

Memory, sexual abuse and the politics of learning disability

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[p.157]**Introduction**

Evening falls. In a neat house in a pleasant neighbourhood an elderly woman prepares for bed. As she changes into her nightdress and picks out fresh clothes for the morning, her demeanour changes. She begins to mutter, then shout. Her words are sometimes muffled, but include a man's name, followed by a string of self-directed obscenities, "You slag; you bitch; you dirty whore; you fucking cunt", repeated over and over. As the litany continues she begins to hit out – striking walls, furniture and herself with equal ferocity. She punches her face with clenched fist, leaving bruises. As her voice rises higher, the bedroom door opens. A younger woman appears and stands in the doorway urging the older woman to quieten down and to come downstairs – to watch TV, drink cocoa, anything that will take her away from her memories and bring her back to the present. After a few minutes the older woman becomes calmer and does indeed come downstairs, joining the other residents and staff. But the same pattern is repeated night after night.

This is a description of 'Mary' one of the many people with learning disabilities with whom the first author worked during almost ten years as a support worker/residential social worker in group homes for adults with learning disabilities. Mary had previously lived for decades in a long-stay 'mental handicap' hospital, where it was believed that she had been serially sexually abused. Her night time terrors often included reference to the same man, although the hospital denied that they had ever employed anyone of that name. It was never possible to 'prove' that Mary had been sexually abused, but no-one who knew her well ever doubted that she had been. Since leaving hospital and moving 'into the community' considerable care had been taken to

support Mary in many ways: support to learn self-care skills, support to participate in domestic chores such as cooking, cleaning and shopping, support to attend adult education classes and to participate in leisure activities. But there was *no* effective support to help with the burden of her past, to help her find a way of coping which did not involve self-harm. It was not that the staff were uncaring, they were not, but neither did they have [p.158] the skills necessary to offer the kind of support which Mary needed. Moreover, because of her learning disability, the ‘true’ facts of her history remained unclear. Mary’s only known relative was an elderly brother, with whom she had limited and infrequent contact. In many ways, other than the behavioural evidence of her abuse, Mary had no history – nobody to share her memories, good or bad, of her years in hospital; nobody who could ever know – let alone begin to understand – how the story of her life had been shaped.

Elements of Mary’s experiences are typical of those of many people with learning disabilities. We will refer to her story throughout this chapter as we investigate the links between sexual abuse, memory and powerlessness in the lives of people with learning disabilities. Whether or not they have lived in institutional settings, people with learning disabilities are more likely than other children or adults to experience abuse of all kinds, including sexual abuse. At the same time, they are less likely to have their abusive experiences understood, believed or externally ‘validated’ in any way. Moreover, their own capacity to remember and make sense of histories of abuse is limited. This chapter will explore the reasons why memory in general, and memories of sexual abuse in particular, is problematic for people with learning disabilities. We will set out what is currently known about the sexual abuse of people with learning disabilities and relate this to the social and political circumstances in

which most people with learning disabilities live. We use the term ‘political’ here to denote that the circumstances of this group of people have not been arrived at by chance, but are contingent upon particular social policies, laws and service provision.

Defining learning disability; exploring power relations

Learning disability is notoriously difficult to define with any degree of precision and, as a group, people with learning disabilities are extremely heterogeneous. They range from individuals who show no visible outward sign of disability, but whose limited cognitive abilities nevertheless restrict their educational achievement and social engagement, through to people with multiple physical and cognitive impairments who are unable to survive without 24-hour care. Between these two extremes are people whom the general public might recognise as typical of the ‘mentally handicapped’ – for example, people with Down’s syndrome. The confusions arising from this heterogeneity are further compounded by rapid changes in nomenclature which, in recent years have embraced and/or discarded terms including mental handicap, mental retardation, developmental disability and intellectual disability. Medical definitions of learning disability remain influential (e.g. Gillberg & Soderstrom, 2003) but standardised tests of intelligence quotient (IQ) are no longer regarded as a definitive diagnostic tool. Similarly, genetic causes can only be identified for a small proportion of people with learning disabilities. In the UK, the Department of Health offers the following definition, which has received general acceptance within services: [p.159]

Learning disability includes the presence of: a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development. (Department of Health, 2001, p. 14)

This definition is broad enough to encompass people with learning disabilities with a wide spectrum of abilities ranging from relatively minor difficulties with abstract concepts and social norms of behaviour through to almost complete dependency on others. An alternative definition might therefore describe people with learning disabilities as individuals who are unable to live their lives without the ongoing assistance of family members and/or support services. In practice, it has been argued, this has created a *de facto* definition of learning disability as being any people who use specialist learning disability services (Simons, 2000).

