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Exploring violence and vulnerability: Experiences of victimization among adults with intellectual disabilities

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A dissertation submitted in fulfillment of the requirements for the degree of Doctor at the University of Barcelona

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Barcelona, 2024

UNIVERSITAT DE BARCELONA

Acknowledgments - Agraïments

Primer de tot vull agrair a la meva directora, la Noemí, la seva proximitat i atenció. Per la confiança i la llibertat que sempre m'ha brindat per buscar la meva direcció i superar els meus límits. Ella m'ha vist créixer com a alumne i com a persona al llarg d'aquests més de 10 anys que fa que ens coneixem.

Gràcies també a la meva mare, per haver-me donat suport a i ajudat sempre de forma incondicional, sense dubtar mai que podia aconseguir tot el que em proposes. Hem passat per moltes coses a la vida, però tu sempre m'has acompanyat donant-me la mà i amb un somriure als llavis. Al meu pare, que ben segur que si fos aquí estaria molt orgullós. Ell va ser una de les primeres persones que em va recolzar en tota aquesta aventura que ha estat la psicologia i el doctorat. Segur que hagués estat molt feliç de ser a primera fila el dia de la defensa, així que va per tu papa.

Al Diego, el meu company de vida, que ha estat al meu costat des de l'inici, en els bons i en els mals moments. Sens dubte sense ell tot això no hauria estat possible. Gràcies per ajudar-me, escoltar-me, entendre'm i estimar-me com ho fas i ho has fet sempre.

A les amigues i companyes, que m'heu vist riure i plorar. Amb les que hem compartit vivències, alegries i també moments baixos. També a vosaltres noies del GReVIA, perquè d'una forma o altra heu construït moments inoblidables. A totes aquelles persones que he conegut i m'han ajudat d'una forma o un altre al llarg d'aquest camí.

A la Universitat de Barcelona, per donar-me l'oportunitat de poder dedicar-me a temps complet a aquesta tesi, gràcies al contracte Predocs UB.

Per acabar, però no menys important, agrair a totes i cadascuna d'aquestes 260 persones amb diagnòstic de discapacitat intel·lectual que van compartir amb nosaltres les seves valuoses experiències. Segurament mai llegireu aquestes línies, però sense vosaltres aquesta tesi no hauria estat possible. Espero que tot això serveixi d'alguna manera perquè la vostra veu sigueu escoltada.

INDEX

LIST OF FIGURES

LIST OF TABLES

Abstract

People with intellectual disabilities (ID) seem to be at an increased risk of experiencing interpersonal victimization, especially for the most violent types, such as physical and sexual aggression. However, figure disparities across studies contribute to an inconclusive portrayal of the phenomenon. Still, they are often considered a vulnerable group towards victimization simply because of their disability, without considering other risk factors that may have a significant impact on the course of victimization.

This dissertation aims to contribute to the knowledge and understanding of vulnerability and victimization among people with ID. It consists of three empirical studies analyzing the self-reported experiences of victimization in a sample of adults with ID and a narrative review analyzing different layers and intersecting vulnerabilities to victimization and offending. The study sample for the empirical studies consisted of 260 participants (154 men and 106 women) with ages ranging from 20–71 ($M = 41.69$, $SD = 12.05$) and a diagnostic of ID.

Study 1 explores the rates of different forms of lifetime victimization and poly-victimization using the JVQ questionnaire and introduces a gender and age-related approach. The results showed high rates of lifetime victimization, with nearly all participants reporting some victimization experience (96.9%). Conventional crimes, including some forms of property crime, was the most frequent type of victimization among this sample (87.7%). High rates of physical and sexual violence were also reported. If the mean number of different victimization types experienced for the whole sample was six, poly-victims experienced more than double victimizations (13 or more incidents). Overall, women and early adults tended to experience higher rates of victimization in comparison with men and older adults.

Study 2 examines the rates and characteristics of sexual victimization experiences among the sample. The results showed that 35% of the participants had been sexually victimized at some point in their lives, with fondling being the most reported victimization (19.2%). Rape showed the greatest gender differences, with a higher risk for women of being raped compared to their men counterparts ($OR = 4.28$, $p < .001$). Being a woman, being declared legally incapable, and having comorbid mental health diagnoses were the most relevant characteristics of sexual victims with ID. The offender was generally a known adult

man, and the percentage of incidents reported to the authorities was low (7.4%). The abuse led to negative psychological consequences for the victims.

Study 3 explores the rates and characteristics of caregiver victimization, a disability-related abuse particularly relevant for people with ID. This study outlines high rates of lifetime caregiver victimization (59.2%), with physical abuse, verbal abuse, and neglect being the most frequently reported forms. Those who live in residential care settings were at particular risk, experiencing significantly more victimization incidents and a broader range of victimization forms than their counterparts outside residential care. Most participants disclosed their victimization to someone, but only a small number reported it to the police (9.8%). The experiences of victimization led to adverse psychological consequences and, in some cases, physical harm (33.8%).

Study 4 is a critical and historical narrative review exploring the complexity of the acts of violence involving women with ID. They face multiple adversities, being involved in the phenomenon of violence both as victims and as perpetrators. These two roles are not mutually exclusive, but the interrelation between statuses owes its variability and dynamics to other interacting variables. This study synthesizes different layers of analysis (i.e., ID label, vulnerability, mental health comorbidity, poverty, social deprivation, ethnicity, and race) using an intersecting approach, which has been particularly neglected in disability studies.

This thesis revealed high self-reported victimization rates among people with ID when a lifetime assessment was conducted. Significant gender, residential, age, and disability-related differences concerning the rates and numbers of victimization experienced were identified. This helps to identify those ID profiles requiring special protection given their increased vulnerability.

Resum

Les persones amb discapacitat intel·lectual (DI) semblen presentar un major risc de patir victimització interpersonal, especialment d'aquells tipus més violents, com poden ser l'agressió física i la sexual. Tanmateix, les disparitats entre xifres que mostren els estudis contribueixen a una representació poc concloent del fenomen. Tot i això, sovint se'ls considera un grup vulnerable davant la victimització només pel fet de la seva discapacitat, sense tenir en compte altres factors de risc que poden tenir un impacte significatiu en devanir de la victimització.

Aquesta tesi pretén contribuir al coneixement i comprensió de la vulnerabilitat i la victimització entre les persones amb DI. Es compon de tres articles empírics que analitzen les experiències autoinformades de victimització en una mostra d'adults amb DI, així com d'una revisió narrativa que analitza diferents aspectes que s'entrecreuen a la vulnerabilitat, la victimització i l'ofensa. La mostra pels tres articles empírics va consistir en 260 participants (154 homes i 106 dones) amb edats compreses entre els 20 i els 71 anys (*M* = 41,69, *DT* = 12,05) i amb un diagnòstic de DI.

L'estudi 1 explora les taxes de diferents formes de victimització i poli-victimització al llarg de la vida mitjançant el qüestionari JVQ i introdueix un enfocament centrat en el gènere i l'edat. Els resultats mostren taxes elevades de victimització al llarg de la vida, amb gairebé tots els participants havent patit alguna experiència de victimització (96,9%). La victimització comuna, la qual inclou algunes formes de delictes contra la propietat, va ser el tipus de victimització més freqüent entre aquesta mostra (87,7%). També es van registrar taxes elevades de violència física i sexual. En general, les dones i aquelles persones més joves tendien a experimentar taxes de victimització més altes en comparació amb els homes i els adults més grans. Si el nombre mitjà de diferents tipus de victimització experimentats per a tota la mostra era de sis, les poli-víctimes en van experimentar més del doble (13 o més formes).

L'estudi 2 examina les taxes i les característiques de les experiències de victimització sexual reportades per la mostra. Els resultats mostren que el 35% dels participants havien estat victimitzats sexualment en algun moment de la seva vida, sent els tocaments la forma de victimització més freqüent (19,2%). La violació va mostrar les diferències de gènere més

marcades, amb un risc més elevat per a les dones en comparació amb els seus homòlegs masculins (*OR* = 4,28, *p* < 0,05). Ser dona, ser declarada legalment incapaç i tenir un diagnòstic de salut mental comòrbid eren les característiques més rellevants de les víctimes sexuals amb DI. L'agressor va ser generalment un home adult conegut i el percentatge d'incidents denunciats a les autoritats va ser baix (7,4%). El maltractament va tenir conseqüències psicològiques negatives per a les víctimes.

L'estudi 3 explora les taxes i les característiques de la victimització perpetrada pels cuidadors, un abús relacionat amb la discapacitat especialment rellevant per a les persones amb DI. Aquest estudi descriu taxes elevades de victimització perpetrada pels cuidadors al llarg de la vida (59,2%), sent l'abús físic, l'abús verbal i la negligència les formes més freqüents. Aquells participants que vivien en entorns d'atenció residencial estaven en especial risc, experimentant molts més incidents de victimització i una gamma més àmplia de formes de victimització que els seus homòlegs fora de l'atenció residencial. La majoria dels participants va explicar els fets a algú, però només un petit nombre ho va denunciar a les autoritats policials (9,8%). Les experiències de victimització van comportar conseqüències psicològiques adverses i, en alguns casos, dany físic (33,8%).

L'estudi 4 és una revisió narrativa crítica i històrica que explora la complexitat dels actes de violència en dones amb DI. Aquestes s'enfronten a múltiples adversitats, implicant-se en el fenomen de la violència com a víctimes però també com a agressores. Aquests dos rols no són mútuament excloents, però la interrelació entre els dos estatus deu la seva variabilitat i dinàmica a altres variables que n'interactuen. Aquest estudi sintetitza i analitza diferents dimensions d'anàlisi (com ara el diagnòstic de DI, la vulnerabilitat, la comorbiditat amb la salut mental, la pobresa, la privació social, l'ètnia i la raça) mitjançant un enfocament interseccional, sovint infrautilitzat en els estudis sobre discapacitat.

En conclusió, la tesi revela altes taxes de victimització autoreportades entre les persones amb DI especialment quan se n'avaluen les experiències al llarg de la vida. S'hi detecten diferències significatives relacionades amb el gènere, la residència, l'edat i algunes variables relacionades amb la discapacitat, pel que fa a les taxes i el nombre de victimitzacions experimentades, cosa que ajuda a identificar aquells perfils amb DI que requereixen una protecció especial donada la seva major vulnerabilitat.

1. Introduction

1.1. Historical overview

The definition and conception of Intellectual Disabilities (ID) have undergone many changes throughout history. The stigma and rejection have gone hand in hand with the social perception of this group. From the ancient unspecific concept of mental illness, fed by lack of knowledge and superstition through immorality, religious and sin-related conceptions in the Middle Ages (Roth et al., 2019). The frameworks of stigma and abnormality were still present in the early attempts at diagnostic taxonomy in the late 1800s and early 1900s, comprising different labels such as idiots, *imbeciles,* or feebleminded (Roth et al., 2019). Especially during the eugenics movement, they were considered dangerous individuals prone to criminality, keeping them in asylums and institutionalization, in which they were subjected to severe ostracism and maltreatment (Roth et al., 2019). The social approaches defining the features that lead to the failure to adapt to the environment in a socially acceptable way have been characteristic of a great part of the ID's contemporary history (Schalock et al., 2007).

Significant research advancements in the field of intellectual disability (ID) emerged during the 1950s and 1960s from various disciplines, including biology, psychology, and education. This resulted in a shared body of knowledge that helped fill some of the gaps in the field (Parmenter, 2004). In this climate of scientific improvement genetics identified the causes of Down syndrome and Fragile X syndrome during this period, revealing chromosomal abnormalities as a common cause of ID (Vissers et al., 2016). Additionally, the intelligence construct became a popular and reliable measure for obtaining IQ scores (Schalock et al., 2007). This led to a new clinical diagnosis approach, which changed the way ID was perceived and understood. The focus shifted to understanding the difficulties and experiences of individuals with ID.

The official diagnosis of mental retardation was in use until the early 2000s when the term ID start gaining popularity. This new term was more in line with current times, policies, social disability rights movements, scientific knowledge, and association efforts (Roth et al., 2019; Schalock et al., 2007). Despite all, today this population still faces institutional, environmental, and attitudinal discrimination, is often overlooked by health and social services, has difficulties receiving and acceding basic care services, and still experiences high odds of victimization (Brooker et al., 2015; Hughes et al., 2012; Yeo & Moore, 2003).

1.2. Prevalence and causes of intellectual disabilities

1.2.1. Epidemiology

The estimated worldwide prevalence of people with ID is approximately 1% based on metanalytical studies (Maulik et al., 2011). This meta-analysis identified differences across countries, with higher prevalence rates in the low- and middle-income countries (1.64% and 1.59% respectively), and lower in the high-income countries (0.92%).

Previous studies estimate the global prevalence of ID to be higher, between 1% and 3% (Harris, 2006). However, changes in diagnostic criteria, improvements in public health, prenatal diagnosis strategies, and increased knowledge of risk factors may partially explain the decline in the ID population (Maulik et al., 2022).

The severity of disability in the world is difficult to estimate due to the great heterogeneity of classifications and assessments used across different countries (Maulik et al., 2011). According to some authors, mild ID is the most common, accounting for 85% of cases, while moderate, severe, and profound ID are less frequent, making up 10%, 4%, and 2% of the population respectively (King et al., 2009).

People with ID often experience a range of physical and mental health conditions and have a higher risk of premature mortality compared to the general population (Cooper et al., 2015; Mazza et al., 2020). According to the meta-analysis by Mazza et al. (2020) people with ID commonly experience psychiatric disorders, with mood disorders (6.7%), anxiety disorders (5.5%), schizophrenia (4.8%), and personality disorders (2.8%) being the most reported. People with ID are also more likely to have co-occurring conditions such as epilepsy, sensory impairments, or autistic spectrum disorders (Cooper et al., 2015; Maulik et al., 2022).

1.2.2. Etiology

This is a heterogeneous and extensive group of conditions with different etiologies that have in common a series of impairments in cognitive and adaptative abilities (van

Bokhoven, 2011). ID can be caused by a variety of biological and environmental factors, which in turn can be complexly related to each other (Maulik et al., 2022). Factors causing ID can occur at different stages of development. **Figure 1** shows the most relevant factors throughout the prenatal, perinatal, and postnatal periods.

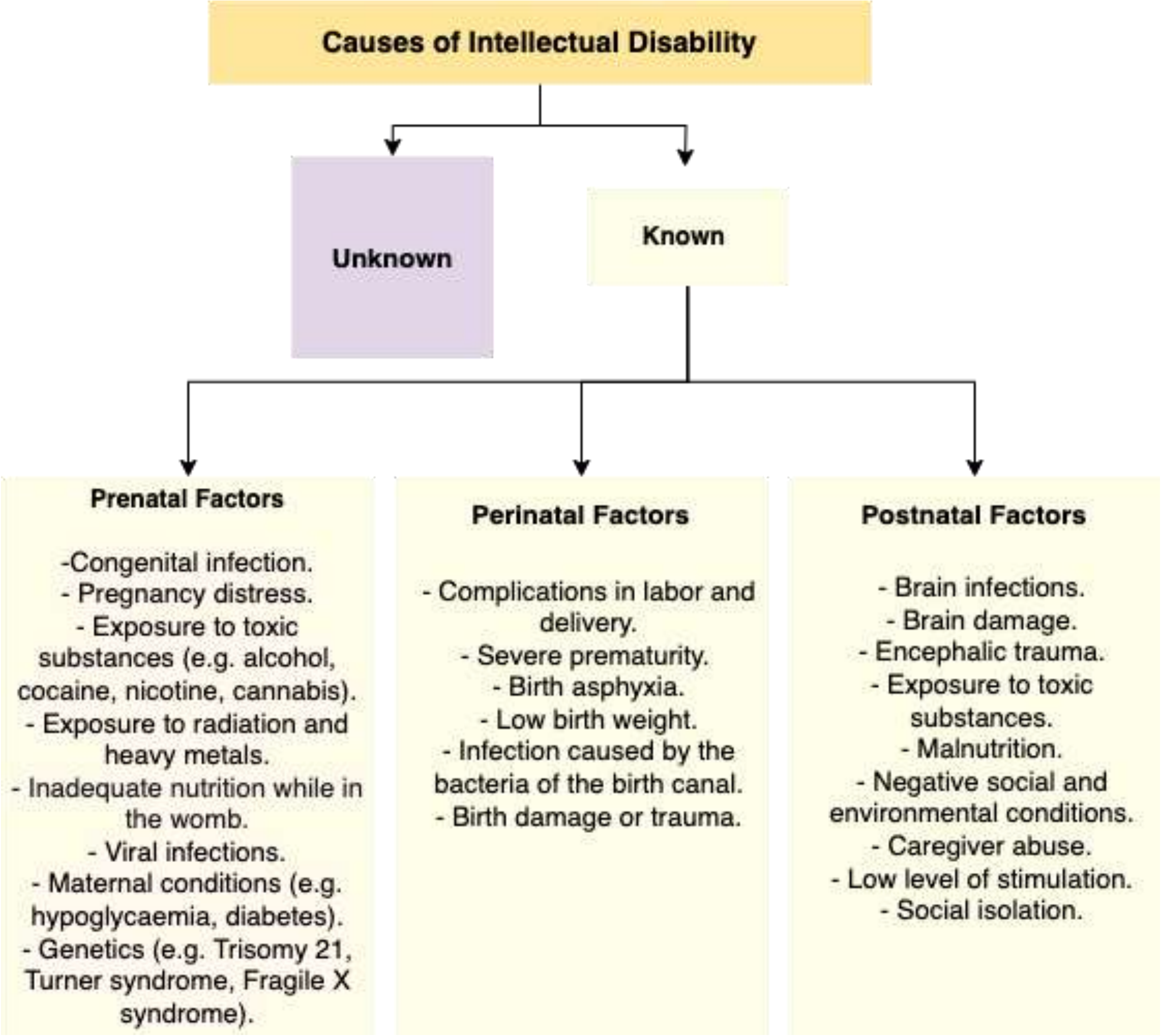


Figure 1. The most relevant known causes of ID according to Maulik et al. (2022).

Recent advances in genetics have played a crucial role in understanding the causes of ID. These advances have allowed for the identification of specific alterations in genes and chromosomes that make it possible to detect a small percentage of cases prematurely. One example is Down's syndrome, the best-known chromosomal cause of ID, in which Trisomy 21 is responsible for over 95% of the syndrome (Maulik et al., 2022). Despite these advances, the reality is that most of the causes of ID are still unknown (Maulik et al., 2022; van Bokhoven, 2011).

1.3. Diagnosis of intellectual disabilities

Several classification systems include the diagnosis of ID. The Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), and the International Classification of Functioning Disability and Health (ICF) are the most outstanding. Although these classifications approach intellectual disability from different perspectives, they are aligned with the same principles. The DSM-5 (APA, 2013) replaced the outdated term “mental retardation” with “intellectual disability” and classified it as a neurodevelopmental disorder. It also defines severity levels (mild, moderate, severe, and profound) based on adaptive functioning instead of IQ. The ICD-11 (WHO, 2022) classifies them as "disorders of intellectual development," but agrees with the DSM-5 in grouping this diagnosis under the category of neurodevelopmental disorders. While medical classification systems typically provide diagnostic criteria, the ICF (WHO, 2001) adds the assessment dimension of human functioning. Based on this classification, disabilities are defined as any anomalies, defects, or loss of one or more functions (such as physiological, cognitive, or sensory) or body structures (such as organs or anatomical areas). This functionality aids professionals in evaluating the distinct individual differences within this diverse group.

The American Association of Intellectual and Developmental Disabilities (AAIDD) is one of the oldest associations that advocates for the welfare, good practices, and interests of individuals with ID. Their manual (Schalock et al., 2021) focuses on understanding the systems and classifications that involve those with ID and developmental disabilities. Explores their nuances, to provide a comprehensive explanation and description of these diagnoses and their peculiarities. **Table 1** shows how the AAIDD incorporates criteria from different diagnostic systems to comprehensively shape the diagnosis of ID.

Table 1. Diagnostic criteria for intellectual disabilities according to the 12th edition of the American Association of Intellectual and Developmental Disabilities' (AAIDD) manual.

Intellectual functioning	Significant limitations in intellectual functioning with scores of approximately 2 (or more) standard deviations below the mean. Measured with a reliable, valid, complete, individually administered, and standardized IQ test.
Adaptative behavior	Significant limitations in conceptual, social, and practical skills, measured with reliable, valid, and standardized instruments that yield a measure for each of the three domains.
Age of onset	During the developmental period, defined as before the age of 22 years. The diagnosis may also be retrospective when the individual did not receive an official diagnosis of ID during the developmental period.

Note. Adapted from Schalock et al. (2021).

1.4. Vulnerability

People with ID are often described as a vulnerable group. The idea of vulnerability has an underlying moral character, related to protection, and need (Mackenzie, 2016), socio-politically operationalized around dependency (Scully, 2014). The concept of vulnerability serves the purpose of safeguarding certain groups from being subjected to unnecessary distress or harm, targeting those on whom the institutions in charge of their protection must ensure certain guarantees.

When referring to people with ID the condition of vulnerable is applied as a trait that defines all persons that pertain to this category (Snipstad, 2022). Although some vulnerabilities that this population features are undeniably the result of physical or cognitive boundaries attributable to the disability, others are not that clearly inherent (Scully, 2013). Mackenzie (2016) distinguishes between two types of vulnerability – intrinsic and situational vulnerability. Intrinsic vulnerability derives from individuals' corporal limitations, needs, or dependence; while situational vulnerability can be caused or aggravated by external social, political, economic, and environmental factors. Therefore, an individual's own vulnerability risk will depend on the combination of both. **Figure 2** illustrates how sources of vulnerability to victimization combine in people with ID. Otherwise, applying vulnerability to all individuals in a particular group may cause what Snipstad (2022) describes as the vulnerability paradox. This means that the concept, which is intended to protect, instead becomes harmful by creating stereotypes and disempowering the individuals in the group due to its disabling and excluding implications.

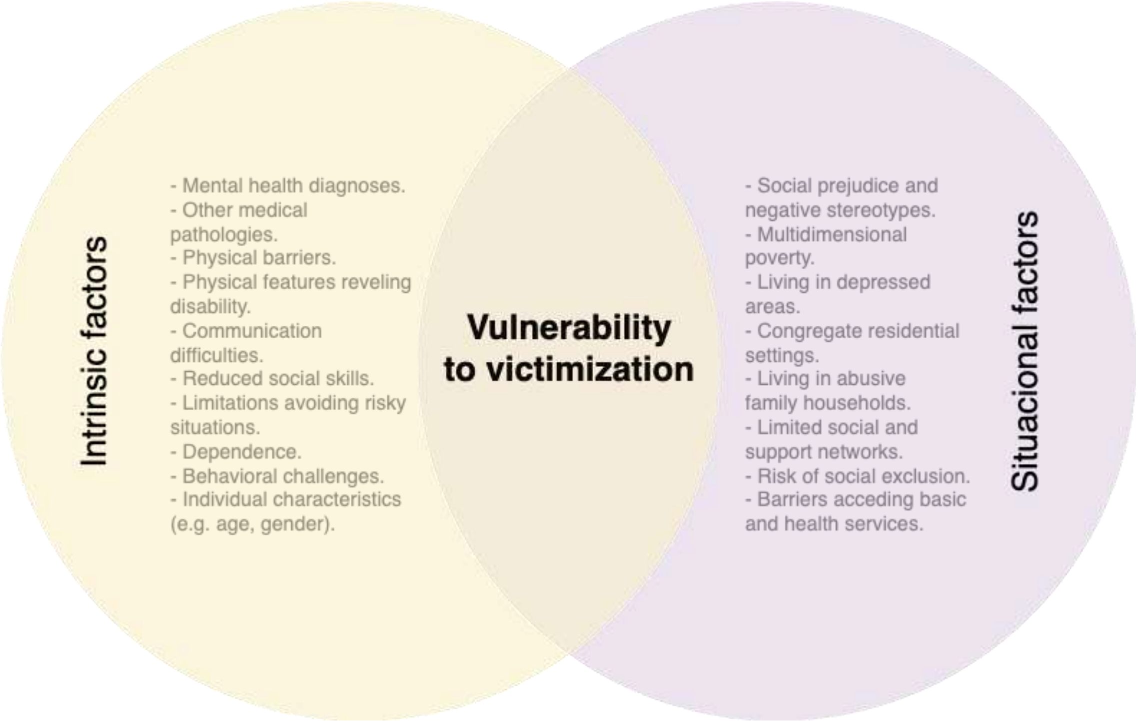


Figure 2. Convergence of factors for vulnerability to victimization in people with intellectual disabilities applying Mackenzie's (2016) sources of vulnerability model.

