**Title:** Self-reported experiences of Intimate Partner Violence in a Female forensic ID population

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**Author Details**

**Author 1** Name: Dr Deborah Morris

Department: Academic Centre & Research Centre

Institution: St Andrews Healthcare

Town: Northampton

Country: UK

**Author 2 Name**: Dr Claudia Camden-Smith

Department: Oxford Clinic

Institution: Oxford Health NHS Foundation Trust.

City: Oxford

Country: UK

**Author 3 Name**: Robert Batten

Department: Psychology

Instution: University of Lincoln

City: Lincoln

Country: UK

**Corresponding author:** Dr Deborah Morris, Academic and Consultant Clinical Psychologist.

**Corresponding Author’s Email:** DMorris@standrew.co.uk

**Biography**

Dr Deborah Morris is an Academic and Consultant Clinical Psychologist based in the Academic Centre and Research Centre, St Andrew’s Healthcare, UK.

Dr Claudia Camden-Smith is a Consultant Learning Disabilities Psychiatrist, Oxford Clinic, Oxford Health NHS Foundation Trust.

Mr Robert Batten is a Trainee Clinical Psychologist, University of Lincoln.

**Title: Self-reported experiences of Intimate Partner Violence in a female forensic Intellectual Disability population**

**Purpose:** Intimate Partner Violence (IPV) is a complex public health and social issue. Women with an Intellectual Disability (ID) are at greater risk of experiencing IPV. However, little is known about the IPV experiences of women with an ID and forensic care needs. The current study explored the history of experienced and perpetrated IPV in women detained to a secure specialist ID forensic service.

**Design:** Participants completed the Conflict Tactics Scale -2 (CTS-2, Straus et al., 1996). The CTS-2 measures experienced and perpetrated relationship tactics of common forms of IPV.

**Findings:** All participants (*N=14)* who completed the CTS-2 reported experiencing, and 13 reported perpetrating, IPV. Overall, participants reported they were as likely to experience as to perpetrate IPV. The only significant differences was ‘minor sexual coercive behaviour’ where participants were significantly more likely to experience than perpetrate this behaviour.

**Research implications and limitations:** Further research exploring the risk factors that contribute to IPV is needed. Shortcomings in the current study are acknowledged.

**Practical Implications:** Women with an ID and forensic profiles may present with treatment needs as victims and perpetrators of IPV. Clinical activities of women in Forensic ID services should include possible IPV care needs. The importance of developing national guidance and interventions to prevent and manage IPV are discussed.

**Originality:** This is the first paper, to the author’s knowledge, to explore experiences of IPV in women with an ID and forensic care needs.

**Introduction and background**

Intimate Partner Violence (IPV) can be defined as, “cognitive, physical and emotional activities” (pge5. Loue, 2001) that either threaten or result in psychological, or physical harm between individuals engaged in an intimate adulthood relationship (Kornblit, 1994). IPV can manifest as psychological abuse, physical and sexual violence and financial exploitation. More recent definitions have also included; controlling, isolating, stalking, harassing, coercing and degrading behaviours (Krebs, et al., 2011).

The deleterious impact of IPV for victims can include physical injury, mental health disorders, and social and economic hardship. Studies suggest that depression, mood disorders, Post-Traumatic-Stress-Disorder (PTSD), substance misuse, low self-esteem, self-harming behaviours and suicide are common psychological consequences of IPV (Bacchus, et al., 2003; Bailey & Daugherty, 2007; Coker, 2007; Devries et al, 2013; Vincent & Jouriles, 2000). Moreover, prolonged exposure to IPV can also trigger neurodevelopmental changes including ‘rewiring’ of threat assessment and fear networks (Le Doux, 1996; Meloy, 1992; Malek et al, 2000; Monahan & O’Leary, 1999; Smith, Mills & Taliaferro, 2001; Wilbur et al, 2001). IPV is also associated with adverse physical health outcomes including permanent physical disability, cardiovascular, neurological, nervous, immune and gastrointestinal system disorders, musculoskeletal damage, poor sexual and reproductive health and pregnancy difficulties (Black, 2007).