These two ways of defining people with learning disabilities conceptualise their difference from other people by comparing their characteristics (intelligence; social functioning) to those of the general population or to the (ever-changing) eligibility criteria of public services. Neither adequately locates people with learning disabilities within the context of their ongoing individual and collective powerlessness, a powerlessness which is unthinkingly replicated by the definitions themselves – the first because it is a deficit model (it defines people by what they cannot do, rather than what they are or can do), the second because being defined in relation to public service provision would be unthinkable for almost any other group (imagine defining women as ‘people who are eligible to receive gynaecology services’). Whilst

thorough immersion in the debates surrounding the definition of 'learning disability' is beyond the scope (and unnecessary to the purpose) of this chapter, it is nevertheless worth emphasising that our understanding of learning disability accords broadly with Hughes & Patterson's (1997) proposed extension to the social model of disability. Hughes and Patterson argue that the social model can be extended to include embodiment by developing a 'sociology of impairment' which, instead of implicitly ceding the body and its abilities to medicine and biology, investigates the ways in which impairment itself is socially produced. In what follows we make the related argument that, with respect to memory, social and material conditions actually help constitute (rather than merely contextualise) learning disabled people's difficulties in remembering sexual abuse.

In terms of people's lived experience, the presence of a learning disability places individuals at the social, economic and geographic margins of society. Mild and moderate learning disabilities are associated with poverty and are more prevalent in deprived urban areas (Department of Health, 2001). More severe or profound learning disabilities are evenly distributed across socio-economic groups, but are associated with other disadvantages, including [p.160] physical or sensory impairments and communication difficulties. Although there now exist substantial bodies of academic work concerning the individual or collective memories and histories of other socially and economically disadvantaged groups (e.g. working class people, women, people from black and minority ethnic communities) little has been written which systematically explores the disempowerment of people with learning disabilities. In fact, it is symptomatic of their disempowerment that people with learning disabilities have almost no historical voice, leading Ryan & Thomas (1987, p.85) to comment

that “What history they do have is not so much theirs as the history of others acting either on their behalf or against them”. It is only recently that attempts have begun to be made to explore the individual and shared histories of people with learning disabilities *from their perspective* (Atkinson & Walmsley, 1999). Such work is important in broadening our understanding of people’s lived experience, but may be of limited value to people with learning disabilities who are not themselves directly involved, since few have the literacy skills required to read the autobiographical accounts of others. If used to educate support staff such accounts could support collective remembering, but few services are designed to allow time for this kind of activity. Moreover, the rapid turnover of (low-paid) staff ensures that reminiscence work is sidelined and individual histories are limited to the duration of employment of the longest-serving staff member. This, then, is a group of people for whom history and remembering has been afforded little value. Notably, in the context of this chapter, although there are a number of academic studies which have looked at short-term memory in people with various degrees of learning disability, there is no corresponding body of literature examining their abilities or difficulties in relation to autobiographical memory.

We would argue that, over and above the impact of their cognitive impairments, individual abilities to remember have further been impeded by the manner in which most people with learning disabilities live out their lives. Historically, people like Mary were often placed in hospital from a young age. Such hospitals were usually found in the countryside on the edge of large conurbations and their locations ensured that only limited contact with the outside world was possible. Male and female ‘patients’ lived on segregated wards in dehumanising conditions: people were allowed

few, if any, personal possessions – for example, clothes were provided from central stores rather than owned by individuals (May, 1994). These ‘total institutions’ provided the perfect environment in which abuse of all kinds could flourish, to the extent that acts which the outside world would construe as abusive interactions between individuals could come to be regarded not merely as commonplace but as part of the normative fabric of life (Goffman, 1968).

In the UK, the preferred model of service provision for people with learning disabilities has changed radically in the past half century, driven to a considerable extent by responses to abuse inquiries (Fyson, Kitson, & Corbett, 2004). Nowadays adults with learning disabilities who live outside the family home [p.161] typically live in residential care homes or supported living services. However, the manner in which this change in provision was brought about is telling. Since 1969, more than 58,000 beds in ‘mental handicap’ hospitals have been closed and the former patients have been relocated ‘into the community’ (Department of Health, 2001). During the resettlement process, however, managerial and financial considerations often took precedence over individual wishes (Wing, 1989). For Mary and others this typically meant being separated from longstanding friendships groups and returned to the care of the local authority from which they had first been admitted to hospital, regardless of whether or not they still had any social or familial ties to the area.

