

# TO REPORT OR NOT TO REPORT

## Confidentiality Issues Regarding Sexual Abuse Concerning Victims and Perpetrators with Learning Disability

### Introduction

Sexual abuse of adults and children with learning disabilities has only recently become a recognised phenomenon yet it is likely to challenge the ethical procedures of professionals working in this field as it has with child care professionals. Indeed the challenge may be far greater than in areas of child protection as professionals have to address difficult issues around consent and the ability of victims to provide accurate disclosures.

Although the process of moral deliberation over issues relating to adults or children with learning disabilities is not new to learning disability professionals, many are not familiar with the ethical theories underlying decision making. The two main theories dominating the literature are utilitarianism; which considers the overall consequences of any decision that may be made and deontology; which refers to the moral duty of a professional to respect an individual's wishes (Barnitt, 1993). For example if a perpetrator of sexual abuse was to disclose the abuse to a therapist in confidence, the therapist must weigh up the need to respect therapeutic confidentiality (deontological), against the risk to the victim or other vulnerable persons of further abuse (utilitarian).

It is useful to introduce these two main theories into everyday clinical practise in order to provide a conceptual framework for difficult clinical decision making. The very

*nature of sexual abuse is such that it thrives on a mixture of confusion and poor communication between professional disciplines. With an increasing emphasis on accountability for risk taking and responsibility for the overall protection of vulnerable persons, professionals need to have a firm grasp of the ethical issues arising in this field and demonstrate an ability to have reflected on the process of moral deliberation.*

### Confidentiality - A Tradition in Transition.

Although the law is said to respect and protect the confidentiality of the doctor-patient and lawyer-client relationship, it does not so readily apply this to social workers, psychologists and other agencies including those working with adults or children with learning disabilities who have been sexually abused. The Children Act clearly states that the duty of all agencies working in child protection is to share and exchange relevant information related to a child perceived to be at risk. Despite clarification of the differing statutory responsibilities for professionals carrying out child protection work, the Children Act has not resolved some of the difficult day to day dilemmas faced by professionals who are trying to work together yet have different clinical and statutory responsibilities. At a conference convened

by the Social Services Inspectorate in March 1994 on the prevention and treatment of sexual abuse of people with learning disabilities, recognition was given to these difficulties. The document proposed that professionals should share **common** professional codes of conduct to overcome potential discrepancies between disciplines (ARC and NAPSACC, 1996).

At present there are no national guidelines available for professionals working with adults who have been abused. The Law Commission has explored this issue in their report "Mentally Incapacitated and Other Vulnerable Adults - Public Law Protection" and proposed adopting a similar framework to that devised for child protection under the Children Act. It recommends that social services act as the responsible authority to lead investigation of allegations of abuse. Inter-agency co-ordination could be greatly enhanced by the setting up of local Adult Protection Committees. This would comprise of a multiprofessional expert panel that could create a forum for development, planning and dissemination of information as well as offering specialist advice to agencies (ARC and NAPSACC 1993). National guidelines are, however, clearly required in order to avoid different practises developing throughout Britain.

### **Learning From Past Mistakes?**

Learning Disability professionals working with sexual abuse need to take heed of the lessons to be learnt from past ethical dilemmas concerning clinical confidentiality. In 1976 the California Supreme Court ruling following the

Tarasoff case created an enormous stir in the United States after the mandate placed civil responsibilities on therapists to take due steps to warn third parties of a client's potential dangerousness. The mandate emerged after a young male student revealed his violent, jealous feelings towards a fellow female student to his therapist. The therapist duly informed the police who subsequently detained the man only to release him later after his denial of intent. The patient broke off treatment with his therapist and two months later murdered the student. The University was then sued by the victim's parents for failure to warn them of the man's dangerousness. The family lost the suit but won on appeal grounds that therapists have a duty to warn potential victims (Gunn and Taylor, 1993). Although much of the resultant outcry related to breaching therapeutic confidentiality, therapists also objected to the mandate because of additional concern over the difficulty of accurately predicting dangerousness. It was anticipated that fear of civil liability would lead to over reporting and widespread disruption of the therapeutic process.

Parallels can be drawn between the Tarasoff mandate and mandatory sexual abuse reporting laws. It is difficult to determine the degree of risk to a victim of sexual abuse, yet protective legislation (especially where children are concerned) is often rigid with limited room for clinical flexibility. Furthermore, therapeutic options for both the victim and perpetrator after protective legislation has been implemented, are often limited. Although child legislation in Britain is not quite so severe we must be careful that the effect of the recommendations arriving from the

*Cleveland and Orkney Island inquiries is not a restriction of clinical flexibility and allows room for therapeutic interventions to be offered to all parties concerned.*