Indirect victims of IPV, including children and family members who witness violence, can also experience enduring psychological and attachment disorders, care giver disruption, poor educational outcomes and physical health difficulties (Edelson, et al, 2007; Harvey et al, 2007; Krug et al, 2002; Ridley & Feldman, 2003). Children who witness IPV are more likely to become victims and/or perpetrators of IPV in their adulthood relationships, highlighting the intergenerational transmission and enduring impact of IPV.

IPV has considerable social and financial impact, with the cost of IPV in 2008 alone, being reported as £15.7 billion to the UK economy (Walby, 2009). This figure rose to £66 billion for England and Wales in 2016 / 17, with the costs for physical and emotional harm (£47,287m), health services (£2,333m), policing (£1,257m), legal proceedings (£336m) and lost output (£14,098m) incurring the highest impact (Oliver et al., 2019).

**Prevalence and impact of IPV**

International studies suggest that between 0.9% to 69% of women, who have ever engaged in an intimate relationship, have experienced sexual or physical IPV across the lifespan (Devries et al, 2013; Nerøien & Schei, 2008; Schumacher, Fals-Stewart & Leonard, 2005).

Studies in the UK suggest 28% of women and 14.7% of males have experienced IPV in their lifetime (Smith et al., 2008/09). The Office for National Statistics reports that 8.5% of the general female population and 4.5% of the general male population experienced IPV within the previous year, with an estimate of 1.4 million females, and 700,000 males experiencing IPV in 2013 -2014 (ONS: Office for National Statistics, 2015a). In the UK, it is estimated that approximately two female homicides occur every week in the context of IPV (ONS, 2015a, 2015b).

**IPV and Intellectual Disability (ID) populations**

Intimate relationships are important to people with an ID and in many respects mirror the relationships of people without an ID (Ward et al., 2010). This includes exposure to and engagement in IPV. Despite the failure of many large studies to differentiate between physical and intellectual disabilities in their samples, evidence suggests that having an ID significantly increases the risks of being a victim of and engaging in IPV (e.g. Capaldi et al., 2012; Rosen, 2006). UK studies and international studies suggest that women and girls with a disability may experience up to 40-50% higher exposure to being a victim of IPV (Brownridge 2006; Rosen, 2006), with up to 85% of women with a disability experiencing IPV during their lifetime (Feuerstein, 1997).

Women with an ID experience the range of IPV behaviours that are comparable to women without an ID. This includes being subject to psychological abuse, financial exploitation, physical assaults with weapons, sexual violence and rape, including during pregnancy (Bowen & Swift, 2017; McCarthy et al., 2017). Research also suggests women with an ID may have an increased risk of experiencing more subtle, more severe and prolonged exposure to IPV resulting in physical, sexual and psychological consequences than those without an ID (Ballan et al, 2014; Brownridge, 2006; Coker, et al., 2005; Du Mont & Forte, 2014; Focht-New et al., 2008; Lund, 2011). Similarly, males with an ID are also more likely to experience some forms of IPV, than males without an ID, in the form of stalking and psychological aggression (Breiding & Armour, 2015).

The increased vulnerability to victimisation is, perhaps, unsurprising as people with an ID experience a greater number of distal and proximal factors associated with an increased risk of victimisation for IPV in the non-ID literature. Specifically, people with an ID are more likely to be from a low socio-economic status group, to have a history of childhood maltreatment, have limited education opportunities and to report feeling bullied at school (e.g. Capaldi et al., 2012). They are also more likely to be unemployed or receiving benefits, to experience low social support and social bonding, report low self-esteem and to have mental health and attachment disorders (Capaldi et al., 2012).

Risk factors identified in the non-ID literature for increasing the risk of experiencing IPV have also been found in the small ID IPV literature. This includes, having a co-morbid mental health diagnosis, self-reporting inadequate ‘self-protection skills’, difficulties in reporting abuse, experiencing a traumatic childhood, witnessing their mothers as being victims of IPV and a lack of role-modelling of safe and healthy relationships (Douglas & Harpur, 2016; van Drielet al., 2011; Hoog, 2004; McCarthy, 2017).