Unlike the hospitals they replaced, current services generally purport to place great emphasis on supporting choice and independence for service users: indeed, they are required to do so (Department of Health, 2001). People living in such services are generally encouraged to make ‘choices’ about what to eat, what to wear, or whether or

not to engage in a particular activity. However, it remains the case that few people with learning disabilities are given a say in the bigger choices which frame their lives – such as where and with whom to live, or from whom they receive support (Fyson, Tarleton, & Ward, 2007; Gorfin & McGlaughlin, 2003). Moreover, recent public inquiries have continued to demonstrate that, regardless of the size or organisational structure of the service in which they are supported, people with learning disabilities continue to suffer serious, and often systematic, abuse (Commission for Social Care Inspection & Healthcare Commission, 2006 & 2007). The disempowerment and abuse of people with learning disabilities can therefore be seen to be something more enduring than service structures and it is naïve to assume that younger people in ‘modern’ services are necessarily less vulnerable than hospital residents (Fyson & Kitson, 2007).

In attempting to define learning disability within the context of power relations, and to relate this to vulnerability to abuse, it is also important to recognise the prevailing discourses which link disability and sexuality. Two powerful yet contradictory discourses dominate understandings of the sexuality of people with disabilities in general, and people with learning disabilities in particular (Brown, 1994; Craft, 1987; Priestly, 2003; Ryan & Thomas, 1987). The first discourse constructs adults with learning disabilities as asexual ‘eternal children’ who should be protected from sexual knowledge and prevented from engaging in sexual activity of any kind. This discourse can be traced back to early Christian beliefs about disabled children being ‘holy innocents’ or ‘gifts from God’ (Ryan & Thomas, 1987). It remains influential amongst some parents and carers, who erroneously believe that sexual ignorance can protect from sexual abuse. The second, equally enduring, discourse suggests the

complete opposite and constructs people with learning disabilities as possessors of vast and unnatural sexual appetites, which must be suppressed. This idea was central to the eugenics movement, which flourished in the UK and elsewhere until after the Second World [p.162] War, and which actively campaigned to ensure the segregation of the ‘feeble-minded’ and ‘moral defectives’ from the rest of society. One earlier effect of this discourse was to facilitate the creation and maintenance of long stay ‘mental handicap’ hospitals. Its ongoing legacy can be seen not only in the continuing social segregation of people with learning disabilities (Forrester-Jones et al., 2006) but also in hate crimes against people with learning disabilities – for example the recent case in which a man was tortured and killed after being falsely accused by his tormentors of being a paedophile (Morris, 2007).

Sexual abuse in the lives of people with learning disabilities

Research now demonstrates beyond reasonable doubt that disabled children, including those with learning disabilities, are not only more likely to be abused than their non-disabled peers (NSPCC, 2003; Sullivan & Knutson, 1998, 2000; Westcott & Jones, 1999) but that their abuse is typically of longer duration (Westcott & Jones, 1999). Moreover, even after abuse is disclosed, statutory social services are less likely to intervene decisively or to offer therapeutic support (Cooke, 2000; Cooke & Standen, 2002). Indeed, the fact that disabled children are at greater risk of abuse is so well-established that it is now incorporated into UK child protection guidelines (HM Government, 2006). Studies which specifically identify the risk of sexual abuse for children with learning disabilities are less common, but Sobsey (1994) provides

evidence of childhood sexual abuse prevalence rates amongst children with learning disabilities ranging from 39% - 68% for girls and 16% - 32% for boys, depending on the definition of sexual abuse and the sampling method used. More recently, in the UK, Balogh et al (2001) reported on sexual abuse amongst a sample of children and adolescents with learning disabilities admitted to a psychiatric in-patient facility, finding that 37 out of 43 had been sexually abused.

