

**Cognitive behavioural therapy for people with ID who
are victims of crime –
can it be accessed and does it work?**

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Abstract

The paper examines the research evidence on the use and effectiveness of CBT with people with ID who are victims of crime. There is not a large body of research on the use of CBT with people with ID, and the research that has been conducted within the criminal justice area tends to focus primarily upon accused persons and offenders, rather than victims of crime. There is a dearth of research about the effectiveness of CBT with victims of crime, who may suffer from a number of psychiatric and psychological disorders including anxiety disorder, post-traumatic stress disorder and depression, as well as behavioural difficulties. There are few practitioners who are expert in the dual fields of CBT and victims of crime with ID, and hence it is difficult for service users and their carers to access this form of intervention. In turn, the small number of clinicians working in this field means that few research studies are conducted; when research is conducted, the sample sizes tend to be small and unrepresentative.

Introduction

A person with an intellectual disability (ID) is more likely to be a victim of crime, and also more likely to suffer a psychiatric disorder, compared with the general population. In summary,

- People with ID, especially women, are more likely to be the victims of crime than their non-disabled counterparts
- The high level of vulnerability may be related to social isolation, dependency, feelings of helplessness and powerlessness, ignorance about violence and sexuality, and susceptibility to coercion and bribery
- People with ID have higher rates of psychiatric conditions than the general population
- Psychiatric morbidity is hidden in an estimated 50% of cases of victims of crime with ID
- Therefore, the high rate of psychiatric morbidity in people with ID may be partly a consequence of their high rate of victimisation (Hayes, 2004)

The effect of violence on people with ID is an area in which there is not a large body of research. Despite the high rate of crime against people with ID, there is comparatively little known about treating the effects of having been the victim of trauma, neglect or abuse.

Victims of crime with ID

A study of 15 people with ID, compared with 77 non-disabled participants, all of whom had been victims of crime, showed the following (Hayes, 2004):

- Sixty per cent showed symptoms of depression (cf. 88% of the non-disabled group, chi square $p < .01$)
- Forty-seven per cent indicated that they currently or previously had suicidal ideation (cf. 53%, no difference)
- Forty per cent had attempted suicide (cf. 17.3%; chi-square $p < .05$)
- Two-thirds reported symptoms of post traumatic stress disorder (cf. 85.3% of the non-disabled group; no significant difference)
- Sixty per cent indicated symptoms of anxiety disorder (cf. 80%; no significant difference)
- One third reported having panic attacks (cf. 41%; no significant difference)
- On average, participants in both groups reported three psychiatric disorders

In this small group, one person with ID had been the victim of domestic violence, three had been victims of non-sexual assaults, eleven had been the victim of one sexual assault and one had been the victim of two sexual assaults. Clearly some individuals had been assaulted several times.

The pattern of crime against people with ID differed from that against their non-disabled counterparts, with the ID group being more likely to be the victims of sexual assault, whilst the non-disabled group were more likely to be victims of domestic violence or non-sexual assault.

Whilst crimes against or abuse of people with ID can occur in unfamiliar environments, much of the abuse occurs in the places where they are meant to be safe, in their place of residence, in the workplace, or whilst travelling between work and home. The prevalence of violence in the daily lives of some people with ID is so great that some researchers have described it as “accepted as a natural part of the daily care for adult person with ID”, with most of the violence in helping care situations being physical or psychological (Strand, Benzein and Saveman, 2004).

White, Holland, Marsland and Oakes (2003) maintain that popular explanations of abuse tend to emphasise the role of the individual, especially the characteristics of the person with ID which might contribute to them becoming a victim of abuse – their “fault” - rather than the role of the broader context of care. A number of features of care environments have been identified as promoting abuse of people with ID; on a positive note, if these factors were changed, there may be greater likelihood of appropriate recognition of and intervention for psychological and psychiatric symptoms in clients with ID, and prevention of further abuse.