Risk factors, intrinsic to the life experiences and social and cultural context of many people with an ID, also increase their risk of experiencing IPV (McCarthy et al., 2016). Namely, increased dependence upon their partner, higher levels of social isolation and poverty, greater difficulties in reporting abuse (Walter-Brice et al., 2012) and their perceived vulnerability by potential perpetrators, all contribute to chronically elevated risks of IPV in this population (Hassouneh-Phillips & Curry, 2002). Poorer levels of sexual knowledge and support from services have also been suggested to contribute to risks (Murphy et al., 2011). In addition, women with an ID may also be more willing to ‘accept’ abuse within relationships to achieve a sense of belonging and social value (Petska & Wendt, 2014) and to not report IPV (Bowen & Swift, 2017).

Adults with an ID also present with additional vulnerabilities to IPV associated with ‘cuckooing’ and ‘mate crime’, which have not been addressed within the wider non-ID IPV literature. ‘Cuckooing’ or ‘mate crime’ is a process where by an individual, whom the person with an ID believes they are in a [intimate] relationship with, or they are in the early stages of a relationship with, quickly move into their homes and assume control of their resources, home and life; and subsequently exploit and abuse them (Landman, 2014). Whist the underlying motivations of ‘cuckooing’, ‘mate crime’ and IPV may differ, there are key similarities and overlap between these different forms of abuse, especially in the behavioural manifestations, problems with reporting the crimes and their impact. In addition, McCarthy et al., (2017) report that the majority of men who perpetrated IPV against women with an ID in their qualitative study did not have an ID, suggesting a possible additional risk variable for women with an ID.

Studies also suggest people with an ID, may, due to their life experiences, be over representation in different categories of risk factors associated with perpetrating IPV. However, there is an absence of studies involving participants with ID to test risk factors for engaging in IPV found in people without an ID.

Research completed in the non-ID population suggests that childhood variables including low socio-economic status, early onset of behavioural difficulties, problems in school, feeling unsafe at school, exposure to IPV and child maltreatment in the home increase risk of engaging in IPV (Capaldi et al., 2012). Stewart & Power, (2014), in a Canadian study, also report that having a ‘learning disability’, the criteria of which was not defined, increased risk of engaging in IPV. It must be noted however that for 3,763 of their 4,261 sample, the ID status was ‘missing data’, which could have biased their results. In adulthood, being unemployed / receiving benefits, having mental health difficulties and aggressive behaviours are also important distal and proximal risk factors for engaging in IPV (Capaldi et al., 2012). By contrast, substance misuse, which is considered to be a key proximal risk factor in IPV in the non-ID population, is lower in ID populations (Capaldo et al., 2012; Chapman et al., 2012).

ID services in the UK are beginning to acknowledge IPV as a clinical need. In a recent UK study of community ID teams, Swift et al., (2018) reported that 19.4% of males referred to a forensic ID community team, and 2.5% of referrals to a community ID team, over a two year period, were in response to IPV. This suggests that IPV, as a clinical need, may be more prevalent within forensic services. This figure also suggests that one in four referrals to forensic services are for clinical needs of which there are no evidenced based treatment programmes. In addition, evidence also suggests that IPV in adults with an ID may be recorded as ‘challenging behaviour’, which can lead to an under-reporting of the clinical need (Lee & Carson, 2012). Both of the UK studies also only explored perpetration by males, and the clinical needs of women with an ID who experience and perpetrate IPV, including those within forensic services, is not known. Given the high number of risk variables for experiencing and perpetrating IPV this population present with, especially in forensic services, gaining an understanding of the clinical need for women with an ID is important.

**Aims of the current study**

The current study aimed to explore the prevalence and different types of self-reported relationship tactics (IPV) that were

1. Experienced in a detained female forensic ID population
2. Perpetrated in a detained female forensic ID population.
3. And to explore if there are differences in the levels of experienced and perpetrated IPV in a detained female forensic ID population.

**Methodology**

*Participants*

Participants were a convenience sample of adult females detained under the Mental Health Act (1983, amended 2007) to a secure specialist forensic ID service. This service provides specialist ID forensic care to working age adults who predominantly have mild learning disability and complex mental health disorders in the context of forensic care needs. At the time of the study, the female ID service consisted of one medium secure and one low secure unit, both with 14 beds on each.