However, unlike most other groups of people, vulnerability to sexual abuse for people with learning disabilities does not diminish once they enter adulthood (Brown & Turk, 1994). Studies of adults with learning disabilities continue to show a high levels of sexual abuse, with prevalence rates ranging from 61% for women and 25% for men (McCarthy & Thompson, 1997) to 83% for women and 32% for men (Sobsey, 1994). Other studies, which have explored the characteristics of victim, offender and offence in cases of sexual abuse of adults with learning disabilities, confirm that both women and men with learning disabilities are at higher risk than those in the general population (Brown, Stein, & Turk, 1995; Sobsey, 1994); that the perpetrators of this abuse are most often men with learning disabilities, male family members, or paid staff (Brown et al., 1995; McCarthy, 1993; McCarthy & Thompson, 1997; O'Callaghan, Murphy, & Clare, 2003); and that severity of disability does not – as once believed – serve as a protective factor (O'Callaghan et al., 2003).[p.163]

Given the extent of their individual and collective disempowerment it is unsurprising that both children and adults with learning disabilities are subject to high levels of sexual abuse. As has been demonstrated, this vulnerability is created by a confluence of social and political factors. However, it is also further compounded by the nature of

learning disability itself and the range of impairments with which it is commonly associated – including physical or sensory impairments and communication difficulties in addition to the intrinsic cognitive impairment. For example, a person with significant physical disabilities may quite literally be unable to escape their abuser, communication difficulties may prevent direct disclosure, and the need for help with intimate personal care may blur the boundary between caring and abusive touch (Cambridge & Carnaby, 2000). The last point is particularly important, not least because it is sometimes argued that the physical and sexual abuse of people with learning disabilities is unimportant because they do not know that they are being abused.

Whilst may indeed be true that some people with learning disabilities remain unaware of the wider social context of their experiences, this does not mean that their experiences are not damaging. For example, in her description of the sexual experiences of women with learning disabilities, McCarthy (1993) notes that:

... they are largely unaware that things could be, and often are, very different for other women. Most people with learning disabilities find it very difficult to imagine how other people experience sex: people with learning disabilities generally find it hard to think in the abstract and have few avenues for finding out anything concrete about other people's sex lives. (p. 281)

She goes on to say that:

This abuse by men with learning difficulties, with whom the women are often in close daily contact, is not usually perceived by the women themselves as abusive, but rather as ‘normal’ sex. (ibid, p. 283)

So abuse is not homogenous, and those forcibly excluded from normative societal understandings may well fail to recognise their abuse as such when it is not accompanied by overt coercion, violence or pain. For such individuals, it may even be that ignorance of social norms partially insulates them from the shame, fear and anger typically experienced by non-disabled victims of sexual abuse. However, this certainly does not happen in all cases and there is compelling evidence that many people with learning disabilities, including those with severe and profound disabilities (who are unlikely to have concepts of ‘abuse’) respond to sexual abuse in much the same way as other people [p.164] (O’Callaghan et al., 2003; Sequeira & Hollins, 2003; Sequeira, Howlin, & Hollins, 2003). Indeed, the fact that some people who display symptoms of severe distress may be intellectually ‘unaware’ that they have been sexually abused may be indicative of the extent to which people with learning disabilities are already set apart from the rest of society. Amongst other influences, this separation is both mirrored, and partially created, by wider social and politico-legal structures. For example, in the UK prior to 2003 (when a new Sexual Offences Act was placed on statute) it was not legally possible for a woman with severe learning disabilities to be raped – her attacker could only be charged with the ‘lesser’ crime of “sex with a defective” (Gunn, 1996).

One effect of the high prevalence of childhood sexual abuse amongst people with learning disabilities is that many people will carry personal histories of abuse into

their adult years. For those who are unable to communicate verbally, or whose experiences are not believed or supported, memories of abuse may become externalised in ways that services regard as inappropriate. This could range from public masturbation to violent outbursts, or self harm like Mary's - all of which are likely to result in the individual concerned being labelled as having 'challenging behaviours'. Given what is now known about the links between childhood abuse and adult mental health problems (Read, van Os, Morrison, & Ross, 2005) this may be one of the many reasons for the higher prevalence of psychiatric diagnoses and 'challenging behaviours' amongst adults with learning disabilities. Recent literature on the impact of trauma in the lives of people with learning disabilities (Mitchell, Clegg, & Furniss, 2006; Sequeira & Hollins, 2003; Sequeira et al., 2003) supports this hypothesis, which stands in stark contrast to the behaviourist approaches commonly adopted within many learning disability services in response to such outward signs of distress.

