potentially abusive behaviour occurring	5	35.71

Table 16. Factors Prompting a Later Referral.

4.8. Timing of Referral and Ease of Treatment

This section was completed for all 24 clients (Table 17). 18 of these had not been referred as a consequence of their first known instance of abusive sexual behaviour. Professional staff endorsed items indicating their view that the abusive behaviour of 10 clients would have been more amenable to treatment if referral had been earlier . For only 4 clients was earlier referral endorsed as unlikely to make a difference to ease of treatment. None considered an earlier referral would have made treatment more difficult.

For the 6 clients who were referred earlier in relation to their first known sexually abusive behaviour, 4 endorsed the view that early referral made no difference to ease of treatment, with the remaining 2 felt treatment had been somewhat easier.

	DELAYED REFERRALS	EARLIER REFERRALS
	No of Clients (n=18)	No of Clients (n=6)
Treatment would have been considerably easier	4	0
Treatment would have been somewhat easier	10	2
Earlier referral would have made no difference to ease of treatment	4	4
Treatment would have been somewhat more difficult	0	0
Treatment would have been considerably more difficult	0	0

Table 17. Perceptions of Ease of Treatment

5. Descriptions Of Free Responses To Vignettes

A rigorous content analysis was not planned for this part of the study as it was originally intended to provide information during piloting for the construction of the questionnaire. However, these spontaneous responses illustrated differences in explanations for behaviour according to whether or not the perpetrator had a learning disability, and therefore the results will be briefly described.

The list of responses (Appendix 4) only illustrates the main content of explanations and does not provide information regarding the frequency of comments.Where participants comments were identical in content, albeit with different vocabulary, only one instance is given, or the two have been combined e.g. 'Impulsive', and 'just happened without any thought' were combined to 'Impulsive-just happened without any thought'.

Participants' comments were then assigned to broad categories, (e.g. knowledge and understanding), which were derived from the literature, representing key types of attributional explanations for behaviour.

Knowledge and Understanding

This category included any statement regarding knowledge or understanding of the behaviour or it's consequences. It also included comments relating to skills. In accordance with the main hypotheses relating to the questionnaire, the explanations of the behaviour of the actor with a learning disability contained numerous comments about lack of knowledge, understanding and socio-sexual skills. Comments of this nature were

conspicuously lacking where the actor did not have a learning disability. Indeed, comments tended to reflect the belief that this actor fully realised what he was doing.

Sexuality

This category included comments relating to sexual orientation, motivation and deviance. It also contained comments which gave an explicit alternative to a sexual interpretation of the behaviour. With regard to sexuality, the responses for the 'learning disability' vignettes reflected alternative non-sexual explanations for the behaviour, such as 'experimenting' and 'showing affection'. Explanations also included comments that whilst the actor's sexual feelings might be 'normal', he may not 'understand' the feelings or how to act on them appropriately. Where the victim was a child there were several comments regarding the actor acting in accordance with their mental age, or seeing themselves as a child, or not recognising the child as a child , i.e. not being able to discriminate between child and adult. There was only one suggestion that the actors sexual orientation may have been to children in preference to adults. Where the victim was a female adult sexual frustration was also suggested as an explanation. Where the victim was a male adult there were several suggestions that the actor may be gay. There was one suggestion that the actor may be apparently gay although this might be due to opportunity rather than 'true orientation'.

The responses for the 'non-learning disability' vignettes clearly reflected the beliefs that there was a definite sexual motivation for the behaviour, and that arousal or behaviour patterns may be deviant. Where the victim was a male adult explanations included being

gay, 'perverted', being aroused by the risk taking involved in the behaviour, and fantasising about 'that kind' of sex. Where the victim was a female adult, one explanation also included fetishism, and gaining arousal through inflicting pain, humiliation and submissiveness. (The vignette did not imply any aggression being employed). Where the victim was a child, sexual deviation and deviant arousal were the main explanations given. It was also suggested that , if the preference was for male children, the actor was homosexual but was unable to acknowledge it. Several responses suggested there were likely to be multiple victims.

The responses illustrate that whilst the non-learning disabled perpetrator's behaviour is perceived as sexually motivated, often with deviant patterns. In contrast, that of the perpetrator with the learning disability was more likely to be seen as non-sexual, or where it was sexually motivated this was more likely to be due to his not understanding his sexuality or lacking the knowledge and understanding to act on the feelings in a more socially appropriate manner.

Control

This category included comments relating to impulse control. Responses to vignettes where the actor had a learning disability strongly reflected the belief that the behaviour resulted from impulse. These explanations applied to all victims. Whilst the same belief was also expressed where the actor did not have a learning disability, the majority of comments suggested that the behaviour was considered and planned by the perpetrator.

This were particularly noticeable where the victim was a child and there were several comments about perpetrators luring and tempting their victims.

Again, these comments reflected explanations in accord with the hypotheses relating to the questionnaire, i.e. that men with learning disabilities were more inclined to act on impulse than pre-plan their behaviour.

Influence of the Other Person

This category included comments relating to any influence the victim may have had on the behaviour of the perpetrator. Where the actor had a learning disability , and the victim an adult, there were suggestions that the victim had influenced the behaviour through encouragement or enticement. This was particularly evident where the victim was a female adult. Several comments suggested the victim possibly 'misinterpreted the behaviour'. Such comments tended to be made in cases where the respondent had provided a non-sexual interpretation of the behaviour.

Where the actor did not have a learning disability, there were no comments regarding the influence of male adult victims. Where the victim was a female adult however, there were a few suggestions she might have encouraged the perpetrator, and in one instance there were doubts expressed as to which of the two individuals in the vignette might have been telling the truth. Where the victim was a child there were two comments regarding the possibility of children 'making up' the incident, to 'get at someone' or 'copying' something told them by another party.

These explanations indicated that irrespective of whether or not the perpetrator had a learning disability, the victim was seen as having some influence on the behaviour, particularly if a female adult.

Influence of Other External Factors

There was some overlap between the items included in this section, and those in the 'Knowledge and Understanding' and 'Other Personal Factors'. The criterion for including items in this section was that they reflected clear environmental or situational factors such as institutional lifestyle, or control over lifestyle by others which might have had effects, for example, of not providing the perpetrator with normative life experiences.

Responses to the vignettes where the actor had a learning disability strongly reflected explanations regarding abnormal living environments, lack of opportunity for, and discouragement of, more normative socio-sexual experiences. Comments also suggested the behaviour was an attempt to emulate that seen in the media and between other people. Exposure to pornography and 'reflecting society's attitudes towards women' were explanations suggested where the victim was a female adult.

Where the actor did not have a learning disability there was a notable absence of comments regarding external factors, except where the victim was female. Explanations for the behaviour toward this victim predominantly centred around it being a reflection of society's attitudes toward women, such as portrayal as sex objects, non-assertion, not meaning 'no' and pornography. There were also several comments about the behaviour

reflecting society's myths and attitudes about men, such as not being able to control sexual impulses, and the belief that 'if a woman goes so far he has a right to expect the lot'. Where the victim was a child, exposure to child pornography was suggested as an explanation.

These explanations suggest that for both perpetrators, there are some attributions of responsibility to external factors, particularly where the victim is female. However, there was a greater variety of external explanations, and for all victims, where the actor had a learning disability.

Influence of Other Personal Factors

Again there was some overlap between this and other sections. The criteria for inclusion was that a comment should primarily centre on some internal state, e.g. mood , personality trait. Where the actor had a learning disability, for all victims, explanations included attention seeking, lack of confidence and poor self esteem, loneliness, need for love and affection. Where the actor did not have a learning disability, there were clear differences in the explanations according to the victim. Loneliness and low self-esteem were suggested where the victim was male, and 'power issues' and dislike of women, where the victim was female. Where the victim was a child, explanations included mental illness, feelings of inadequacy, power issues, and being 'perverted' .

Thus, explanations, regarding other personal factors, for the learning disabled actor embraced similar themes irrespective of victim whereas the explanations for the non-learning disabled perpetrator varied more according to the victim.

Other Comments

This section included the comments which did not clearly belong to another category, or which, because of the multiplicity of content, could have belonged to more than one category. Where the actor had a learning disability there were several comments advocating that the actor should not be held responsible, be blamed or punished for their behaviour, suggesting instead that appropriate education and social opportunities were required. There were several suggestions that the actor being a victim of prior abuse might be a factor in the behaviour, reflecting the belief that the abused become abusers. It was also suggested that people other than the victim may misinterpret the behaviour and overreact. Where the victim was a child it was suggested that the behaviour might be 'playing around that got out of hand'.

Where the actor did not have a learning disability there were also several suggestions, for all victims, regarding the actor being a victim of abuse. Comments also suggested an 'inadequate sex life' as an explanation. There were also several comments specific to the various victim groups. Where the victim was a male adult it was suggested that the actor might be 'gay' but fears 'coming out', and that he might not 'know how else to get sex'. Where the victim was female, explanations included women's non-assertion, not 'taking women and their rights seriously' , and being insulted by being 'told no'. Where the

victim was a child, there were several suggestions that sexual gratification might be easier with children. It was also suggested that the actor might uses bribes and threats and make the child fearful of disclosing, and that whilst 'outwardly caring' toward children, the actor could still be abusive.

The 'other' explanations of the behaviour of the two actors differed, with those for the perpetrator with a learning disability stressing the feasibility that the behaviour might be misinterpreted or 'overreacted to', and the inappropriateness of blame and punishment. There were no comments implying that the non-learning disabled actor should be absolved of blame. Prior abuse was an explanation common to both actors.

Summary

This pilot exercise involved participants giving free responses to a request to explain the behaviour described in a series of vignettes, with each participant receiving vignettes describing both learning disabled and non-learning disabled perpetrators. An informal analysis of participants' explanations demonstrates clear differences between the two types of actor, and also differences in explanations according to the type of victim.

CHAPTER 4 : DISCUSSION

This study addressed issues surrounding the identification and acknowledgement of sexual abusive behaviour by men with learning disabilities. Part 1, the questionnaire examined the attributions made about behaviour depending on whether or not a perpetrator had a learning disability. Part 2, the survey, examined the number and nature of referrals to learning disability services in Plymouth and Cornwall over a two year period, and the factors relating to delays in referral for assessment and treatment. For simplicity, these two components of the study will be discussed separately, with links between them drawn where applicable. These will be further augmented by qualitative information from participants' free responses to the pilot vignettes. However, as the vignettes used for this pilot phase of the study differed slightly from those comprising the questionnaire, the comparisons should be treated with a degree of caution.

1. Part 1: The Questionnaire

1.1. Methodological Issues

There are several criticisms that can be made of the vignettes and questionnaire. The vignettes were merely brief descriptions of an actor behaving toward a target person and contained no additional information regarding the individuals, or the situation, concerned. In real life, people generally have more information on which to base their explanations of behaviour. However, participants commented that despite this drawback, the behaviours described reflected those they had encountered in real life.