Drawing on the work of these authors, the factors that have the potential to affect the care environment positively include:

1. Good management, supervision and accountability; willingness to challenge abusive staff or clients
2. Support of staff, development of good morale and job satisfaction, staff development
3. Staff attitudes and behaviours that are respectful of clients and promote dignity, within appropriate staff-resident boundaries
4. Staff induction and in-service training in the areas of abuse and protection; sexuality; intimate care; record keeping (especially of incidents); preventing and responding to challenging behaviour; supporting client communication; and coping with anger or stress
5. Power, status and autonomy for both services users and staff; staff culture which encourages open review and reporting of abuse
6. Contact and interaction with the community outside the service; outside support, vigilance and monitoring, especially at night and on weekends
7. Service conditions, design and placement that encourage safety, constructive activity and which do not allow concealment of poor care standards or abusive practices

If victims of crime with ID are receiving services from service providers which comply with these good environmental “markers”, the abuse or crime is more likely to have been recorded, their psychological or psychiatric symptoms are more likely to be noticed, and staff will be motivated to provide or assist the client to access therapeutic interventions such as CBT.

The need for treatment for people with ID who have been victims of crime

Given the high rate of victimisation of this group, it is astonishing that relatively little research and few reports on clinical practice focus upon therapeutic interventions. The lack of information about the area may be in itself indicative of a tendency to devalue this group. As Peckham, Howlett and Corbett (2007) point out, ID has been routinely used as an exclusion criterion for psychotherapy and group interventions for these clients. Other publications comment on the restriction of services such as psychotherapy for marginalised groups including people with ID (Department of Health, 2004).

Sequiera and Hollins’ comprehensive review of the clinical effects of sexual abuse on people with learning disability (2003) nevertheless establishes that victims of crime with ID suffer the range of symptoms, psychopathology and behavioural difficulties that is experienced in the general population, including PTSD, depression, loss of self-esteem, self-destructive tendencies, anger, schizophreniform psychosis, personality disorder, dissociative symptoms, self-harm and alcohol abuse. On the basis of clinical experience, victims also often suffer anxiety disorder and panic attacks.

In about one-third of victims, the symptoms of PTSD are unlikely to resolve even after a considerable period of time (Kessler, Sonnega, Bromer, Hughes, and Nelson, 1995). Determining the range and severity of symptoms in both victims and offenders can be compromised by communication difficulties, especially limitations in the ability to describe internal subjective experiences.

Ironically, an offender with ID may have a greater likelihood of accessing CBT (and other forms of therapy) than a victim (Victorian Department of Human Services, 2000) – amongst the offender group in this service in Victoria (Australia), two-thirds of offender clients received group or individual CBT from a psychologist. This trend appears to be similar to service delivery in other nations (Sinclair, Murphy, and Hays, 2007; Taylor, Novaco, Gillmer and Thorne, 2002). These studies on CBT and offenders are useful, however, in demonstrating that CBT can be used effectively with people with ID. They also serve as a useful reminder that many offenders with ID have also been victims of prior abuse or violence.

Therefore, whilst there is undoubtedly a need for therapeutic interventions with people with ID who have been victims of crime, there is a need for further investigation of clinical effects of these traumatic events.

Effectiveness of CBT with victims of crime – the research

There are four areas that can be examined for evidence of the effectiveness of CBT:

- Non-disabled victims of crime
- People with ID who are neither victims nor offenders, but who may have psychological symptoms or behavioural difficulties that can be treated with CBT
- Offenders with ID
- Victims of crime with ID

There is compelling evidence that CBT is effective in the treatment of trauma for victims of crime with no known disability (Foa, Keane and Friedman, 2000). Brief CBT has been shown to be more effective, particularly for female sexual assault survivors, than an assessment condition or supportive counselling (all over four 2-hour sessions) immediately post-treatment and at 3-month follow-up. Early intervention seems to increase the rate of natural recovery of sexual assault survivors, which clearly would also reduce the misery of the victim (Foa *et al.*, 2006).

Regarding people with ID who are neither victims nor offenders, there is ample evidence that CBT can be used effectively, although there are some limitations, for example Verbal IQ (Willner, Jones, Tams and Green, 2002) and verbal ability generally.

Other factors which affect the individual's capacity to engage in CBT include (Willner, 2006):

- Motivation
- Capacity to recognise and label emotions
- Ability to link emotions and events
- Ability to differentiate between thoughts, feelings and behaviours

Furthermore, the clients who respond best are those whose carers participate in the CBT programme, assisting the client to apply the principles in real life settings and to practise the skills after cessation of the group. This is reflected with non-disabled participants – homework compliance has been strongly associated with better CBT outcome (Foa *et al.*, 2006). These research findings emphasise the point made earlier, concerning the importance of the environment of the service of which the person with ID is a client. If the service is willing to locate CBT, allow a worker to accompany the client to the therapy sessions, and to assist with practice, the outcome will be better for the client.