In a population as diverse as people with intellectual disabilities, their medical and genetic conditions, as well as environmental factors, determine their unique set of strengths and challenges (Burack et al., 2021). This, in turn, can affect their level of risk in certain situations or contexts. For instance, some inherent characteristics of certain types of ID, such as distinctive physical features in Down and William syndrome, or limited risk awareness and avoidance in those on the autistic spectrum (Fisher et al., 2016), can expose them to certain types of victimization or criminal activities. An example of a specific form of violence would be how the combination of physical barriers that prevent escaping the possible abusive situation and limited understanding of sexuality may increase the risk of sexual victimization (Assink et al., 2019; Byrne, 2018).

Individuals with ID may require varying levels of support to carry out daily activities such as self-care, personal hygiene, eating, communication, social interaction, managing money, and accessing community and health services (Patel et al., 2020; Schalock et al., 2021). In parallel, they are also more prone to other concomitant pathologies and health problems (Maulik et al., 2011; Mazza et al., 2020), which may increase their need for assistance and vulnerability. Due to their increased dependence on others for assistance, they are more likely to be victims of disability-related abuse which is a form of victimization directly linked to the presence of a disability (Hughes et al., 2011). A study analyzing the risk of victimization and crime found that individuals with a dual diagnosis (ID and a comorbid mental illness) were over twice as likely to be victimized (Thomas et al., 2019).

It is also important to consider the personal history of victimization when assessing the risk of future victimization. Individuals who have experienced persistent victimization in the past are at a higher risk of being victimized again in the future compared to those who have not been victimized before (Tillyer, 2014).

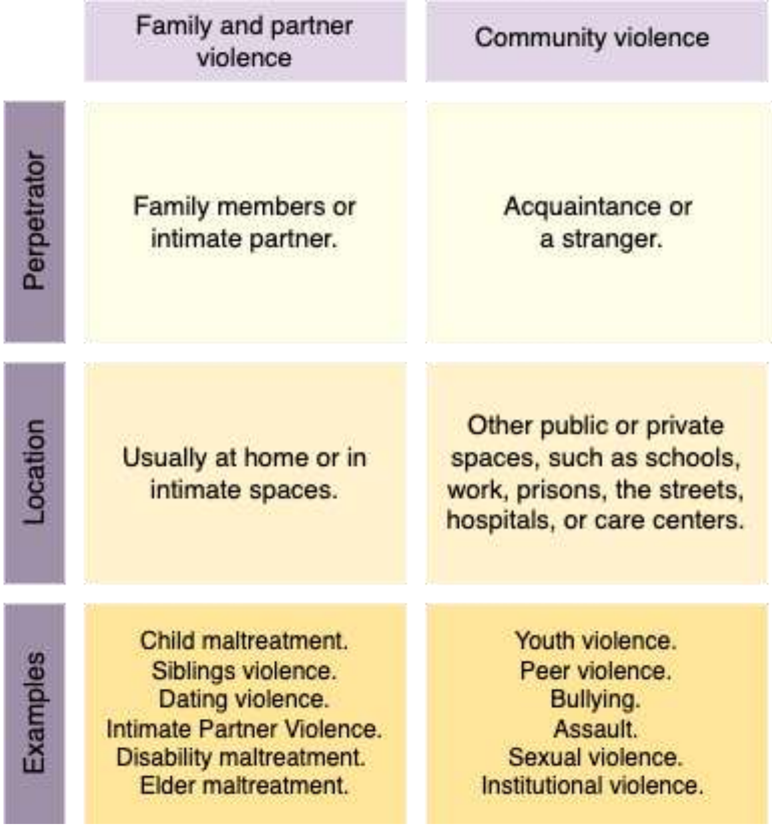
Vulnerability can stem from various environmental factors, in addition to individual characteristics. These may include living in congregate residential settings (e.g., institutions, residential care), being isolated or having a limited support network, or can result from the barriers encountered acceding and communicating with the agencies providing support and protection services because of their lack of collaboration and training (Assink et al., 2019; Beadle-Brown et al., 2010; McGilloway et al., 2020). Social perception can also increase the risk of victimization. Negative attitudes, stereotypes, and misconceptions about ID often revolve around a lack of agency, inferiority, dehumanization, objectification, and hostility (Meer & Combrinck, 2015; Nario-Redmond et al., 2019) and can lead to victim-blaming arguments or undervaluing the victimization (McGilloway et al., 2020). Some disabilities, incapacities, or behaviors may elicit irritation, anger, or dislike in some people increasing the risk of victimization to those who display them (Assink et al., 2019). In cases of sexual victimization, some perpetrators may view individuals with ID as having diminished value, lacking sexual agency, and therefore not requiring consent in sexual interactions (Meer & Combrinck, 2015).

Thus, in sum, vulnerability to victimization has more to do with a cascade of factors that place people in vulnerable positions than with the person's condition. That is why it is fundamental to integrate intersectionality approaches into the study of ID and violence. Intersectionality refers to the critical understanding of variables operating as reciprocally overlapping entities, instead of as isolated mutually exclusive layers (Collins, 2015).

1.5. Victimization in people with intellectual disabilities

The term victimization is used by approaches that focus on the victims' experiences, consequences, and impact on vulnerability and quality of life (Muratore, 2014). In that sense, victimization is the terminology used in studies that analyze crime and violence from a victim-centered perspective. However, the conceptualization of victimization is complex and must be described and measured in a manner that accurately identifies those who experience it and reveals the true extent of the phenomenon (Daigle et al., 2016). Broadly, victimization is defined as the process of being victimized, from a physical, psychological, sexual, or moral point of view (Muratore, 2014). Violence is described by the World Health Organization (WHO) as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (Krug et al., 2002, p.5). But violence can also take multiple forms, such as self-directed violence (such as suicide or self-harm); collective violence (such as war, terrorism, or genocide); or interpersonal violence (Krug et al., 2002), the latter being the subject of interest of this thesis.

Interpersonal violence refers to the deliberate use of force or power by an individual or a small group of individuals against others. Such violence can take various forms including physical, sexual, or psychological abuse, and may in turn involve deprivation and neglect (Mercy et al., 2017). Can be categorized into two types: family or partner violence and community violence. Some further details about both types of interpersonal violence can be seen in **Figure 3**.



	Family and partner violence	Community violence
Perpetrator	Family members or intimate partner.	Acquaintance or a stranger.
Location	Usually at home or in intimate spaces.	Other public or private spaces, such as schools, work, prisons, the streets, hospitals, or care centers.
Examples	Child maltreatment. Siblings violence. Dating violence. Intimate Partner Violence. Disability maltreatment. Elder maltreatment.	Youth violence. Peer violence. Bullying. Assault. Sexual violence. Institutional violence.

Figure 3. Characteristics and examples of interpersonal violence based on Mercy et al. (2017).

The term “interpersonal victimization”, derived from developmental victimology, amalgamates both interpersonal violence and victimization. Interpersonal victimization includes a range of negative experiences, including (among others) neglect, homicide, and sexual, physical, or emotional abuse. Other notable adverse experiences that may occur in life result from illnesses, accidents, or natural disasters, but interpersonal victimization focuses on the harm that occurs because of human actors behaving in ways that violate social norms (Finkelhor, 2007). Interpersonal victimization is a construct built to describe child victimization, but it aligns well with other groups — such as the elderly and people with disabilities — that share an important salient characteristic: the dependency status and power imbalance that leads to a greater degree of vulnerability to abuse.

Both children and adults with ID have a greatly increased risk of experiencing interpersonal victimization (Hughes et al., 2012; Jones et al., 2012), especially for the most violent types such as physical and sexual aggression (Fang et al., 2022; Jones et al., 2012;

Mailhot Amborski et al., 2022) A summary of pooled prevalence of victimization and odds ratios from the available meta-analyses can be seen in **Table 2**.

Table 2. Pooled prevalence and odds ratios (OR) from meta-analyses including intellectual disabilities populations, for any type of victimization, and violent victimization.

	n[a]	Any type of violence		Physical violence		Sexual violence	
Meta-analysis		%	*OR* (95% CI)	%	*OR* (95% CI)	%	*OR* (95% CI)
Hughes et al. (2012)	26	6.1	1.60 (1.05–2.45)	9.9	-	-	-
Jones et al. (2012)	17	21.2	4.28 (2.12–8.62)	26.8	3.08 (2.08–4.57)	14.5	4.62 (2.08–10.23)
Fang et al. (2022)	98	33.0	2.35 (1.90–2.91)	35.3	3.1 (1.62–5.93)	8.7	2.37 (1.48–3.79)
Mailhot Amborski et al. (2022)	68	-	-	-	-	-	1.81 (1.14- 2.87)

Note. Some information was not available due to either the scope of the meta-analysis or insufficient data.

[a] Total number of studies included in the meta-analysis. The number of studies used to calculate the prevalence and OR for those with ID differed in each case.

Determining the general prevalence of victimization among ID populations is a challenge, given the variability of research methodologies, samplings, and definitions across studies. This issue has been consistently and repeatedly highlighted in previous works (Daigle et al., 2016; Fisher et al., 2016; Horner-Johnson & Drum, 2006; Hughes et al., 2012). Consequently, the figure disparities contribute to an inconclusive portrayal of the phenomenon.

Gender is a classic variable of analysis in this field. When gender variation is analyzed, less pronounced differences are noted in the ID population when it comes to victimization in general (Platt et al., 2017). Except for sexual victimization, in which women seem to be more victims compared to their men counterparts (Cambridge et al., 2011; Nixon et al., 2017; Platt et al., 2017). However, some studies (Mitra et al., 2016; Nixon et al., 2017) suggest that when compared to the general population, men with ID also have an increased risk of experiencing sexual abuse in comparison with both men and women without disabilities. Overall estimations of sexual victimization among this population are difficult to determine due to the sampling and methodological variability between studies, a problem that has been repeatedly highlighted (Hughes et al., 2012; Mailhot Amborski et al., 2022). In any case, there is a consensus that the existence of a disability is a risk factor for sexual victimization (Assink et al., 2019; Jones et al., 2012; Mailhot Amborski et al., 2022).

Among all types of victimization, sexual victimization in people with ID is one of those that has aroused the most interest among researchers, with multiple available reviews on the topic (Byrne, 2018; McGilloway et al., 2020; Smit et al., 2019; Wissink et al., 2015). The findings highlight increased odds of sexual victimization in childhood and adulthood and the experience of multiple episodes of abuse being more common than a single incident. The perpetrator is usually known to the victim, with men family members, partners, acquaintances, and caregivers being the most frequently reported abusers. Higher rates of Post-Traumatic Stress Disorder (PTSD) are found among people with ID who have been victims of sexual victimization (Smit et al., 2019). Although sexual victimization is a recognized concern among people with ID, it is a complex interconnection of vulnerabilities, barriers, and social attitudes that prevent the amelioration of this phenomenon.

Additionally to sexual victimization, this group experiences multiple intersecting forms of victimization and discrimination, which may involve force or physical violence. Across studies, it is found that physical abuse is one of the most prevalent forms of violence experienced by people with ID (Hughes et al., 2012; Jones et al., 2012). This physical violence may be part, for example, of intimate partner violence (IPV), bullying, bias-motivated violence, or disability-related abuse.

In their systematic review, Bowen and Swift (2019) point out that IPV is a common experience among adults with ID, living this type of situation across various relationships and with different partners. A wide variety of victimizations ranging from psychological, physical, verbal, and sexual abuse, controlling behaviors, and other severe forms of physical violence such as battering, choking, or stabbing have been reported across studies. Disability is known to be a risk factor for IPV (Brownridge, 2006; Hahn et al., 2014; Hughes et al., 2012), especially among women with physical and mental health impairments (Hahn et al., 2014). The presence of ID increases the risk of serious harm in IPV cases, raising the risk for both sexes of intimate partner violence-related hospitalizations compared to men and women without ID (Li et al., 2023). A complex combination of factors (for example, barriers, lack of credibility, negative self-view, and social attitudes) may overshadow the existence and reporting of gender-based violence (Meer & Combrinck, 2015).

When school-aged, people with ID may face different forms of bullying, such as physical, relational, verbal, and cyber victimization (Beckman et al., 2020; Maïano et al., 2016). Bullying victimization rates were found to be high in children and adolescents with ID, the same way as rates of being both victims and perpetrators at the same time (Beckman et al., 2020; Maïano et al., 2016). Heterogeneity among measures, definitions, and studies did not allow the available systematic reviews to draw clear conclusions regarding whether there are differences in the experiences of bullying, the school settings, or severity between population groups with ID and those in the general population. Lower social skills were one of the most widely used explanations across the studies to understand bullying figures among this population (Christensen et al., 2012; Maïano et al., 2016).

The impact of stigma on several life domains leads to people with ID facing a range of experiences of social exclusion, marginalization, discrimination, and abuse (Ditchman et al., 2016). People with disabilities are significantly more likely to experience bias victimization than people without disabilities (Emerson & Roulstone, 2014). Bias-motivated violence emanates from stigma because it is partially or entirely based on the prejudice held by the perpetrator against one or multiple identities such as disability condition, race, ethnicity, religion, sexual orientation, or gender identity (Díaz-Faes & Pereda, 2022). The studies on this phenomenon with ID populations are scarce. Still, the data shows that bias-motivated violence could be a frequent experience in the lives of people with ID and may cause psychological and physical consequences (Díaz-Faes et al., 2023a; Sherry & Neller, 2016). Similarly, When specific samples with ID are analyzed, high rates of repeated experiences of bias-motivated violence are detected (Díaz-Faes et al., 2023a).

Another form of victimization that is unique to persons with disabilities is disability-related abuse. Understand as those forms of victimization directly linked to a disability and the support needs and functional limitations arising from it (Lund, 2021). Denial of assistive technology (for example, wheelchairs or medical equipment), denial of personal assistance or care (for example, taking medication, getting out of bed, bathing), or financial abuse are some examples of disability-related victimizations (Lund, 2021; McFarlane et al., 2001). When the perpetrator is the caregiver, especially when the ones assisting are family members or friends, some difficulties in recognizing and defining abusive situations can arise (Saxton et al., 2001). Other forms of abuse perpetrated by formal or informal caregivers while carrying out their caregiving responsibilities are also a concern. Beadle-Brown et al. (2010) found that people with ID were more likely than people without ID to be abused in residential care settings by members of staff, being common co-occurrence of multiple types of abuse, but above all physical abuse (Strand et al., 2004) also highlighted the use of physical force by the staff members in care settings when trying to help the user who did not cooperate or who refused assistance, or because both the caregiver and the user reacted violently to each other.

In addition to the forms of abuse mentioned above, there are further forms such as property crime (for example, theft, robbery, property destruction), assault, intimidation, stalking, or institutional abuse that, although covered by some studies (Fisher et al., 2016; Horner-Johnson & Drum, 2006), remain largely understudied, finding contradictory figures. While some studies claim that people with ID are at increased risk for any violent or non-violent victimization (Horner-Johnson & Drum, 2006; Krnjacki et al., 2016), some others indicate that in contrast to violent and sexual victimization, the risk of experiencing non-violent types among people with ID is lower than in the general population (Fogden et al., 2016; Nixon et al., 2017). Some of the authors' interpretations of these results are that people with ID may own less property, so they are less targeted or report less of these types of victimization. A study found that the risk of victimization in people with disabilities changes across growth stages, with those with ID facing a higher risk for violent victimization at a very early age, and during middle childhood an increased risk for property crime (Vanderminden et al., 2023).

1.6. Polyvictimization in people with intellectual disabilities

Poly-victimization is the phenomenon of experiencing multiple and diverse types of victimization (Finkelhor et al., 2005). Represents a condition of victimization rather than a mere set of experiences, with those considered poly-victims being exposed to victimization from multiple contexts and sources, going to be more likely victimized again in the future in comparison to those who are not poly-victims (Finkelhor et al., 2007; Tillyer, 2014). In contrast to a single type or isolated event experiences of victimization, poly-victimization helps to understand the complex personal stories of those individuals who experienced patterns of repeated and cumulative abuse and violence.

Poly-victimization has a powerful detrimental effect on health and development, being associated with trauma and an increased risk of adverse negative outcomes. Trauma symptoms are more highly related to poly-victimization than to experiencing repeated victimizations of a single type (Finkelhor et al., 2007; Ford et al., 2010). Poly-victims show more PTSD, anxiety, depression, substance use, and involvement in antisocial and delinquent behaviors (Ford et al., 2010).

Although it is well known that people with ID face more victimization, there is little work that brings together victimizations of different kinds and captures a complete picture of this population’s experiences. It is known that adverse experiences often overlap, and individuals who have experienced severe and prolonged victimization are more likely to experience further victimization in the future (Matsumoto et al., 2023; Tillyer, 2014). Therefore, it is possible that a significant number of people in this group may have experienced poly-victimization. Also, other features associated with poly-victimization have been reported in ID samples who experienced victimization, such as higher PTSD or being involved in criminal behaviors (Anstis & Thomas, 2022; Daveney et al., 2019; Fogden et al., 2016).

In a recent multi-wave study, Vanderminden et al. (2023) examined victimization and poly-victimization among children with and without disabilities using the Juvenile

Victimization Questionnaire (JVQ). Those with ID were included in the developmental disabilities group. The authors found that these children were at higher risk for poly-victimization, especially between the ages of 5 to 11. Other studies using the poly-victimization concept with children with ID also found high rates of lifetime poly-victimization and trauma (Lapshina & Stewart, 2021).

1.7. Consequences of victimization

The experience of being victimized is associated with detrimental effects on self-esteem, mental health, and overall well-being. Dembo et al. (2018, 2021) analyzed the consequences of violence on adolescents and young adults with disabilities (with high representativeness of people with cognitive disabilities), finding that those with disabilities, in comparison with those without disabilities, were more likely to experience physical symptoms such as severe distress, head and stomach aches, fatigue, sleep problems, changes in food habits, and muscle pain. In that sense, these authors suggest that although these symptoms are not unique to people with disabilities, the effects of violence on physical and mental health are worse for those with disabilities. Some gender differences were noted, with women presenting more negative psychological consequences resulting from violence compared to men with ID and men and women without disabilities (Dembo et al., 2018). According to Smit et al. (2019) review, victims of sexual abuse, regardless of the ID, experience high odds of anxiety, depression, and PTSD. However, conduct disorders, sexualized behaviors, self-harm, poor feelings of personal safety, and persistent feelings of anger are more common in those with ID.

Proportions of PTSD among people with ID are higher than in the general population (Daveney et al., 2019). But as happens with other psychiatric disorders, people with ID often express the symptomatology of PTSD differently (Fletcher et al., 2007). The signs of psychological trauma in people with ID manifest more commonly through behavioral expressions such as aggressiveness, behavioral deterioration, challenging behaviors, altered arousal, or acts of self-harm (McNally et al., 2021). This often leads to diagnostic overshadowing, which consists of the practitioners overlooking mental health problems by attributing behavioral changes as part of the ID itself because of the unfamiliarity with the population's expression of psychopathology (Fletcher et al., 2007).

2. Justification of the current research

Research on victimization among the ID population has significantly expanded in the last few decades. However, it still presents several gaps and numerous limitations. Some of these shortcomings are related to inadequate sample sizes, methodological issues, and discrepancies across studies in the definitions of violence (Horner-Johnson & Drum, 2006; Hughes et al., 2011). Moreover, there is a paucity of studies that examine various forms of violent and non-violent victimization within the same sample (Beadle-Brown et al., 2010; Fogden et al., 2016; Krnjacki et al., 2016; Nixon et al., 2017). Some of these studies have yielded mixed findings, raising questions about the extent of vulnerability to victimization within this population.

This thesis comprehensively explores victimization experiences among adults with ID in Catalonia. It explores a wide range of victimization experiences, including well-documented ones like sexual and physical victimization, as well as less-studied types such as theft, assault, bias attacks, caregiver victimization, disability-related victimization, witnessing violence, and electronic victimization. The study analyzes these victimizations separately and in combination, aiming to examine the phenomenon of poly-victimization. The research benefits from a validated survey previously used in similar disability populations (Turner et al., 2011; Vanderminden et al., 2023). Some studies find that factors such as gender, age, residential status, or co-morbid mental illnesses (Beadle-Brown et al., 2010; Platt et al., 2017; Thomas et al., 2019; Vanderminden et al., 2023) influence the likelihood of experiencing certain victimizations. Sociodemographic data collection for this thesis studies includes these and other salient characteristics of this population, allowing the analysis of how different factors may influence victimization in the sample. The intersectional approach is used to analyze and understand the uniqueness and nuances of these experiences. Furthermore, sensibility is essential when working with these populations. This includes adapting surveys to meet their specific needs and addressing victimizations unique to them, such as disability-related incidents or those involving caregivers. To ensure accessibility for individuals with ID, the study employed easy-to-read elements and pictograms, and the interviews were conducted in a way that was sensitive to the needs and limitations of the population.

3. Objectives and hypothesis

This thesis aims to contribute to the knowledge and understanding of vulnerability and victimization among people with ID. For this purpose, a project was designed, which resulted in three empirical studies analyzing the experiences of victimization in a sample of adults with a diagnostic of ID and a narrative review analyzing different layers and intersecting vulnerabilities to victimization and offending. Titles, objectives, and hypotheses of each of the studies can be seen in **Table 3.**

The participants sample for the empirical studies consisted of 260 participants. It was carried out through a collaboration with the federation DINCAT, an association of social organizations that provide services, including care, education, employment, and leisure activities for individuals with ID and their families throughout Catalonia. After obtaining the approval of the University of Barcelona's bioethics committee, a collaboration agreement was signed with the federation, and an easy-to-understand document was created to ensure that participants fully understood the study's purpose and was used to obtain their express consent. The participation was voluntary, and the exclusion criteria were: 1) being under eighteen, 2) being unable to understand the study's objectives, provide informed consent, or effectively communicate their thoughts and experiences to the interviewer. The survey was administered individually in interview format with the use of pictograms.

Table 3. Summary of the objectives and hypothesis for the studies.

Study	**Objectives**	**Hypothesis**
1	*Lifetime victimization and poly-victimization in a sample of adults with intellectual disabilities*	
	(1.1) Explore the rates of different forms of lifetime victimization in a sample of adults with ID.	Individuals with ID will report high overall victimization rates. Physical, sexual, and disability-related victimizations would be higher than the

		other victimizations among the whole sample.
	(1.2) Find out gender and age differences with respect to the risk of experiencing the different types of victimization.	There would be gender and age differences. Women and middle/late adults will show a greater risk of victimization compared to men and young adults.
	(1.3) Examine rates and risk of poly-victimization among this sample.	A greater range of victimization types and higher poly-victimization rates would be observed among the general sample, especially among women and middle/late adults.
2	*Characteristics and prevalence of lifetime sexual victimization among a sample of men and women with intellectual disabilities*	
	(2.1) Identify those forms of sexual victimization most reported by the sample.	Individuals with ID will report high rates of all forms of victimization, especially the most severe ones involving physical contact.
	(2.2) Explore gender differences concerning the different types of sexual victimization.	Women will be at higher overall risk for sexual victimization, but there will be gender differences for each type of victimization separately.
	(2.3) Examine the main characteristics of the last sexual incident reported by the participants.	Information on the incident's location, the victim's age, the offender's characteristics, and their relationship with the victim will be provided.