Memory and abuse in people with learning disabilities

Having established that sexual abuse is more common amongst people with learning disabilities than in other sectors of the population, we will now discuss some of the ways in which its recall may be more troublesome. Our discussion will show how the social and political influences upon the lives of people with learning disabilities that we have described are not merely contextual. Rather, these influences supply many of the mediating and facilitating factors by which memories of abuse are constituted. This is because they influence the availability and organisation of the various artefacts

and practices by which such remembering is mediated and enabled. Our focus is not on some abstract notion of ‘pure’ remembering: rather, we are concerned with the kinds of remembering and forgetting that are actually, practically possible for people with learning disabilities in the social and material conditions of their lives.

Our discussion borrows concepts and analytic frames from the analyses of remembering and forgetting in Middleton & Brown (2005), who offer a range of strategies that make memory tractable from a social perspective. [p.165] Middleton and Brown draw upon authors including Deleuze and Guattari, Serres, Derrida and Latour; for example, they utilise notions of translation, mediation and ‘punctualisation’ to characterise the ways in which selected aspects of experience get collectively packaged, in networks of actors and objects, and made available as joint, composite memories. However, the core of their analytic frame is derived from the creative tension they set up between the work of Halbwachs and Bergson. Rejecting the troubling ‘container’ metaphors of memory frequently found in cognitive psychology, they follow Bergson (e.g. 1908, 1922) in postulating a notion of memory as ‘always on’, such that the past is continually both ‘swelling’ and ‘gnawing into the present’. Bergson’s is a process philosophy within which memory equates to ‘duration’ or the lived time of life (as opposed to the clock or calendar time of science and bureaucracy). Experience consists of perceptions or images ‘thickened’ by habit memories carried in the body, interspersed with recollection memories. These recollection memories are action-oriented ‘actualisations’ of the past, called out in the present in the service of a specific activity. They are extracted from the totality of prior experience, which therefore remains ‘virtual’ but nevertheless always potentially accessible – but in the process of extraction they get more-or-less subtly transformed,

in line with the exigencies of present activity, Remembering, then, involves the actualisation or somewhat artificial ‘cutting out’ of aspects of prior experience, and their simultaneous reinsertion into the present. It is these processes of cutting out and reinsertion that transform the flow of experience from a ceaseless instantaneity, an eternal present, into a succession of sensible, graspable moments: in other words, it is memory that creates the lived time of duration.

In order to better understand how remembering is concretely achieved as the cutting out of aspects of experience, Middleton and Brown turn to Halbwachs (1925, 1950), whose sociological analyses of memory emphasised the importance of collective frameworks and the mediation of artefacts, bodily gestures and divisions of space. Halbwachs describes the sensitive interdependency of personal and collective memory, showing how what we might take to be entirely private memories – for example, recollections of a dream – are organised and bound up with familial, relational and social concerns and hence are already collective at the same time as they are also personal. This is not to claim that the personal is simply identical to the collective, but rather to recognise that what we recognise as individual or personal is in fact a ‘prior mode of sociality’ that is already dependent upon and produced through the collective. People use collective frameworks – images of the past that are organised by its social relations – to lend substance and form to their memories. These frameworks are ‘localised’: rehearsed, and worked up jointly through the mediation of language, objects and spaces to provide the ‘common sense mentality’ of a group. Collective frameworks, then, are neither abstract nor individual, but are sustained by the complicated, mediated relations between humans and artefacts. Collective frameworks can ‘territorialise’ space, by apparently lending it their character; [p.166]

moreover, by mediating activity they can inform the actual organisation of social space, a process Halbwachs calls *implacement*. Once an environment is thus shaped by a collective framework, reciprocally it ‘supports and reinforces that framework to the point that it appears (erroneously) to be its very origin’ (Middleton & Brown 2005, p.48).

Although the families and carers of people with learning disabilities figure only incidentally in Middleton and Brown’s work, through their discussion of Hewitt’s (1997) study of life story work with people with profound and multiple impairments, in which abuse is not discussed, their conceptual framework can usefully be applied to this group. We will now take up some of the analytical and conceptual strategies they supply, using them to identify difficulties that people with learning disabilities may encounter when remembering abuse. In so doing we will make frequent reference to Mary’s story, in order to show how such troublesome consequences of abuse can be related directly to her material and social circumstances as well as to her embodied cognitive impairments.