*With the increasing awareness of the sexual abuse of adult and child victims with learning disabilities it seems vital that we do not extrapolate the mistakes made in child protection to this group of vulnerable persons. In cases where the suspected abuse may be borderline e.g. the alleged perpetrator has moderate learning disabilities and has previously had a physical relationship with the victim whose consent is ambiguous, it may be difficult to assess the degree of abuse and ongoing risk. In such circumstances it is essential for the professionals involved in the case to work together in the sharing of appropriate information and respond to each case individually and not merely apply rigid statutory rules for fear of being deemed clinically negligent. Indeed the Law Commission examined the issue of mandatory reporting of suspected abuse of vulnerable adults and concluded that there was little place for it in the law of England and Wales.*

### **Confidentiality Issues For The Victim And The Perpetrator**

*Where there is reasonable belief to suspect that sexual abuse of a child or adult with a learning disability has occurred, full confidentiality cannot be maintained with the victim. This should not exclude the individual from a right to any confidentiality. Although it is important to avoid mirroring previous collusion around the abuse over secrets that are clearly*

*harmful to the victim, disclosure of confidential material by the therapist should be kept to a minimum and only occur where essential. Where possible the victims should be encouraged to report the abuse themselves or at least give permission for the therapist to do so (Babiker, 1993). The victim should be carefully informed in a manner that is understandable, (preferably at the beginning of any therapeutic work), of the therapist's inability to fully maintain confidentiality in certain situations i.e. when a vulnerable person might be significantly at risk. The use of pictorial images could be a useful tool to explain the necessary sequence of events following a disclosure with individuals who find verbal comprehension difficult. It may be important to allow a period of time for clinical reflection before a decision can be made as to whether to report.*

*Until recently very little was known about the characteristics of perpetrators who sexually abuse people with learning disabilities. Turk and Brown's study (1992) showed that 42% of alleged perpetrators in their sample also had a learning disability. This has significant implications when addressing the needs of the perpetrator. Admittedly there are difficulties in generalising about a group which is likely to be heterogeneous with a wide range of learning disabilities and each case must be taken on its own merit. However, the likelihood will be that a perpetrator with learning disabilities lacks appropriate ways of expressing his own sexuality. He may have had negative early sexual experiences and even himself been sexually abused (Clare, 1993). Sex offenders with learning disabilities have*

often received inconsistent and unclear messages concerning acceptable sexual behaviour. Hayes (1991) suggests that there is often a tendency for sexually offending behaviour to be initially minimised until an individual's tolerance e.g. a member of the public, is exceeded by repeated offending and the offender is subsequently dealt punitively by the carers, hospital or courts. Such inconsistency by staff, carers and agencies is in itself cruel and potentially abusive.

However, failure to report clearly abusive behaviour may be out of fear that the perpetrator will be harshly punished by a penal sentence. In reality this is unlikely as it goes against Home Office policy that convicted offenders with learning disabilities should not receive custodial sentences unless unavoidable. Reporting of suspected sexually abusive behaviour by staff might, however, happen in a more consistent manner if therapeutic options for the perpetrator with learning disabilities were more readily available. Although probation orders and admissions to hospital may be implemented in an attempt to contain difficult sexual behaviour, they are not necessarily therapeutic.

Confidentiality for the perpetrator inevitably cannot be maintained particularly if there is a risk of the individual re-offending. The individual concerned must be made aware of this around disclosure and before entering any kind of therapeutic treatment. Breaching confidentiality is often assumed to be against the therapeutic interests of the perpetrator. In reality it is unlikely to be so providing the therapist or professional is clear about his/her overall responsibilities. More relevant is the manner in which such

sensitive material is processed and which professionals need to know. Close liaison between staff that work on a day to day basis with the perpetrator and professionals who are providing therapeutic intervention for the individual is important in order to prevent confusion and misunderstandings developing. Staff that lack training and feel unsupported are often fearful of professional negligence. Allington (1992) showed that 88% of day care staff from Local and Health Authority services in their survey felt that further training on sexual abuse should be made available in their work settings. In such circumstances staff are more likely to over-report and over-react to clinical situations that require a minimal degree of risk taking. This can create unnecessary tension and anxiety in situations that really require common sense.

## **Countertransference Issues and Disclosure**

The countertransference can strongly influence the desire to breach or protect confidentiality of the client be he/she a victim or perpetrator. This acts at a personal level and can be very powerful. The therapist - client relationship may be in danger of mirroring the abuse dynamics unless the therapist is prepared to actively acknowledge and deal with difficult and intense emotional responses that sexual abuse can evoke. Betrayal of trust and collusion are both major themes in sexual abuse. Babiker (1993) therefore suggests that specialist supervision is required to contain the intense transference and countertransference issues that develop

between the client and therapist. He emphasises the importance of separating specialist supervision from day to day supervision of clinical work.