	(2.4) Describe the physical and psychological consequences that followed these experiences.	In general, most victims will have had some kind of traumatic symptomatology resulting from the incidents, and some of them involving physical contact may also have resulted in corporal injury.
	(2.5) Determine which sociodemographic characteristics are associated with sexual victimization by comparing those who have experienced sexual victimization to those who have not.	Gender, age, having been declared legally incapable, having greater support needs, and having a co-occurring secondary disability will be the sociodemographic characteristics most significantly associated with sexual victimization.
	(2.6) Exploring the disclosure and reporting of these experiences.	Given the nature of the sexual victimization, a small number of these will have been reported to the authorities.
3	*Better at home or in residential care? Victimization of people with intellectual disabilities at the hands of caregivers*	
	(3.1) Analyzing the different forms of caregiver victimization.	High overall rates of caregiver victimization will be detected. Among all types, physical victimization would be the most reported victimization.
	(3.2) Exploring gender and residential differences with respect to the risk of experiencing caregiver victimization.	Being a woman and living in a residential care setting would both be factors that increase the risk of experiencing caregiver victimization.

	(3.3) Describing the main characteristics of the latest victimization incidents in relation to residential status.	Information about the incident location, victim's age, offender characteristics, and relationship to the victim will be provided.
	(3.4) Describe the physical and psychological consequences of caregiver victimization.	Victims of abuse may suffer physical injuries, but the most commonly reported consequences will be psychological.
	(3.5) Exploring the disclosure and reporting of these experiences.	Due to the overlapping of offender and caregiver, disclosure and reporting opportunities will be limited.
4	*Women with intellectual disabilities: Unraveling their victim-offender status*	
	This book chapter is a narrative review exploring the topic of women with ID involved in victimization and offense. Published as part of *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence*.	It provides a critical and historical review of the role of women with ID as victims and perpetrators of crime, by synthesizing the different levels of analysis of the subject using an intersectionality approach.

4. Study 1. Lifetime victimization and poly-victimization in a sample of adults with intellectual disabilities

Codina, M., Pereda, N., & Guilera, G. (2022). Lifetime victimization and poly-victimization in a sample of adults with intellectual disabilities. *Journal of Interpersonal Violence, 37*(5–6), 2062–2082. https://doi.org/10.1177/0886260520936372

Journal Metrics

JCR 2022, Impact Factor: 2.5

Criminology & Penology (SSCI) 18 out of 69, Q2

Family Studies (SSCI) 18 out of 46, Q2

Psychology, Applied (SSCI) 48 out of 83, Q3

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Abstract

People with intellectual disabilities appear to be more vulnerable to victimization. However, few studies have assessed victimization in these groups and those that do exist are highly heterogeneous and tend to focus only on specific forms of violence. This study attempts to shed light on the phenomenon of victimization among adults with intellectual disabilities by assessing victimization and poly-victimization throughout their life course. The sample consisted of 260 adults (154 men and 106 women) with an intellectual disability diagnosis recruited from the Catalan Federation for People with Intellectual Disabilities (DINCAT) in Spain. They ranged in age from 20–71 (*M* = 41.69, *SD* = 12.05). Victimization experiences were assessed using an adaptation of the retrospective version of the Juvenile Victimization Questionnaire. The results showed that 96.9% of the participants had suffered some kind of victimization throughout their lives. Concerning the types of victimization, the most frequent were conventional crimes (87.7%), witnessing and indirect victimization (67.3%), victimization by caregivers (59.2%), sexual victimization (35%), and electronic victimization (23.5%). Women and early adults tended to experience higher rates of victimization. The poly-victimized group experienced 13 or more incidents of victimization throughout their lives. This study highlights the elevated rates of lifetime victimization among people with intellectual disabilities. It adds to previous evidence that special protection programs are required to address this issue and emphasizes the need for prevention and intervention measures in this particularly vulnerable group.

Keywords: intellectual disability; victimization; poly-victimization; Juvenile Victimization Questionnaire; gender; early adults; middle-late adults.

Introduction

Disability is a strong risk factor for interpersonal victimization in both adults and children (Hughes et al., 2012; Jones et al., 2012). According to meta-analyses (Hughes et al., 2012), the probability of victimization is 1.5 times higher in adults with disabilities than in samples without disabilities. Moreover, those with intellectual disabilities (ID) are 1.6 times more likely to suffer violent victimization. When age is taken into account, older adults with general disabilities are the group at the highest risk of violence and abuse (Cooper et al., 2008).

Thus, compared to other forms of disability (such as physical disabilities, mental disorders, and other, nonspecific disabilities), people with ID seem to be at a greater risk of victimization, especially the most violent types (Fisher et al., 2016; Horner-Johnson & Drum, 2006; Nixon, et al., 2017; Rand & Harrell, 2009). The review by Fisher et al. (2016) shows that lifetime prevalence rates of sexual abuse may be as high as 80% in people with ID. The consensus seems to be that sexual victimization is more common among women with ID than among men with the same disability (Cambridge et al., 2011; McCarthy & Thompson, 1997). However, Byrne (2018) suggests that the very fact that a man has an ID increases his risk of suffering sexual abuse throughout his life compared to men without disabilities or with other types of disabilities. Other studies (Powers et al., 2002, 2008), carried out in the US with samples of men and women with ID, indicate that 65% of men and 67% of women have suffered physical abuse at some point in their lives, while 53% of women and 24% of men have suffered sexual abuse. Beadle-Brown et al. (2010) examined official UK figures for several consecutive years and found that almost half of the ID sample, which included both men and women, had suffered some form of physical abuse (48%), while 20% had experienced sexual abuse.

Another form of victimization studied in people with ID is intimate partner violence (IPV). Ward et al. (2010) conducted a study in Alaska and found that 60% of the participants in their sample had suffered some type of IPV; emotional violence was the most common (90% of men and 79% of women). A national study carried out in Taiwan showed that 41.5% of people with disabilities who had experienced IPV had an ID; this made them the most frequently victimized group (Lin et al., 2010). Two recent studies with Spanish samples addressed the growing phenomenon of cyber-victimization among adult populations with ID and found that 15.2% (Jenaro et al., 2018) and 64.4% (Iglesias et al., 2019) had suffered some type of electronic victimization. Both studies agreed that verbal victimization was the most common type (88% and 74.5%, respectively).

Finally, other types of criminal behavior, such as common crimes, have been largely unexplored among this group. Wilson & Brewer (1992) conducted a study that examined 174 adults with ID from Australia and detected higher rates of several types of victimization, including assault (11.4%) and robbery (5.1%). Bryen et al., (2003) conducted a study on a sample of 40 people with communicative and cognitive difficulties and found that 56% of the participants had suffered theft and 44% had been threatened with a physical attack over the last year. McMahon et al. (2004) explored 127 cases involving people with ID and reported that the three most common types of victimization were simple assault, intimidation, and property damage. In addition, the risk of being a victim of a hate crime motivated by ID is particularly high and, according to a study conducted in the UK by Emerson & Roulstone (2014), affects up to 7% of this population.

However, when studying the phenomenon of victimization, it is important to remember that forms of violence rarely occur in isolation; rather, the same individual may experience a wide range of victimization types throughout his or her life. In a systematic review by Fisher et al. (2016), the authors warned that, in all studies that addressed more than one form of victimization, most individuals with ID had experienced multiple types. This phenomenon has been named poly-victimization and is defined as the occurrence of multiple victimization experiences in different episodes (Finkelhor et al., 2007). Thus, analyzing a single form of violence or different types in isolation in people at high risk of victimization, such as people with ID, leads to underestimation of the wide range of victimization experiences to which this group may be subjected (see, for example, the study on poly-victimization in minors with ID by Turner et al. (2011).

Finally, it should be noted that studying victimization experiences among adults with ID presents several limitations. One of these is that most research on this topic is general and often treats all disability types as if they were a homogeneous group (see, for example, Berg, et al., 2015; Krnjacki et al., 2016; Sullivan & Knutson, 2000). Thus, quantitative studies that specifically examine victimization and ID are scarce (Mikton, et al., 2014), and frequently focus on sexual victimization (Basile et al., 2016; Cambridge et al., 2011; Gil, et al., 2019; McCarthy & Thompson, 1997). Moreover, the literature available on ID and victimization rarely includes victims with severe disabilities, due to the difficulties associated with collecting these data, and focuses only on mild or moderate cases (Callaghan et al., 2003; Krnjacki et al., 2016). This prevents the most severe cases from coming to light. In addition, no previous research has evaluated poly-victimization among older adults (Felitti et al., 1998), even though it seems to be a frequent phenomenon (Fisher et al., 2016). Furthermore, comparing the results of the studies available on this topic is complex because of the different methodologies, populations, and definitions used. Nonetheless, the common finding of reviews and meta-analyses (Fisher et al., 2016; Horner-Johnson & Drum, 2006; Hughes et al., 2012; Hughes et al., 2011; Jones et al., 2012) is that all studies analyzed reported high victimization rates among people with ID.

Aims of the Study

Thus, this study aims to: (a) identify the rates for the different forms of victimization in a sample of Spanish adults with ID throughout their lives; (b) explore whether there are gender differences concerning different experiences of victimization; (c) analyze whether there are age-related differences among early and middle/late adults concerning different experiences of victimization; and (d) find out whether the participants are subjected to poly-victimization or have had multiple victimization experiences throughout their lives.

Method

Sample

The sample consisted of 260 adults with an ID diagnosis recruited from the federation DINCAT, which runs social initiative entities that work to improve the quality of life of people with ID and their families in the northeast of Spain. The majority of the population with ID in Spain live with their families or, less frequently, in a center (Navas et al., 2017). Most of them receive some kind of public assistance (mainly the provision of care services and financial support). Other studies (Giné et al., 2015; Vilaseca et al., 2017) have also pointed out that families are the main caregivers of people with ID in Spain.

A non-probabilistic sampling of consecutive cases was applied, and the inclusion criteria were as follows: participants had to be over 18 years of age, have an ID diagnosis, and be capable of consenting to the study and communicating their thoughts and experiences to the interviewer (by themselves or with the help of their usual caregiver). The purpose of the study was to include as many individuals with more serious diagnoses and communication difficulties as possible. The only exclusion criterion applied to individuals with severe cognitive difficulties that prevented them from understanding the study and its objectives.

Measures

Sociodemographic Data. A sociodemographic datasheet was created ad hoc to collect the participants' data. This included how they answered the questionnaire (by themselves, through pictograms, or with their caregiver's support), the age, gender, place of residence, country of birth of the participants and their parents, the type of schooling they received (e.g., regular education or special education), and the service they received from DINCAT (e.g., occupational or care). Disability information was also collected (e.g., whether they were declared legally incapable and who was their guardian), their degree of autonomy, and the type of support they received (e.g., general or limited). Information about other secondary disability diagnoses, disorders, or illnesses suffered by the participants was also collected. This information was sometimes self-reported (78.5%) and sometimes provided by the caregiver (21.5%).

Victimization. An adaptation of the Juvenile Victimization Questionnaire, Adult Retrospective Version (JVQ; Finkelhor et al., 2005), was used to collect the victimization experiences throughout the lives of the participants. Twenty-eight specific victimization events distributed in five modules were evaluated: a) conventional crime (6 items), b) caregiver victimization (6 items), c) sexual victimization (6 items), d) witnessing and indirect victimization (4 items), and e) electronic victimization (6 items). The questionnaire was presented in Spanish and administered in a retrospective interview format. The original version of this questionnaire has been shown to have adequate psychometric properties (Finkelhor et al., 2005). The Spanish version has also been validated (Pereda et al., 2018). It is, in addition, the most appropriate tool for evaluating poly-victimization (Finkelhor et al., 2005). All participants responded to the questionnaire by themselves, with the help of pictograms, but some were assisted by another person or a caregiver (9.6%).

Procedure

The federation DINCAT was invited to participate in the study. A collaboration agreement was signed, and the express consent of all participants and their legal representatives was obtained. Adapted and easy-to-read versions of the documents were created to ensure that the participants understood the objectives and characteristics of the study in which they voluntarily agreed to participate. Ten interviewers were trained in the application of the tool and the recording of the responses. The questionnaire was administered individually in an interview format with the use of pictograms, and if necessary, the participants were helped by their usual caregivers. The study was carried out in accordance with the basic ethical principles of the Helsinki Declaration on Research Involving Human Subjects (World Medical Association, 2013).

Data Analysis

For the statistical analysis, version 25 of the IBM SPSS Statistics program was used. A univariate descriptive analysis was performed for sociodemographic data and victimization experiences and, subsequently, bivariate analysis was conducted to examine the association measures between variables. For age, two groups were established: early adulthood (20-40) and middle/late adulthood (41-71). The rationale behind these categories is Levinson's adulthood developmental periods (Levinson, 1986) which distinguishes different phases in the life course of adults and sets the early 40s as the entry into middle adulthood. Respecting this transition point idea, we fixed 40 years old as the cut-off age to create the two categories. Thus, to compare the number of victimization events between age groups and genders, the Mann-Whitney U test was applied, and the significance level was set at a p-value < 0.05. The odds ratio (OR) measured the effect size of the association between gender (men vs. women) and age group (early vs. middle/late adulthood) with victimization rates, and the corresponding confidence intervals at 95% were obtained. Poly-victims were identified based on the total number of victimization events reported by the participants in the questionnaire. Thus, the top 10% of people with the highest number of victimization events throughout their lives were established as the cut-off point to determine poly-victimization, as suggested by

Finkelhor, Ormrod, &Turner (2009). This approach takes account of the increasing number of victimization types with age.

Results

Sociodemographic Characteristics

The sample comprised a total of 260 adults, 154 men and 106 women (59.2% and 40.8%, respectively), aged between 20 and 71 years (*M* = 41.69; *SD* = 12.03). The majority of participants were Spanish (95.8%), with a recognized legal disability (62.3%) and a secondary disability diagnosis in 66.9% of the cases. The main sociodemographic characteristics of the participants are shown in **Table 4**.

Table 4. Sample characteristics

Variable	Men		Women		Total	
	n	%	*n*	%	*n*	%
Age						
Early adulthood (20-40)	74	48.1	52	49.1	126	48.5
Middle/late adulthood (41-71)	80	51.9	54	50.9	134	51.5
Country of origin[a]						
Spain	147	59.3	101	40.7	248	95.8
Other	7	63.6	4	36.4	11	4.2
Type of education[b]						
Regular education	60	59.4	41	40.6	101	43.9
Regular education + support	25	50.0	25	50.0	50	21.7
Special education	50	63.3	29	36.7	79	34.3
Legally incapable[c]						
Yes	96	59.3	66	40.7	162	62.3
No	54	58.7	38	41.3	92	35.4
Unknown	4	66.7	2	33.3	6	2.3
Legal guardianship[d]						
Institution	37	57.8	27	42.2	64	26.2
Family members/relatives	54	61.4	34	38.6	88	36.1
Others	5	50.0	5	50.0	10	3.8
Type of support needed[e]						

General	10	58.8	7	41.2	17	7.8
Extensive	31	66.0	16	34.0	47	21.5
Limited	49	63.3	26	34.7	75	34.2
Intermittent	39	48.8	41	51.2	80	36.5
Type of service received[f]						
Occupational center	90	60.8	58	39.2	148	56.9
Special work center	34	50.0	34	50.0	68	26.2
Leisure entity	6	75.0	2	25.0	8	3.1
School	1	33.3	2	66.7	3	1.2
Specialized care center	2	66.7	1	33.3	3	1.2
Regular company	13	81.3	3	18.8	16	6.2
None	7	58.3	5	41.7	12	4.6
Unknown	1	50.0	1	50.0	2	0.8
Secondary disability diagnosis[g]						
No	49	57.0	37	43.0	86	33.1
Yes	105	60.3	69	39.7	174	66.9
Type of secondary diagnosis						
Physical disability	45	60.8	29	39.2	74	42.5
Mental disability	44	64.7	24	35.3	68	39.0
Both	16	50.0	16	50.0	32	18.4

[a] The country in which the person was born.

[b] The type of education received in the past: regular education is traditional education in regular schools; regular education with additional special support; special education means education for children with intellectual disabilities.

[c] According to Spanish Civil Code, the one who is not able to handle personal, financial, and legal affairs and needs a legal guardian

[d] Is the authority conferred to someone to take care of the one declared legally incapable and help them with the decision-making.

[e] Support required to carry out daily activities.

[f] The type of service accessed at the time of the survey.

[g] Another diagnosed disability that coexists alongside the main intellectual disability.

Victimization Experiences

Almost all participants (96.9%) reported having suffered at least one type of victimization during their lives. **Table 5** shows the rates for the different types of lifetime victimization.

Conventional crime. A large number of participants (87.7%) reported having experienced conventional crimes. Among these victimization events, verbal aggression was the most commonly reported (64.5%) and was most likely to occur among women and early adults. This same trend could be seen with intimidation, which was suffered by 38.1% of both women and younger adults. A total of 35.6% of people reported having suffered a bias attack, with women having experienced this more than men, although this difference was not significative. There were no statistically significant differences between age groups. Robbery was experienced by 47.7% of the participants, followed by assault (39.6%) and threatened assault (31.5%). Both assault and threatened assault were most frequently reported by men (OR = 0.77, $p < .05$; OR = 0.84, $p < .05$ respectively) while intimidation and assault by younger adults (OR = 0.54, $p < .05$; OR = 0.56, $p < .05$ respectively).

Table 5. Lifetime victimization

Victimization items	Total		Gender (%)			Age group (%)		
	n	%	Men	Women	OR[1]	Early	Middle/late	*OR*
Conventional crime	228	87.7	87.0	88.7	1.17	87.3	88.1	1.07
Robbery	124	47.7	48.7	46.2	0.91	49.2	46.3	0.89
Verbal aggression	167	64.5	60.8	69.8	1.49	68.0	61.2	0.74
Bias attack	89	35.6	33.3	38.8	1.27	35.8	35.4	0.98
Intimidation	81	31.4	26.8	38.1	1.68	38.1	25.0	0.54^{*}
Threatened assault	81	31.5	33.1	29.2	0.84^{*}	36.5	26.7	0.63
Assault	103	39.6	42.2	35.8	0.77^{*}	46.8	32.8	0.56^{*}
Caregiver victimization	154	59.2	56.5	63.2	1.32	64.3	54.5	0.67
Theft by a caregiver	30	11.6	10.5	13.2	1.30	15.2	8.2	0.50
Verbal/relational abuse	64	24.6	18.8	33.0	2.13^{*}	30.2	19.4	0.56^{*}
Psychological abuse	36	13.9	11.8	17.0	1.53	14.4	13.5	0.92
Neglect	50	19.5	17.8	22.1	1.32	21.0	18.2	0.84
Physical abuse	94	37.3	32.7	44.1	1.63	39.5	35.2	0.83

Infringement of personal rights	46	18.4	17.4	19.8	1.17	16.9	19.8	1.21
Sexual victimization	91	35.0	26.0	48.1	2.64***	34.9	35.1	-
Forced kiss	40	15.8	11.4	22.1	2.20*	17.1	14.6	0.83
Fondling	50	19.2	12.3	29.2	2.94***	21.4	17.2	0.76
Masturbation/sexual stimulation	32	12.3	8.4	17.9	2.37*	14.3	10.4	0.70
Rape	37	14.3	7.1	24.8	4.28***	16.0	12.7	0.76
Exhibitionism	29	11.2	6.6	17.9	3.10**	9.5	12.9	1.40
Indecent exposure	34	13.1	9.1	18.9	2.33*	11.9	14.2	1.22
Witnessing victimization	175	67.3	67.5	67.0	0.98	71.4	63.4	0.69
Violence between parents	64	25.1	22.5	28.8	1.40	26.8	23.5	0.84
Sibling assault by parent	61	24.9	26.8	22.3	0.79	22.9	26.8	1.23
Assault on another relative by parent	11	4.5	4.3	5.0	1.17	6.0	3.2	0.52
Other assaults	143	55.4	55.9	54.7	0.95	61.9	49.2	0.60*
Electronic victimization	61	23.5	18.8	30.2	1.86*	36.5	11.2	0.22***
Harassment	29	11.2	9.2	14.2	1.64	16.7	6.0	0.32**
Insults	20	7.7	5.8	10.5	1.89	11.9	3.8	0.29*
Sexual solicitations	9	3.5	3.3	3.8	1.16	4.8	2.2	0.45
Exposure to pornography	20	7.7	7.1	8.5	1.21	11.1	4.5	0.38*
Sexting	19	7.3	4.5	11.3	2.68*	12.7	2.2	0.16***
Online grooming	23	8.8	11.0	17.9	1.76	23.0	5.2	0.18***

[1] Significance was shown by asterisks: * $p < .05$; ** $p < .01$; and *** $p < .001$.

Caregiver Victimization. This was reported by more than half of the sample (59.2%). The most prevalent types of victimization were physical abuse (37.3%) and verbal abuse (24.6%). Women and early adults reported more verbal abuse compared to men and middle/late adults ($OR = 2.13$, $p < .05$; $OR = 0.56$, $p < .05$; respectively). The rate of psychological abuse was 13.9%, that of neglect was 19.5%, and that of infringement of personal rights was 18.4%. In general, women and early adults showed higher rates of caregiver victimization than men and middle/late adults, but the differences were non-significant, except for the ones in verbal abuse.

Sexual Victimization. Sexual victimization was reported by 35% of the sample. Its rate was significantly higher in women than in men (*OR* = 2.64, $p < .001$). The most frequently reported behaviors were fondling (19.2%), followed by forced kissing (15.8%) and rape (14.3%). All types of sexual victimization included in the module were experienced substantially more often by women than men. Being all these differences statistically significant. In contrast, age did not appear to be a significant variable for sexual victimization in any of its modalities.

Witnessing and Indirect Victimization. A total of 67.3% of the sample experienced some type of witnessing and indirect victimization. More than half of the sample (55.4%) witnessed other assaults, while 25.1% witnessed violence between parents and 24.9% witnessed the assault on a sibling by a parent. Only 4.5% witnessed an assault on another relative by a parent. No general significant differences were detected in this module in terms of gender or age, except for witnessing other assaults in which early adults experienced significantly more (*OR* = 0.60, $p < .05$).

Electronic Victimization. Among the participants, 77.3% said they regularly use some type of electronic device with internet access (mobile, tablet, computer or other). Among these people, 23.5% reported having suffered electronic victimization. The most frequently reported victimization experiences were harassment (11.2%) and online grooming (8.8%). Differences were detected regarding gender (*OR* = 1.86, $p < .05$) and age (*OR* = 0.22, $p < .001$). Thus, women and early adults were found to suffer from more electronic victimization than men and middle/late adults. Among all the victimizations, sexting was the victimization showing more significant gender and age differences.

Poly-victimization. The information regarding poly-victimization is presented in **Table 6**. Based on the people who were identified as victims, the mean number of victimization events suffered throughout their life was calculated as 6.29, and statistically significant differences in terms of gender and age were observed ($U = 6{,}866$, $p = .029$; $U = 7{,}028$, $p = .019$; respectively).

A total of 38.8% of the victims turned out to be above this mean in terms of the number of victimization events suffered, and the top 10% of the whole sample were identified as lifetime poly-victims, i.e., those who experienced the highest number of lifetime victimization events (13 or more). In the poly-victim group, the numbers of women (16.5%) and early adults (12.1%) were higher than the numbers of men (5.3%) and middle/late adults (7.8%).