The vignettes were necessarily limited to specific behaviours to enable comparisons to be made between subjects. Thus only two behaviours were presented to participants,(i.e. the

actor rubbing his own penis and the actor rubbing his hand over the clothed genitals of the victim). Obviously, abusive sexual acts involve a multiplicity of behaviours each of which can further vary on many dimensions, such as degree of coercion used. Therefore, whilst the results of the study apply to the particular behaviours presented, any generalisation to other types of behaviour must be tentative.

The design and analysis of the questionnaire study was complex. There was a need to balance simplicity with the amount and quality of information obtained and with potential threats to validity. Had the six vignettes received by participants been identical, it might have been clear that it would enable the experimenter to make specific comparisons between responses. Such task transparency can be a threat to the validity of research. It is well known that participants often try to 'guess' the true reason for the study, and that participants may bias their answers toward those they believe are expected. However, this was guarded against in two principle ways. Firstly, the between subjects design reduced the likelihood of participants guessing that comparisons would be made between actors with and without a learning disability. Secondly, to reduce the likelihood of participants guessing that comparisons would be made between different victims, a Contact vignette was paired with a Non-Contact vignette for each victim category (e.g. male and female adult). Although this design meant a more complex analysis was necessary, this was felt to be justified in order to increase validity.

Spontaneous comments made by participants suggested these precautions were worth taking. Several said they had tried to guess what study aimed to find but, as the vignettes varied in terms of behaviour and victim, they were unable to do this. Also, in the debriefing

session following the administration of the questionnaire, it was explained that comparisons would be made between learning disabled and non-learning disabled actors. Of the participants who commented on this, all said they had not guessed that there were two different sets of questionnaires and that such a comparison would be made.

Ethical considerations included informing participants that the vignettes 'may' contain descriptions of behaviour which could be construed as sexual. Whilst this might have had a sensitising effect for participants in both conditions, there is a possibility that this may have been more salient and had more of an effect for those receiving the non-learning disabled vignettes. This might be especially the case where individuals 'deny' the sexuality of learning disabled people. Therefore, there is a risk that this effect may have accentuated the differences in the results between the two groups. The sensitising effect of instructions deserves closer attention.

The presentation of the questionnaire was discussed during piloting. Although the pages appeared densely written, comments were made that it was preferable to having questions pertaining to one vignette on separate pages. Several participants later commented that they found it easy to read and understand, and others said that they thought the questions were very interesting, and had found it a stimulating and thought-provoking task.

A broad sample of staff, with a wide range of working backgrounds participated in the study. They could therefore be assumed to be representative of the wider population of staff working with people with learning disabilities. It could, though, be argued that the

inclusion of voluntary and private sector staff and family carers would have enhanced the generalisability of the results.

Although not formally matched, the groups between and within the two main conditions were extremely similar in terms of qualification and years of experience. These are not the only factors though which are likely to influence results. Different services and units within learning disabilities services tend to evolve their own cultures. Such cultures foster and maintain certain sets of beliefs and attitudes, perhaps through training. It was evident from informal discussions with participants that the different groups had received a variety of training packages regarding learning disability and sexuality, with different emphases and underlying philosophies. This might partly explain the differential findings between the two replications for several of the questionnaire items, as despite attempts to randomly allocate questionnaires, the staff from one particular establishment were over represented in one of these groups.

1.2. Hypotheses and Results: The Questionnaire

Overall the results supported the main hypotheses that, compared with non-learning disabled offenders, staff would perceive those with learning disabilities as more impulsive and lacking understanding of the consequences of their behaviour, and their behaviour as less sexually motivated, and more influenced by the victim and other personal or external factors. The results strongly suggest that the attributions made about people with learning disabilities serve to impede the recognition and acknowledgement of sexually abusive behaviour. For clarity the individual questionnaire items will be discussed separately.

Impulsivity

As hypothesised, staff perceived the actor with a learning disability to behave more impulsively than the non-learning disabled actor. This finding was highly significant for both replications, strengthening the validity of the result. In terms of attribution theory, behaviour perceived as more 'planned' than 'impulsive' would be also be imbued with 'intention'. Attributions of intentionality are proposed as one the principle determinants as to whether or not the actor is held responsible and culpable for his actions (Jones & Davis, 1965). The fact that those with learning disabilities were seen as more impulsive strongly suggests they were also perceived as less responsible and blameworthy. This notion received additional support from the 'free response' analysis. The content of participants' comments showed attributions of impulsivity where the actor had a learning disability, and perceptions of planning and consideration where the actor was non-learning disabled. Although asked to make comments regarding *explanations* for behaviours, where the actor had a learning disability several participants spontaneously commented that the individual with a learning disability should not be 'blamed' or 'punished' for their behaviour.

Level of Understanding

Again, the actors with a learning disability were attributed with considerably less understanding of the consequences of their behaviour than those without a learning disability, with the results being highly significant. As with impulsivity, attributions about the actor's degree of understanding regarding the consequences of a behaviour determine the extent of attributions about intentionality. Level of understanding may also underpin the perceived 'ability' of the actor to perform the behaviour. If attributed with low understanding and low ability, it might be thought that the person could not have

knowingly or independently behaved in that manner. Consequently the victim or other factors may be attributed with relatively more influence over the behaviour.

As suggested in the clinical literature, a common way that the behaviour of learning disabled people is excused or tolerated (generally with benevolent intent) is to make attributions about their poor understanding of the meaning of the behaviour or it's consequences (Griffiths et al, 1989). This type of attribution may of course depend on the perceived cognitive ability of the individual, thus, this may be a more common attribution for people with a moderate or severe learning disability, but less evident where the person has a relatively mild disability. This prediction would need to be examined further.

Sexual Motivation

As hypothesised, the behaviour of actors with learning disabilities was perceived as considerably less 'due to sexual thoughts and feelings' than that of the non-learning disabled actors. This finding was highly significant for both replications, again lending validity to the findings. A tendency to desexualise the behaviour of men with learning disabilities is likely to be an important barrier to the recognition and acknowledgement of sexually abusive behaviour. Support for these findings also comes from the survey where, for nearly half the referred clients, therapists perceived delayed referral as due to staff/carers not considering the behaviour to 'be primarily sexual in nature'.

Although not reaching significance, in Replication 1 the scores suggested that where the actor had a learning disability, his behaviour was seen as less sexually motivated if the victim was a child than if an adult, with or without a learning disability. It also appeared

their was less sexual motivation attributed when the victim was a male adult than female adult. In Replication 2, however, the effect of Target was significant and there was a significant Actor by Target interaction. The learning disabled actor was seen as less motivated by 'sexual thoughts and feelings' when the victim was a male child, a male adult, or a male adult with learning disabilities. Curiously, when the victim was a female child, the actor with learning disabilities was perceived as more motivated by sexual thoughts and feelings than the actor without a learning disability. In addition, although the behaviour toward the male child involved physical contact, and the behaviour toward the female did not, the learning disabled actors behaviour was perceived as more motivated by 'sexual thoughts and feelings' when the victim was female. The descriptions of the free responses provides some tentative clues to explain these findings.

In the free responses, where the victim was a child, explanations suggested the learning disabled actor was 'acting his mental age'. It was suggested that if the victim was a female child, the learning disabled individual might be 'sexually attracted', but not realise his victim was a child and therefore an inappropriate partner. It was further suggested that if the victim was a male child, that 'normal adolescent experimenting' might be responsible. Where the victim was male, explanations also included 'adolescent experimenting'. It was also suggested that although the actor might apparently be 'gay', this might have been simply due to opportunity rather than an intrinsic sexual preference. Sexual 'frustration' was only provided as an explanation where the victim was a female adult. Thus, it would appear that behaviour is more likely to be perceived as motivated by sexual arousal where the victim is a female adult or child, but where the actor targets a male child or a male adult, various desexualised explanations are more commonly invoked to rationalise the

behaviour. There thus appears to be a reluctance to acknowledge that men with learning disabilities might be sexually attracted to males, whether child or adult. There are potential links with this finding and the literature in that 'homophobia' and negative peer and societal reactions to males being the victims of sexual violence, (Nasjeleti, 1980) have been found to be factors associated with non-reporting, and responses to disclosure, where males are victims of males.

It must be queried as to why there were no effects of target found in the other replication. Whilst it is possible that the Contact variable confounded the results, it might also be that this group differed in some way from the other. It was previously noted that there seemed to be differences in the nature of training regarding learning disability and sexuality between different services and establishments. Although comparisons between establishments were not formally examined, it appears that staff from one particular establishment were over represented in one of the replications. Thus, it can be hypothesised that the culture of this establishment, including the nature of their training, might influence the beliefs held about people with learning disabilities and their sexuality. Given the debate about the effectiveness of training, this would seem a useful line of further enquiry.

Other Personal Factors

There was a significant difference between actors with regard to the behaviour being attributed to 'other personal factors' for both replications. Thus, the behaviour of the actor with learning disabilities was attributed more to 'other personal' factors than that of the non-learning disabled actor. This finding gains support both from the survey and the free

responses to vignettes. In the survey, the behaviour of just over 70% of delayed referral clients was perceived to have been 'excused' because of their 'learning disability or other personal characteristics'. The free response explanations included, where the actor had a learning disability, personal factors such as 'loneliness, attention seeking, low confidence and low self-esteem, and the need for love and affection'. For the non-learning disabled actor however, whereas loneliness and self-esteem were suggested where the victim was male, 'power issues' and 'dislike of women' were explanations where the victim was female, and 'mental illness' and 'perversion' where the victim was a child. Thus it appears that as well as 'other personal factors' being seen as having a greater contribution to the behaviour where the perpetrator has a learning disability, the nature of the 'personal factors', or 'dispositions,' also varies according to whether or not the actor has a learning disability. The personal dispositions ascribed to the learning disabled individual could be construed as those which are less likely to invoke censure, and more likely excuse the behaviour, (e.g. low self-esteem) than those attributed to the non-learning disabled perpetrator (e.g. 'perverted').

As suggested by the attribution literature, people's perceptions are influenced by certain biases which may operate independently of the evidence with which they are presented (Shaver et al 1986). Information, or expectations, about and individual which are derived form various cues such as the 'category' to which the person is perceived to belong (such as 'learning disability') , provide the basis for making 'personal disposition' attributions. Behaviour which is discrepant from that which is expected is prone to being minimised and disregarded Jones & McGillis, 1976). Thus, it can be inferred from the results that despite the behaviour of the two different actors being identical, the 'personal dispositions' ascribed

differ according to whether or not they have a learning disability. Furthermore, the attributions made about the behaviour of the learning disabled actor may appear more benign, and thus serve to minimise the behaviour.

Influence of the Other Person

As hypothesised, in Replication 1, the behaviour of the actor with a learning disability was seen as more influenced by the target, than was the behaviour of the non-learning disabled actor. Although the trend was in the same direction, the difference for Replication 2 did not reach significance. Although the 'Contact' variable may have influenced the differential findings, the fact there was a significant effect of Target for both replications helped eliminate this possibility.