Of the twenty eight-females detained, four were not approached to complete the CTS-2 due to their lack of capacity to consent to, and their ability to understand psychometric measures. Of the 24 approached, 16 agreed to complete the CTS-2. Reasons for non-completion were; no history of engaging in an intimate relationship (N=4), self-reported concern about their inability to tolerate the distress caused by the subject (*N*=3) and one participant did not give a reason for declining. One participant did not complete the CTS-2 as they had not previously engaged in an intimate relationship. Of the 16 participants who agreed to take part, two discontinued. One participant did not complete the CTS-2 as they had not previously engaged in an intimate relationship, and another participant discontinued the CTS-2 before completion. Discontinuation was due to problems of sustaining attention for the length of the questionnaire, rather than the content. The incomplete questionnaire was excluded from all analyses. This yielded a dataset of 14 participants.

**Table 1** illustrates that participants had a mean age of 28 years, and the most common developmental disorder diagnosis was a mild learning disability. Most participants were detained under Part III of the Mental Health Act (71%), indicating they had been subject to criminal proceedings. Most had co-morbid psychiatric diagnoses, mostly commonly Personality Disorder. Participants typically had three diagnoses in total, with four participants reporting four or five ICD-10 diagnoses.

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## *Measures*

The Conflict Tactics Scale -2 (CTS-2, Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to measure the presence of IPV in intimate relationships. It is a 78 item self-report questionnaire that asks if respondents have engaged in, or experienced, five different types of tactics used in relationships. ‘Negotiation’, the only ‘positive’ relationship tactic measured by the questionnaire, includes questions such as “My partner explained his or her side of a disagreement to me”. The CTS-2 has four ‘negative’ tactic scales. *Psychological abuse,* e.g. “My partner called me fat or ugly”. *Physical aggression,* e.g. “I slapped my partner.” *Sexual coercion,* e.g. “I used force (like hitting, holding down, or using a weapon) to make my partner have sex” and *Injury*, e.g. I felt physical pain that still hurt the next day because of a fight with my partner.”

Each of the five scales are split into a further two subscales; cognitive or emotional (for negotiation) and minor or severe for all other scales. For example, the ‘Injury’ subscale has ‘minor injury’ and ‘major injury’ subscales within it. Examples of ‘minor’ tactics include, “insulted or swore at my partner” (psychological abuse); “I punched or hit my partner with something that could hurt (Physical aggression); “I had a sprain, bruise, or small cut because of a fight with my partner (physical injury); “I slapped my partner (physical aggression) and “I insisted on sex when my partner did not want to (but did not

use physical force). Examples of major tactics include “I destroyed something that belonged to my partner” (psychological aggression); “I choked my partner” (physical aggression); “I had a broken bone from a fight with my partner (injury) and, “I used force (like hitting, holding down, or using a weapon) to make my partner have sex” (sexual coercion).

Questions on the CTS-2 are scored on a 0-7 likert scale that measures frequency of the experience. For the purpose of this study the scoring was recoded to a categorical response as people with an ID may struggle with understanding likert scales (Martley & McLean, 2006), especially longer likert scales (Fang et al., 2011). Participants were only asked if the behaviour had ever been present in any of their relationships. All responses to the questionnaire were therefore coded as categorical variables as either being present (“1”) or not present (“0”) for any previous intimate relationship. Subscales and scales are calculated by adding the scores together for the individual items within the scale.

*Demographic information*

## All demographic data relating to age, legal status, diagnoses, primary forensic need and intimate relationship status were recorded on a proforma developed for the study. Demographic data was collected from existing participant records.

## Procedure

Prior to completing the measure, informed consent was sought and recorded within participant files. Participants who lacked capacity to consent to the assessment did not complete the measure. Participants were aware they could approach nursing or psychology staff for support after the assessment if they were concerned or distressed by the measure.

The measure was administered by the registered psychologist or ST6 Psychiatry trainee who were members of the participant’s care team. Participants were given a copy of the CTS-2 and the psychologist / psychiatrist read the questions with the participant and recorded the responses. Participant understanding of questions and terms used was checked throughout the assessment and, where needed, terms were explained. Some participants reported difficulty with some of the terminology used around sexual behaviour and the terms oral and anal sex were explained to some participants during the interviews.