Table 6. Lifetime poly-victimization status

	Lifetime (%)				
	Total (*n* = 260)	Men (*n* = 154)	Women (*n* = 106)	Early adults (*n* = 126)	Middle/late adults (*n* = 134)
Number of victims[a]	252 (96.9%)	149 (96.8%)	103 (97.2%)	124 (98.4%)	128 (95.5%)
Mean number of victimization events among victims (*SD*)	6.29 (4.56)	5.64 (4.02)	7.23 (5.12)	6.96 (4.91)	5.65 (4.11)
Victims above mean	98 (38.8%)	63 (42.3%)	42 (40.7%)	56 (45.1%)	51 (39.8)
Poly-victims[b]	25 (9.9%)	8 (5.3%)	17 (16.5%)	15 (12.1%)	10 (7.8%)
Number of victimization events in the poly-victim group	13+	12+	15+	14+	12+

[a] With at least one victimization event in their lifetime.

[b] The top 10% of the victimized sample with the highest level of lifetime victimization.

Discussion

The results of the present study are relevant because they confirm the high rates of lifetime interpersonal victimization experienced by people with ID. The fact that nearly all of them reported having been victimized at least once and that they had suffered a mean of six different victimization types demonstrates the vulnerability and additional risk associated with ID, and ultimately only highlights the need to safeguard and protect this group.

An innovative element of the present study is the age-related approach toward a sample of adults with ID. It provides new information about how victimization patterns differ according to the stage of adulthood of individuals with ID, an aspect that has barely been explored in the past, particularly in the later stages of life. In this study, the older adults seemed to show lower lifetime victimization rates than their younger peers. As suggested by Hamby et al. (2016), later life is a particularly vulnerable period, so we assumed that a greater range of victimization types and higher poly-victimization rates would be observed among middle/late adults. However, contrary to our expectations, middle/late adults were subjected to more victimization in just four of the victimization types analyzed (infringement of personal rights, exhibitionism, indecent exposure, and the witnessing of an assault on a sibling by a parent). These rates are probably underestimated, since many older people may be reluctant to report victimization and younger adults are more likely than older adults to self-report abuse (Acierno et al., 2010). They may also view abuse differently and accept certain acts that professionals would label as abusive (Taylor et al., 2014). As pointed out by Hamby et al. (2016), it is important to assess specific forms of abuse in later life and some important forms of elder abuse that have recently emerged, such as financial abuse (Eslami et al., 2016). This was not included in the tool used for the study and should be explored in future research.

Another strength of this study is that it analyzed different victimization types using a tool that has been used in previous works with similar samples (Chan et al., 2018; Turner et al., 2011). However, it also included types that are especially relevant to people with ID, such as infringement of personal rights and bias attack. The most relevant findings revealed that conventional crimes are relatively frequent among those with ID, but it seems not to occur alone but alongside other forms of victimization. This seems to be a widespread phenomenon that similarly affects people with ID, regardless of gender or age, as suggested by Fisher et al. (2016). In line with other studies (Bryen et al., 2003; McMahon et al., 2004; Wilson & Brewer, 1992), assault, intimidation, threats, and robbery were found to be common experiences among people with ID, consistently with the ones detected with the conventional crimes analyzed in this study. Bias attack presented gender differences, even though no significant. No age differences, thus suggesting that this phenomenon is due more to the fact of having lifelong ID status than to any age or gender factor. Nevertheless, these results should be interpreted with caution, since research conducted on hate crime and disability so far is scarce and limited (Roulstone & Mason-Bish, 2013; Sin, 2014), and the studies that do exist, such as Emerson & Roulstone (2014), compare people with and without disabilities instead of analyzing intragroup sociodemographic differences of people with ID. These results and the inability to compare them with similar results give rise to the need for further research on this issue, with samples from both genders.

Witnessing was the second most commonly reported victimization type; more than half the sample had witnessed an assault. It seems that neither gender nor age are especially relevant for this type of victimization. However, regarding the age differences, it is possible that older participants regard these experiences as distant memories (e.g., in the case of witnessing violence between parents and parent-sibling abuse) or that they view them as having less obvious negative consequences for themselves and do not identify them as actual victimization experiences (Nandlal & Wood, 1997).

Caregiver victimization was also one of the most widely reported victimization types. That is consistent with the fact that most participants in the sample required some kind of support on a regular basis, thereby resulting in more opportunities for victimization by caregivers. That caregivers are common perpetrators has been noted in studies with both ID samples (Beadle-Brown et al., 2010; Brown & Stein, 2000) and care staff samples (Strand et al., 2004). The three studies mentioned were consistent with ours in that the most commonly reported victimization type was physical abuse. The regular physical manipulation of people's bodies in care situations helps explain why violence manifests itself through physical contact. The gender differences observed in terms of verbal abuse were consistent with Brown & Stein (2000), who found that women were the most commonly targeted victims.

Electronic victimization is particularly relevant today, as people are increasingly using the internet and new technologies daily, and those with ID are no exception. Even so, some limitations still appear to exist, since they seem to have less internet access than other groups, due to economic and social barriers, usage restrictions, a lack of experience and support, and individual impairments (Chadwick et al., 2013). However, their progressive engagement on the internet carries some inevitable risks. In this regard, the present study showed that age differences are by far the most pronounced in electronic victimization. This makes sense, since younger adults are more in touch with new technologies and use them regularly, thus increasing their risk of victimization. The gender differences are also notable, with more women victims, in line with the findings of Jenaro et al. (2018). Even though harassment and insults are frequently reported by women, gender differences are especially obvious in sexual electronic victimization, particularly sexting. This may be due to the shortage of real-life opportunities to develop romantic or intimate relationships (Healy et al., 2009), which can lead some people with ID to take risks when interacting with strangers. This is compounded by the perception that young people with ID are more vulnerable to online sexual risk (Löfgren-Mårtenson et al., 2015), which can lead potential perpetrators to take advantage of them. These results reinforce the need to protect this group in both the real and virtual worlds. As technology advances, more forms of victimization will emerge, and the risks may increase.

In terms of sexual victimization, our findings were consistent with the Spanish study by Vara et al., (2021), who observed higher rates of rape, which was one of the most frequently reported types of sexual victimization. However, in contrast to their findings, our study showed substantial gender differences in all sexual victimization types. This is nothing new and has been reported repeatedly in other studies (Cambridge et al., 2011; McCarthy & Thompson, 1997). Similarly, it has been observed in meta-analyses on the general population (Barth et al., 2013; Pereda et al., 2009; Stoltenborgh et al., 2011). In any case, as with our study results, there were no age differences, thus demonstrating that gender accounts for more of the differences than age. In essence, women with ID are more frequently victimized than men, regardless of their age.

In this regard, the gender perspective is relevant in terms of the results of this study, since there is a general trend toward greater victimization of women. As argued by Foster & Sandel (2010), intersectionality is key to understanding this, since the combination of having a disability, with the associated negative social attitudes and perceptions, and the harmful effects of sexism and misogyny makes women with ID more vulnerable to violent experiences (Meer & Combrinck, 2015). In light of this, recommendations must be issued to care professionals and other social agents to implement targeted strategies to prevent vulnerable women with ID from structural risk of victimization.

A final point to highlight is that violent victimization forms were the most commonly reported, in line with the pattern detected in previous studies (Fisher et al., 2016; Horner-

Johnson & Drum, 2006; Nixon et al., 2017; Rand & Harrell, 2009). It seems that ID increases the risk of suffering these particularly damaging types of victimization, which, as Hollomotz (2013) postulates, is due to the fact that disabled people are perceived as being different and having less power, and this label contributes to their marginalization and makes them targeted as victims more frequently.

Limitations

This study presents some limitations. First, with regard to the type of sampling used, the absence of a control group, the small number of participants, and the fact that they came from one region of Spain means that the results should be interpreted cautiously and have limited generalizability.

Furthermore, the people who participated in this study were cared for in specialized centers or institutions belonging to DINCAT; therefore, individuals who did not attend an entity within this federation did not have the opportunity to participate in this study, thus excluding more socially isolated cases. Similarly, those with severe cognitive or communicative difficulties were poorly represented in this study due to the limited number of these individuals in the final sample.

Another point to take into consideration is that the study focuses on lifetime victimization and poly-victimization, leaving out of the scope of the study the analysis of the past-year victimization experiences' rates. Finally, some of the participants were assisted by another person or caregiver to conduct the interview. Thus, the victimization incidents reported may have been altered or biased due to the presence of another person while the individuals were disclosing the abuse and the lack of anonymity this implies. In fact, the caregivers themselves might have been the perpetrators, which would represent an obvious barrier.

Conclusions

This study revealed high victimization rates among people with ID, especially when a lifetime assessment was conducted. There were significant gender and age-related differences with respect to the rates and numbers of victimization events, and this was especially evident in specific types of victimization. Thus, sexual victimization was more common among women and electronic victimization was more common among the youngest individuals in the sample. In addition, it is worth pointing out how polyvictimization was operationalized. By establishing the top 10% to define the phenomenon, the group of polyvictims characterized the most serious cases within the sample. This information is valuable since it not only provides new data on this phenomenon, which has been poorly studied among people with ID, but it also identifies those people with ID who require special attention. These findings highlight the direction professionals should take and help provide evidence of the need to develop special protection programs for victimization and emphasize the need for prevention and intervention measures among people with ID, especially the most vulnerable individuals, i.e., poly-victims.

5. Study 2. Characteristics and prevalence of lifetime sexual victimization among a sample of men and women with intellectual disabilities

Codina, M., & Pereda, N. (2022). Characteristics and prevalence of lifetime sexual victimization among a sample of men and women with intellectual disabilities. *Journal of Interpersonal Violence, 37*(15–16), 14117–14139.
https://doi.org/10.1177/08862605211006373

Journal Metrics

JCR 2022, Impact Factor: 2.5

Criminology & Penology (SSCI) 18 out of 69, Q2

Family Studies (SSCI) 18 out of 46, Q2

Psychology, Applied (SSCI) 48 out of 83, Q3

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Abstract

This study examines the prevalence and characteristics of sexual victimization experiences suffered by people with ID. The sample consisted of 260 adults with an ID diagnosis (154 men and 106 women), ranging in age from 20 to 71 (*M* = 41.69, *SD* = 12.05). The results showed that 35% of the sample had been sexually victimized at some point in their life. Being a woman, being declared legally incapable, and having comorbid mental health diagnoses were the most relevant characteristics of sexual victims with ID. Fondling was the most reported victimization, and rape showed the greatest gender differences, with a higher risk for women with ID of being raped compared to their men counterparts ($OR = 4.28$, $p < .001$). The offender was generally a known adult man, and the percentage of incidents reported to the authorities was very low (7.4%). The psychological consequences of abuse were general distress, anxiety, and depressive symptomatology. Intervention and prevention programs targeting this population, as well as the training of professionals and caregivers, are essential to deal with sexual victimization and to protect and ensure the quality of life of people with ID.

Keywords: intellectual disability, sexual abuse, sexual victimization, JVQ, psychological consequences.

Introduction

People with intellectual disabilities (ID) have a greatly increased risk of interpersonal victimization (Hughes et al., 2012; Jones et al., 2012), especially sexual and violent victimization (Fisher et al., 2016; Nixon et al., 2017). Having a chronic mental condition (i.e., involving low IQ, learning difficulties, or functional limitations) is strongly associated with the risk of suffering child sexual abuse (Assink et al., 2019). People with ID are thus considered more vulnerable to abuse, and the reasons behind their vulnerability regarding sexual victimization are multiple and strongly linked to their need for care and their subsequent dependency (Wissink et al., 2015). Simply assuming that an intellectual disability (ID) will lead to victimization is an error that should be avoided, since this has more to do with a range of cumulative factors. At an individual level, personal risk factors can lead to greater accessibility and the risk of being sexually victimized. These include difficulties discerning limits of intimacy due to continued physical contact with caregivers (Saxton et al., 2001), dependency as a result of disability (Plummer & Findley, 2012), a lack of sexual education (Byrne, 2018; Medina-Rico et al., 2018), limitations in identifying and avoiding situations that can lead to victimization, as well as a limited repertoire of defense strategies (Assink et al., 2019; Fisher et al., 2016). From a social point of view, people with ID face a unique kind of discrimination and oppression. The inherent ableism in Western societies dominated by a hegemonic medical model perceiving disability as a pathological abnormality (Olkin & Pledger, 2003) contributes to non-disabled people having negative attitudes and stereotypes of those with ID, which often revolve around inferiority and incapacity (Meer & Combrinck, 2015). Some forms of ableism, such as dehumanization, objectification, or infantilization (Nario-Redmond et al., 2019), alongside the false assumption of asexuality (Milligan & Neufeldt, 2001) have resulted in people with ID being not seen as having sexual agency, which means that potential perpetrators may consider consent to be dispensable in sexual interactions (Meer & Combrinck, 2015). Intersectionality can contribute to a better understanding of the complexity of the experiences of people with ID, especially when we talk about women and sexual victimization, addressing the confluence of multiple stigmatized identities (Turan et al., 2019).

The prevalence of sexual abuse in the general population indicated by currently available metanalyses (Barth et al., 2013; Pereda et al., 2009; Stoltenborgh et al., 2011) varies significantly between countries, although sexual abuse is a universal phenomenon affecting between 10–20% of the population. The prevalence among individuals with ID is difficult to determine due to variability between studies due to their methodological differences, a problem that has been repeatedly highlighted (Byrne, 2018; Fisher et al., 2016; Hughes et al., 2012), and this ultimately leads to an inconsistent picture of the phenomenon (Byrne, 2018). Existing prevalence rates range from 14 to 32% (Balogh et al., 2001; Briggs, 2006) for children with ID, and from 7% to 34% for adults with ID (Lin et al., 2009; Mitra et al., 2011). Meanwhile, a meta-analysis featuring studies with child samples with intellectual and mental disabilities (Jones et al., 2012) reported a pooled prevalence of 15% for sexual abuse, and a more than four times increased risk for this type of victimization in comparison with children without disabilities. For adult samples, the meta-analysis by Hughes et al. (2012) showed higher population rates of violence in those with ID when compared with the general population as well as individuals with other disabilities. Unfortunately, for sexual abuse, neither the pooled prevalence nor the risk could be estimated because of an insufficient number of studies. Nevertheless, more recent reviews (Byrne, 2018; Fisher et al., 2016) agree that, in any case, people with ID report high rates of sexual victimization.

Regarding the characteristics of sexual victimization in people with ID, the evidence shows that it is more common among women with ID than among their men counterparts (Cambridge et al., 2011; Fisher et al., 2016; McCarthy & Thompson, 1997; Nixon et al., 2017), although some studies (Mitra et al., 2011, 2016; Nixon et al., 2017) suggest that men with ID have an increased risk of suffering such abuse in comparison with men and women without disabilities. Nevertheless, it is true that studies focusing on sexual victimization among men with ID are indeed less frequent than those with women samples (Byrne, 2018). In addition, the review by Fisher et al. (2016) showed that experiencing multiple episodes of sexual victimization was more common than a single one in the majority of studies examined. This pattern was also found by McCormack et al. (2006) in their longitudinal study of sexual abuse victims with ID. The perpetrator is usually a man, known to the victim (Beadle-Brown et al., 2010; Cambridge et al., 2011; Fisher et al., 2016; McCarthy & Thompson, 1997).

When it comes to reporting abuse, these victims encounter personal barriers that may affect disclosure such as fear, communication difficulties, or a low level of sexual knowledge and understanding (McGilloway et al., 2020). When the abuse is revealed, it is usually disclosed to close relatives, such as the parents, or a well-known trusted adult (Gil-Llario et al., 2019; McCormack et al., 2006; Reiter et al., 2007). In terms of reporting to the authorities, previous studies suggest that sexual victimization involving people with ID is highly under-reported (Petersilia, 2001). In addition, when a report is submitted, the capacity and credibility of the victim are often questioned, and the justice system tends to rely less on their report and testimony (McGilloway et al., 2020; Wissink et al., 2015). The mere knowledge that the victim has an ID acts as a bias in the jurors' perceptions of the credibility of their testimony irrespective of the quality of their actual statement (Peled et al., 2004). The testimony of those with ID often contains fewer details when free recall is used (Henry et al., 2011; Manzanero et al., 2015), indicating that there is a lack of knowledge on those who take the testimony about how to do it properly by adapting the methods to the characteristics of the victim.

The psychological consequences that people with ID experience in the face of sexual victimization differ from those without ID not so much by type but by the intensity and severity of the emotional, physiological, and behavioral symptoms (Byrne, 2018; Dembo et al., 2018, 2021; Murphy et al., 2007; Rowsell et al., 2013; Smit et al., 2019). According to Smit et al.'s review (2019), anxiety, depression, and PTSD are equally prevalent in individuals with and without ID who have experienced sexual abuse, while conduct disorders, sexualized behaviors, self-harm, poor feelings of personal safety and persistent feelings of anger are more common in those with ID. Unfortunately, no physical sequelae of sexual abuse were reviewed in existing studies with ID samples (Smit et al., 2019), meaning that it remains unclear whether, apart from the possible physical injuries resulting from the force exerted during the victimization, the other consequences are similar to those in the general population or differ somehow. In the absence of studies entirely on an ID population, Dembo et al. (2021) analyzed the consequences of violence (including sexual assault) on adolescents and young adults with disabilities (with a high representativeness of people with cognitive disabilities) and found that those with disabilities, in comparison with those without such disabilities, were more likely to experience physical symptoms such as head and stomach aches, sleep problems, changes in food habits, fatigue, muscle pain, and severe distress. In that sense, these authors suggest that broadly, the effects of violence both on physical and mental health are worse for those with disabilities compared to nondisabled individuals.

In Spain, there is increasing interest in this phenomenon, although research is scarce. In an attempt to better understand the experiences suffered by this highly understudied group, González et al. (2013) conducted a study in a sample of 2,099 people with different disabilities who had been involved in police reports over a three-year period. They found that among those with ID (46.64%), 11% suffered sexual victimization in the country. Along the same line, Vara et al. (2021) analyzed the specific characteristics of 25 national proven cases of sexual abuse reported by police and forensic-medical evidence involving victims with ID, finding rates between 40% for men and 60% for women, with penetration being the most common form of victimization (68%) and a known adult being the most common perpetrator (92%). Gil-Llario et al. (2018, 2019) explored the prevalence of sexual abuse among 360 Spanish adults with ID, observing that the prevalence of abuse was 6.10% (9.4% in women and 2.8% in men) when the abuse was self-reported by the victims and 28.6% (27.8% in women and 29.4% in men) when the abuse was reported by professionals. Among the self-reported cases, 86.4% said they were hurt as a consequence of the abuse, while 59.1% disclosed the incident to someone.

However, even today, most studies and recent reviews (Byrne, 2018; Fisher et al., 2016) highlight that further research is needed on sexual victimization among people with intellectual disabilities, both to have more updated data on the phenomenon and to introduce new elements that allow us to continue understanding this phenomenon, especially in Spain.

Purpose of the study

Studies of sexual victimization among people with ID are scarce, especially in relation to its specific characteristics. Therefore the objectives of this study were as follows: (a) to identify the prevalence of different forms of sexual victimization in a sample of adults with intellectual disabilities throughout their lives; b) to explore whether there are gender differences with respect to the different experiences of sexual victimization; c) to examine the main characteristics of the sexual incidents; d) to describe the physical and psychological consequences that followed these experiences; and e) to determine the association of sociodemographic characteristics in connection with the sexual victimization in these victims versus those of other victims experiencing no sexual violence.

Method

Participants

The sample consisted of 260 adults, 154 men and 106 women (59.2% and 40.8%, respectively), aged between 20 and 71 years (*M* = 41.69; *SD* = 12.03) with an ID diagnosis, recruited from the DINCAT federation, which runs social entities that work with people with ID and their families in the northeast of Spain. The daycare centers involved in this study provide support, education, employment, or leisure services to people with ID. The majority of the people with ID in Spain live with their families or in residential centers and receive public assistance through care services and financial support (Navas et al., 2017).

The main sociodemographic characteristics of the participants from the present study are shown in **Table 7**. A non-probabilistic sampling of consecutive cases was applied, and the inclusion criteria were as follows: participants had to be over 18 years of age, have an ID diagnosis, and be capable of understanding, consenting to the study, and communicating their thoughts and experiences to the interviewer (by themselves or with the help of their usual caregiver). The purpose was to include cases of all severities, as far as possible. The only exclusion criterion applied to individuals with severe cognitive difficulties that prevented them from understanding the study and its objectives.

Table 7. Sociodemographic characteristics of the sample.

Variable	Men		Women		Total	
	n	%	*n*	%	*N*	%
Age						
20-40	74	48.1	52	49.1	126	48.5
41-71	80	51.9	54	50.9	134	51.5
Country of origin						
Spain	147	59.3	101	40.7	248	95.8
Other	7	63.6	4	36.4	11	4.2

Legal Incapacity[1]						
Yes	96	59.3	66	40.7	162	62.3
No	54	58.7	38	41.3	92	35.4
Unknown	4	66.7	2	33.3	6	2.3
Place of residence						
With family/relatives	90	58.5	61	57.5	151	58.1
Group home/institution	64	41.6	45	38.7	109	41.9
Type of support needed[2]						
General	10	58.8	7	41.2	17	7.8
Extensive	31	66.0	16	34.0	47	21.5
Limited	49	63.3	26	34.7	75	34.2
Intermittent	39	48.8	41	51.2	80	36.5
Secondary disability diagnosis[3]						
No	49	57.0	37	43.0	86	33.1
Yes	105	60.3	69	39.7	174	66.9
Type of secondary diagnosis						
Physical disability	45	60.8	29	39.2	74	42.5
Mental disability	44	64.7	24	35.3	68	39.0
Both	16	50.0	16	50.0	32	18.4

[1] Legally considered unable to handle personal, financial, and legal affairs and needs a legal guardianship.

[2] Degree of support required to carry out daily activities.

[3] Another diagnosed disability that coexists alongside the main intellectual disability.

Procedure

Following approval by the DINCAT federation, a collaboration agreement was signed, and the express consent of all participants and/or their legal representatives was obtained. Participation was voluntary. Easy-to-read versions of the documents were created to ensure that the participants understood the objectives and nature of the study. Ten interviewers with previous experience in dealing directly with people with ID were trained in the application of the tool and the recording of the responses. The questionnaire was administered individually in an interview format with the use of pictograms, and only a small number of participants were helped by their usual caregiver to respond to the questions

(9.6%). The study was carried out in accordance with the basic ethical principles of the Helsinki Declaration on Research Involving Human Subjects (World Medical Association, 2013).

Measures

Sociodemographic Data

Personal data was collected through a sociodemographic datasheet created ad hoc for the study. This included age, gender, country of origin, disability information (whether they were legally declared incapable, and the type of support they received), as well as information about other possible secondary disability diagnoses. This information was mostly self-reported (78.5%) at the beginning of the interview, but in some cases, if this was not possible, it was provided by the caregiver themselves afterwards (21.5%).

Victimization

An adaptation of the Juvenile Victimization Questionnaire, Adult Retrospective Version (Finkelhor et al., 2005), was used in interview format to collect the victimization experiences of the participants. The Spanish version of the questionnaire was used, as it has shown adequate psychometric properties, like the original version (Pereda et al., 2018; Finkelhor et al., 2005). The Spanish version comprises 28 specific victimization events distributed in five modules: conventional crimes, caregiver victimization, sexual victimization, witnessing and indirect victimization, and electronic victimization. Only the six items of the sexual victimization module were examined for the purposes of this study: (a) sexual victimization with physical contact, which includes those victimizations involving tangible physical victim–offender contact (forced kiss, fondling, masturbation or sexual stimulation, and rape), and (b) sexual victimization without contact, which includes those victimizations in which the victim is exposed to sexual victimization without physical interaction with the offender (exhibitionism and indecent sexual exposure). When the participants answered affirmatively to an item, they were asked about the last incident. The information provided was their age at the time of the episode, their relationship with the perpetrator, the age and gender of the perpetrator, whether the victimization had been reported to somebody, and if so, to whom. They were also asked about the consequences of those experiences both physically (if they were injured as a result) and psychologically (how they felt after the incident).