Overall there was a trend for male and female adults, and female adults with learning disabilities, to be perceived to have more influence on behaviour than the other victims, with least influence being attributed to children. These results find some support from the free responses to vignettes. For the learning disabled actor, these suggested that adult victims had encouraged or enticed the actor. Such suggestions were also made for the non-learning disabled actor and were particularly marked where the victim was a female adult. Although there were suggestions, for both actors, that in rare cases the child may have misinterpreted or fabricated events, there were no suggestions that they might have encouraged the actor.

There was also, in both replications, evidence to suggest that female adults with learning disabilities were perceived as having more influence than male adults with learning

disabilities. This perhaps helps explain the findings of Hard and Plumb (1987) who reported that women with learning disabilities who disclosed abuse were more likely to be disbelieved than their male counterparts. If attributed with more influence, and therefore responsibility, there is a risk that a victim's experiences will be minimised or disregarded.

There is some evidence then to suggest that the behaviour of learning disabled perpetrators is more likely to be perceived as influenced by the victim than the behaviour of the perpetrator without a learning disability, but, the perceived degree of the victim's influence will also, to some extent, depend on the sex, age and other characteristics of the victim. Further exploration of these issues may be of value in alerting us to potential biases which might influence the detection and acknowledgement of abusive behaviour.

Other Factors, External to the Actor

As hypothesised, the behaviour of the learning disabled actor was more likely to be attributed to other 'external' factors than that of the non-learning disabled actor. This finding was highly significant for both replications. Within the context of attribution theory, where external influences are perceived as high, then less responsibility and culpability is attributed to the actor (Shaver, 1975). These findings were supported by the descriptions provided by the free responses.

External factors include various facets of the situation and the environment which may be proximal or distant to the event. Thus, an external factor such as the influence of the target's behaviour is proximal, whereas the influence of lifestyle being controlled by others, is temporally more distant. Apart from the influence of the victim, the free responses for

both types of actor focused on more distant influences. This is most likely to be due to there being little situational information being provided in the vignettes to enable more temporally proximate attributions to be made. There were markedly more external attributions where the actor had a learning disability and, the explanations differed from those for the actor without a learning disability. Where the actor had a learning disability there were numerous comments suggesting abnormal living environments, and lack of the provision and discouragement of, more normative life experiences were factors influencing the behaviour. External attributions where the actor did not have a learning disability were absent where the victim was male, being predominantly made where the victim was female. These explanations centred on the influence on behaviour of society's myths and attitudes toward women, and male sexuality. Exposure to child pornography was the sole explanation offered where the victim was a child.

Concern Regarding Recurrence of the Behaviour

As hypothesised, there was significantly less concern regarding recurrence of the behaviour where the actor had a learning disability than where he was non-learning disabled. This was significant for both replications. It would follow that if the behaviour is seen as less likely to be sexually motivated, more impulsive, and more influenced by the other person and other personal and external factors, then concern that the behaviour might recur would be less. In the survey though, there was only one client for whom the therapist reported delayed referral to result from staff/carers considering there to be a low risk of the behaviour recurring. However, the main perceived reasons for delayed referral were that the behaviour was seen as 'not primarily sexual,' or was 'tolerated' or 'minimised'. It could

then be argued that if staff/carers beliefs were indeed consistent with these perceptions, that they would also have little concern about the recurrence of the behaviour.

There was also a significant within subjects effect of Target for both replications on this measure, with a significant Actor by Target interaction for Replication 1. For both replications, where the actor had a learning disability, the highest concern regarding recurrence was for child victims. This is interesting considering that the behaviour was less likely to be seen as sexually motivated when the victim was a child. Perhaps surprisingly, there was little difference in concern about recurrence according to whether the victim had a learning disability or not. It might have been expected that knowledge of the increased vulnerability of learning disabled adults to abuse (Turk & Brown, 1993) would have created more concern than for non-disabled adults. There are several possible explanations for this. As with other minority groups, people with learning disabilities have long been devalued. Despite the influence of philosophies such as 'social role valorisation', such devaluing may still be pervasive (Sinason, 1986). It can be argued that the abuse of a devalued person will be met with less concern than that of one who is valued. However, as learned from the literature on 'victim blaming', there can be attempts to preserve one's belief in a 'just world' by attributing responsibility to the victim rather than perpetrator (Jones & Aronson, 1973). If the victim with learning disabilities is seen as 'less deserving' of the experience than the non-learning disabled adult, this injustice may be rationalised by blaming the victim or in some other minimising the impact of the behaviour. This might then be reflected in less concern regarding recurrence than would otherwise be predicted.

The results suggest then, that where the perpetrator has a learning disability, there are (for various reasons), less concerns about the recurrence of abusive behaviour. Where there is less concern that a behaviour might be repeated, there is less likelihood that it will be considered serious and warranting attention, and consequently be reported. It might be expected that concern would increase following a subsequent instances of the behaviour, and that this would be reflected in the courses of action endorsed by staff.

Actions in Response to the Behaviour

Where the actor had a learning disability, the most favoured actions were to speak directly to the actor and to inform/consult professionals. With the exception of 'informing no-one', 'informing the police' was the least favoured option. In contrast, 'informing the police' was highly favoured where the actor did not have a learning disability, particularly for a subsequent occurrence of the behaviour. These findings are supported by findings that the learning disabled perpetrator is less likely to be referred to the criminal justice system (Charman & Clare, 1992).

For both actors, the number of endorsements for 'inform police, inform actor's family, and inform/consult professionals' all increased with the subsequent instance of abusive behaviour. Endorsements of 'speak directly to the actor' decreased with a subsequent instance. For the learning disabled actor, endorsements of 'inform victim's family' did not change with a subsequent instance, but doubled where the actor had a learning disability.

It was noted that, where the perpetrator had a learning disability, a very high proportion of staff endorsed informing or consulting a professional even following a first instance of

abusive behaviour. Two participants commented that although the questionnaire had not suggested this question was answered from the viewpoint of having professional responsibility for the actor, they had replied according to what they thought they ought to do, rather than how they actually might in that situation. They further suggested that as qualified staff were often overstretched, many incidents were dealt with by direct care workers and were not reported on unless considered very serious.

The questions regarding the course of action following instances of abusive behaviour were not analysed according to victim or whether or not the behaviour involved physical contact. It could be hypothesised that the nature of the action endorsed would vary according to the type of victim and the perceived severity of the abusive behaviour. This would be worthy of further examination.

Although it might be expected that concern about the recurrence of abusive behaviour might increase following a subsequent instance, and that the course of action might be different, it is worth considering the real life situation. As Turk and Brown (1993) suggested, cases of alleged sexual abuse are gradually filtered out. Where occurrences are not believed, acknowledged, or recorded, then these may not be subsequently recalled particularly if there is a lengthy period of time between incidents. The likelihood of there being an absence of knowledge about previous incidents is increased where, for instance, there is a high staff turnover or the client attends a succession of service provisions. It then becomes easy to see how abusive behaviour can be unrecognised, unacknowledged and unreported for a considerable period of time.

2. Part 2: The Survey

2.1. Methodological Issues

There were two main reasons why it was decided that the survey should seek a restricted amount of information. Firstly, there was concern that if too time consuming to complete, the return rates would be unacceptably low. Secondly, detailed information about the type of action which was taken in response to abusive behaviour was originally to be requested. However, there was a potential for some information to present legal and professional dilemmas, for example if the abuse of a child had not been reported to the appropriate authorities. It was therefore decided to omit requests for such information .

The survey might have proved difficult for the therapist to complete in the case of some clients. For example, a discussion with one of the participants clarified that the abuse and referral history of one client (who was excluded from the survey for other reasons) was not known as his records were not received from the area from which he originated. It is not known if any clients were omitted by therapists for this reason, or the extent to which lack of knowledge about a person's history affected the reported information. (However, more importantly, this may raise issues about the quality of treatment of clients and communication between services).

The instructions for the completion of the survey forms (Appendix 3) did not specify a minimum age criteria for referred clients. Thus, whilst several participants included clients in their early-mid teens, other participants may only have included 'adults'. This may have influenced the number of referrals reported. Given the importance of the identification of younger offenders, these teenagers were included in the analysis.

Two of the participants enclosed notes with their returns commenting on the number of clients they had with these difficulties and saying that the survey had alerted them to the fact sexual abuse behaviours formed a surprisingly significant proportion of their casework.

2.2. Hypotheses and Results : The Survey

The referrals for assessment and treatment reported by therapists were likely to underestimate the extent of the problem of abusive behaviour in men with learning disabilities. The survey included only those referred or treated within a two year period and as the literature suggests, sexual offending can be a lifelong problem. It is likely that there may be other men whose behaviour had not been reported by victims, nor detected, nor acknowledged as serious. Additionally, not all therapists working with this client group participated, for example because having only worked in the service for a short time. As previously mentioned, the exclusion of a minimum age criterion may have reduced the number of reported referrals. Thus, as suggested by Turk and Brown (1993), the reported cases may only represent a fraction of real instances.

Client IQ

Unfortunately, details of IQ scores were available for less than half of the reported clients. It is therefore difficult to draw any conclusions from the available scores. However, of note was that four clients fell in the WAIS-R IQ range 71-80 and this would mean that some services would not consider these men 'learning disabled'. However, the cut-off score of 70 is arbitrary and a broad definition of learning disability, as suggested by the BPS (1991), permits the individual's adaptive behaviour to be considered regarding appropriate services

for that person. For this reason, those clients scoring above 70 were included in the analysis.

Client Age

As predicted by Hypothesis 1, and consistent with other studies (e.g. Gilby et al, 1989), clients' first known offences tended to occur during adolescence or early twenties. There was only one notable exception to this: a young man whose abusive behaviour began when he was only 3 years old.

Hypothesis 2 predicted there would be at least a year between the first known offence and referral for treatment. Although the results did not support this hypothesis, clients ages tended to be given in full years rather than months and years. This had the effect of reducing the differences between the ages for the two events. Additionally, several therapists noted that they lacked details regarding some client's histories, being only aware of very recent incidents. Also, assuming that earlier instances may have been less serious, given the evidence regarding increasingly serious behaviour over time, it is likely that these instances were never detected or reported. These factors also introduce bias into the age of 'first known offence'. No conclusions can therefore be drawn from these particular findings.

The results also supported the hypothesis that referral would be more likely to be in response to a 'subsequent' rather than 'first known' offence, (Hypothesis 3). Indeed three times as many referrals were for a 'subsequent' offence. There are several factors to consider when interpreting this finding. Participants were asked to consider offences which were strongly suspected as well as those which were corroborated as abuse is rarely

substantiated by incontrovertible evidence (Turk & Brown 1993), and thus to include only 'proven' cases would further underestimate incidence. However, 'strongly suspected' was not defined in the instructions and so it could be argued that there must be doubts about the basis for allegations. Conversely, as earlier or less serious offences may have escaped detection, the proportion of referrals for 'first known' offences may be an over-estimate.