The CBT technique has also been used with people with ID who are non-victims, in the treatment of depression (McCabe, McGillivray, and Newton, 2006). In the latter study, the intervention had a significant impact not only on depression, but also on other psychosocial variables, self-esteem and frequency of negative thoughts, with the results being sustained over at least a three month period.

For those people with ID and offending or challenging behaviour, CBT has been successfully employed in the areas of anger treatment (Willner *et al.*, 2002; Taylor, Novaco, Gillmer and Thorne, 2002), and sex offending (Sinclair, Murphy, and Hays, 2007).

Finally, in treating victims of crime (or survivors) with ID, imagery rehearsal has been shown to produce significant reductions in distress cause by nightmares (Stenfert Kroese and Thomas, 2006).

The use of CBT for some selected clients with ID has face validity as an effective intervention. Some victims of crime report that they dislike counselling which involves “going over and over” the traumatic event, and express a wish for interventions that are practical, action-oriented and where they can discern progress. Apart from the lack of perceived progress with some verbal counselling techniques, participants report that repetition of aspects of the trauma prevents them from putting the trauma behind them, and increases their level of distress after each session. CBT would appear to fit the bill as a technique which would be acceptable to this client group.

Availability of CBT

A major difficulty in implementing CBT or other therapeutic interventions for people with ID who are victims of crime is the likely time delay in accessing treatment. Ideally, CBT commences between 2-5 weeks following trauma, and consists of several sessions (Foa, Zoellner and Feeney, 2006). However, the experience of victimisation of this group may not be noted for some time, possibly until severe behavioural changes are noticed by family or service providers. Notification of a possible crime to police may then take longer, or indeed may not occur at all. If acceptance into a victim counselling programme is dependent upon the crime being reported, then there is likely to be a significant delay in implementation of therapy for some or many victims with ID. The longer the delay, the more likely it is that the symptoms may become chronic and that the victim may engage in behavioural alterations – such as restricting their daily routine and avoiding reminders of the trauma (Foa, 2006) – that in turn affect their enjoyment of life and begin to increase the negative thought processes.

A search of the Australian Psychological Society website of psychologists practicing privately within 100 kms of Sydney, and who were registered with Medicare (a government funded universal medical care scheme which has recently included psychological intervention) found that 75% indicated that CBT was one of the range of therapies that they offered – however, none of these practitioners indicated that people with ID were included in the client groups to whom they offered services. There are, of course, psychologists who work for government or non-government agencies providing services for people with ID; clients report that there are waiting lists of up to six months for an initial appointment, and follow-up appointments occur at a frequency of 2-3 weeks, usually with a cap of about three months duration. Of 74 clients who have been the victims of crime and who have been assessed by this author in the past 18 months in relation to claims for victims compensation from the NSW state government, almost all of the clients had been referred for some form of therapy prior to being assessed. Not all of these clients had intellectual disabilities. Only three had participated in CBT.

On the basis of this limited group of clients who have been victims of crime, it appears that CBT is seldom used, at least by psychologists who are on the NSW Attorney General's Victims Services list of approved counsellors.

The paucity of professionals expert in both CBT and intellectual disability is likely to be paralleled in other countries. Whilst not referring specifically to CBT, the availability of psychotherapy services for people with ID in England are described as patchy, eclectic, and often provided by untrained therapists who are not under supervision (Royal College of Psychiatrists, 2004). A survey of clinical psychologists in the field of learning disabilities indicated that 35% routinely used CBT (Nagel and Leiper, 1999, as cited in Willner *et al.*, 2002).

Foa (2006) maintains that non-specialists can be taught how to practise effective CBT, and gives examples of how short training (she cites four or five day training programmes

for professionals with some prior mental health training and experience) in CBT can assist professionals to deliver CBT competently. She emphasises the importance of rapid training, especially where there is a major disaster involving large numbers of victims. Treatment by counsellors with brief CBT training can be as effective as treatment by CBT experts (Foa, Hembree, Cahill, Rauch, Riggs, Feeny, and Yadin, 2005). Furthermore, short interventions over a median of eight sessions were found to produce positive results.