Data Analysis

Version 26 of the IBM SPSS Statistics program was used to run the statistical analysis. A univariate descriptive analysis was performed for sociodemographic data and sexual victimization experiences. Then bivariate analysis was conducted to examine the association between variables. The odds ratio (*OR*) measured the effect size of the association between gender (men vs. women) and sexual victimization rates. The OR was considered statistically significant when the 95% confidence interval (CI) did not include the value of 1. Men and women were compared in relation to the characteristics of the last sexual victimization episode (offender's age, offender's gender, victim-offender relation, resulting injury, disclosure, and feelings). The *OR* and its associated significance were obtained. Finally, sexual victims were compared with victims of other events (conventional crimes, caregiver victimization, witnessing and indirect victimization, and electronic victimization) about their sociodemographic characteristics (gender, age, place of residence, being legally incapable, and secondary mental disorder diagnosis). The chi-square test was used to determine whether there was an association between variables, and the size of this association was quantified by obtaining the OR.

Results

Prevalence of Sexual Victimization

Thirty-five percent of the sample reported experiencing some type of sexual victimization during their life course, with a higher risk for women in comparison with men ($OR = 2.64$, $p < .001$). Among the victims, of the six possible victimizations, 39.6% had experienced a single type, 24.2% two, and 36.3% from three to six different types. Thus, more than half of the victims (60.5%) had experienced multiple sexual victimizations during their life course. Sexual victimization implying physical contact was more prevalent (32.5%) than victimization without contact (17.1%). The most frequent victimizations were fondling (19.2%) and indecent exposure (13.1%) respectively. Meanwhile, of all typologies, the one showing the greatest gender difference was rape ($OR = 4.28$, $p < .001$), with women having a four-times greater risk of being raped compared to their men counterparts. For further details, see **Table 8**. Regarding the frequency at which the victims experienced the different types of victimization, for all the modules, experiencing multiple episodes (61.7%) was more frequent than an isolated event (30%).

Table 8. Lifetime prevalence of sexual victimization.

Sexual victimization	Total		Gender (%)		
	n	%	Men	Women	*OR*[2]
Any sexual victimization[1]	91	35.0	26.0	48.1	2.64***
With physical contact					
Forced kiss	40	15.8	11.4	22.1	2.20*
Fondling	50	19.2	12.3	29.2	2.94***
Masturbation/sexual stimulation	32	12.3	8.4	17.9	2.37*
Rape	37	14.3	7.1	24.8	4.28***
Without physical contact					
Exhibitionism	29	11.2	6.6	17.9	3.10**
Indecent exposure	34	13.1	9.1	18.9	2.33*

[1] Participants who reported at least one sexual victimization among their lifetime.

[2] Significance was shown by asterisks: * $p < .05$; ** $p < .01$; and *** $p < .001$.

Characteristics of Sexual Victimization

Since a large proportion of the victims experienced multiple episodes of victimization, the characteristics of the most recent episode of sexual victimization were extracted. According to this, 36.9% of the victims were underage when the episode took place, while 59% were adults. The most usual location of the incident was a house (37.8%), with either a relative's or the own victim's or perpetrator's house being the most frequently reported location. Public spaces (18.9%) such as the street, a park, or the beach, followed by residential facilities (13.5%) were the other most reported locations of victimization.

Regarding the offender and their relation to the victim, **Table 9** displays the main characteristics from the last incident. In both men and women, the general trend was for the perpetrator to be an adult and man, although some gender differences were observed. Men had more frequently been abused by a minor than women, while women were more frequently victims of adult offenders. Regarding the gender of the offender, in comparison with women, men were more targeted by women offenders (*OR* = 0.26, *p* < .05).

In relation to the type of relationship, perpetrators were most often known by the victim, being colleagues, friends, or neighbors (40.5%), and familiars or relatives (39.6%). Once again, the gender differences merit particular attention: women experienced more abuse by strangers (*OR* = 1.78, *p* < .05) in comparison to men, and men were victimized by colleagues, friends, and neighbors (*OR* = 0.63, *p* < .05) more than by any other type of offender.

Regarding disclosure, 60.8% of the victims had explained what had happened to someone else, with women being more prone to share their experience than men (*OR* = 1.48, *p* < .05). The person to whom the disclosure was made was in most cases someone close to the victim, usually a family member or a friend (67.4%), with the victim's mother being the most frequent confidant (47.3%). The victimization was disclosed also or directly to a professional such as social educators, caregivers, psychologists, or doctors in 44.4% of the cases. Only 7.4% of the incidents were reported to the authorities.

Table 9. Characteristics of the offender and relation to the victim

	Total (%)	Men (%)	Women(%)	*OR*[1]
Age of the offender				
Minor (less than 18 years)	14.4	24.1	9.3	0.32
Adult (18 years or more)	81.1	75.9	90.7	3.10
Gender of the offender				

Men	79.7	47.9	60.8	1.69
Women	17.1	21.4	6.5	0.26*
Both	1.4	30.8	32.7	1.09
Relation victim-offender				
Stranger	11.7	8.4	14.1	1.78*
Family/Relative	39.6	38.6	41.5	1.13
Partner/Ex-partner	2.7	1.2	48.2	1.78
Colleagues/friends/neighbours	40.5	48.2	37.0	0.63*
Caregiver/Professionals	3.6	3.6	3.7	-

[1] Significance was shown by asterisks: * p <.05

Consequences Related to the Experience of Sexual Victimization

In relation to the consequences derived from these experiences, victimizations involving physical contact may result in some kind of harm or injury because of the violence of the act. As a result of these victimizations[1], 37.9% of the victims reported having been injured. Women were more likely to be harmed ($OR = 3.99$, $p < .001$). In addition, when they were asked how they felt after the victimization, the most commonly reported answers for both genders were feeling distressed (49.1%) and anxious-depressive symptoms (12.2%). Other feelings like shame/guilt (8.6%), anger/rage (6.8%), and fear (4.5%) were less frequently reported. Gender differences were detected in the two most commonly reported psychological consequences. While men victims suffered more distress ($OR = 0.54$, $p < .05$), women displayed more anxious-depressive symptomatology ($OR = 2.48$, $p < .05$) compared to their counterparts.

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[1] Computed taking into account the items fondling, masturbation/sexual stimulation and rape. Forced kiss was not included since no one reported being physically harmed as a consequence.

Sociodemographic Characteristics of the Sexual Victims

The sociodemographic characteristics (previously presented in **Table 7**) of the group of sexual victims were compared with those of other ID victims with no sexual victimization experiences, and the significant associations are shown in **Table 10**. The victims of sexual victimization were more often women, with a secondary mental disorder diagnosis and declared legally incapable. However, no association between sexual victimization and age, place of residence, type of supported needed, or other secondary disabilities was observed.

Table 10. Sociodemographic significant characteristics of the sexual and non-sexual victims.

	Sexual victims (*n* = 91)		Non-sexual victims (*n* = 169)		Association measures[1]
	n	%	*n*	%	
Gender					$\chi^2(1) = 13.53$** OR = 2.64, 95% CI [1.56–4.46]
Man	40	26.0	114	74.0	
Woman	51	48.1	55	51.9	
Age					$\chi^2(1) = 0.00$ OR = 1.01, 95% CI [0.61–1.68]
20-40	44	34.9	82	65.1	
41-71	47	35.1	87	64.9	
Country of origin					$\chi^2(1) = 0.01$ OR = 1.08, 95% CI [0.31–3.78]
Spain	86	34.7	162	65.3	
Other	4	36.4	7	63.6	
Place of residence					$\chi^2(1) = 0.24$ OR = 0.88, 95% CI [0.53–1.47]
With family/relatives	51	33.8	100	66.2	
Group home/institution	40	37.7	69	69.6	
Declared legally incapable					$\chi^2(1) = 10.02$** OR = 2.51, 95% CI [1.41–4.47]
Yes	69	42.6	93	57.4	
No	21	22.8	71	77.2	
Needs support					$\chi^2(1) = 0.23$ OR = 1.19, 95% CI [0.58–2.43]
Yes	78	35.6	141	64.4	
No	13	31.7	28	68.3	
Secondary mental disorder diagnosis					$\chi^2(1) = 4.67$* OR = 1.90, 95% CI [1.06–3.43]
Yes	28	46.6	32	53.3	

No	63	31.5	137	68.5

[1] Significance was shown by asterisks: * $p < .05$; ** $p < .01$; and *** $p < .001$.

Discussion

The rates of sexual victimization found in this study were high for both genders, but consistent with other studies that examined lifetime sexual abuse in people with ID (Mitra et al., 2011; Powers et al., 2002, 2008). In this context, the prevention of sexual victimization in this group is a relevant issue that professionals and caregivers should pay more attention to, for both men and women (Doughty & Kane, 2010).

Characteristics of Sexual Victimization

Women with ID were more frequently sexually victimized than men, which is also consistent with previous studies comparing samples from both genders (Cambridge et al., 2011; McCarthy & Thompson, 1997, Nixon et al., 2017). Women showed a clearly higher risk, not only for any type of sexual victimization but also for each and every one of the types separately. The victimization that presented the most marked gender difference was rape, in which 70% of the victims were women. This upward trend of sexual penetration in people with ID has been highlighted by some authors (Akbaş et al., 2009; Basile et al., 2016; Vara et al., 2021) and is a highly worrying fact given the extra advantage of the aggressor towards their victim due to the victim's condition, and because the more severe forms of sexual abuse are associated with greater severity of disturbance (Sequeira et al., 2003), which obviously translates into worse negative effects on the victim.

The most usual location of the victimization was the house of the victim or the perpetrator, being the perpetrator mainly a known man adult. In that sense, we found the same general trend for both genders that studies have been finding repeatedly (Beadle-Brown et al., 2010; Cambridge et al., 2011; Fisher et al., 2016; McCarthy & Thompson, 1997; McCormack et al., 2006). Some gender differences in terms of victims were noted regarding the offender, since in the case of underaged women offenders, they target men victims more often than women victims. We do not know the reason behind this, but together with the fact that the most usual perpetrators were friends and colleagues, and the people in this sample belonged to entities working entirely with this disability type, this makes it highly probable that these aggressors were also ID peers. This suggests the importance for future research in examining the overlap phenomenon, in which one can be experiencing sexual victimization and may be acting as a sexual offender at the same time or may have previously been a victim of sexual abuse before becoming the sexual offender (Jennings et al., 2014). This sexually abused–sexual abuser interaction has been well described in the general population (Jespersen et al., 2009), and explored in samples with ID of both sexes (Lindsay et al., 2011), indicating that one possible explanation is that those abusers with ID might be less able to understand the abusive nature of the sexual victimization and consequently more likely to replicate it without understanding that what had happened to them should not be repeated on others.

Despite the general underreporting of sexual violence found in previous studies (Willott et al., 2020), more than half of the present sample disclosed the victimization to someone. This result contrasts with the low reporting of cases to the authorities, considering that a high percentage of these disclosures were made to professionals who should be committed to the care and protection of this group of people. The social reactions to the disclosure of sexual violence in people with ID have been shown to be negative, such as perpetrators not being held accountable (Rittmannsberger et al., 2020). The fact is that professionals usually do not do what they should do with the information they receive, either because of a lack of knowledge, a deficit in collaboration between service providers, or little investment of resources for these cases (McGilloway et al., 2020). It is important to underline the secondary victimization that people with ID suffer due to these gaps and poor management of their reports by professionals. Secondary victimization is not usually studied in this group and is surely more relevant than it might seem since when a system is not prepared to understand and meet everyone’s needs, it is excluding and causes discomfort to those who are outside its scope (Spaan & Kaal, 2019). In this sense, it is worth noting the predisposition and accuracy with which the participants developed their responses to the interview conducted in this study, demonstrating that when asked, people with ID can offer a story as credible and sincere as anyone else. So, a real need, as McCormack et al. (2005) said, is to train the professionals in abuse detection to create an organizational culture intolerant of abuse.

Consequences Related to the Experience of Sexual Victimization

The participants in the present study reported serious consequences derived from the sexual victimization experience. However, they generally indicated that no treatment was received as a result. In this sense, it is important to highlight the possible diagnostic overshadowing in which the presence of ID overshadows some indicators of psychopathology, wrongly ascribed by the professionals to the disability rather than to the actual disorder (Reiss et al., 1982). Therefore, it is necessary to pay close attention to signs that are out of the ordinary as they can indicate a sexual victimization experience and, in that case, as in any other group, its consequences need to be treated as soon as possible.

We found that women suffered more anxious-depressive symptoms than men as a consequence of sexual victimization, and this is backed up by studies such as that by Lunsky (2003), which claimed that similarly to the correlation between mental health problems and victimization in the general population, women with ID coming from abusive situations such as sexual abuse present higher depression scores. However, the fact that man victims also reported a high level of distress should not be ignored and is equally worrisome. Some studies have concluded that these psychological symptoms could be explained by the PTSD conceptual framework (Rowsell et al., 2013); however, there is a lack of evidence obtained from victims with ID to confirm that this is so (Mevissen & De Jongh, 2010). Thus, it is essential to intervene early and in the most targeted and effective way in these cases of sexual victimization, to try to mitigate their long-term consequences. This is especially relevant because some studies have shown the very limited recovery made by victims of violence with ID (Rowsell et al., 2013). Nevertheless, specific techniques and tools for this specific group should be developed and used to evaluate these cases in order to avoid the chronification or exacerbation of mental issues, which are already more prevalent among people with ID (Mazza et al., 2020).

Sociodemographic Characteristics of the Sexual Victims

Those sociodemographic variables that were shown to be associated with sexual victimization were being a woman, having been declared legally incapable, and having a diagnosis of mental health coexisting with the ID. This is something that is well known in the risk factors literature and was recently confirmed by Assink et al. (2019), who found that the most significant risk factors associated with sexual abuse were the child's characteristics, including being a woman, having psychiatric disorders, and having chronic mental conditions.

The intersectional approach can explain how all these negative and incapacitating labels may contribute to this cycle of vulnerability: when gender interacts with disability status itself, it increases the risk of sexual victimization (Bones, 2013), in the same way that a comorbid mental health diagnosis added to ID doubles the likelihood of being victimized (Thomas et al., 2019). Being declared incapable only accentuates the status of disability, in addition to stripping the individual of any real capacity to exercise their rights, which paradoxically contributes to the lack of protection of this collective.

Surprisingly, contrary to what we expected, age did not have much to do with sexual victimization, demonstrating that similarly to other types of victimization analyzed in samples of people with ID that took into account gender and age, gender accounts for more of the differences than age, since the victimization phenomenon has more to do with the fact of having lifelong ID status than any age factor (Codina et al., 2022).

Limitations

This study presents some limitations. Due to the type of sampling used, the small number of participants, and the fact that they came from specialized centers, the results should be interpreted with caution and are not considered to be generalizable. The collaboration agreement between the federation of associations, DINCAT, gave us access to some of the institutionalized people with ID from a specific region in Spain. This left out from the sample individuals who are not institutionalized, those who are more socially isolated, and those who attend other centers different from the ones participating in the study. People with severe cognitive or communicative difficulties were poorly represented in this study due to the limited number of these individuals in the final sample. Although the response rates were considered relatively good, there were issues with some of the items requiring details of the victimization. Although the questionnaire was adapted to take into account the special needs of the people with ID, information regarding the number of episodes, the stage when the victimization occurred, and the age of the victim/offender when the victimization happened was difficult to obtain. To help address this, the items that normally involve numerical answers were converted into general and easy-to-understand categories. Another limitation of this study was recall bias. Since this was a retrospective study, problems could have arisen in the accuracy or the details of past experiences. Finally, some of the participants were assisted by another person or caregiver during the interview, which affected the participant's anonymity and confidentiality, but was unavoidable given their special needs. Thus, some of the incidents reported or details may have been hidden or omitted due to the presence of the other person, who could have even been the perpetrator or known to them.

Conclusions

Given the high rates of sexual victimization presented in this study, especially the most serious types such as rape, it is essential to know more about this problem and to encourage the other regions of Spain to generate new research to collate results.

Since there is a lack of public initiatives to prevent sexual victimization and other related risky behaviors, institutions that care for and provide services to people with ID should use the findings of this study to launch a prevention and detection campaign among their users, as well as promoting campaigns to target the users who are the most difficult to reach. Sexual and affective education can prevent exposure to potentially abusive situations, while early detection and effective intervention can mitigate the injuries and psychological effects resulting from the sexual abuse. In this sense, early education and prevention should be encouraged in a language and format appropriate to this group. It is also essential that professionals, as well as the people responsible for caregiving and education, become more aware of the problem and begin to address it as a key issue for protecting and ensuring the quality of life of people with ID. They must also be aware of their duty to report sexual victimization and to provide suitable attention and psychological support if it has already happened. This is only possible if there is a real effort to build awareness, for example, through the dissemination of information on specific aspects of sexual victimization in this group such as the ones provided in this article, the rates of the victimizations, the characteristics of the most vulnerable victims, the potential aggressors, the harmful consequences of victimization, and the low reporting rates.

6. Study 3. Better at home or in residential care? Victimization of people with intellectual disabilities at the hands of caregivers

Codina, M., Díaz-Faes, D. A., Pereda, N. (2024). Better at home or in residential care? Victimization of people with intellectual disabilities at the hands of caregivers. *Research in Developmental Disabilities, 146*, 104689. https://doi.org/10.1016/j.ridd.2024.104689

Available online (Open Access) on February 3, 2024

Journal Metrics

JCR 2022, Impact Factor: 3.1

Education, Special (SSCI) 3 out of 43, Q1

Rehabilitation (SSCI) 6 out of 73, Q1

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Abstract

Background: People with intellectual disabilities often need assistance of some kind in their everyday life. Support needs can increase the risk of their victimization at the hands of professional and family caregivers. This Study explores the differences in caregiver victimization between participants living in residential care settings and those who are not. **Method:** A sample of 260 adults (59.2% men) with an intellectual disability diagnosis was assessed using an adaptation of the Juvenile Victimization Questionnaire comparing prevalence, sum, and variety scores. **Results:** More than half of the sample (59.2%) experienced some form of caregiver victimization throughout their lifetime, with physical abuse, verbal abuse, and neglect being the most frequently reported forms. Participants in residential care settings experienced significantly more caregiver victimization incidents and a broader range of victimization forms than their counterparts outside residential care. Significant differences were found based on the individuals' place of residence and gender. Details are provided on the last victimization incident, the perpetrator, the psychological and physical consequences of the victimization, and the reporting rates. **Conclusions:** This study outlines high rates of lifetime caregiver victimization, with those who live in institutional settings at particular risk. Further research is needed to understand the nuances of disability-related victimization and prevent abuse in caregiving contexts.

Keywords: intellectual disabilities, violence, abuse, victimization, residential care.

What does this Study add?

To date, there has been scarce research addressing the victimization experiences of people with ID at the hands of those who provide care to them. It is an important topic due to the unique care and support needs that may make people with ID vulnerable to victimization by their caregivers. This study contributes to the existing literature examining the phenomenon by comparing two groups: participants living in residential care settings and their counterparts who do not. The increased risk of living in residential care is discussed. Additionally, we provided context for victimization experiences by exploring specific details such as the characteristics of the victimization, incident location, perpetrator relationships, disclosure, and the physical and psychological consequences experienced by the victims.

Introduction

The concept of intellectual disabilities (ID) is defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) as a combination of limitations in intellectual functioning and adaptive behavior (Schalock et al., 2021). Adaptive functioning, in terms of practical domains, refers to the potential difficulties that individuals may encounter in achieving personal independence and social responsibility (Patel et al., 2020). Consequently, individuals with ID require varying degrees of support to carry out everyday activities such as self-care, personal hygiene, eating, communication, social interaction, money management, and accessing community and health services (Patel et al., 2020; Schalock et al., 2021). This population is also prone to the presentation of other concomitant physical and mental health problems (Maulik et al., 2011; Mazza et al., 2020), which may increase the need for assistance. The role of the caregiver may fall on relatives or other direct support professionals. The primary caregivers of individuals with ID are frequently family members, such as parents, siblings, or partners (Saxon et al., 2001; Vilaseca et al., 2017). These are known as informal caregivers since they are not professionally paid for their support and assistance. The population in question may also receive the services of professional caregivers, either at home, in a daycare center, or residential care.

People with ID are at high risk of interpersonal violence (Hughes et al., 2012). Indeed, the perpetrator may be somebody known to the victim, mainly residential staff members and other peers with ID in institutional contexts, but also family members and other acquaintances (Fisher et al., 2016). The increased dependence on others for assistance with daily activities is a contributing factor to the higher risk of disability-related abuse, understood as a form of victimization directly linked to the presence of a disability (Hughes et al., 2011). Lund et al. (2017) identify two forms of this type of abuse: deliberate physical abuse and harmful negligence. The first can take, for example, the form of pain induction, altering medication to reduce the victim's functional abilities or sedation. The second involves unintentional physically harmful behaviors resulting from negligence or neglect in the provision of assistance. In this respect, people with disabilities are particularly vulnerable to physical violence in a way that other groups are not (Lund et al., 2017). In addition to these specific types of disability-related violence, people with ID are at high risk of the co-occurrence of other multiple types of victimization, such as sexual abuse, psychological abuse, intimate partner violence, robbery, verbal abuse, neglect, or financial abuse (Codina et al., 2022; Fisher et al., 2016; Hughes et al., 2012).

Most of the studies into caregiver victimization focus on residential facilities or other specialized care or health settings. Living in a congregate setting is an environmental factor of vulnerability that increases the risk of experiencing victimization among people with ID (Fisher et al., 2016). Not only are these individuals more exposed to victimization, but the position of authority in which caregivers are placed enhances the power imbalance between them and users with disabilities, who can be forced to tolerate neglectful and abusive behaviors (Lund, 2021). Caregivers might also harbor prejudices and hostility toward the group that can drive mistreatment and violent behavior (Díaz-Faes et al., 2023a). On the other hand, caregivers' insights reveal that they face high loads of work-related stress, instability, and burnout (Ryan et al., 2021; Skirrow & Hatton, 2007) and they must frequently deal with behavioral problems and aggressiveness from users (Emerson et al., 2001; Nevill et al., 2022). Some of the disruptive behaviors displayed by people with ID may include physical and verbal aggression, hostility, destructive behaviors, and self-injury. Such aggressiveness may contribute to burnout differently depending on severity (Nevill et al., 2022). Ultimately, all of these work-related circumstances can contribute to high levels of distress, exhaustion, depersonalization, and burnout (Ryan et al., 2021; Skirrow & Hatton, 2007), ultimately leading to mistreatment or abuse of the user (Strand et al., 2004). Strand et al. (2004) asked staff members in care settings for people with ID in Sweden about violent situations involving their users. During the previous year, 35% of staff had been involved in, or witnessed, an incident involving violence while working with people with ID. In 61% of reported cases, the caregivers stated that the first aggressive reaction came from the user, whereas 14% of caregivers admitted to being the perpetrators. Most of the incidents started after trying to help a user who did not cooperate or who refused assistance, or because both the caregiver and the user reacted violently to each other. Physical abuse was the most frequently reported victimization.