With regard to the victims, results supported those of other studies in that offences were against a range of victims and involved a range of abusive behaviours. In slight contrast to Gilby et al's (1989) study, which found that males and females were equally likely to be victims of the learning disabled offender, this study found all female categories more likely to be targeted than any of the male categories. However, the small number of cases in this study makes generalisation difficult. Also, there is evidence to suggest that the abuse of males is less likely to be reported than that of females (Pescosolido 1989).

Female children were the group targeted by the most number of clients (10 of the 24). There may be several explanations for this. Campaigns such as Childline and Kidscape may have increased the reporting rates for these victims. Perhaps also offences against female children are viewed as being more serious than offences against other types of victim, and therefore be more likely to be reported. There is support for this proposition from the responses to the questionnaire regarding concern about recurrence of the behaviour. Within the Learning Disability condition, concern about recurrence was higher where the victim was a child, than if an adult or an adult with learning disabilities. Interestingly though , there was some evidence that concern about recurrence may be greater for boy than for girl victims. This may suggest that factors other than degree of concern about

recurrence influences the reporting where boys are the victims, such as negative reactions from others (Nasjleti, 1980).

Fractionally under half of the referred clients had targeted more than one victim category. This supports Hypothesis 4 which predicted more than a quarter of referred clients would be likely to have targeted more than one type of victim. Of these clients there were a few instances of specific preferences, e.g. female only, or child only, but no clear category preference in other cases. Even though slightly over half had offended against one victim category only, it should be borne in mind that there may have been multiple victims for each offender. Indeed, for some of these clients therapists indicated that multiple offences had occurred. The number of victims for each client was not requested, and besides, this would be difficult to establish with any certainty without focused case studies.

Consistent with the literature on offenders in the general population (Kercher and McShane, 1984), the commonest behaviours were those generally considered less serious, e.g. exposure, making explicit demands and requests, (Table 9). Fewer clients engaged in the more invasive behaviours, such as attempted or actual penetration. There are other factors to consider making inference about these results. Firstly, the questionnaire did not specify a complete range of sexual activities, for example voyeurism was not included. During piloting the categories were considered to encompass a broad spectrum representative of the most frequently encountered behaviours, and into which most behaviours could be subsumed, for example, making obscene telephone calls could be included in the category 'makes explicit sexual statements, requests, etc.'. Neither do the categories provide any information about the manner in which the behaviour was

performed. 'Severity' of abuse can be defined in various ways, such as the degree of aggression used. Therefore, it cannot be assumed that the behaviours generally perceived as less serious, are necessarily less traumatic for the victim and less worthy of concern. It has also been suggested that the less serious behaviours are part of the grooming process adopted by offenders to engage potential victims (Kercher and McShane, 1984), and therefore their importance should not be prematurely minimised. Perhaps most importantly, several therapists commented that they did not know the history of certain client's behaviours and were therefore only able to report the few of which they were aware. A striking feature of some therapists' reporting was that where a client was indicated to have performed one of the more invasive behaviours, there was an absence of reporting those which were less invasive. It might be predicted that a person engaging in more serious behaviours might also perform those which are less invasive, but, being comparatively less salient, the less invasive behaviours are less likely to be considered. When all these factors are taken into consideration, it would suggest that those behaviours reported conveyed only a fraction of those which had actually occurred.

The main reasons perceived by therapists for delayed referrals were that the behaviour was excused because of the client's learning disability or other personal factors, that staff/carers devised their own interventions and that the behaviour was not considered primarily sexual in nature. For a further seven clients, even where detected or reported, offence behaviour was either not considered serious, or was tolerated or minimised by staff /carers. The perceptions of excusing, minimising, and desexualising of the behaviour support Hypothesis 5, and the findings from the questionnaire, in that where the perpetrator has a learning disability he is perceived to have less understanding, be more impulsive, and that

his actions are more likely to attributed to the victim, and other internal and external factors - in other words he is held less responsible and less blameworthy. There may also be some parallels with the phenomenon of denial encountered in a significant number of partners and spouses of abusers (Salter, 1988). Where the perpetrator is known and previously trusted, it may be easier to minimise and deny the abuse has occurred rather than face harsh realities.

The principle prompt, as perceived by therapists, to make a later referral was that the same or similar behaviour occurred. This finding supported Hypothesis 6 and again is consistent with the literature which repeatedly reports multiple offending in the general population and those offenders with learning disabilities. For only two clients was 'more serious abusive behaviour' given as the perceived motivation for referral. However, given the lack of information about client histories reported by therapists, it is likely that progression to more serious offences would be known only in a few cases. This finding was in accordance with that of the questionnaire in that with subsequent abusive behaviour staff were more likely to endorse 'consulting/informing a professional. '.

It was interesting to note that, for eight clients, referral was perceived to have been deferred because 'staff/carers devised their own interventions to deal with the behaviour'. However, for 6 clients, the perceived motivation for a later referral was that 'staff/carer interventions did not reduce or eliminate the behaviour'. The treatment of sexually abusive behaviour can be complex, incorporating many elements, and numerous factors will determine the successfulness of the outcome. It is therefore not unexpected that preliminary attempts might not be successful. However, the fact that staff/carers had seen

fit to implement interventions of some kind indicates that problems were recognised and met with concern.

With regard to ease of treatment, a majority of therapists considered that this would have been enhanced had the referral been made earlier. Thus Hypothesis 7 was supported. As suggested in the literature, offending behaviour is strengthened over time, which tends to make treatment more complex and lengthy the longer the behaviour has occurred (Marshall & Eccles 1991). This has enormous implications for the offender, and also for services in terms of costs and demands on resources.

3. Clinical Implications and Directions for Future Research

The findings of this study suggest that sexually abusive behaviour performed by men with learning disabilities may be less likely to be identified than if performed by someone without a learning disability. Even where it *is* detected, abusive sexual behaviour may be minimised and tolerated. Further research is required to clarify how recognition and acknowledgement is influenced by factors such as the type of victim and the nature of the behaviour, and the beliefs and attitudes of staff and carers.

Conte (1991) suggests that whilst disbelief and denial are common psychological mechanisms for dealing with 'unpalatable truths', these biases also 'taint the thinking and practice' of professionals responsible for service design and delivery. In consequence, professionals and care workers who hold theories about abusive sexual behaviour which serve to minimise the offender's behaviour, (e.g. that it's about power, that it's not sexual, or that it's his way of 'showing affection'), are not likely to be in a position to effectively

help offenders or their victims. It also serves to maintain the systems which, some would suggest , predispose those with learning disabilities to abuse, and also make vulnerable to becoming a victim of abuse.

However, not all learning disabled men who behave in a sexually inappropriate manner toward others will have the more serious pathology typically associated with sex offences. For these people, skills deficits and the problems associated with inadequate and institutional living may well be the most parsimonious and appropriate explanations for behaviour, and skills training accordingly be the most suitable form of treatment. However, more information is required before such distinctions can be easily and confidently made. The heterogeneity of sex offenders in the general population is well documented (Marshall & Eccles, 1991), though typologies and discriminatory factors are continually being refined. Taxonomic systems may help to provide information about etiology and effective prevention and treatment. However, the subtle differences between the learning disabled and non-learning disabled offender, and the ways in which aspects of learning disability interact with various offender characteristics, are still largely unclear and based primarily on clinical case studies. There is a need to develop validated methods of assessment and treatment, and to augment valuable clinical findings with empirical study.

The evidence of barriers to detection, and delayed referrals for treatment, also suggests that services need to consider developing strategies and procedures to facilitate effective reporting and assessment. Given the complexity of assessment and treatment, and a low number of cases spread over a large geographical area, there is a risk that services for learning disabled people who sexually offend will be piecemeal and lacking a core of

expertise. Although individually tailored treatment programmes have been shown in many cases to be effective, irrespective of the degree of learning disability (Schilling & Schinke, 1989), not all approaches are effective, nor are many programmes effective for some types of offender (Marshall & Eccles, 1991). The adaptation and development of treatment approaches for learning disabled offenders is a ripe area for further study and would benefit from case studies as well as a more empirical approach. Unfortunately, where treatment is lacking, inappropriate or inadequate, there may be a reliance on custodial care, segregation, and behavioural control through psychopharmacological methods.

The results of the study also suggest, as do those examining the abuse of people with learning disabilities, that to increase the likelihood that abusive behaviour will be recognised and acknowledged, ~~that~~ staff and carers would benefit from education. Furthermore, as evidence suggests that offending behaviour begins in adolescence and that earlier treatment benefits the offender, victims, and service resources, then education needs to be provided for those involved with younger learning disabled people. Although, the historical negative views - largely based on myths and stereotypes, of the sexuality of the learning disabled persons have largely disappeared, it would be understandable should there be concerns that such views might be reawakened by raising awareness regarding men with learning disabilities who sexually offend. However, if the area of sexual problems is encompassed within the whole context of relationships and sexuality, and if the main aim is to enable people with learning disabilities understand, take responsibility for, and express their sexuality in socially acceptable ways, this may sensitively increase awareness, and help prevent sexual offences.

4. Conclusions

Although the actual reported number of learning disabled men referred for the assessment or treatment of sexually abusive behaviours is small, the evidence is that offences are under-reported, and that multiple offending is not uncommon. The costs in terms of the number of victims and the extent of harm done is not known.

This research has shown that staff in learning disabilities services make different attributions about abusive sexual behaviour according to whether or not the perpetrator has a learning disability, and that these attributions may serve to hinder the early identification, acknowledgement and reporting of such behaviour where the perpetrator is learning disabled.

It is hoped that the implications and recommendations of this study may ultimately help prevent abuse, and promote treatment opportunities for the learning disabled offender.

Director of Operations
Cornwall & IoS Learning Disabilities Trust
57 Pydar Street
Truro.

Dear Peter,

Doctorate in Clinical Psychology Course : Research Project

I am conducting a research project which has been approved by Devon and Cornwall Local Research Ethics Committees. My field supervisor is Dr Paul Robinson, and the academic supervisor is Kevin Simpson/Helen Saxby at the University of Plymouth, Clinical Teaching Unit.

The aims of the research are :
* **Part 1** to assess attributions, using rating scales, made by care staff about sexual behaviour described in vignettes.
* to gather information about the number and types of referrals to professional staff in learning disabilities services for the assessment / treatment of illegal sexual behaviour conducted by men with learning disabilities.
* **Part 2** To examine whether staff attributions about sexual behaviour might influence the referral process.

I am seeking your approval to invite staff in the Learning Disabilities Trust to participate in this study.

Part 1 of the study involves reading six brief vignettes giving a brief description of a potentially abusive sexual behaviour toward another person. Each vignette is followed by several rating scales describing attributions about the behaviour. Participants will be asked to mark their favoured response from a series of options. The entire task takes about 15 minutes to complete. I am hoping to obtain 35-50 care staff for this task. All participants and their responses will be completely anonymous.

Part 2 is a postal survey questionnaire for professional staff including psychologists, and psychiatrists. The questionnaire requests information about the nature of illegal sexual behaviour referred for assessment/ treatment during the last two years, client's IQ, and stage at which the client was referred, and factors which staff consider may have prompted or delayed referral. Again it is only necessary for staff to mark their chosen response from a series of options and all participants and their responses will be completely anonymous.