## Ethical considerations

The study was approved by the Clinical Effectiveness team within the organisation as a service evaluation project. The CTS-2 measure used in the study was routinely used within the ID service as a part of a wider battery of assessment measures.

**Data analysis**

Descriptive statistics report the prevalence of the different relationship tactics on the subscales of the CTS-2 for experienced and perpetrated IPV.

Data was entered into IBM Statistics SPSS 25. Statistical analysis was used to make within-subjects comparisons to explore if there were differences in the rates of experienced and perpetrated IPV. Tests of normality indicated the data was normally distributed and met the assumptions of parametric tests. Paired t-tests are reported to explore differences between experienced and perpetrated IPV in the sample.

# Results

**Relationship tactics experienced by females**

**Graph 1** illustrates that all participants reported experiencing positive ‘negotiating’ tactics in a previous relationship. All participants reported experiencing negative relationship tactics. The most common negative tactics reported were minor (100%), and major (64.3%) psychological abuse. Major psychological tactics identified by questions of the CTS-2 included being called a derogatory name, being threatened and having items destroyed.

Participants also reported that physical violence occurred in at least one previous intimate relationship with over three quarters of the sample reporting experiencing at least one ‘minor’ and 50% reporting at least one ‘serious’ assault. Serious assaults, identified on questions on the CTS-2 included being hit, kicked, and threatened with a weapon, choked and being slammed against a wall.

Seven (50%) participants reported experiencing physical injuries following IPV; and over a third (35.7%) reported receiving ‘severe’ injuries following an incident of IPV. Severe injuries identified on the CTS-2 questions included needing to see a doctor following an assault, needing medical treatment and passing out following an assault. Just under half the sample (42.8%) reported experiencing ‘minor’ sexual coercion; with over a third (35.7%) also reporting being subject to ‘severe’ sexual coercion. ‘Severe’ sexual coercion identified on the CTS-2 questions included being threatened and forced to engage in oral / penetrative sexual activities.

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**Graph 2** illustrates the total number of different negative relationship tactics experienced by participants reported in the subscales of the CTS-2 (eight sub-categories in total). The mean, mode and median average number of negative relationship tactics experienced by women was five. Two women reported experiencing all eight sub-categories of negative relationship tactics.

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**Relationship tactics perpetrated by females**

**Graph one** illustrates that most participants (85.7%) reported engaging in minor and severe (64.3%) and psychological abuse negative relationship tactics. Nearly two thirds of the sample (64.3%) reported engaging in minor assaults and 42.9% reporting engaging in severe assaults. Assaults resulted in minor (43.7%) or severe injuries (35.7%) to the victims. Two participants reported engaging in minor (14.3%) and severe (14.3%) sexual coercion tactics.

**Graph 2** illustrates that only one participant reported not engaging in any minor or severe negative relationship tactics. The mean average number of negative relationship tactics perpetrated by women was 4.7, with the median and mode being five.

**Comparison between experienced and perpetrated tactics by women**

There were no significant differences in the overall total CTS-2 score between experienced ($\overbar{x}$ = 14.71, SD 7.63) and perpetrated IPV in the sample ($\overbar{x}$ = 11.93, *SD* = 6.62), *t(13)=1.56*  *p=* .143.

A series of paired t*-*tests were carried out for all ten subscales of the CTS-2. No significant differences in the presence of experienced and perpetrated IPV were found for minor, severe and total scores for the negotiation, psychological tactics, physical assault and injury subscales on the CTS-2. A significant difference was found for minor sexual coercion only, with women being more likely to experience minor sexual coercion ($\overbar{x}$ = .64, SD = .84) than to perpetrate it ($\overbar{x}$ = .14, SD= .36), *t(13)=* -2.46, *p=* .029.

**Discussion**

The study found that all participants within a forensic ID service who had been involved in an intimate relationship, reported experiencing IPV; and 13 of the 14 reported perpetrating IPV. This could indicate possible bilateral patterns of psychological and physical aggression in intimate relationships. The relationship between experiencing and perpetrating sexual coercion was more complex. Participants reported comparable levels of engaging and perpetrating ‘major’ sexual coercion in relationships; and greater levels of experiencing than perpetrating ‘minor’ sexual violence.