In another study analyzing referrals of abuse committed against people with ID in the Southeast of England that had been reported to authorities over a seven-year period, Beadle-Brown et al. (2010) found that people with ID were more likely than people without ID to be abused in a residential care center by members of staff or service users. The risk seems to increase for individuals placed out-of-area, meaning those living in a residential care setting outside of their local community or geographical area, disconnected from their environment and family. The most usual was the co-occurrence of multiple types of abuse (33%), followed by physical abuse (29%). Other victimizations relevant to people with ID were also reported, including financial abuse, institutional abuse, and neglect. However, the study did not have comparative data on those not living in residential facilities, so it cannot be established whether the risk of victimization is higher or lower than for those living with their family or in other types of facilities or housing.

Few studies, however, focus on disability-related victimization by informal caregivers. In one study, Saxon et al. (2001) examined a sample of women with ID and physical disabilities and highlighted the difficulties in recognizing and defining situations of abuse, especially when assistance is provided by family members or friends. Moreover, when receiving support from such caregivers, women encounter a whole range of challenges such as boundary issues, power imbalances, difficult interpersonal dynamics, excessive protectiveness, and control. Because of these dynamics, a fear of facing reprimand, threats of social isolation, concerns about maintaining relationships with family members, feelings of being a burden, and self-blame emerge as significant barriers that prevent the victimized women from reporting or responding to abuse (Lund, 2021; Saxon et al., 2001).

Finally, it is important to emphasize that the consequences of violence against people with disabilities have worse effects on their physical and mental health than they do for individuals without disabilities (Dembo et al., 2021). Moreover, adults with ID may display specific PTSD symptoms that manifest through behavioral expressions such as challenging behaviors and aggressiveness, although more common emotional manifestations such as psychological distress are also frequent (McNally et al, 2021). Thus, it is important to be aware of the different manifestations of violence against this group to prevent its negative consequences.

Literature in the field is limited, so the present study aims to contribute by (a) analyzing the different forms of lifetime caregiver victimization in a sample of adults with ID; (b) exploring any gender or residential differences concerning victimization; (c) describing the main characteristics of the latest victimization incidents in relation to residential status; (d) depicting the negative consequences of such experiences; and (e) exploring the disclosure and reporting of such experiences.

Method

Participants

The study sample comprised 260 adult men and women with an ID diagnosis who were recruited in collaboration with a federation of social organizations that provide a range of services, including care, education, employment, and leisure activities for individuals with ID throughout Catalonia. The participants had a mean age of 41.7 years (SD = 12). The main sociodemographic characteristics of the participants are shown in **Table 11**.

Table 11. Sociodemographic information.

	Total	
	n	%
Gender		
Man	154	59.2
Women	106	40.8
Legal guardianship^a		
Institution	64	39.5

Family members/relatives	88	54.3
Others	10	6.2
Place of residence		
Non-residential care	151	58.1
Residential care	109	41.9
Regular contact with relatives		
No	19	7.3
Yes	241	92.7
Type of support needed[b]		
General	17	7.8
Extensive	47	21.5
Limited	75	34.2
Intermittent	80	36.5
Secondary disability diagnosis[c]		
No	86	33.1
Yes	174	66.9
Type of secondary diagnosis		
Physical disability	74	42.5
Mental disability	68	39.1
Both	32	18.4

[a] Among those who have been declared legally disabled (*n* = 162), a person needs to be judicially named to assist the person with their duties, obligations, and needs.

[b] Degree of support required to carry out daily activities and self-care.

[c] Another diagnosed disability that coexists with intellectual disability.

Procedure

The study obtained the approval of the University's bioethics committee. A collaboration agreement was signed with the federation, making them responsible for disseminating the study information among their partner centers to recruit users interested in participating. Subsequently, an easy-to-understand document was created to ensure that participants fully understood the study's purpose and was used to obtain their express consent. The only exclusion criteria were being under 18 and being unable to comprehend the study's objectives, provide informed consent, or effectively communicate their thoughts and experiences to the interviewer. Consequently, this criterion excludes individuals with the most severe difficulties.

Ten interviewers were trained in the proper application of the questionnaire, including instructions on how to interact with and be sensitive to the needs of participants. The questionnaire was administered individually in interview format with the use of pictograms. Before starting the interview, a pre-questionnaire was administered to inquire about everyday events unrelated to victimization. This ensures that participants comprehend the questions, as well as the follow-ups, and the overall dynamics of the interview. A small number of participants with communication difficulties (9.6%) were helped to answer by a known assistant, as and when required.

Measures

Participants' personal information was obtained through a sociodemographic data sheet, as detailed in **table 11**. Most of this data was self-reported by the participants. When self-reporting was not possible, caregivers provided the missing information afterward (21.5% of the sociodemographic collected data). To collect the victimization experiences, an adaptation of the Juvenile Victimization Questionnaire, Adult Retrospective Version (Finkelhor et al., 2005) was used (Pereda et al., 2018) under the consent of the original authors. In this adaptation, the question statements were enhanced with personalized cards containing pictograms corresponding to each question and accompanied by illustrative examples. It comprises 28 specific victimizations grouped into five modules: conventional crime, caregiver victimization, sexual victimization, witnessing and indirect victimization, and electronic victimization. The reliability of JVQ in this study was good (α = .827). The frequency of victimization was measured in a four-point Likert scale (never, one time, sometimes, many times). The six items in the caregiver victimization module were examined for the current Study. These items refer to victimizations perpetrated by individuals who provide care or support to the participant, such as family members or professional caregivers, while carrying out their caregiving responsibilities. For a description of each of the six specific victimizations see **Table 12**.

When participants reported affirmatively to any of the six caregiver victimization items, they were asked a series of specific follow-up questions. To obtain the details of each victimization, including the age of the victim at that time, their relationship to the offender, the offender's gender, the location of the incident, whether they reported the victimization and to whom, and the physical and psychological consequences that they experienced; participants were asked to recall the last time it happened.

Table 12. Description of the items in the caregiver victimization module.

Items	**Description**
Financial abuse	Blocking access to the other's money, making non-consensual use of their money or property, or stealing their money or possessions.
Verbal abuse	Criticizing and insulting in a destructive way with the aim of damaging the other person's self-concept and intentionally making them feel bad.
Psychological abuse	Emotional abuse, denigration, disqualification, control, social isolation, subjugation, emotional extorsion and/or coercion.
Neglect	When physical and daily needs (e.g., food, clothing, hygiene, medical or daily care) are temporarily or systematically unmet by caregivers.
Physical abuse	Intentional physical injury, trauma or other body harm with the objective of punishing or causing harm or suffering to the other.
Denial of personal rights	Denying or hindering access to health services, information, education or work, a living place, having relationships, etc.

Note. All items refer to the caregivers, whether they are professional caregivers in a care center, residence or institution or they are informal caregivers.

Data analysis

A descriptive analysis of the sociodemographic and victimization data was performed. Then a bivariate analysis was conducted to examine the association between the study variables. Two levels or groups of analysis were created to analyze the victimization experiences: gender (man = 0, woman = 1) and place of residence (non-residential care = 0;

residential care = 1). The category ‘non-residential care’ includes those who live with family members, their partner, alone, or in independent shared housing. Meanwhile, the category ‘residential care’ refers to those living in facilities specializing in the care of individuals with ID.

To analyze caregiver victimization based on the six self-reported items, we use three measures: prevalence, sum score, and variety score. Prevalence refers to the rate of people who have experienced any caregiver victimization. The sum score is calculated by adding the participant’s responses for each item on an ordinal scale, which ranges from zero to eighteen, providing a composite score to capture the total frequency. The variety score depicts the number of caregiver victimizations experienced by each participant, ranging from zero to six, given that the module contains six items. Employing the three measures enables us to compare caregiver victimization in several ways: 2 x 2 table comparison (prevalence), accounting for the total frequency (sum scores) and assessing the different forms of caregiver victimization by limiting the influence of extreme cases (variety score). Using multiple indicators or measures of victimization allows for comparison and a better understanding of the nature and severity of the phenomenon that might otherwise be overlooked (Daigle et al., 2016). Sum and variety scores were standardized as z-scores ($M = 0$, $SD = 1$). Chi-squared (X^2) and Welch’s t-test (t) were respectively used for group comparison for categorical and continuous variables, and odds ratio (*OR*) and Cohen’s d (d) as measures of effect size to calculate the strength of the association between residential groups and gender with respect to caregiver victimization. Pairwise deletion to handle missing data was used due to the low rate of missing values in the caregiver victimization module, ranging from 0% to 3%. Significance was set at the p-value < .05. IBM SPSS Statistics Version 29 was used to conduct the statistical analysis.

Results

We present the descriptive and bivariate analyses for caregiver victimization prevalence by participants’ place of residence and gender in **Table 13**. More than half of the sample (59.2%; $n = 154$) had experienced some type of caregiver victimization throughout their lifetime. More specifically, 43.5% of women and 56.5% of men had been the victim of at least one type of caregiver victimization. Within the caregiver victimization module, the most reported victimizations were physical abuse (37.3%) and verbal abuse (24.6%), followed by neglect (19.5%) and the denial of personal rights (18.4%). There is a significant difference between the place of residence and the experience of caregiver victimization ($\chi^2[df] = 5.510[1]$, $p = .019$). People living in a residential care setting are at greater risk for caregiver victimization than those not living in a residential care setting (*OR* = 1.89, 95% CI [1.11, 3.22], $p = .019$). By type of victimization, those living inside institutions are at a significantly greater risk for neglect ($\chi^2[df] = 6.01[1]$; $p =.014$; *OR* = 2.17, 95% CI [1.15, 4.06]) and denial of personal rights ($\chi^2[df] = 7.50[1]$; $p = .006$; *OR* = 2.44, 95% CI [1.27, 4.68]). There were no significant gender differences in the prevalence of caregiver victimizations in general, except for verbal abuse ($\chi^2[df] = 6.81[1]$; $p = .009$), for which women face double the risk of their men counterparts (*OR* = 2.12, 95% CI [1.20, 3.76]).

Table 13. Caregiver victimization and odds ratio by place of residence and gender.

	Total		Place of residence			Gender		
	n	%	% Non-residential care	% Residential care	*OR*	% Man	% Women	*OR*
Any victimization	154	59.2	41.6	58.4	1.89*	56.5	43.5	1.32
Financial abuse	30	11.6	63.3	36.7	1.04	53.3	46.6	1.30
Verbal abuse	64	24.6	64.1	35.9	1.01	45.3	54.7	2.12**
Psychological abuse	36	13.9	52.8	47.2	1.77	50	50	1.53
Neglect	50	19.5	50.0	50.0	2.17*	54	46	1.32
Physical abuse	94	37.3	59.6	40.4	1.47	52.1	47.9	1.63
Denial of personal rights	46	18.4	47.8	52.2	2.44**	56.5	43.5	1.17

Note. * $p < .05$, and ** $p < .01$.

When analyzing gender differences, those not living in residential care show significant gender differences compared to their counterparts not living in residential care ($\chi^2[df] = 5.239[1]$; $p < .022$), with women facing double the risk of experiencing caregiver victimization (*OR* = 2.08, 95% CI [1.11, 3.91]). By contrast, those living inside institutions show non-significant gender differences.

Accounting for sum and variety scores, **Table 14** demonstrates that individuals living in a residential care setting experienced significantly more caregiver victimization incidents and a broader range of victimization forms compared to their counterparts not living in residential care, underscoring the consistency of the results, regardless of whether the sum or variety scores are considered. The results on gender for both measures show significant differences between men and women, with women having greater sum and variety scores than men.

Table 14. Comparison for any caregiver victimization means between sum and variety scores by residential group and gender.

	Sum score			Variety score		
	M	*SD*	*Statistics*	*M*	*SD*	*Statistics*
Place of residence						
Non-residential care	2.43	3.44	*t*(*df*) = 1.93(*177*);	1.09	1.39	*t*(*df*) = 2.14(*185*);
Residential care	3.33	3.75	*p* = .028; *d* = .252	1.48	1.44	*p* = .017; *d* = .278
Gender						
Man	2.36	3.21	*t*(*df*) = 2.03(193);	1.07	1.27	*t*(*df*) = 2.10(191);
Woman	3.31	3.99	*p* = .022; *d* = .262	1.46	1.60	*p* = .018; *d* = .271

Note. *M* = mean; *SD* = standard deviation; *t*(*df*) = Welch's *t*-test (*degrees of freedom*); *d* = Cohen's *d*.

Characteristics of the last incident and the perpetrator

In terms of the characteristics of the perpetrator and the incident, **Table 15** shows the main results. Significant differences were found between participants living in a residential care setting and those who are not in terms of their relationship with the perpetrator ($\chi^2[df] = 10.42[3]$; $p = .015$) and the location of the incident ($\chi^2[df] = 22.87[5]$; $p < .001$). In turn, no significant differences were found with regard to the gender of the perpetrator, since it is most common for both residential groups to have multiple perpetrators of both genders. Also, family members are the most common perpetrators for both groups, with fathers, mothers, and siblings being the most frequently reported specific perpetrators. Similarly, the two groups are also victims of multiple perpetrators. The difference between the two groups, however, lies in the higher rates of victimization by professional caregivers in those living in a residential care setting, which is the second most prevalent type of perpetrator for this group (23.8%).

Home was the most common scenario for both groups, but especially for those not living in a residential care setting. They tend to be victimized in several more scenarios than those living in institutions (12.7% vs. 3.6%). For those living in a residential care setting, the setting and an occupational or educational center are the other most relevant scenarios where victimization takes place.

Table 15. Percentages of perpetrator and location of the victimization by place of residence.

	Total	Residential care	Non-residential care	Statistics	
	%	%	%	$\chi^2(df)$	*p-value*
Gender of perpetrator				1.13 (*2*)	.568
Man	32.1	27.9	33.3		
Woman	26.5	24.6	27.8		
Multiple of both genders	42.4	47.5	38.9		
Relationship with perpetrator				10.42 (*3*)	.015*
Family member/relative	63.4	54	70		
Care staff/professional	13.7	23.8	6.7		
Acquaintance/friend/neighbor	3.3	1.6	4.4		
Multiple perpetrators[a]	19.6	20.6	18.9		
Location of incident				22.87 (5)	< .001***
Home	57.8	44.6	67		
Residential care setting	17	33.9	5.1		
Occupational/educational center	8.2	10.7	6.3		
Other care services[b]	3.7	3.6	3.8		

Public places[c]	4.4	3.6	5.1
Multiple scenarios[d]	8.9	3.6	12.7

[a] Refers to different victimizations at the hands of various perpetrators belonging to different categories (family members, professionals, other caregivers).

[b] Refers to hospital, mental health facilities, etc.

[c] Refers to street, park, etc.

[d] Refers to different victimizations experienced in several of the scenarios shown.

Note. $X^2(df)$ = Chi-squared (*degrees of freedom*). *p < .05, **p < .01, and ***p < .001.

Consequences and disclosure

Participants were asked about the physical and psychological consequences of their victimizations. Only some of the incidents resulted in physical harm to those who experienced them. Neglect and physical abuse were the experiences that resulted in 33.8% of the victims being physically injured. There were no significant differences by gender or place of residence.

Eighty-three percent of the victims reported having some type of negative psychological consequence as a result of their victimization. However, the gender differences were not significant. The most commonly reported consequences were feelings of distress (38.6%), anxious-depressive symptoms (24.2%) and anger reactions (15.2%). Other participants reported feeling fear (10.6%) or helplessness and shame (8.3%). These experiences were revealed to someone after they happened in 59.7% of the cases, while the remaining 40.3% disclosed them for the first time to the interviewers in the present study. Among those who had previously disclosed to someone, the most common confidants were staff or professional caregivers (37.8%), followed by parents (25.6%) and other family members like siblings (19.6%). Those living in a residential care setting disclosed the incident more to parents than those living inside ($\chi^2[df] = 5.747[1]$; $p = .017$). Only 9.8% of victims reported the incident to the police.

Discussion

The present study shows that caregiver victimization is a relatively common experience throughout the lifetime of people with ID and that physical abuse, verbal abuse, and neglect are the most frequent types of victimization. Physical abuse shows the highest prevalence just as it did in the studies undertaken by Beadle-Brown et al. (2010) and Strand et al. (2004). Physical maltreatment appears as one of the most common forms of interpersonal violence experienced by people with ID in general (Fisher et al., 2016; Hughes et al., 2011; Hughes et al., 2012), so it is not surprising that when we analyze the types of abuse committed by caregivers, the same trend appears.

When analyzing gender differences in caregiver victimization, men and women with ID seem to experience victimization similarly. Less pronounced gender differences in victimizations in ID populations – except for sexual abuse – is a feature noted in the literature when gender variation is analyzed (Fisher et al., 2016; Platt et al., 2017). However, we do find gender differences when the residential factor is considered, with women being at twice the risk of caregiver victimization than men when they live at home with their family or partners. This may have to do with women experiencing different forms of violence at the hands of a greater variety of perpetrators, including family members and intimate partners among others (Hughes et al., 2011), and the socialization of women with disabilities, which revolves around vulnerability and the acceptance of abusive situations arising from their support needs and subsequent dependence (Saxon et al., 2001). Gender differences also appeared when sum and variety scores were considered, with women experiencing more types of victimization and with greater frequency than men. These results contrast with those obtained based only on frequency, which were apparently not significant. This indicates that more sensitive ways of exploring victimization may work better in understanding gender differences within the group and prevent its invisibility, uncovering more subtle ways in which violence manifests among women. In any case, further research is needed to better understand the nuances of gender differences in caregiver victimization of people with ID.

One of the strengths of the present study lies in its analysis of abuse forms that are unique to individuals with disabilities in the specific population. This is crucial for bringing visibility to the existence of disability-related abuse and preventing such specific forms of victimization from being wrongly grouped under general categories of violence. In this respect, being assaulted by a stranger on the street and being subjected to physical abuse by a professional caregiver may share certain characteristics, but they are distinct phenomena.

The denial of personal rights is also a unique form of victimization that is especially relevant for those living in institutions. From a human rights model of disability, the denial of personal rights impairs equality and emphasizes discrimination (Degener, 2016). These results underscore the need to explore the types of victimization that are often used as a strategy to control or limit some aspects of the life of people with ID under the pretense of care or risk prevention.

Adults living in residential care settings are at increased risk of caregiver victimization. They experience a significantly higher number of victimizations and with greater frequency than those not living in residential care settings. This is consistent with previous findings about congregate centers as an environmental risk factor for people with ID (Beadle-Brown et al. 2010; Fisher et al., 2016). To date, few studies have compared caregiver victimization experienced by people with ID living in residential care settings and their counterparts not living in residential care. In addition, the individuals in the sample share the characteristic of being more socially exposed than other groups, since they all generally participate in other social or educational activities, and they also work in some cases. This increases community exposure, the number of staff members, monitors, and other specialists with whom they interact, and likewise the opportunities for victimization. Unsurprisingly, this type of sample presents a higher prevalence of lifetime victimization and polyvictimization (Codina et al., 2022).

Although the place of residence yields relevant results, some of the characteristics of victimization are not as notable as expected even though significant differences arise. Some reasons behind this result could be that 90.9% of victims were, to some extent, in contact with or spent time with their families despite living in residential care. This can translate into opportunities for victimization by family members, even among those who regularly live in residential care settings. Another point to consider is the retrospective lifetime nature of the present study. Some of the victimizations (28.6%) happened when participants were still in childhood, that is, in the early stages of their lives when their residence may have been different from their current one.

The negative consequences of victimization reported by the participants presented no gender differences, which is similar to the findings of Platt et al. (2017). While the findings were consistent with the consequences of trauma in ID populations (McNally et al., 2021), the behavioral expressions were, by contrast, less common in the present sample as a consequence of trauma, with anger reactions being manifested by only a small group of victims. This may be due to the characteristics of the sample, perhaps showing higher social and cognitive functionality than in populations of greater complexity that may show a wider repertoire of behavioral responses (Emerson et al., 2001).

Finally, most of the participants disclosed their victimization to someone, but only a small number made a report to the police even though a third of the cases resulted in physical injury. Downplaying the importance of abuse, together with the barriers discussed by Lund (2021) and Saxon et al. (2001) as well as other limitations related to communication, knowledge or awareness of their rights, the inadequacy of the authorities' response, and erroneous assumptions about capacity and credibility in the testimony of victims (McGilloway et al., 2020), may contribute to an underreporting of victimization incidents and should be kept in mind when analyzing official victimization rates in this specific population.

Limitations

This is a cross-sectional non-probabilistic study, which limits the generalizability of its results to the general ID population. The individuals in the sample present generalized support needs to a greater or lesser extent. They also present multiple physical and mental disabilities that increase their dependency. However, some valuable characteristics, such as the degree of disability or any specific secondary diagnoses, were not available. Individuals with severe cognitive or communicative difficulties were excluded from the study because they could not meet the inclusion criteria. Individuals not receiving any external support or services were not among the federation users, so they are not represented in the study. As a result, more vulnerable and isolated victims may have been overlooked. Also, since the responses to the survey are self-reported, the rates of abuse must be interpreted with caution. Recall bias may lead to underreporting or overreporting depending on the capacities and memory of each respondent, as well as their awareness, knowledge, or understanding of the abuse.

Conclusions

This study outlines the high rates of lifetime caregiver victimization among an ID population. The findings emphasize the importance of addressing disability-related abuse as a distinct form of violence. Moreover, individuals living in residential care settings face higher risks of caregiver victimization than those living outside them. The study underscores the need for further research on caregiver victimization in different settings and the consequences of victimization for the adults in question. It also highlights the need to address gender differences comprehensively. Prevention efforts should focus on empowering individuals with ID to recognize and report abuse, providing them with accessible information about their rights, and making support and help services available. Professional caregivers should receive comprehensive training on ethical caregiving support and practices, recognizing signs of abuse and neglect, and promoting relationships built on respect and tolerance. Additionally, implementing robust monitoring systems and regular assessments of caregiving staff and environments can help to identify and address potential risk factors, ensuring the safety and well-being of adults living in residential care settings.

7. Study 4. Women with intellectual disabilities: unravelling their victim–offender status.

Codina, M., Díaz-Faes, D. A., & Pereda, N. (2023). Women with intellectual disabilities: unravelling their victim–offender status. In *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence* (pp. 109–123). Emerald Publishing Limited. https://doi.org/10.1108/978-1-80382-255-620231008

Publication date: 2 August 2023

Book's information

ISBN: 978-1-80382-256-3

eISBN: 978-1-80382-255-6

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Abstract

Over the last few decades, there has been increased interest in studying the phenomenon of violence among people with intellectual disabilities (ID). Research addressing offending and victimization among this population suffers from generalized androcentrism by extrapolating findings to women and is also homogenizing, ignoring any individual and gendered differences. Existing research also demonstrates a clear focus on vulnerability and increased risk of victimization, but very little attention has been paid to women with ID as perpetrators of crime. Many factors play a role in the process of victimization and offense, which implies the need to deconstruct the hegemonic vision of violence and examine its different manifestations and nuances. Therefore, this chapter provides a critical and historical review of the role of women with ID as victims and perpetrators of crime, by synthesizing the different levels of analysis of the subject using an intersectionality approach. In conclusion, the evidence so far does not elucidate the prevalence or characteristics of these offenders. What we do know is that this group faces interacting individual, social, and environmental difficulties. They report high rates of victimization and mental health comorbidity. Altogether reveals an overlapping status of victim and offender.

Keywords: women, intellectual disability, learning disabilities, violence, mental health, intersectionality.

Introduction

Historically, the ontology of women's acts of violence has been overlooked. The traditional view of violence and its theoretical underpinnings have been overwhelmingly androcentric (Cook, 2016), and it is only recently that gendered views of offending have begun to be fully considered in the discipline. Despite advances made in recent decades, epistemologically, much of the dominant research is based on approaches, such as controlling for sex, that tend to taxonomize women offenders based on comparison with their men counterparts (Chesney-Lind, 2006). The contributions of such studies are crucial but have failed to disentangle the gendered pathways to aggression and violence owing to their limited scope.