All potential participants would be provided with written information about the nature of the study, the nature and content of the task, and be asked to sign a consent form indicating their willingness, or otherwise, to participate.

If you are in agreement that staff may be invited to participate, then I would like to conduct the study during November . My thoughts were that it might be most convenient, for Part 1 of the study, for staff to undertake the task in groups, e.g. at the end of a house meeting.

I have enclosed a draft letter for your approval to Local Service Managers regarding the project. As they may participate in the project, the information about the aims brief. I have also included an example of a vignette, letters inviting participation and the consent form.

I am currently most easily contactable at Grenville Ward, Penrice Hospital, St Austell, (Tel 0726 66138) where I am based on placement Monday to Thursday, or at my home address and number, given above, on Fridays.

I look forward to hearing from you

Yours Sincerely

Caroline Yates
Clinical Psychologist in Training.

Copies to :

[redacted]

Local Services Manager
North Cornwall Core Team
10 Exeter Street
Launceston

Dear Debbie ,

Doctorate in Clinical Psychology Course : Research Project

I am conducting a research study as part of the above course. The study has been approved by the Local Research Ethics Committee. I am supervised by Dr Paul Robinson and Kevin Simpson/Helen Saxby at the University of Plymouth.

I am writing to request your approval to invite direct careworkers in the SDH's in your locality to participate in the study.

The aim of the project is to assess attributions, using rating scales, made by care staff about behaviour. It involves reading six brief vignettes giving a short description of a potentially abusive sexual behaviour toward another person. Each vignette is followed by several rating scales describing attributions about the behaviour. Participants will be asked to mark their favoured response from a series of options. The entire task takes about 15 minutes to complete.

All participants and their responses will be completely anonymous. It would be most convenient for staff to undertake the task in groups, e.g. as part of a weekly meeting

I would ask you, at this stage, not to discuss the nature of the project with staff as this might influence the results.

If you are happy for me to proceed with this research project in your locality then I would like to make arrangements with home leaders through liaison with you. Further to our telephone conversation I have included letters for home leaders.

I am currently contactable at Grenville Ward, Penrice Hospital, St Austell, (Tel 0726 66138) where I am based on placement Monday to Thursday, or at my home address given above.

I look forward to hearing from you

Yours Sincerely

Caroline Yates
Clinical Psychologist in Training.

INSTRUCTIONS

PLEASE READ THESE CAREFULLY BEFORE TURNING THE PAGE

All your replies will be completely anonymous.

1. Read one page at a time in the order it is given.

2. For each of the rating scales, circle the response which best suits your opinion. Work through each item *quickly* but carefully.

3. Please answer all the questions *without looking back* at your previous answers.

4. When you have finished, please put your forms in the envelope provided.

Please do not discuss this task with colleagues in other establishments, at least for a few weeks, as they may be participating in the project during this time.

Before you begin, please indicate your qualifications and experience in the box below.

<table>
<tr><td>Do you have a formal qualification for your current post, e.g. RMNH, NVQ</td><td>YES</td><td>NO</td><td>in training</td></tr>
<tr><td rowspan="2">Approximately how many years experience do you have working with people with learning disabilities?</td><td>1-5</td><td>6-10</td><td>11-15</td></tr>
<tr><td colspan="3">16 or more</td></tr>
</table>

H is an adult man with a learning disability. He approached a man in a secluded place. He undid his own trousers took out his penis and rubbed it.

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

M is an adult man with a learning disability . He approached a woman with a learning disability in a secluded place. He rubbed his hand over the woman's clothed genitals

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

S is an adult man with a learning disability. He approached a man with learning disabilities in a secluded place, took out his own penis and rubbed it.

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc.	

H is an adult man with a learning disability. He approached a man in a secluded place. He rubbed his hand over the man's clothed genitals

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

H is an adult man with a learning disability. He approached a woman in a secluded place. He undid his own trousers took out his penis and rubbed it.

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

D is an adult man with a learning disability. He approached an eleven year old boy in a secluded place. He undid his own trousers took out his penis and rubbed it.

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal factors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

T is an adult man with a learning disability. He approached an eleven year old girl in a secluded place. He rubbed his hand over the girls clothed genitals

1. To what extent do you think his behaviour was planned or impulsive?

highly likely to planned	somewhat planned	uncertain	somewhat impulsive	highly likely to be impulsive

2. To what extent do you think he understood the consequences of his behaviour?

very good understanding	good understanding	uncertain	poor understanding	very poor understanding

3. To what extent do you think his behaviour was due to sexual thoughts and feelings?

highly likely to be due to sexual thoughts &feelings	likely to be due to sexual thoughts & feelings	uncertain	unlikely to be due to sexual thoughts & feelings	highly unlikely to be due to sexual thoughts &feelings

4. To what extent do you think his behaviour was due to other personal factors such as his life history, mood, social status, self esteem, loneliness, etc?

highly likely to be due to other personal factors	likely to be due to other personal factors	uncertain	unlikely to be due to other personal fatcors	highly unlikely to be due to other personal factors

5. To what extent do you think his behaviour was influenced by the other person?

highly likely to be influenced the by other person	likely to be influenced the by other person	uncertain	unlikely to be influenced the by other person	highly unlikely to be influenced the by other person

6. To what extent do you think his behaviour was due to other factors such as poor quality of relationships, poor opportunities to make relationships, poor sex education, poor use of time, etc,.

highly likely to be due to other factors	likely to be due to other factors	uncertain	unlikely to be due to other factors	highly unlikely to be due to other factors

7. How concerned would you be that he might behave this way again?

very high degree of concern	high degree of concern	uncertain	low degree of concern	very low degree of concern

8. If you knew him, and this was the first incident of this type that you were aware of, what main course of action do you think you would take? *(mark with a tick)*. Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform, or seek advice from, professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

9.If you knew him, and this was at least the second incident of this type you were aware of, what main course of action do you think you would take?(*tick*) Put a cross against any you would **not** take.

Inform the police		Inform the other person's family	
Inform his family		Inform no-one	
Speak to him directly		Inform professional,eg, psychologist, psychiatrist, nurse, social worker, etc	

SURVEY OF MEN WITH LEARNING DISABILITIES WHO HAVE BEEN REFERRED FOR ILLEGAL SEXUAL BEHAVIOUR

Thank you for participating in this study

Please read this information carefully before you begin

1. Please include those clients who have been referred to you for assessment and/or treatment for illegal sexual behaviour, within the last two years,
OR, who may have been referred prior to this time but with whom you have continued to work during the last two years.

2. Each client's details are to go on separate forms. One form takes about 5 minutes to complete, including referring back to case notes.

3. Please **do not** identify the client by name, but by initials and age only. These are required to ensure that each person's data is only processed once in instances where details are supplied from different sources. Thereafter each person will be completely anonymous.

4. A sheet containing code letters for various categories of illegal sexual behaviour is attatched to be used for section 2. of the survey form.

5. Your responses will be completely anonymous, unless you choose to identify yourself on the form

6. When you have completed the form, seal it in the stamped addressed envelope provided and post it.

7. Please feel free to add any additional comments in the space provided.

Once again, thanks for your time and effort in helping with this research.
Caroline Yates
(Clinical Psychologist in Training)

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

1. Include only adult *male* clients referred to you, or with whom you have been working, since January 1993. You may need to refer to client's notes for some information.

2. Complete a separate questionnaire for each client.

3. Clients initials are requested solely to check for duplications when collating the information. Initials will not be used to identify individuals. All clients and involved professionals will remain completely anonymous.

4. The term 'abusive sexual behaviour' has been used on the questionnaire. This is defined as :- *'looking at or touching certain parts of a second persons body for the purpose of gratifying or satisfying the needs of the first person and when a barrier to consent is present for the second person'. This may include compelling the second person to look at or touch certain parts of the first person's body (Sgroi, 1989). Barriers to consent include the use of threat or force by the first person, age below 16 or cognitive inability to understand sexual behaviour on the part of the second person, and the presence of a power imbalance.*

5. Descriptions and codes for sexually abusive behaviours are provided on a separate sheet. Please circle on the questionnaire the code letter which best suits the behaviour/s demonstrated by the client.

6. CLIENTS FIRST KNOWN ABUSIVE SEXUAL BEHAVIOUR.
Please include incidents which are corroborated or strongly suspected to have occurred. This will include prior incidents which are identified whilst clarifying the client's background history, as well as those for which the client has been referred.

7. Seal completed questionnaires in the stamped addressed envelope provided and post.

With thanks for your interest and participation

Caroline Yates (Clinical Psychologist in Training)

CLIENT'S INITIALS		CLIENT'S AGE NOW	Yrs Ms
FULL SCALE WAIS-R SCORE (IF KNOWN)	40 OR LESS 41-50 51-60 61-70 71-80		

TYPE OF ABUSIVE SEXUAL BEHAVIOUR

* Put a tick in each shaded box which describes the victim/s this client has targeted.
* Against each ticked box, circle the code of each type of illegal sexual behaviour this client is known to have displayed. *The code reference sheet attached provides codes for descriptions of behaviour.*

VICTIM DESCRIPTION	TICK BOX	CODE LETTERS							
(MALE ADULT) (OVER 16)		A	B	C	D	E	F	G	H
FEMALE ADULT/s (OVER 16)		A	B	C	D	E	F	G	H
MALE ADULT/s WITH LEARNING DISABILITY		A	B	C	D	E	F	G	H
FEMALE ADULT/s WITH LEARNING DISABILITY		A	B	C	D	E	F	G	H
MALE CHILD/ren (UNDER 16)		A	B	C	D	E	F	G	H
FEMALE CHILD/ren (UNDER 16)		A	B	C	D	E	F	G	H

ASSESSMENT / TREATMENT HISTORY

CLIENT'S AGE AT FIRST KNOWN ABUSIVE SEXUAL BEHAVIOUR (i.e. as reported by client, victim, or other)	Yrs Ms
CLIENT'S AGE AT FIRST KNOWN REFERRAL TO PROFESSIONAL SERVICE FOR ASSESSMENT/TREATMENT OF ABUSIVE SEXUAL BEHAVIOUR	Yrs Ms
WAS THE FIRST REFERRAL FOR ABOVE ASSESSMENT/TREATMENT A DIRECT CONSEQUENCE OF THE FIRST KNOWN **OR** SUBSEQUENT ABUSIVE SEXUAL BEHAVIOUR? Circle appropriate answer	FIRST KNOWN SUBSEQUENT

If referral for assessment/treatment of the behaviour did not immediately follow the first known illegal sexual behaviour, why do you think this was?
Please mark with a tick each reason/s you think strongly applies.