The finding that a considerable number of participants experienced and perpetrated IPV is perhaps unsurprising given the atypical nature of the sample, who presented with a high number of risk variables for experiencing IPV. It is not possible to compare the findings for women with an ID perpetrating IPV due to the lack of other published studies using this population. The high figures for perpetration are also unsurprising as all participants had histories of physical violence that necessitated their detention under the MHA. A minority had previously engaged in sexual offending or sexually harmful behaviours that were not pursued through the courts. Research suggests that previous arrests for violence are reported in 16% of women later arrested for IPV (Shorey, 2014), suggesting that engaging in non-IPV related violence may be a risk factor for engaging in IPV in this population. The atypical nature of the population in this study suggests caution should be used in generalising the findings of this study as women with an ID detained in forensic services are arguably not representative of the wider female ID population.

The pattern of self-reported bilateral violence found in the current study supports a growing clinical picture of a complex relationship between female victimisation and perpetration of IPV. Whilst IPV has been characterised as gendered problem of females as victims of [male] violence, more recent studies suggest that there is gender symmetry in the rates of perpetrating IPV. However, research also suggests women inflict less severe injuries from IPV compared to men (Chapman & Gillespie, 2019).

**Relationship between Intellectual Disability and IPV**

At present, the relationship between ID and IPV is poorly understood. The range of risk factors for victimisation and perpetration of IPV experienced by the ID population would suggest multiple pathways to, and typologies of, IPV in this population. The complexity of which would likely require different treatment and management responses.

The high levels of reported perpetration in IPV in this study could lead to the simplistic and erroneous conclusion that women with an ID are pre disposed to engage in IPV. It is more likely that the elevated risk does not necessarily reflect having an *ID*, and is more likely to reflect the accumulative impact of negative early life experiences, mental health difficulties and social disadvantages experienced by this population (Capaldi et al., 2012). For example, adults with an ID in forensic services have been exposed to very high levels of developmental trauma, with nearly two thirds meeting criteria for Developmental Trauma Disorder (Morris, Shergill & Beber, 2019). Evidence suggests a strong relationship between IPV and early trauma, which may, in part, account for higher levels of IPV perpetration in this population, although this has not been empirically tested.

The current findings reinforce the vulnerability of some women with an ID to IPV and further questions the current culture of conceptualising IPV as an individual(s) problem and placing responsibility to the individual (victim) to manage (McCarthy et al., 2018). This approach arguably leaves people with an ID chronically vulnerable especially in the context of current limited safeguarding and NICE guidance for Domestic Violence and ID populations. Safeguarding is a key area of practice for healthcare professionals in this speciality (Jenkins & Davies, 2011). Safeguarding practice for intimate relationships is highly complex and requires balancing the competing demands of autonomy against the dependency and exploitation that can occur in relationships (Dixon and Robb, 2011). However, it has been argued that current clinical practice lacks the use of standardised processes, especially around risk, to support women with an ID in relationships (Dixon & Robb, 2016). The current findings illustrate the need to develop structured guidance and decision making to support people with an ID to have safer relationships.

NICE guidance for the management of Domestic Violence (Nice, 2014) outlines the responsibilities of services in the recognition and management of IPV, including referrals to specialist support services. Whilst NICE guidance suggests that adjustments should be made to services to ensure they can be accessed by people with an ID, they fail to acknowledge their status as a high risk population and to ensure their needs are considered. The omission of the needs of people with an ID in NICE guidance is a concern.