Many of the central correlates related to crime are believed to be gender invariant (e.g., childhood adversity, poor parenting, antisocial peers, history of antisocial behavior), albeit the intervening variables and emotional consequences of these experiences may vary across genders and others remain unclear (Kruttschnitt, 2013). Experimental research has found gender differences in aggression, showing that women are more prone to engage in indirect aggression, but the underlying neural mechanisms in women's aggression are mostly unclear due to the underpowered nature of the evidence (Denson et al., 2018).

Developmentally, women's antisocial behavior can follow different trajectories and patterns of offending (Widom & Osborn, 2021), so gender-specific norms are needed to better understand these patterns. However, most of the research has been based on man samples, reflecting their overrepresentation in crime statistics leading to a masculine-centered view of women's violence where various methodological limitations persist (Fontaine et al., 2009). Such a focus on a masculine-centered view is also reflected in the nature of data sources (i.e., crime data) and the use of aggregate measures of antisocial behaviors (thus masking etiological differences). There is also an emphasis on narrow definitions of risk factors, prevailing behaviors, and outcomes that are less frequent in women than in men based on the same identification criteria (e.g., age of onset), and the preponderance of small samples of women (Fontaine et al., 2009).

Research on sex and gender differences has revealed multiple similarities and several disparities in psychological variables between men and women (Hyde, 2014). At the same time, the social construction of gender, gender role models, and expectations shape psychosocial attributes and influence behavior. Therefore, a comprehensive explanation of aggression and violence needs to recognize these processes. Both men and women are gendered beings. The social-psychological process of gender construction takes place under the pressure of social structures characterized by social dynamics of dominance and inequality between men and women, in which the set of assumptions linked to masculinity and feminity outline and shape attributes, interests, and behaviors (Daly & Chesney-Lind, 1988). Masculinity is typically constructed as the opposition of feminity. Masculine-centered view or androcentrism mediates social human activity and knowledge but is presented as the objective viewpoint. Along with other dimensions of stratification, the weight of gender inequalities, gendered social roles, masculinity, and the construction of female identity, plays a pivotal role in social behavior. Thus, inherently, gender implies social practices and processes that drive or prevent antisocial behavior or offending (Bottcher, 2001).

Definition, limitations, and caveats on intellectual disabilities framework

The dominant narrative about people with disabilities is ambivalent in two ways. First, people with disabilities are overrepresented in the criminal justice system and theoretical foundations posit that they are per se more prone to offend or be victimized despite the scant research on the subject (Mueller, Forber-Pratt and Sriken, 2019). Second, paternalistic and discriminative practices hinder their diversity and voices and promote approaches that ignore or neglect their experiences and are driven by ideologies and systems that foment and institutionalize ableism (Thorneycroft & Asquith, 2021). This issue is particularly acute in people with ID, whose prevalence worldwide has been estimated at around 1% (McKenzie et al., 2016).

The term ID, a construction with multiple nuances and attributions, is commonly used internationally, although there are other coexisting terms such as learning disability, which is mainly used in the UK. According to the American Association of Intellectual and Developmental Disabilities (AAIDD), ID is a disability characterized by significant limitations in both intellectual functioning and adaptive behavior, having originated before the age of 22 (Schalock et al., 2021). The truth is that not only have the definitions of ID changed over time, but even today there are difficulties in its diagnosis since in many countries there is no systematized diagnostic protocol and much less a population census. Thus, those who have failed to be diagnosed or are detected after childhood may be left out of the scope.

This accepted narrow perspective on ID leads to a homogeneous ontological view that has many implications. First, there are problems associated with the definition/measure of 'ID' and other related issues and assumptions (e.g., inclusion/exclusion, knowledge, stigma, bias, prejudice, attitudes). For instance, those who have not been registered or monitored by the system are left out of the figures (e.g., people cared for by their families, homeless, non-diagnosed, or incorrect diagnoses). Second, much criminal offending goes undetected or unreported, and research often only deals with those in contact with the law, disability or mental health services, or those with registered ID diagnoses. Overall, this leads to an incomplete and biased picture of this population.

Intersectionality layers

Research beyond dualistic epistemologies has begun to unravel how the structuring variables shape or influence the differences in offending. Intersectionality was introduced as a key concept, research framework, and analytical strategy to capture and deconstruct the complex interaction of multiple layers or identities including, but not limited to, gender, class, disability, race, or ethnicity (Crenshaw, 1989). Intersectionality refers to the critical understanding of these variables operating as reciprocally overlapping entities, not as isolated mutually exclusive layers (Collins, 2015). Intersectionality approaches have contributed to mapping the interplay and clustering effects of the intertwined inequalities entailing structural, political, and representational dimensions. However, applied intersectionality in quantitative research is still uncommon, and its empirical transfer is conceptually and methodologically challenging although is developing.

Intersectionality has been particularly neglected in disability studies, and this population is still frequently perceived as a homogeneous group regardless of their background. This entails that the disability condition is the defining element, ignoring other determinants or variables by which these people identify themselves, and even when these are considered, the approach is additive or independent instead of interactive. The social identity framework has been suggested as a possible bridge to robustly capture the experience of persons with disabilities, using its historical, cultural, social, and political features to address this problem from a psychological perspective (Dirth & Branscombe, 2018).

One of the main reasons why it is fundamental to integrate intersectionality into the study of people with ID is to understand how stigma is ubiquitous and affects their lives. The cultural, social, and structural mechanisms of stress have a significant influence on their well-being. Minority groups often transit through multiple disadvantaged social categories or labels and associated overlapping processes. The co-occurrence of several stigmatizing identities –known as double stigma– particularly affects people with ID, since various outcomes of the disability (like behavioral and speech difficulties linked to identities other than being young, white, and male) contribute to a complex experience of stigma, which if internalized may be linked to negative outcomes and poor psychological well-being (Ali et al., 2015). So, the shaping and construction of their intersecting identity face many barriers and power imbalances with respect to majority groups.

Intellectual disability label

The most obvious issue is the effect of the ID label itself, which is socially perceived as a pathological and abnormal attribute and is strongly associated with negative attitudes and stereotypes that often revolve around infantilization, inferiority, incapacity, dehumanization, objectification, and hostility (Snipstad, 2022). In parallel, women with ID construct their identities around a range of medical diagnoses and impairments imposed on them by others (e.g., psychiatrists, and case managers). They do not necessarily perceive these elements as negative in themselves, but the concomitant value-based labels such as underprivileged, incapable, unwanted, or failure contribute to their poor self-perception constructed around feelings of rejection and inadequacy (Levine et al., 2018).

Vulnerability

Vulnerability is deeply linked to the concept of ID and is often used to conceive and describe this group. The idea of vulnerability has an underlying moral character, related to protection and need (Mackenzie, 2016), socio-politically operationalized around dependency (Scully, 2013). The concept of vulnerability serves the purpose of protecting certain groups from being subjected to unnecessary distress or harm, targeting those on whom the social structures must ensure certain guarantees. But often ends up being disempowering, excluding, and oppressive. This is described by Snipstad (2022) in the field of ID research as the vulnerability paradox. This author warns that applying vulnerability to all individuals in a particular group stereotypes them as victims, passives, or helpless. Along the same lines, the concept of pathogenic vulnerability describes how some interventions designed to mitigate the effects of vulnerability paradoxically increase it (Mackenzie, 2016). An example of this would be the abuse committed by caregivers in residential care settings.

Although some vulnerabilities are undeniably the result of physical or cognitive boundaries, others are not that clearly intrinsic (Scully, 2013). Mackenzie (2016) distinguishes between two sources of vulnerability: intrinsic, which derive from individuals' corporal limitations, needs, or dependence; and situational, which can be caused or aggravated by external social, political, economic, or environmental factors. An individual's own vulnerability risk will depend on the combination of both.

In such a highly heterogeneous population as people with ID, all the factors together shape the individual's unique set of strengths and challenges which in turn will play a role in some situations or contexts of risk (Burack et al., 2021). For example, some individual characteristics that are intrinsic to certain types of ID, such as features associated with appearance (e.g., Down and William syndrome), or limitations in identifying and avoiding risk situations (Fisher et al., 2016), may expose them to certain types of victimization or criminal activities.

Vulnerability has more to do with the factors that place people in vulnerable positions than with the inclusion of a person in a group. For that reason, to advocate for a comprehensive notion of vulnerability, without demonizing the concept but recognizing its limitations. Ultimately, it should serve as a vehicle to promote the voice of people with ID in matters concerning their lives and experiences, instead of a labeling tool.

Mental health comorbidity

Epidemiologically, mental health comorbidity is overrepresented in persons with ID in comparison with the general population (Buckles et al., 2013). In addition to the critical and cross-cutting aspects of the construction of psychopathology and its dimensions, the effect of sex and gender is largely unexplored and inconsistent in the discipline, and terminology issues and methodological biases may contribute to differences in results (Hartung & Lefler, 2019).

Underdiagnosis, misdiagnosis, and underutilization of mental health services are potential risks for this population caused by inadequate screening and detection as well as the existing barriers to meeting their mental health needs. The clinical attention they receive is frequently derived from their problem behaviors, which may be mistakenly attributed to a comorbid diagnosis, a phenomenon called diagnostic overshadowing. Diagnostic overshadowing is a negative bias and misclassification, which is based on the tendency to confer a person's symptoms and behaviors to their cognitive resources and behavioral repertoire instead of another mental health problem or condition (Jopp & Keys, 2001). This issue may contribute to the off-label psychotropic medication of people with ID, reinforcing the tendency for overmedication that is ineffective and iatrogenic (Matson & Neal, 2009). This can be framed in the historical context of the oppression of this group, the roots and effects of which are still present, and which need to be faced in order to move forward into the future (for a review of ongoing inquiries in critical disability studies, see Goodley et al., 2019).

Knowledge of the ID and mental health comorbidity rates in prison populations remains limited. One of the few studies considering both genders, found to be more likely for those with a dual diagnosis of mental health and ID to be charged with criminal offenses as well as being victims of crime in comparison with those with an ID diagnosis only (Thomas et al., 2019).

Poverty and social deprivation

Poverty is a complex construct that interacts with several variables. Social exclusion comprises not only low income but the process of cumulative disadvantages and marginalization. People with ID face institutional, environmental, and attitudinal discrimination (Yeo & Moore, 2003). These overlapping vulnerabilities may put them in a position to be and remain in chronic poverty, understood as a long-term, severe, and multi-dimensional poverty status (Hulme & Shepherd, 2003).

Multi-country studies analyzing poverty and disability reported that this group is disproportionally represented among the poorer sections of the population (Hosseinpoor et al., 2013). Showing higher and more severe multidimensional poverty, especially among older adults and those with multiple disabilities (Mitra et al., 2013).

Although there is a link between poverty and disability, a causality pathway is difficult to establish and be generalized to all contexts (Mitra et al., 2013; Yeo & Moore, 2003). Yeo and Moore (2003) depicted this linkage with the so-called vicious circle of poverty and disability, showing how having a disability increases the probability of being poor, whereas being poor increases the likelihood of having or becoming disabled. Research has identified some of the factors that push people with ID to remain in the poverty line: high levels of dependence, extra costs of living with a disability, lack of social networks and political voice, the perception of low earning capacity, and the employment gap (Hulme & Shepherd, 2003; Mitra et al., 2013). In parallel, other factors associated with poverty as limited access to education, health assistance, poor nutrition, or precarious living conditions, increase the risk of illness and disability (Yeo & Moore, 2003).

Ethnicity and race

The need for an embedded approach is a long-term claim in Criminology, and while more and more studies are taking into consideration the intersection between race, class, and gender, and the subsequent inclusion of other social categories such as ethnicity, little attention has been paid to cultural, religious, and ethnic diversity with regards its interplay with disability (Björnsdóttir & Traustadóttir, 2010). Different cultures and ethnic groups understand and perceive ID in different ways, with diverse levels of awareness and stigmatizing beliefs (Scior et al., 2013). The stigma of the intersecting identities of being from an ethnic minority group, being a woman, and having ID combines the effects of racism, ableism, and misogyny and should be considered in order to understand other realities such as social isolation, structural poverty, and involvement in antisocial or illegal activities.

Offences committed by women with intellectual disabilities

Significant research on offenders with ID did not begin until the 1990s. For a long time, it was believed that sex offenses and arson were the most common crimes among people with ID, but subsequent research quickly dismantled this hypothesis, (Holland et al., 2002). The limitations in the research on people with ID hinder making any definitive conclusions, but it seems that as with other offender populations, they potentially commit all types of crimes (Hodgins et al., 1996). Nonetheless, some types of offenses (e.g., white-collar crimes) appear less likely to be committed by people with ID due to their lack of skills and restricted opportunities (Holland et al., 2002).

Women with ID who carry out antisocial behaviors are in general an under-studied population. Research is scarce and tends to be grounded on stereotyped and sexist assumptions. To illustrate this issue, Wilson et al. (2010) conducted a thematic analysis among four salient ID journals and found important differences in the topics covered depending on whether they focused on men or women. The articles on crime, antisocial, and problematic sexual behaviors were mainly men-focused, whereas the articles on women generally covered topics related to health or well-being. However, in recent years there has been increased integration of gender and multilevel perspectives into the analysis of violence that has allowed us to go beyond the simplistic and binary views.

A few studies have focused on women with ID who have offended (Farr, 2022; Levine et al., 2018; Lindsay et al., 2004), while others present limited or incomplete data segregated by gender or mention women almost accidentally, but to date we do not have enough data to draw convincing conclusions. We cannot determine the prevalence of women offenders among this group, although some authors (Lindsay et al., 2004) claim that rates of women offenders with ID (9% of the total sample) remain consistent with the proportion of women reported in mainstream offender samples. Other studies examining convictions or criminal recorded charges on people with ID compared to community samples found higher percentages than expected. Some studies suggest distributions other than those of the general offender population among offenders with ID. Nixon et al. (2017) reported that 11.87% of women with ID had offending charges compared to 4.33% of the community women group. Hodgins et al.'s (1996) cohort study found in the first and second waves that 13.5% and 11.5% of women with ID had a criminal record compared to 1.3% and 2.1% of women without disability, respectively.

The behaviors found in studies analyzing women samples with ID are diverse, including breach of the peace, theft, fraud, vandalism, robbery, prostitution, assault, drug trafficking, child neglect, murder, manslaughter, and sexual assault (Farr, 2022; Hodgins et al., 1996; Levine et al., 2018; Lindsay et al., 2004). Unfortunately, this heterogeneity is seen by some authors as an indicator of a general tendency toward violence, leading to them claiming that women are at increased risk of being involved in violent and criminal behaviors because of the ID. This increased risk of committing violent offenses among women with ID in comparison to women without ID differs dramatically depending on the study, ranging from 5.5 to 25 (Hodgins et al., 1996; Nixon et al., 2017). These studies do not provide sufficiently extended interpretations of the results when it comes to explaining these high rates in women with ID. So the results should be interpreted with caution. Consequently, there is insufficient compelling evidence to undoubtedly assert that people with ID commit more offenses than other populations.

Readings that revolve around the hypothesis of risk and propensity to crime linked to ID, when incorrectly supported, can lead to biased and ableist arguments. Because in essence, they misinterpret and transfer the idea that low IQ is related to offending to some extent (Mears & Cochran, 2013). Multiple biases entailing intelligence, IQ measures, and codification, the high police detection rates of low IQ individuals, and the overlooking of third variables or clustering effects, can be behind some pumped-up results. Publications such as the Bell Curve have promoted a detrimental view that has received a great deal of attention and been widely disseminated, but which is based on ideology and reductionism that reinforces the relationship between poor cognitive abilities and adverse outcomes (Cullen et al., 1997).

Indeed, there is evidence supporting the relationship between IQ and offending in women, suggesting that IQ is a relatively important predictor of women's offending (Hubbard & Pratt, 2002). But this requires a little further qualification since the relationship is not linear, that is, the lower the IQ the greater the propensity to offend and vice versa. Undoubtedly one of the most revealing findings is the curvilinearity of the relation between IQ and offending, showing that the lower and higher levels of IQ are associated with lower levels of offending (Mears & Cochran, 2013).

Behind the offending narrative

Many problems faced by women with ID are framed within a hostile system that actively excludes and ignores social minorities, causing and perpetuating social, economic, health, and institutional inequalities. People with ID display a higher number of adverse conditions, including associated, comorbid, and secondary conditions, however, this population is often overlooked by public health, with inadequate care needs attention and poor access to healthcare services (Brooker et al., 2015). The health and social services as well as the criminal justice, are not created to be used or accessible by groups with special needs (Hayes, 2007; Levine et al., 2018). Once women offenders with ID enter the justice system, they face problems while serving the sentence and when released. Women with ID are a small group within a man-focused justice system, that experience non-existent or under-resourced educational, therapeutic, and healthcare services while in the correctional (Hayes, 2007). When released, they encounter difficulties that can lead to victimization or re-offending, such as difficulties in accessing community mental health services, lack of post-release support, or adequate housing (Levine et al., 2018). The difficulties of the protection systems to meet these needs, leave people at inherent environmental risk.

Victimisation

As the body of research has noted, exposure to violence seems a constant trend in the life course of women with ID, and when stories of the offenders are examined, violence, trauma, sexual, physical, and emotional abuse, neglect, and abusive relationships are often found throughout their childhood and later adult life (Farr, 2022; Levine et al., 2018; Lindsay et al., 2004; Nixon et al., 2017). This is not surprising, since in contrast with the perpetration-focused literature, the extensive research focusing on victimisation has allowed the performance of meta-analyses showing a greater risk of suffering interpersonal victimization (Hughes et al., 2012). Especially the most violent types such as physical and sexual aggression (Fisher et al., 2016; Nixon et al., 2017). Another form of violence that is particularly relevant for minorities is bias victimisation. Bias victimization involves acts of violence based on negative stereotypes, prejudice, or hatred against a specific group. Although it has received little attention in the context of people with ID, a recent study suggests that it may be a common experience, especially among those who have experienced multiple victimisations (Díaz-Faes et al., 2023a).

Some studies have found that, among all types of victimisation, sexual victimisation shows the most marked gender differences, with women being more often sexually abused, especially via the most violent forms of abuse such as rape (Codina & Pereda, 2022; Fisher et al., 2016; Nixon et al., 2017). However, a recent meta-analysis (Tomsa et al., 2021) showed a high overall prevalence of sexual victimisation among people with ID (32.9%) but found significantly higher rates in men (39.9%) compared to women (31.8%). It is argued that, besides the lower amount of research attention given to men and the methodological differences between studies, gender roles may help explain these figures. That is, men exhibit less overprotection, control over their bodies, and a less restricted daily routine than women, which may lead to more opportunities to be sexually abused.

Overall, when people with ID are victims, rather than experiencing an isolated incident they tend to suffer multiple victimisations of different types throughout their lives (Codina et al., 2022; Fisher et al., 2016). This explains why simplistic analyses based on isolated variables or a single violence-related event fail to explain the phenomenon in a comprehensive way. Similarly, the background rooted in prejudice, identity, and attitudes that perpetrators may hold and display needs to be analyzed to understand the victimisation experiences of women with ID (Díaz-Faes & Pereda, 2022).

In the view of Levine et al. (2018), the experiences of women with ID “in conflict with the law” place them in positions of multiple, complex, and ongoing risk, starting from compromising positions whereby they had suffered childhood adversity and trauma and continuing into a negative spiral involving crime, addictions, and other adverse life events.

Victim-offender overlap

The biased tendency to analyze the phenomenon of violence unilaterally (only victimization or offense) is an important barrier to understanding it correctly. Some disconnected findings in both victimization and offending studies in ID populations seem to give clues that point to the so-called victim-offender overlap, which has already been identified in other populations from different theoretical perspectives (Berg & Mulford, 2020). The finding of victimization among institutionalized individuals at the hands of other peers with ID (Codina & Pereda, 2022; Fisher et al., 2016; Tomsa et al., 2021), the already mentioned life stories of victimization reported in women offenders with ID studies, and the victimization experiences that operate as a risk factor for engaging in delinquent behavior in women (Hubbard & Pratt, 2002), seem to pivot around the idea of overlapping roles, but fail to build an integrated explanation. A risk factor study showed how the accumulation of negative social and environmental circumstances impacts the likelihood of becoming an offender, as well as how experiencing severe family conflict or having abusive friends are the factors that most increase this probability (Wheeler et al., 2014).

The overlap approach is a pending task in the field of research on people with ID, although there are already case-linkage studies that aim to determine whether there are connections between previously unrelated cases of victimization and perpetration, helping to shed light on some repeated findings from both fields. Using the Australian databases, including disability services, public mental health services, and police records, Nixon et al. (2017) conducted comparative research matching the criminal charges and reports of victimization among people with ID and a community comparison sample. The results showed that rates of violent and sexual victimization and offending were significantly higher in women with ID in comparison with a group of women without ID. The authors also noted increased mental disorders comorbidity in the women with ID. They suggest that the same rationale used to explain this overlapping trend in other populations, that is the routine activities and the general theory of crime (Berg & Mulford, 2020), also works for individuals with ID. In any case, more studies need to be done, especially prospective designs, adding other layers of analysis to avoid certain biases inherent in research on people with ID (Snipstad, 2022).

Summary

The diversity among the ID population is still not well understood, yet mainstream research and clinical practice are beginning to embrace many of the long-term claims. The legacy of the views that emanate from abnormality and impairment is outdated but still has a deep hold. The ID concept has many nuances and implications, and this label is intertwined with other social categories and identities in which women offenders with ID have been stigmatized or ignored over time. To disentangle this, we have highlighted and analyzed the intersecting layers of these women (i.e., ID label, vulnerability, mental health comorbidity, poverty, social deprivation, ethnicity, and race). Throughout this chapter, we have untangled the complexity of the violence committed by women with ID. We have highlighted, explained, and reflected on the nuances extracted from the current knowledge, which shows how the victim and offender roles are not mutually exclusive.

Women with ID face multiple adversities, being involved in the phenomenon of violence both as victims and as perpetrators. As victims, they are at a higher risk of victimization, especially for the most severe forms such as physical or sexual abuse. As perpetrators, besides the awareness of this role, the existing knowledge is not yet able to estimate the prevalence of offending across this population or their main features. The interrelation between these two statuses has not yet been studied in sufficient depth, and certainly owes its variability to other interacting variables, giving rise to different criminal trajectories. Future directions should encompass integrative analyses to reduce adversity and risk while addressing women's needs from a gender-sensitive perspective.

8. Discussion

Measuring and defining violence is inherently challenging (Daigle et al., 2016), but when it comes to doing so in samples with ID, this adds extra layers of complexity. Disparities in research methodologies, small sample groups, or alternative definitions of abuse across studies are just some of the problems that research on violence in this group faces (Daigle et al., 2016; Horner-Johnson & Drum, 2006; Hughes et al., 2012). This leads to overall inconsistent or even mutually contradictory results regarding the occurrence of violence among people with ID. Some studies claim that people with ID are at increased risk of victimization in general, while others only find that the high risk applies to certain types of victimization (Fogden et al., 2016; Krnjacki et al., 2016). The truth is that determining the extent of victimization risk in this group is challenging. It is shaped by intricately interlinked and continually interactive factors such as individual characteristics, attributes and skills, and environmental and sociocultural factors (Hollomotz, 2009).