No service to refer to	
Staff/carer did not know who to refer to	
Client moved area or establishment attended	
The behaviour was not recognised as significant by staff / carers of this client	
The behaviour was not reported by the victim.	
The behaviour was detected/reported by victim and was considered potentially serious, but a referral for assessment/treatment was not made or pursued	
The behaviour was detected/reported by victim but was not considered serious	
The behaviour was detected/reported by victim but was tolerated or minimised by staff/carers	
The behaviour was not considered to be primarily sexual in nature, e.g. was primarily attributed to social skills / knowledge/deficit of appropriate opportunities.	
The behaviour was excused because of this client's learning disability or other personal characteristics	
Staff/carers of this client devised own interventions to deal with the behaviour	
Staff /carers thought there was a very low risk of the behaviour recurring	

If referral for assessment/treatment of the behaviour did not immediately follow the first known illegal sexual behaviour, what prompted a later referral ?
Please mark with a tick each reason/s you think strongly applies.

The same or similar behaviour recurred	
The behaviour was not detected/reported by victim until some time after it occurred	
More serious abusive sexual behaviour occurred	
Staff/carers interventions did not reduce /eliminate the behaviour	
This client requested referral for assessment/ treatment	
Staff/carer/ other involved person requested referral for assessment/ treatment	
Staff/carers thought there was a high/ increased risk of potentially abusive sexual behaviour occurring.	

If this client had been referred earlier, do you think it would have made any difference to how amenable their sexual behaviour was to treatment? *Circle which best suits your opinion*

Treatment would have been considerably easier	Treatment would have been somewhat easier	Earlier referral would have made no difference to ease of treatment	Treatment would have been somewhat more difficult	Treatment would have been considerably more difficult

OR If this client was referred early what difference do you think this has made to treatment? *Circle which best suits your opinion*

Treatment considerably easier	Treatment somewhat easier	Early referral made no difference to ease of treatment	Treatment somewhat more difficult	Treatment considerably more difficult

Thank you for taking the time to complete this survey.

DESCRIPTIONS AND CODES FOR ABUSIVE SEXUAL BEHAVIOURS

CLIENT DOES, OR ENGAGES VICTIM TO DO :	CODE
Make explicit sexual statements, requests, demands.	A
Expose genitals	B
Masturbate self or other person	C
Touching body, over or under clothing (e.g. breasts, buttocks, thighs)	D
Touching genitals over or under clothing with hands	E
Touching genitals over or under clothing with genitals	F
Oral contact with body or genitals	G
Penetration or attempted penetration (vaginal or anal).	H

Appendix 4

Pilot Vignettes used for Free Responses

M is an adult man/ M is an adult man with learning disabilities. While in a secluded place he approached a man and rubbed his hand over the man's body and buttocks

D is an adult man/ D is an adult man with learning disabilities. While in a secluded place he approached a woman and rubbed his hand over her body and breasts

S is an adult man/ S is an adult man with learning disabilities. While in a secluded place he approached an 8 year old child and rubbed his hand over the childs legs and under their clothes.

Appendix 4. Free Responses to Pilot Vignettes

Summary of main themes of participants' responses

ACTOR WITH A LEARNING DISABILITY

VICTIM:MALE ADULT

Knowledge/Understanding
Ignorance - not knowing the difference between right & wrong
Not understanding the consequences of their behaviour/effectson other person
Innocence -not really knowing what they're doing/that they're doing something wrong
Ignorance through inadequate sex/personal relationships education
They might not realise they've done something wrong if inappropriate sexual behaviour has been tolerated or ignored
in the past because of being in an institution or treated like a child
Not have the skills to make relationships with women

Sexuality
May not be sexual, other motivation e.g affection
May not realise that what they are doing is sexual
Normal sexual feelings-just don't know what to do with them and with whom
Easy to misinterpret as sexual when might be a rational non-sexual explanation
Homosexual /gay - although may not be true orientation -just taking any opportunity
Just experimenting like healthy adolescents -as adolescence may be later or people with learning disabilities

Control
Impulsive/just happened without any thought
May just have been spur of the moment and it not really matter what the sex of the other person was-could have been either and not necessarily a preference for men

Influence of the Other Person
Provoked/encouraged/ enticed/ by other man
Other person may not know about LD, might get the wrong impression about what was done

Influence of Other External Factors
They've been discouraged from having normal sexual relationships /relationships with females/learned they get into trouble by touching women
Used to only being with men, like in an institution/used to sex with men because of abnormal environment- living in sex segregated place-learned behaviour
Abused by men
Lack of appropriate opportunities for a normal social / sex life

Influence of Other Internal Factors
Attention seeking / good way of making sure you get a response from someone
Shy of women/ not have confidence with women

Other
Punishment inappropriate/shouldn't be punished- just need education and opportunities

ACTOR WITH A LEARNING DISABILITY
VICTIM: FEMALE ADULT

Knowledge/Understanding
Lack of education and social skills
Not realising consequences of their behaviour/effects on other person
Ignorance - not knowing the difference between right & wrong
Innocence -not really knowing what they're doing
Not understanding about consent
They might not realise they've done something wrong if inappropriate sexual behaviour has been tolerated or ignored in the past
Doesn't know difference between different sorts of relationships e.g.friends, boyfriend/girlfriend etc
Not understanding the cues given by the woman

Sexuality
Sexual frustration
Might have sexual feelings but not understand what they are or know how to express them/or with whom to express them
Might misinterpret as sexual when might be non-sexual explanation - easy to jump to conclusions because of our own expectations
May not be sexual, may be other motivation e.g affection

Control
Impulsive/spur of the moment /not thinking

Influence of the Other Person
Other person involved might have misinterpreted what was happening
Being 'led on'/provoked/encouraged by other person
Don't know what she might have been wearing or how she was behaving
- might have been provocative
May not know about LD, might misinterpret what he did.

Influence of Other External Factors
Lack of appropriate opportunities being providedfor a normal social / sex life
Copying what they've seen on the TV/picked up from other people, media etc
Exposure to pornography
Just reflecting society's attitudes and behaviour toward women - being seen as sex objects

Influence of Other Internal Factors
to gain affection/only way of getting affection/reassurance of physical touch
Attention seeking

Other
If being forceful, may be because that's how they've been treated themselves
Just be trying to be like everyone else -society norms- like having normal sexual relationships
Other people might make more of it than there really is / others (staff etc) might over-react
Shouldn't be punished- just need education and opportunities

ACTOR WITH A LEARNING DISABILITY
VICTIM: CHILD

Knowledge/Understanding
Poor social skills
Ignorance through lack of adequate sex /personal relationships education
Not realising consequences of their behaviour/effects on other person
Not knowing the law
They've probably never been told that that sort of thing is wrong
Innocence -not really knowing what they're doing/that they're doing something wrong

Sexuality
Easy to misinterpret as sexual when might be anotherl explanation
Probably not because they're perverted
Just experimenting like a healthy adolescent , especially like boys might do together,
-adolescence may be later for people with learning disabilities
may not see the child as much younger than them
Not realise that what they are doing is sexual
Sexually attracted to kids rather than adults
Normal sexual feelings-just don't know what to do with them and with whom
If a girl could be sexually attracted, but he might nor realise she's a child and not an appropriate partner

Control
Impulsive/spur of the moment /just happened without any thought

Influence of the Other Person
Child might exaggerate/misinterpret because they are afraid they might get into trouble/ child might be worried that they've done something wrong

Influence of Other External Factors
Lack of appropriate sexual partner
Lack of appropriate opportunities for a normal social / sex life
May be treated as a child themselves most of the time

Influence of Other Internal Factors
loneliness / lack of sexual partner
Just a way of giving and receiving affection /reassurance/love

Acting mental age /see themselves as more of a child than an adult
Not have the confidence to make relationships with adults
Children are probably only ones they feel confident with/not scared of approaching
Attracted to kids but because they're not as threatening rather than a sex thing
Low self esteem and less likely to get rejected by child as may have a history of rejection by more appropriate partners
Just playing around/wanting physical contact without any sort of malicious intention

Other
Likely to have been sexually abused- more vulnerable
Shouldn't be blamed, it's really the fault of services and families for not providing appropriate education about relationships or creating opportunities for them to be sexual.
Playing around that got out of hand-might have got sexual afterwards

ACTOR NON LEARNING DISABLED
VICTIM: MALE ADULT

Knowledge/Understanding
Must know what he's doing

Sexuality
Homosexual/ gay
Perverted / sexual deviation
Gets a kick out of/arousal taking the risk
Probably has fantasies about that kind of sex

Control
May be the type who hangs about e.g. in public toilets, waiting for victims.
Doubt it's impulsive

Influence of the Other Person

Influence of Other External Factors

Influence of Other Internal Factors
Lonely
Low self esteem

Other
Doesn't know how else to get sex
If gay he may not want to 'come out' so tries to get sex anonymously
May have been abused in childhood

ACTOR NON LEARNING DISABLED
FEMALE ADULT

Knowledge/Understanding
Might not truly understand consent if he believes women don't mean what they say

Sexuality
May be like having a fetish about breasts, feet, knickers- maybe the only way they can get aroused- may be a sexual deviation
Sexually aroused by inflicting fear/ pain/ humiliation/ submissiveness
Frustrated

Control
Probably know the victim and have thought about doing this kind of thing
May be acting on impulse

Influence of the Other Person
How can you tell- what if woman goes along with it and only decides afterwards for whatever reason that she didn't give consent?? How do you decide who is telling the truth?
She might have been provoking him even if she didn't realise what she was doing
May have encouraged him

Influence of Other External Factors
Exposure to pornography
Influence of society's attitudes to and myths about women / sex objects/ women always available/doesn't really mean "no"/attitudes of police and judges in rape cases a typical example/ socialised into seeing women in negative ways or portrayed in society/media etc as sex objects
Reflection of society's attitudes to and myths about men e.g not being able to control sexual impulses, dangerous to get aroused but not 'come'/ that men are utterly desirable to all women/ if a woman goes so far then he has a right to expect the lot -

Influence of Other Internal Factors
Abuse of power
Rape not necessarily sexual - more to do with power
Hates /dislikes women

Other
Thinks women are there just to please men
Probably aggressive, domineering /powerful even if he comes across as really charming
Women not being assertive in the past, has learned can get away with it
Not taking women and their rights seriously
Inadequate relationships with women
Might take it as an insult to be told 'no'

ACTOR NON LEARNING DISABLED
VICTIM:CHILD

Knowledge/Understanding
They know what they are doing
How could they not know it's wrong/illegal with all the publicity about it
Lacks the skills to make relationships with women

Sexuality
Perverted- sexually attracted to kids instead of adults / sexual deviation
Like a fetish - not sexually attracted to appropriate people
Probably have lots of victims like the Mary Bryant owner
If they prefers boys they are probably homosexual and cannot acknowledge it

Control
Get themselves into positions where they can get easy access to children, e.g. children's homes.
Set out to lure children e.g. Michael Jackson's playground
Spur of the moment temptation with an available child
Has probably spent a long time grooming the child

Influence of the Other Person
May be rare cases where child makes it up, e.g wanting to get at someone, or is copying what they have been told them by someone else

Influence of Other External Factors
Exposure to child pornography

Influence of Other Internal Factors
If very young children and babies they are really sick and perverted
Mentally ill
Probably quite sad and inadequate sort of people
Easier to use power and control- may be the only time they are in a position of power

Other
May have been abused as a child
Abusive - even though might outwardly be considerate and caring toward children
Perhaps easier to get sexual gratification ,and more frequently, from children than with adults
Might be abusing own children
Uses bribes and threats/makes child fearful of telling
Inadequate normal sex life e.g no partner or poor relationship

Appendix 5. Invitation to Participate & Consent Form: Questionnaire.