Furthermore therapists rarely consider that their working with other agencies may create a systemic countertransference. Several papers have highlighted the negative effect of this and how these can mimic the dynamics within the family where abuse has occurred and with whom they are working (Dale et. al., 1983; Furniss, 1983; Pollack and Levy, 1989). Indeed there may be a reluctance to report suspected abuse to social services out of general mistrust. (MacPherson and Babiker, 1994). There appears to be an unspoken belief by some professionals that the statutory legalisation implemented to protect the victim and others is more a legal solution than a moral one.

Inter and intra-agency conflict can only be prevented if multidisciplinary teams who are working in this field are prepared to spend time exploring the countertransference issues. There appears to be a much needed role for expert supervision provided by trained psychotherapists not only within professional agencies but also between agencies.

## Conclusion

Sexual abuse of individuals with learning disabilities is a highly traumatic experience which thrives on a mixture of secrecy, collusion and denial. It is important for professionals to find a middle way when intervening which respects a limited degree of confidentiality for all individuals concerned whilst maintaining

good interdisciplinary co-operation and communication. Professionals need to have a firm grasp of their clinical and statutory responsibilities and these should be drawn from national procedural guidelines.

Comprehensive treatment options for victims and perpetrators who have learning disabilities need to be made available alongside protective legislation. This would help dispel the fear amongst staff that an alleged perpetrator would only be dealt with in a punitive manner if suspected abuse was reported. Exploration of co-ordinated multi-agency treatment protocols would allow a more efficient pooling of resources between Health, Social and Probation services and encourage closer working together between different professional groups. It would also help to dispel any pre-existing mistrust between professionals.

There is a clear need for staff training both at a carer level and also at a more senior professional level. Adequate interdisciplinary training and expert supervision needs to happen in practise and not just paid lip service.

## Summary

Sexual abuse of individuals with learning disabilities resembles child sexual abuse in that it thrives on a mixture of secrecy, collusion and denial. There are lessons to be learned from past mistakes, in particular the recommendations that arose out of the Cleveland and Orkney Island inquiries. There is a need for clinical flexibility that allows room for therapeutic interventions to be offered to all parties concerned. It is important for professionals

to find a balance when intervening which respects a limited degree of confidentiality for all individuals concerned whilst maintaining good interdisciplinary co-operation and communication. In order for professionals to do so, they will need to have a firm grasp of their clinical and statutory responsibilities. Ideally these should be drawn from national procedural guidelines.

Exploration of ways in which different agencies might work effectively together would allow a more efficient pooling of resources between Health, Social and Probation services. Furthermore such exploration might help to dispel any pre-existing mistrust between professionals working for different agencies.

At a day to day clinical level there is a clear need for staff training which should be tailored according to the professional's needs. Adequate interdisciplinary training should include expert supervision which will address the sensitive and complex dynamics that occur around sexual abuse.

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## References

- Allington, C. (1992) Sexual abuse within the services for people with learning disabilities. *Mental Handicap*, 20, 59-63.
- ARC and NAPSACC (1993) "It could never happen here." *The prevention and treatment of sexual abuse of adults with learning disabilities in residential settings*. 15-22. Further revised with assistance from the Social Services Inspectorate (1996). Chesterfield and Nottingham.
- Babiker, I. (1993) Managing sexual abuse disclosure by adult psychiatric patients-some suggestions. *Psychiatric Bulletin* 17, 286-288.
- Barnitt, R. (1993) What gives you sleepless nights? Ethical practice in occupational therapy. *British Journal of Occupational Therapy* 56, 207-212.
- Clare, I. (1993) Issues in the assessment and treatment of male sex offenders with mild learning disabilities. *Sexual and Marital Therapy* 8, 167-180.
- Dale, P., Waters, J., Davies, M., Roberts, W. and Morrison, T. (1986) The towers of silence: creative and destructive issues for therapeutic teams dealing with sexual abuse. *Journal of Family Therapy*. 8, 1-25.
- Furniss T. (1983) Mutual influence and interlocking professional-family process in the treatment of child sexual abuse and incest. *Child Abuse and Neglect* 7, 207-223.
- Gunn, J. and Taylor, P.J. (1993) Ethics in Forensic Psychiatry. In: Gunn, J. and Taylor, P.J. (Eds.). *Forensic Psychiatry. Clinical, Legal and Ethical Issues*. 857-884. Oxford: Butterworth/Heinemann.
- Hayes, S. (1991) Sex offenders. *Australian and New Zealand Journal of Developmental Disabilities*. 17, 221-227.
- Law Commission Consultation Paper No. 130. Mentally incapacitated and other vulnerable adults. *Public Law Protection*. HMSO 29-40.
- MacPherson, R. and Babiker, I. (1994) Who works with adult victims of childhood sexual abuse? *Psychiatric Bulletin* 18, 70-72.
- Pollack, J. and Levy, S. (1989) Countertransference and failure to report child abuse and neglect. *Child Abuse and Neglect*. 13, 515-522.

**Turk, V. and Brown, H. (1992) Sexual abuse and adults with learning disabilities. *Mental Handicap*. 20, 56-58.**