The studies in this thesis notices that the examined sample experienced high rates of lifetime interpersonal victimization, with nearly all participants reporting some victimization experience. High rates of physical and sexual violence were reported, in line with previous results (Fang et al., 2022; Jones et al., 2012; Mailhot Amborski et al., 2022). The most frequently reported forms of physical violence were robbery, bias attack, assault, and physical abuse by a caregiver. These findings suggest a tendency to experience particularly damaging types of victimization. Study 1 revealed that conventional crimes, including some forms of property crime, is the most frequent type of victimization among this sample (87.7%). This is consistent with the results of Vanderminden et al. (2023), suggesting an increased risk for this type of victimization. This study is aligned with those that present high overall victimization rates among the population with ID (Beadle-Brown et al., 2010; Horner-Johnson & Drum, 2006; Krnjacki et al., 2016).

The mean number of different victimization types experienced by the sample was six. The repeated occurrence patterns of victimization are consistent with those highlighted in reviews exploring multiple forms of violence (Fisher et al., 2016; Horner-Johnson & Drum, 2006). The poly-victim group experienced more than double victimizations compared to the rest of the victims. Poly-victimization offers additional insight into the field of vulnerability to victimization in people with ID, as it brings together the most exposed and damaged victim profiles. In that sense, this is one of the few current existing studies (Lapshina & Stewart, 2021; Vanderminden et al., 2023) that explore poly-victimization among this group.

However, these overall results showing high victimization rates should be interpreted with caution since without a comparison group such as one from the general population or other disability groups, it is not possible to speak of increased risk groups, only about intragroup differences. To test these intragroup differences and avoid generalized attribution of risk to the whole sample, we decided to analyze, in a study out of this thesis, the response patterns of our participants conducting a latent class analysis (Díaz-Faes et al., 2023b). The objective was to identify different unobserved groups of victims that otherwise would have gone unnoticed. The results identified three unobserved groups of victims within the sample based on the distribution of the victimizations. Half of the participants fell into the low victimization class (*n* = 136; 52.3%), and the high victimization class aligned with the poly-victims group detected in Study 1, which represents a small portion of the victim population showing an increased vulnerability profile.

After detecting a significant report of sexual victimization among the sample in Study 1 and given the literature addressing this issue stating that sexual violence is a serious problem for this group (Byrne, 2018; McGilloway et al., 2020; Smit et al., 2019; Wissink et al., 2015), Study 2 aimed to analyze the details and gender differences in these victimizations. The study found that most sexual victimization occurred in private spaces such as victim's or offender's homes, and that the offender was mainly a known man adult. Women were more frequently sexually victimized than men, consistent with previous research on sexual abuse in individuals with ID (Cambridge et al., 2011; Nixon et al., 2017; Platt et al., 2017). They faced a higher risk for all types of sexual victimization, especially for rape, with more than four times higher risk compared with men.

Some explanations behind these results include rape myths acceptance, which is strongly associated with hostile behaviors toward women and actively reinforces gender inequalities (Suarez & Gadalla, 2010). According to this meta-analysis, rape myth acceptance correlates with other oppressive beliefs, such as racism or classism, analogous in our case to ableism. In the case of people with ID, these myths and misconceptions about sexual victimization revolve around justification, victim-blaming, or downplaying the relevance of sexual assault (McGilloway et al., 2018) and contribute to the entrenchment of these behaviors. Sexual assault can be conceived as a form of hostile ableism (Nario-Redmond et al., 2019) in which victims are targeted because of their disability, being perceived as more vulnerable, accessible, easily manipulated, and believed will not report compared to other women (Barger et al., 2009).

However, this study also detected other peers with ID as perpetrators of sexual victimization. This brings to light the ongoing debate on victim-offender overlap among this population, as recent studies have done (Anstis & Thomas, 2022). It reminds us that violence is not a compartmentalized phenomenon and that the same person considered vulnerable to victimization can also be an offender toward other more vulnerable peers. This is not surprising since when examining the life histories of men and women offenders with ID, repeated experiences of victimization are frequently found (Lindsay et al., 2012; van der Put et al., 2014).

People with disabilities may also experience victimization coming from those who assist and provide care, such as family members or care staff. These abuse forms are unique to individuals with disabilities, and Study 3 explores them among the ID population. An extensive part of the literature on this type of abuse has been conducted with people with physical disabilities (Hughes et al., 2011; McFarlane et al., 2001; Saxon et al., 2001), but fewer studies are exploring it in samples with ID. The results show that physical abuse, verbal abuse, and neglect are the most prevalent forms of caregiver victimization. Physical abuse is particularly prevalent, aligning with previous research (Beadle-Brown et al., 2010; Strand et al., 2004). Some explanations for these results may have to do with caregiver stress, burn-out, or reactivity to aggressive or challenging behaviors of the individual, which ultimately can lead to abuse, mistreatment, and the use of physical restrain (Nevill et al., 2022; Ryan et al., 2021; Strand et al., 2004).

A notable finding is that adults living in residential care settings are at greater risk of caregiver victimization, experiencing a higher number and frequency of victimizations compared to those not in residential care. This risk factor has been noted in previous reviews and studies (Beadle-Brown et al., 2010; Fisher et al., 2016). These studies point out that living in care settings increases opportunities for victimization among their residents due to greater exposure to multiple caregivers, practitioners, and other people in comparison to those who live at home. In these types of environments, staff and managers may hold poor or abusive institutional practices, failing to recognize and prevent victimization and laying the foundations for a culture of abuse (Fyson & Patterson, 2020). It should also be noted that even today, providers and services for people with ID continue to use restraint, restrictive intervention, and seclusion as measures to control aggressive and problem behaviors, even though they pose a threat to the health and life of those to whom they are applied (Friedman & Crabb, 2018).

Following the studies that compose this thesis, Study 4 provides a critical review of women with ID involved in violence as victims and perpetrators of crime, synthesizing the different levels of analysis using an intersectional approach, which has been particularly neglected in disability studies (Dirth & Branscombe, 2018). One of the main reasons it is fundamental to integrate intersectionality into the study of this population is that minority groups, such as people with ID, often transit through multiple disadvantaged identities or social categories associated with negative overlapping processes (Ali et al., 2015). The co-occurrence of several stigmatizing identities (known as double stigma) notably affects people with ID. This stigma, in turn, combines with the effects of racism, ableism, and misogyny and should be considered to understand how these are related to victimization, social isolation, poverty, or involvement in antisocial or criminal activities.

The approach in Study 4 served as a theoretical underpinning for analyzing how other sociodemographic factors that fall into individual (e.g., gender, age, race) disability-related (e.g., more support needs, other co-occurring disabilities), and environmental characteristics (e.g., residence, contact with relatives) might relate to the experience of violence. The articles conforming to this thesis reveal how additional factors to disability increase the risk of victimization.

Gender is a central variable of analysis across all four studies. It is important to understand gender differences since some studies claim that the overall picture of victimization in people with ID is one of gender similarities rather than differences (Platt et al., 2017). In line with these results, Study 1 showed less pronounced overall differences between men and women than expected, except for sexual victimization, which showed marked gender differences. In contrast, gender seems to be relevant in the most vulnerable group among victims, the poly-victims, in which the number of women was overrepresented. Although previous meta-analyses have detected some gender differences operating on the risk of victimization in women, such as the effect of bonding or previous victimization experiences (Pusch & Holtfreter, 2021), this issue requires further study in ID samples.

Study 2 highlights how those women with multiple stigmatized identities face a higher risk of experiencing sexual victimization. Being a woman, being declared legally incapable, and having a co-occurring mental health diagnosis were the most significant characteristics related to being a sexual victim. These findings fuel the debate about intrinsic vulnerability, showing how a combination of meaningful factors rather than just having a specific condition better explains the vulnerability to violence. One example, in line with these results, is the study of Thomas et al. (2019), which found that compared to people with ID alone, those with comorbid mental illnesses were a potentially multiply stigmatized group at higher risk of victimization.

As in the previous studies, in Study 3, victimization was explored in a gender-sensitive way, uncovering more subtle ways in which violence manifests among women. Although apparently, there were no significant differences between men and women in caregiver victimization, when exploring the residential factor, women presented twice the risk of caregiver victimization than men when living at home with their family or partner, experiencing more types of victimization and with greater frequency than men. If only the general picture had been taken into consideration, these nuances would not have come to light, rendering some forms of violence against women invisible.

The age-related approach was also examined in Study 1. It revealed differences in victimization patterns according to the stage of adulthood. A higher risk was expected for older people, as later life is a particularly vulnerable period (Hamby et al., 2016), and elder abuse is a serious problem that seems to affect one in six older adults worldwide (Yong et al., 2017). Instead, older adults showed lower lifetime victimization rates than their younger peers. Likewise, the older group was less represented in the poly-victim group compared to the younger one. Two possible explanations for these results revolve around the perception of abuse and the predisposition to report. Older people may be reluctant to report their experiences of victimization in contrast to younger adults, who seem to be more open to self-reporting abuse (Acierno et al., 2010). They may also perceive and understand abuse differently, accepting certain acts that may be labeled abusive as tolerable (Taylor et al., 2014).

Another notable finding highlighted by Studies 2 and 3 is the low reporting to law enforcement authorities (both studies below 10%). Factors contributing to underreporting relate to the system not being prepared to understand and help people with ID, often encountering impossible-to-overcome barriers when reporting victimization. This includes downplaying the importance of abuse, barriers related to communication and knowledge of their rights, inadequate responses from authorities, and myths and misconceptions about victims' capacity and credibility (McGilloway et al., 2020).

Despite this limited attention to victimization by the authorities, the studies in this thesis also reveal the negative effects of victimization for those who experienced it. Study 3 notes physical injuries resulting from the caregiver's victimization, even though the most usual consequence was psychological distress. Participants in Study 2 reported serious psychological impact, with outcomes compatible with PTSD symptomatology in victims of sexual abuse (Smit et al., 2019), although they claim not receiving treatment.

9. Strengths and limitations

An outstanding aspect of this thesis is the reasonably large number of individuals with ID reached, given the difficulties of acceding this group. Another one is its comprehensive analysis of different types of victimization and the specific details gathered. This was possible because the study was designed in a manner that made it accessible for the population to comprehend and actively engage with the survey. Asking people with ID directly about their experiences allows us to know details that otherwise would be overlooked. The collection of various forms of victimization allows for the exploration of poly-victimization within this population. Study 1 overviews the general victimization lifetime rates and introduces an innovative age-related approach. It sheds light on how patterns of victimization vary across different stages of adulthood, a perspective that has received limited attention in previous research on this group, particularly in later life stages. Gender is a central variable in all four studies. An intersectional approach is taken to provide a nuanced understanding of gender differences and address the invisibility of certain forms of violence against women with ID. Study 2 explores one of the gender-based forms of violence that most affect women with ID, which is sexual victimization. Notably, this thesis explores victimization types particularly relevant to people with ID, like caregiver victimization in Study 3. This is essential for bringing attention to disability-related abuse and preventing the misclassification of such specific victimization forms under general categories of violence. This study contributes to highlighting the risk of residential environments for people with ID. The results from this thesis, all together, contribute substantially to the body of research on vulnerability to victimization in people with ID.

This thesis has several limitations. Since this is a cross-sectional non-probabilistic study, the generalizability of its results to the broader population of individuals with intellectual disabilities is limited. The results must be cautiously interpreted due to convenient sampling, and lack of a control group. Additionally, the study excluded individuals who were not institutionalized, remained at home, or attended services outside the scope of the federation. Participants with severe cognitive or communication difficulties were also underrepresented due to their incapacity to meet the inclusion criteria. This together leads to potentially overlooking more vulnerable and isolated individuals. The self-reported retrospective nature of the research could have introduced potential recall bias, impacting the accuracy and details of past experiences, as well as underreporting or overreporting victimizations depending on individual capacities, memory, awareness, knowledge, and understanding of abuse. The presence of caregivers or other individuals during participant interviews in 9.6% of the cases may have further affected anonymity and confidentiality, potentially leading to hiding or omitting victimization details. Finally, some characteristics of the sample were not available. The federation accepted almost all survey details but was reluctant to include some victimization questions (for example, bullying) and to provide us with some specific characteristics about the participants (such as the ID diagnosis designation or the severity of the disabilities).

10. Implications for research and practice

These findings help provide evidence of the need to develop special protection programs for victimization among both men and women with ID. Highlight the need for increased attention from professionals and caregivers, especially to the most vulnerable individuals, that is, poly-victims. Future research must explore this phenomenon on larger, representative samples while sensitively addressing gender differences in this group. Similarly, the association between individual characteristics and victimization needs to be better studied to understand how this group's underlying mechanisms of vulnerability manifest. This will help to identify more precisely those profiles within this population requiring additional special protection given their increased vulnerability to victimization. Similar methodologies and definitions among studies would be useful to measure and understand the different forms of abuse in people with ID. Also, studying broadly the victim-offender overlap phenomenon among this population is a pending task and should be encompassed in future research.

Early prevention strategies should be developed and implemented since violence against this group occurs from a very young age (Jones et al., 2012; Vanderminden et al., 2023). Training professionals to detect and respond to abuse effectively with early and targeted interventions is important. Results on Studies 2 and 3 indicate that although people disclosed victimizations, these were often not effectively addressed and rarely reached the authorities. In cases of sexual victimization, a combination of interpersonal, professional, and social-related factors may act as barriers to reporting (McGilloway et al., 2020). One strategy for addressing some of them could be to provide training on sexuality and abuse for both people with ID and professionals. Research suggests that services for people with ID tend to minimize or manage internally some kinds of abuse (Collins & Murphy, 2022; McGilloway et al., 2020). So, care settings and their staff may implement and follow policies and protocols for detection and response to abuse. Study 3 shows that residential settings are risky environments for victimization, and staff members are one of the main perpetrators. Some prevention strategies would consist of increasing the monitoring and unannounced inspections, better supervision and training for care staff, and enhancing the collaboration between professionals (Collins & Murphy, 2022).

Finally, signs of trauma-related consequences were detected in both studies. This alerts us to the negative consequences of victimization, which should be better studied with tools specifically designed for this group and treated effectively.

11. Final conclusions

This thesis contributes to the body of both empirical and theoretical knowledge on violence against people with ID. Several forms of victimization were explored using a single self-reported questionnaire, discovering high overall rates of violence against this group. A general pattern of experiencing multiple episodes of victimization instead of an isolated event was also reported. Special emphasis was given to the most reported and relevant forms of violence detected in the sample, such as conventional crime, physical and sexual victimization, and victimization by caregivers. In addition, this is one of the few existing studies that also explore poly-victimization in people with ID, showing how poly-victims had more than double the number of different victimizations than non-polyvictims. This is a contribution to the field of victimization against individuals with ID since few studies analyze so many types of violence in the same design, enabling them to reach such conclusions.

Despite the high general figures reported in this group, each of the articles presented in this thesis reveals how additional factors to disability increase the risk of victimization. This contributes to the debate on the intrinsic vulnerability in this group. Significant age, gender, residential, comorbidity, and disability-related differences concerning the risk of victimization were identified. These results are in line with the idea that vulnerability to victimization has more to do with a cascade of factors that place people in vulnerable positions than with the person’s condition. From an intersectional perspective, other relevant factors in the equation of violence, such as poverty, social deprivation, ethnicity, and race, were also presented for people with ID, highlighting the need to use integrated approaches in the study of disabilities to avoid simplistic explanations of the complex phenomenon of violence.

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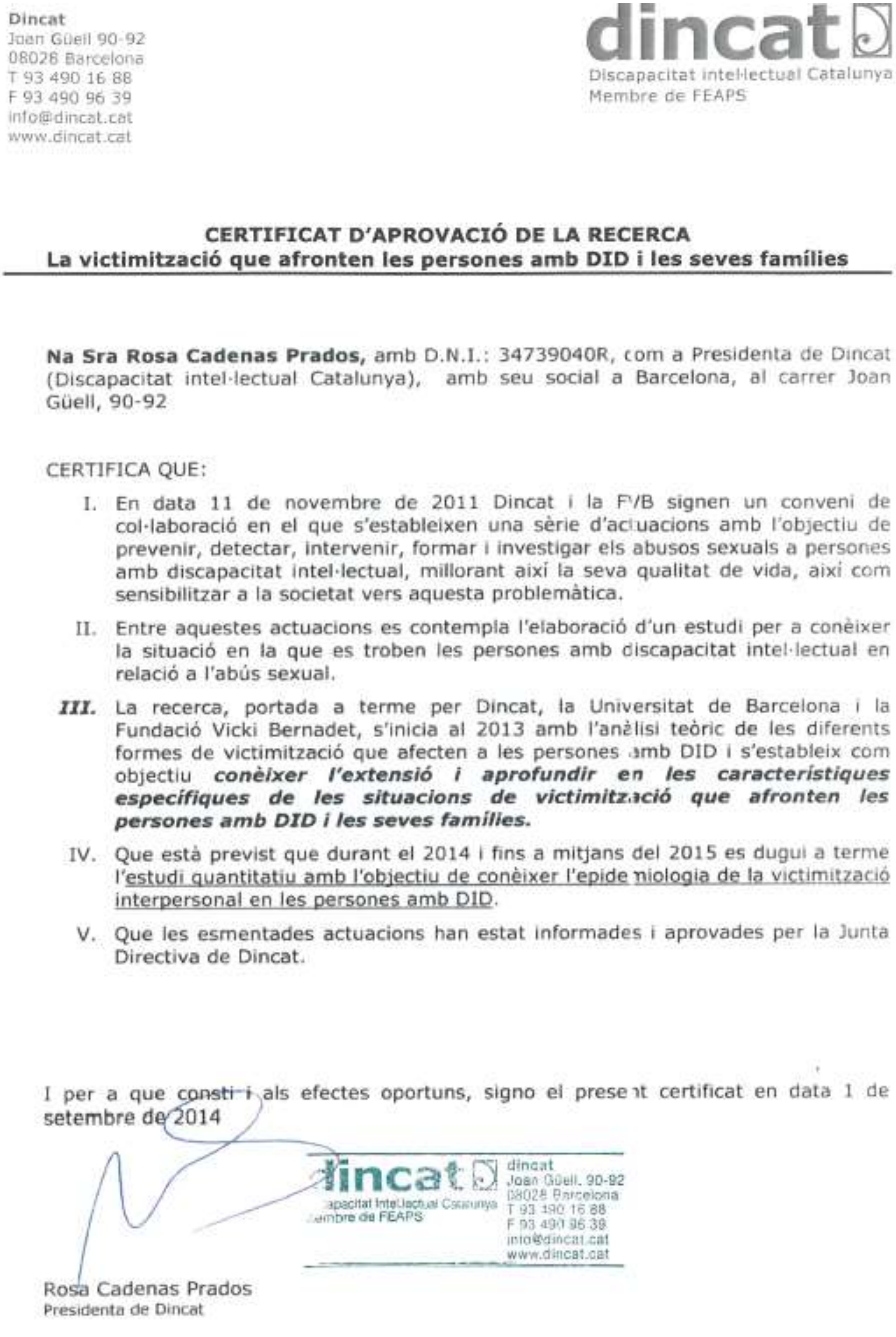
13. Annexes

Annex 1. Collaboration certificate from the Federation of Entities for people with intellectual disabilities



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dincat
Discapacitat intel·lectual Catalunya
Membre de FEAPS

CERTIFICAT D'APROVACIÓ DE LA RECERCA
La victimització que afronten les persones amb DID i les seves famílies

Na Sra Rosa Cadenas Prados, amb D.N.I.: 34739040R, com a Presidenta de Dincat (Discapacitat intel·lectual Catalunya), amb seu social a Barcelona, al carrer Joan Güell, 90-92

CERTIFICA QUE:

I. En data 11 de novembre de 2011 Dincat i la FVB signen un conveni de col·laboració en el que s'estableixen una sèrie d'actuacions amb l'objectiu de prevenir, detectar, intervenir, formar i investigar els abusos sexuals a persones amb discapacitat intel·lectual, millorant així la seva qualitat de vida, així com sensibilitzar a la societat vers aquesta problemàtica.

II. Entre aquestes actuacions es contempla l'elaboració d'un estudi per a conèixer la situació en la que es troben les persones amb discapacitat intel·lectual en relació a l'abús sexual.

III. La recerca, portada a terme per Dincat, la Universitat de Barcelona i la Fundació Vicki Bernadet, s'inicia al 2013 amb l'anàlisi teòric de les diferents formes de victimització que afecten a les persones amb DID i s'estableix com objectiu ***conèixer l'extensió i aprofundir en les característiques específiques de les situacions de victimització que afronten les persones amb DID i les seves famílies.***

IV. Que està previst que durant el 2014 i fins a mitjans del 2015 es dugui a terme l'estudi quantitatiu amb l'objectiu de conèixer l'epidemiologia de la victimització interpersonal en les persones amb DID.

V. Que les esmentades actuacions han estat informades i aprovades per la Junta Directiva de Dincat.

I per a que consti i als efectes oportuns, signo el present certificat en data 1 de setembre de 2014

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Rosa Cadenas Prados
Presidenta de Dincat

Annex 2. Approval from the University of Barcelona's Bioethics Committee.

Universitat de Barcelona

Comissió de Bioètica
de la Universitat de Barcelona

Albert Royes Qui, secretari de la Comissió de Bioètica de la Universitat de Barcelona

CERTIFICO:

Que **la Dra. Noemi Pereda** va presentar el projecte titulat "**Abús sexual i altres formes de violència en persones amb discapacitat intel·lectual i del desenvolupament**", a la convocatòria de «DINCAT»

Que d'acord amb allò establert a la convocatòria, la Comissió de Bioètica de la Universitat de Barcelona ha analitzat tota la documentació presentada per **la Dra. Noemi Pereda** i, per acord amb data 9 de setembre de 2014 ha aprovat informar **favorablement** des del punt de vista bioètic el projecte de recerca de referència.

I, perquè consti i tingui els efectes que corresponguin, signo aquest certificat, amb el vistiplau del president de la Comissió de Bioètica.

Barcelona, 9 de setembre de 2014

Vist i plau
El president de la Comissió de Bioètica de la Universitat de Barcelona

Jordi Alberch Vié

Institutional Review Board (IRB00003099)

Annex 3. Example of the survey sheet used by the interviewer. With the items "robbery" and "verbal aggression" from the conventional crime module.

Cuestionario de experiencias vitales

Delitos comunes

Ahora vamos a hablar de cosas que han podido pasarte en el centro, en la escuela o en la calle, por parte de tus compañeros y amigos, o también desconocidos.

Recuerda que es importante que digas la verdad.

	SÍ	NO
1) ¿Alguien te ha robado dinero o algo que era tuyo?	☐	☐

Si le ha pasado, preguntar lo siguiente:

¿Cuántas veces te ha pasado?	Algunas ☐ Muchas ☐
¿Quién fue?	____________________
¿Dónde pasó?	____________________
¿Qué te robó?	____________________
¿Te hizo daño o alguna herida?	SÍ ☐ NO ☐
¿Cómo te sentiste?	____________________
¿Se lo has explicado a alguien?	SÍ ☐ NO ☐
¿A quién?	____________________

	SÍ	NO
2) ¿Alguien te ha insultado, o te ha dicho cosas malas o feas (idiota, inútil, imbécil, gilipollas) y te ha hecho sentir realmente mal?	☐	☐

Si le ha pasado, preguntar lo siguiente:

¿Cuántas veces te ha pasado?	Algunas ☐ Muchas ☐
¿Quién fue?	____________________
¿Dónde pasó?	____________________
¿Cómo te sentiste?	____________________
¿Se lo has explicado a alguien?	SÍ ☐ NO ☐
¿A quién?	____________________

Annex 4. Example of the pictogram cards used during the interview for items "robbery" and "verbal aggression" from the conventional crime module.

1. ¿Alguien te ha robado dinero o algo que era tuyo?

2. ¿Alguien te ha insultado, o te ha dicho cosas malas o feas (idiota, inútil, imbécil, gilipollas) y te ha hecho sentir realmente mal?