**The Conflict tactics scale**

The CTS-2 is the most widely used research and assessment tool in this area of practice. At present, there are no comparable validated alternative tools that assess perpetration, victimisation and injury from IPV in adult populations. It has strong and well established psychometric properties and has been successfully used with different populations (Chapman & Gillespie 2019). However, it has not been subject to validation studies for people with an ID. Whilst the CTS-2 offers some utility it also has a number of limitations. Firstly, the CTS-2 does not ask about the context, triggers or antecedents to violence, and thus does not differentiate between defensive and retaliatory aggression from instrumental or impulsive IPV. It also does not collect qualitative data about IPV experiences. The failure to do so means the context of violence and the relationship between bilateral IPV is poorly understood, limiting its ability to inform clinical management. The CTS-2 also only considers a limited number of types of IPV and omits more subtle forms of IPV such as rejecting, isolating, financial exploitation and stalking. It also does not address recent technologically facilitated forms of IPV such as ‘revenge pornography’, online harassment, the monitoring and controlling of mobile phones / social media and email, or the use of electronic tracking devices. It also focuses on IPV in a relationship and not post relationship, although evidence suggests women with an ID may be vulnerable to violence from their previous partner after relationships end (McCarthy et al., 2017).

The CTS-2 is also based on the assumptions that respondents are able to differentiate between platonic, exploitative and intimate relationships and requires a reasonable level of sexual knowledge. These assumptions could arguably limit the validity and reliability of the CTS-2, or similar tools, with the ID population. Future studies exploring IPV should consider establishing the respondent’s knowledge of relationships, to ensure the validity and reliability of findings. Overall, whilst the measure was, with support, accessible to the participants, the shortcomings of the CTS-2, in particular those specific to the ID population, would suggest an ID specific measure of IPV is needed.

Despite this, participants in the current study were able to complete the measure. Post-completion there was no evidence of distress or aggression in participants, indicating that exploring IPV was tolerated.

**Limitations**

The current study offered an initial assessment into the IPV experiences of a complex, atypical ID population who present with high levels of vulnerabilities from, as well as, risks to others. As an initial study there are number of shortcomings. The present study was based on self-report that was not substantiated by other sources and a measure of social desirability was not used to test for the accuracy of the responses to the CTS. Due to the limited collateral information available it was not possible to corroborate self-report. Despite this, disclosures of IPV were consistent with the respondents’ histories of aggressive behaviours. Furthermore, concerns about embellishment and concealment were not noted in professionals who administered the tools. Related to this, there were no formal measures to explore participant understanding of what an intimate relationship is, and their responses may have included previous incidents of exploitation outside of relationships. Recording IPV as a categorical variable prevented exploring the chronicity of IPV and could lead to (untested) assumptions of equivalence in the frequency and severity of experienced and perpetrated IPV. The study also did not record the gender(s) of the people that participants were in relationships with, which also limits our understanding of IPV in this population. Finally, as an initial exploratory study, using a small sample, information relating to risk or protective factors and the impact of IPV were not explored.

**Clinical implications and conclusions**

The current study provides an initial exploration into the experiences of IPV in women with an ID and forensic care needs. Findings suggest that integrating assessments and interventions for IPV into routine clinical activities is indicated. Given that IPV has higher rates of re-victimisation compared with other categories of crime (Kershaw et al., 2000a), the need to identify and support those at risk is a clinical priority, especially for those in forensic services. The current results, combined with a growing body of evidence suggests current NICE guidance for IPV should be revised to include the needs of people with an ID. Coupled with this, is the need to develop clinical programmes for people with an ID that support relationship rights and autonomy, whilst also ensuring support to prevent and manage IPV.

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**Table 1:** Demographic information for participants who completed the CTS-2, *N=*14

|  |  |
| --- | --- |
| Age | 28 years (20-50) *SD* 9.2 |
| MHA statusSection 3 MHASection 37Section 37/41 | 4 (29.%)6 (42%)4 (29%) |
| Primary Developmental Disorder DiagnosisMild Learning DisabilityASD | 12 (86%)2 (14%) |
| Primary Psychiatric DiagnosisEmotionally Unstable Personality DisorderPsychosisBipolar DisorderNo psychiatric diagnosis | 9 (65%)3 (21%)1 (7%)1 (7%) |
| Total number of ICD-10 Diagnoses | 2.94 (2-5) *SD.93* |
| Primary Forensic NeedViolence to othersArsonSexual Offending | 8 (57%)5 (36%)1 (7%) |

**Graph 1:** The percentage (%) of participant positively endorsing the presence of items for subscales on the CTS-2, *N*=14

**Graph 2:** Total number of different negative relationship tactics on the CTS-2 reported as being present by participants, *N*=14

Number of Participants