RESEARCH STUDY

Dear Colleague,

You are invited to take part in this study. It involves reading a series of six short scenarios describing some situations. After each scenario you will be asked to answer a few short questions by circling your choice from a range of given answers. The whole task will take about 10 minutes.

The scenarios may contain some descriptions of potentially sexual behaviour. You are free to decide whether or not to participate in the study. When you have decided, please read and sign the form below indicating either your consent, or your wish not participate. You may also withdraw your consent at any time during the task.

I can assure you that you will not be asked to identify your replies, so they will be completely anonymous.

Many thanks for you interest,

Caroline Yates
(Clinical Psychologist in Training)

I consent to participating in the study. I understand that I shall be asked to read and answer questions about scenarios which may describe sexual behaviour and, that I can withdraw my consent at any time during the task. I also understand that my replies will be anonymous.

Signature.....

OR

I do not wish to participate in the study and I do not want to be contacted further.

Signature.....

correspondence via:

Dear Colleague,

Doctorate in Clinical Psychology. Research Project

As part of the above course I am conducting a research study regarding men with learning disabilities who demonstrate illegal sexual behaviours. The study has been approved by the local research ethics committees and service managers.

One of the project aims is to gather information about the number and nature of referrals to learning disabilities services for these problems. This would be helpful for future service development. I would greatly appreciate your participation in this part of this study.

The task is to complete a short questionnaire for each client referred to you, for assessment or treatment of sexually illegal behaviour, during the last two years. Each form takes only a few minutes to complete.

All the information will be completely anonymous.

If you are happy to participate, please read the enclosed instructions and return completed questionnaires to me in the stamped addressed envelope provided.

With thanks
yours sincerely

Caroline Yates
Clinical psychologist in training

REFERENCES

Aadland, J. Afwerke, P. & Schumacher, K. (1988). In J.Schoen & J. H. Hoover (1990)Mentally retarded sex offenders. Journal of Offender Rehabilitation, Vol 16(1/2).

Abel, G. G. Becker, J. V., Cunningham-Rathner, J., Rouleau, J. L., & Murphy W.D. (1987) Self reported sex crimes of non-incarcerated paraphiliacs. Journal of Interpersonal Violence, 2, 3-25.

Abelson, R. B. & Johnson, R.C. (1969). Heterosexual and aggressive behaviours among institutionalised retardates. Mental Retardation. 7 (2), 28-30.

Association for Retarded Citizens-Austin (1984) in G.Losada-Paisey & T.J.H. Paisey (1988) Program evaluation of a comprehensive Treatment package for mentally retarded offenders. Behavioural Residential Treatment, 3, No 4.

Baladerian, N.J., (1991) Sexual Abuse of People with Developmental Disabilities. Sexuality and Disability, Vol 9, no 4.

Banister, P., and Pordham, S. (1994). Public Perceptions of crime seriousness. Issues in Criminological and Forensic Psychology, 21, 4-10.

Berman, L.H. & Friedman, L.Z. (1961) Clinical perceptions of sexual deviates, Journal of Psychology, 52, 157-160.

Baxter, D.J. Marshall, W.L.,Barbaree, H.E., Davidson, P.R. & Malcom, P.B. (1984) In Valliant P M & Antonowicz D H (1992) Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. International Journal of Offender Therapy and Comparative Criminology, 36 (3).

Berdiansky & Parker (1977). Establishing a group home for the adult mentally retarded in North Carolina. Mental Retardation, 15, 8-11.

Berkowitz , L.(Ed) Advances in Experimental Social Psychology. Vol 13, pp 82-139. New York, Academic Press.

The British Psychological Society,: Society Report (1990). Psychologists and Child Sexual Abuse. The Psychologist: Bulletin of the British Psychological Society, (1990), 8, 344-348.

Brown, H., & Craft, A. (eds) (1989) Thinking the Unthinkable. London: FPA Education Unit.

Bruininks, R. H., Meyers, C. E., Sigford, B.B., & Lakin, K.C. (Eds), (1881) Deinstitutionalization and Community Adjustment of Mentally Retarded People (Monograph No 4) Washington DC: American Association of Mental Deficiency.

Burgess, A.W.(1978). Sexual Assault of Children and Adolescents, Lexington,

Caparulo, F. Comte, M. Gafgen, J. Haaven,J. Kaufman, . Kempton, W. Sissala, L. Whitaker, J.M. & Wilson, R. (1988). A summary of selected notes from the working sessions of the First National Training Conference on the assessment and treatment of intellectually disabled juvenile and adult sexual offenders. Columbus, Ohio.

Caparulo, F. (1991) Identifying the developmentally disabled sex offenders. Sexuality and Disability, 9(4), 311-322.

Charman, T. & Clare, I. (1992) .Education about the laws and social rules relating to sexual behaviour. Mental Handicap. 20. Jun.

Conte (1991). In Hollin, C.R. & Howells, K. Clinical Approaches to Sex Offenders and their Victims. Chichester:Wiley.

Craft, A. (1987). Mental Handicap and Sexuality: Issues for Individuals with a Mental Handicap, Their Parents and Professionals. In Craft, A. (Ed) (1987) Mental Handicap and Sexuality: Issues and Perspectives. Tunbridge Wells, Costello.

Craft, A (Ed) (1987) Mental Handicap and Sexuality: Issues and Perspectives. Tunbridge Wells, Costello.

Davis, G. E. Leitenberg, H. (1987). Adolescent sex offenders. Psychological Bulletin 101(3):417-427

Demetral, G.D. (1994). Diagrammatic assessment of ecological integration of sex offenders with mental retardation in community residential facilities. Mental Retardation, 32, No 2, 141-145.

Denkowski, G. C., Denkowski, K. M. & Mabli, J. (1983). A 50 state survey of the current status of residential treatment programmes for mentally retarded offenders. Mental Retardation,21, 197-204

Evans, K.G.(1980). Sterilisation of the mentally retarded - a review. Canadian Medical Association Journal, 123, 1066-70.

Fehrenbach, P.A., Smith, W., Monastersky, C. (1986). Adolescent sexual offenders: Offenders and offence characteristics. American Journal of Orthopsychiatry, 56(2):225.

Felce, D., and de Kock, U., and Repp, A., (1987) An Ecological Comparison of Small Community Based Houses and Traditional Large Hospitals for Severely and Profoundly Mentally Handicapped Adults: The Provision of Opportunities by Staff and Client Engagement in Activity. In Landesman, S., Zietz, P.M., & Begab, M.J. (Eds) Living Environments and Mental Retardation. Washington, American Association of Mental Retardation. 127-149.

Fincham, F.D., & Jaspers, J.M. (1980). Attribution of responsibility: From man the scientist to man the lawyer. In Foucault, M. (1976) The History of Sexuality - An Introduction. Harmondsworth, Penguin.

Finkelhor, D. (1984). Child Sexual Abuse: New Theory and Research. The Free Press, New York.

Foucault, M. (1976) The History of Sexuality - An Introduction. Harmondsworth, Penguin.

Gebhard, P. H., Gagnon, J. H., Pomeroy, W. B. & Christenson,C. V. (1965) Sex Offenders. New York: Harper and Row.

Gilbert, D.T., Pelham, B.W., and Krull, D.S.(1988). On cognitive busyness:when person perceivers meet persons perceived. Journal of Personality and Social Psychology, 54, 733-739.

Gilby, R., Wolf, L. & Goldberg, B. (1989). Mentally Retarded Adolescent Sex Offenders. A survey and pilot study. Canadian Journal of Psychiatry, 34, August.

Ginzel, L.E., Jones, E.E., and Swann, W.B.(1987). How "naive" is the naive attributor?Discounting and augmentation in attitude attribution. Social Cognition, 5, 108-130.

Gostason, R .(1985). Psychiatric Illness among the mentally retarded. Acta Psychiatrica Scandinavia, 71, suppl.318.

Greengross, W. (1976) Entitled to Love. London, Mallaby Press.

Greer, J. G. & Stuart, I. R. (Eds) The Sexual Aggressor: Current Perspectives on Treatment (pp 22-41) New York: Van Nostrand Reinhold Company, Inc.

Griffiths, D. Hingsburger, D., & Christian, R .(1985) .Treating Developmentally Handicapped sexual offenders: The York behaviour management services treatment programme. Psychiatric Aspects of Mental Retardation Reviews, 4(12):49-54.

Griffiths, D.M., Quinsey, V.L., & Hingsberger, D. (1989). Changing Inappropriate Sexual Behaviour: A Community Based Approach for Persons with Developmental Disabilities. Baltimore: Paul Brookes Publishing Co.

Gross, G. (1985). Activities of the developmental disabilities adult offender project. (Annual Report 1983-1984) Olympia, WA: Washington State Developmental Disabilities Planning Council.

Groth, A. N; with Burgess, A. W., Birnbaum, H. J., & Gary, T. (1978.) A study of the child molester; myths and realties. LAE Journal of the American Criminal Justice Association 41:17-22.

Groth, A. N. (1978). Patterns of sexual assault against children and adolescents. In Burgess, A.W. Sexual Assault of Children and Adolescents, Lexington, Mass.pp 3-24.

Groth, A. N. (1979). Men who Rape:The Psychology of the Offender. New York, Plenum Press.

Groth, A. N., & Oliveri , F.J.(1989). Understanding sexual offence behaviour and differentiating among sexual abusers: Basic conceptual issues. In Sgroi, S.M. (1989). Vulnerable Populations, Sexual Abuse Treatment for Children, Adult Survivors, Offenders and Persons with Mental Retardation. Lexington. pp 309-327.

Home Office Criminal Statistics (1989). HMSO

Haaven, J., Little, R., & Petre-Miller, D. (1990) The Intellectually Impaired Sex Offender: A Model Residential Treatment Programme. Orwell, VT: Safer Society Press.

Hamilton, C. L. (1993). Cognitive Mediators of Optimism and Pessimism amongst Care Staff . Unpublished MPhil. Thesis. UCNW Bangor.

Hard, S., and Plumb, W., (1987) Sexual Abuse of Persons with Developmental Disabilities: A Case Study, January 1987 in Baladerian, N.J., (1991) Sexual Abuse of People with Developmental Disabilities. Sexuality and Disability, 9, (4).

Harvey, J.H., Ickes, W.J., & Kidd, R.F. (Eds),(1976). New Directions in Attribution Research Vol 1, pp.389-420. Hillsdale, NJ: Erlbaum.

Heider, F.(1958). The Psychology of Interpersonal Relations. New York:Wiley.

Henn, F.A., Herjanic, M., & Vanderpearl, R.H. (1976) Forensic psychiatry: Profiles of two types of sex offenders. American Journal of Psychiatry, 133, 694-696.