Conclusions

Whilst CBT appears to be an effective intervention for people with ID in addressing a number of problems, this technique appears not to be as widely used as would be expected, partly because of a scarcity of professionals expert in both CBT and ID. However, Foa and colleagues' research on brief training in CBT for service providers with a background in mental health may indicate a way forward for services for people with ID which can encourage staff to acquire relevant skills and obtain appropriate supervision. An increase in the numbers of service providers skilled in CBT will in turn lead to an increase in clinical and research information about the results of CBT with victims of crime with ID.

References

- Department of Health (2004) Organising and delivering psychological therapies, Department of Health, London.
- Foa, E. (2006) Psychosocial therapy for posttraumatic stress disorder, *Journal of Clinical Psychiatry*, **67**, 40-45.
- Foa, E., Keane, T. and Friedman, M. (2000) *Effective treatment for PTSD*, Guilford Press, New York, NY.
- Foa, E., Zoellner, L. A. and Feeny, N. C. (2006) An evaluation of three brief programs for facilitating recovery after assault, *Journal of Traumatic Stress*, **19**, 29-43.
- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C. and Yadin, E. (2005) Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics, *Journal of Consulting and Clinical Psychology*, **73**, 953-964.
- Hayes, S. C. (2004) People with an intellectual disability who are victims of crime – outcomes and needs, In *International Association for the Scientific Study of Intellectual Disability, 12th World Congress*, Montpellier, France.
- Kessler, R., Sonnega, A., Bromer, E., Hughes, M. and Nelson, C. (1995) Posttraumatic stress disorder in the National Comorbidity Survey, *Archives of General Psychiatry*, **52**, 1048-1060.
- McCabe, M., McGillivray, J. and Newton, D. (2006) Effectiveness of treatment programmes for depression among adults with mild/moderate intellectual disability, *Journal of Intellectual Disability Research*, **50**, 239-247.
- Nagle, B. and Leiper, R. (1999) A national survey of psychotherapy with people with learning disabilities, *Clinical Psychology Forum*, **129**, 14-18.

- Peckham, N. G., Howlett, S. and Corbett, A. (2007) Evaluating a survivors group pilot for women with significant intellectual disabilities who have been sexually abused, *Journal of Applied Research in Intellectual Disabilities*, **20**, 308-322.
- Royal College of Psychiatrists (2004) Psychotherapy and learning disability (Council report CR116), Royal College of Psychiatrists, London.
- Sequeira, H. and Hollins, S. (2003) Clinical effects of sexual abuse on people with learning disability. Critical literature review, *British Journal of Psychiatry*, **182**.
- Sinclair, N., Murphy, G. and Hays, S.-J. (2007) Group cognitive behaviour therapy treatment for sex offending, *Intellectual Disability Australasia*, **28**, 12-17.
- Stenfert Kroese, B. and Thomas, G. (2006) Treating chronic nightmares of sexual assault survivors with an intellectual disability - two descriptive case studies, *Journal of Applied Research in Intellectual Disabilities*, **19**, 75-80.
- Strand, M.-L., Benzein, E. and Saveman, B.-I. (2004) Violence in the care of adult persons with intellectual disabilities, *Journal of Clinical Nursing*, **13**, 506-514.
- Taylor, J. L., Novaco, R. W., Gillmer, B. and Thorne, I. (2002) Cognitive-behavioural treatment of anger intensity among offenders with intellectual disabilities, *Journal of Applied Research in Intellectual Disabilities*, **15**, 151-165.
- Victorian Department of Human Services (2000) DisAbility Services Criminal Justice Program. Strengthening service provision, Performance, Planning and Research, DisAbility Services Branch, Melbourne.
- White, C., Holland, E., Marsland, D. and Oakes, P. (2003) The identification of environments and cultures that promote the abuse of people with intellectual disabilities: a review of the literature, *Journal of Applied Research in Intellectual Disabilities*, **16**, 1-9.
- Willner, P. and Hatton, C. (2006) CBT for people with intellectual disabilities. Editorial, *Journal of Applied Research in Intellectual Disabilities*, **19**, 1-3.
- Willner, P., Jones, J., Tams, R. and Green, G. (2002) A randomized controlled trial of efficacy of a cognitive-behavioural anger management group for clients with learning disabilities, *Journal of Applied Research in Intellectual Disabilities*, **15**, 224-235.