Hingsburger, D. H., Griffiths, D. & Quinsey, V. (1991). Detecting counterfeit deviance, differentiating sexual deviance from sexual inappropriateness. The Habilitative Mental Healthcare Newsletter, 10 (9), 51-54.

Hollin, C.R. & Howells, K. (1991) Clinical Approaches to Sex Offenders and their Victims. Chichester:Wiley.

Jehu, D. (1989). Beyond Sexual ABuse. Therapy with WOmen who were Childhood Victims. Wiley.

Johnson, P. R. (1984). Community based sexuality programmes for developmentally handicapped adults. In J. M. Berg (Ed) Perspectives and Progress in Mental Retardation: Vol 1. Social, Psychological and Educational Aspects. Baltimore: University Park Press.

Jones, C. and Aronson, E. (1973). Attribution of fault to a rape victim as a function of respectability of the victim. Journal of Personality and Social Psychology, 26, 415-419.

Jones, E.E. and McGillis, D.(1976). Correspondent inferences and the attribution cube: A comparative reappraisal. In Quattrone, G.A.(1982). Overattributionand unit formation.

When behaviour engulfs the person. Journal of Personality and Social Psychology, 42, 593-607.

Jones, E.E., & Davis, K.E.(1965). From acts to dispositions: The attribution process in person perception. In Berkowitz, L. (Ed) Advances in Experimental Social Psychology. Vol 13, pp 82-139. New York, Academic Press.

Jupp, K. (1991) Seeking the Answers for those People with Learning Difficulties who Sexually Offend. BIMH.

Kempton, W.(1977a) The Mildly Retarded Person. In H. Gochros & J. Gochros (Eds). The Sexually Oppressed. NY, Association Press.

Kercher & Mc Shane. (1984) In Clinical work with the offender in secure settings. In Hollin, C.R. & Howells, K. Clinical Approaches to Sex Offenders and their Victims. Chichester:Wiley.

Kirk, R.E. (1982). Experimental Design Procedures for Behavioural Sciences. Brookes Cole. Pacific Grove, California.

Landesman-Dwyer, S. & Sulzbacher, F. M. (1981). Residential placement and adaptation of severely and profoundly retarded individuals. In R. H. Bruininks, C. E .Meyers, B .B. Sigford, & K. C. Lakin (Eds), Deinstitutionalization and Community Adjustment of Mentally Retarded People (Monograph No 4) Washington DC: American Association of Mental Deficiency.

Landesman, S., Zietz, P.M., & Begab, M.J.(Eds).(1987). Living Environments and Mental Retardation. Washington, American Association of Mental Retardation.

Maletzky, B.M.(1991). Treating the Sexual Offender. Sage.

Marshall, W. L.(1983). The classification of sexual aggressives and their associated demographic, social, developmental and psychological features. In: S. N. Verdun-Jones

A. A. Keltner (Eds.) Sexual Aggression and the Law. Vancouver, B C: Criminology Research Center. Simon Fraser University.

Marshall, W.L. (1989). Intimacy, loneliness and sexual offenders. Behaviour Research and Therapy, 27, 491-503.

Marshall, W.L., Eccles, A., & Barbaree, H.E. , (1990, August). Two Treatment Programmes for Exhibitionists. Paper presented at the Sixteenth Annual Meeting of the International Academy of Sex Research, Stiguna, Sweden. In Marshall, W.L. & Eccles, A.(1991) Issues in Clinical Practice with Sex Offenders. Journal of Interpersonal Violence, Vol 6, 1, 68-93.

Marshall, W. L. & Barbaree, H. E .(1990). In Valliant, P. M.& Antonowicz, D. H. (1992) Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. International Journal of Offender Therapy and Comparative Criminology, 36 (3).

Marshall, W.L. and Barbaree, H.E. (1990) in Marshall, W.L., Laws, D.R and Barbaree, H. E. (Eds). (1990). Handbook of Sexual Assault: Issues, Theories and Treatment of Offenders. New York: Plenum Press.

Marshall, W.L. & Eccles, A.(1991). Issues in Clinical Practice with Sex Offenders. Journal of Interpersonal Violence, Vol 6, 1, 68-93.

Marshall, W.L., Laws, D.R and Barbaree, H. E. (Eds). (1990). Handbook of Sexual Assault: Issues, Theories and Treatment of Offenders. New York: Plenum Press.

Matthews, F. (1987). Adolescent Sex Offenders. A Needs Study. Central Toronto Youth Services.

Miller, J.G.(1984). Culture and the development of everyday social explanation. Journal of Personality and Social Psychology, 46, 961-978.

Mohr , J.W.Turner, R.E. & Jerry M.B. (1964) In D. M. Griffiths, V. L .Quinsey & D. Hinsburger, (1989) Changing Inappropriate Sexual Behaviour, A Community Based Approach for Persons with Developmental Difficulties. Baltimore, Paul H Brookes Publishing Co.

Money, J.W. (1985) The Destroying Angel. Buffalo, NY. Prometheus Books.

Murphy, W.D. Coleman, E.M. & Haynes M.R.(1983) In D. M. Griffiths, V. L. Quinsey & D. Hingsburger (1989) Changing Inappropriate Sexual Behaviour A Community Based Approach for Persons with Developmental Difficulties. . Paul H Brookes Publishing.

Murphy, W. D., Coleman ,E. M. & Haynes, M. R .(1983) .Treatment evaluation issues with the mentally retarded sex offender. In J. G. Greer & I. R. Stuart (eds) The Sexual Aggressor: Current Perspectives on Treatment (pp 22-41) New York: Van Nostrand Reinhold Company, Inc.

Murphy, W.D.(1990) Assessment and modification of cognitive distortions in sex offenders. In **Noonan, M. J. & Bickle, W. K.** (1981). The ethics of experimental design. Mental Retardation, 19(6), 271-274.

Nasjleti, M.(1980). Suffering in silence: The male incest victim. Child Welfare, 59, 269-275.

Noonan, M.J. & Bickle, W.K. (1981). The ethics of experimental design. Mental Retardation. 19 (6). 271-274.

Panton, J. H. (1978), In Valliant P M & Antonowicz D H (1992). Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. International Journal of Offender Therapy and Comparative Criminology, 36 (3).

Perdue, W.C., & Lester, D. (1972). Personality characteristics of rapists. Perceptual and Motor Skills, 37, 1699-1712. In Griffiths, D.M., Quinsey, V.L., & Hingsberger, D. (1989). Changing Inappropriate Sexual Behaviour: A Community Based Approach for Persons with Developmental Disabilities. Baltimore: Paul Brookes Publishing Co.

Perkins, D. (1991) Clinical work with the offender in secure settings. In Hollin, C.R. & Howells, K. Clinical Approaches to Sex Offenders and their Victims. Chichester:Wiley.

Pescosolido, F.J. (1989). Sexual abuse of boys by males: Theoretical and treatment implications. In Sgroi, S.M. Vulnerable Populations, Sexual Abuse Treatment for Children, Adult Survivors, Offenders and Persons with Mental Retardation. pp 85-110. Lexington.

Prentky, R. & Burgess, A.W. (1990). Rehabilitation of child molesters : A cost benefit analysis. American Journal of Orthopsychiatry, 60, 108-117.

Quattrone, G.A.(1982). Overattributionand unit formation. When behaviour engulfs the person. Journal of Personality and Social Psychology, 42, 593-607.

Quinsey, V.L. (1986). Men who have sex with children. In D.N. Weisstub (Ed) Law and Mental Health, International Perspectives. Vol. 2, Elmsford, NY, Pergamom.

Reed, J. (1994) The Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. Vol 7. HMSO.

Russell, D.E.H. (1986). The Secret Trauma: Incest in the Lives of Girls and Women. New York: Basic Books.

Ryerson, E. (1981). Providing Counselling for Handicapped Persons who have been Sexually Abused. Seattle Rape Relief Developmental Disabilities Project.

Salter, A.C.(1988). Treating Child Sex Offenders and their Victims, A Practical Guide. California, Sage.

Samenow, S. E. (1984). In P. M.Valliant & D. H. Antonowicz (1992) Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. International Journal of Offender Therapy and Comparative Criminology, 36 (3).

Schilling, R. F. and Schinke, S. P. (1989). Mentally retarded sex offenders: fact, fiction and treatment. Journal of Social Work and Human Sexuality. 7 (2), 33-48.

Sgroi, S.M. (1989). Vulnerable Populations, Sexual Abuse Treatment for Children, Adult Survivors, Offenders and Persons with Mental Retardation. Lexington.

Shaver, K.G. (1975). An Introduction to Attribution Processes. Winthrop Publishers, Cambridge Massachusetts.

Shaver, K.G., & Drown, D. 1986). On causality, responsibility and self-blame:A theoretical note. Journal of Personality and Social Psychology, 50, 697-702.

Sinason, V.E. (1986). Secondary mental handicap and its relationship to trauma. Psychoanalytical Psychotherapy, 2(2), 131-154.

Swanson, C. K. & Garwick, G. B .(1990).Treatment for low functioning sex offenders; group therapy and inter-agency co-ordination. Mental Retardation 28, 155-61.

United Nations Bill of Rights (1971). In Craft, A. & Craft, M. Sex Education and Counselling for Mentally Handicapped People. Costello.

Turk, V. & Brown, H. (1993) The sexual abuse of adults with learning disabilities: results of a two year incidence survey. Mental Handicap Research, Vol 6, (3), 193-214.

Valliant, P. M. & Antonowicz, D. H. (1992) .Rapists, incest offenders, and child molesters in treatment: Cognitive and social skills training. International Journal of Offender Therapy and Comparative Criminology, 36 (3).

Verdun-Jones, S. N. & Keltner, A. A. (Eds.) (1983). Sexual Aggression and the Law. Vancouver, B C: Criminology Research Center. Simon Fraser University.

Verba, H. Barnard, G.W. and Holzer, C. (1979).In Griffiths D M Quinsey V L & Hinsburger D (1989) Changing Inappropriate Sexual Behaviour. Paul H Brookes Publishing.

Walen, S.R. (1985)In Griffiths D M Quinsey V L & Hinsburger D (1989) Changing Inappropriate Sexual Behaviour. Paul H Brookes Publishing.

Walker, N .& McCabe, S.(1973). Crime and Insanity in England, Vol 2. Edinburgh University Press.

Walmsely, S. (1989). The need for safeguards. In Brown, H. & Craft, A.(Eds) Thinking The Unthinkable: Papers on Sexual Abuse and People with Learning Difficulties. FPA Education Unit. pp5-17.

Wolfe, J. and Baker, V. (1980).In Griffiths D M Quinsey V L & Hinsburger D (1989) Changing Inappropriate Sexual Behaviour. Paul H Brookes Publishing.

Zetlin, A. G. & Turner, J. L .(1985). Transition from adolescence to adulthood: perspectives of mentally retarded individuals and their families. American Journal of Mental Deficiency, 89(6), 570-579.