Whilst Mary is a member of various groups or collectives, both these groups and her relationships to them differ in significant ways from those that non-disabled people take for granted. Collectively, people with learning disabilities are devalued and stigmatised (Szivos & Griffiths, 1990), and have relatively few shared or collective resources (whether material, or symbolic). Additionally, their access to each other is typically restricted by bureaucratic and organisational imperatives that determine, for example, the hours of day centre opening or the routines of the care home. Moreover, relationships and groups of friends may be changed as a consequence of policy or

financial decisions taken elsewhere, such as mergers or closures of hospitals, day centres and other services. To the limited extent that people like Mary are allowed a voice in these decisions, cognitive and other impairments may make it difficult for them to articulate who their friends actually are. In any case, during the allocation of housing and other services, such preferences often take second place to medico-legal and related factors such as gender, degree of learning disability, the availability of suitably adapted accommodation, or more arbitrary indices of sociality and community such as place of birth. Already, then, we can see that opportunities for Mary to casually rehearse her memories with her peers are likely to be limited, arbitrarily available, and perhaps subject to unpredictable disruption over which she and her friends have no control. Whilst these factors alone may impede effective remembering, further insights may be gained by examining how social relations such as these give rise to collective frameworks for remembering with particular characteristics, and also by considering the intersection of the lived duration of people with learning disabilities with the durations and time frames of other people.

With regard to the collective frameworks for remembering that are available to someone like Mary, we can note three ways in which they may differ from those available to other groups. First, as we have seen, Mary's access [p.167] to her peers is more routinised and less spontaneous than that typically enjoyed by non-disabled people; and second, the shared symbolic or cultural resources available to Mary and her peers are relatively restricted. Third, a significant proportion of Mary's relationships are professional ones – for example, with residential support workers, day centre staff, doctors, social workers and clinical psychologists. Such relationships are inevitably less than mutual, and are frequently dominated by the particular

concerns of a specialist service or profession. Within such relationships Mary may struggle to establish the relevance of her memories (psychotherapeutic relationships are an exception here but, in the UK at least, relatively few people with learning disabilities gain access to such services - Arthur, 2003; Wilner, 2005). Because of these differences, the collective frameworks of remembering available to people like Mary are likely to be more fragile than those available to non-disabled people, and the symbolic resources from which they are constituted both more restricted and less equally distributed. Moreover, many of the significant social relations that order these frameworks will be unequal ones in which Mary is unable to direct her own activities and is positioned as comparatively incompetent or helpless. This is significant because self-directed activity is closely associated with effective learning and remembering, both generally and amongst people with learning disabilities (Cromby, Standen, & Brown, 1996).

Further insight can be gained by considering the extent to which these collective frameworks are effectively localised (mediated by language, objects and spaces) and implaced (able to influence the actual organisation of social space). Amongst non-disabled people the localisation of collective frameworks relies heavily on discourse, but many people with learning disabilities have impaired or even no ability with language. And whilst localisation is also mediated by objects and spaces, people with learning disabilities typically have little control over these aspects of their lives. For those who live in institutional settings, even personal spaces are subject to organisational constraints such as fire regulations and ease of access for cleaners. Moreover, people with learning disabilities have limited financial and other resources by which to purchase or obtain objects (photographs, souvenirs etc.) that might

mediate their memories, whilst their ability to place and display these objects in meaningful ways may be regulated by institutional or staff practices – for example, they may be discouraged from ‘hoarding’. For many people, cognitive, sensory or mobility impairments will create further difficulties in both choosing and organising objects that could effectively mediate remembering. In these ways, then, localisation of collective frameworks for remembering in people with learning disabilities encounters a number of significant obstacles. The implacement of these collective frameworks may be similarly problematic, since the ability of groups of people with learning disabilities to materially shape and organise the spaces they occupy is significantly limited: by power relations and institutional strictures on the one hand, and by their cognitive, sensory or mobility impairments on the other.[p.168]

The collective frameworks for remembering available to people with learning disabilities, mediated by their social relations, can thus be seen to be fragmentary, unstable, subject to arbitrary change and frequently imbued with unequal power relations, whilst their localisation and implacement is also problematic. To the extent that individual memories are constituted through such frameworks these features may impede successful remembering, lending it their properties of instability and fragmentariness. These impediments will influence remembering in general, but there will be further, specific consequences for memories of abuse because the social relations that mediate these frameworks are strongly shaped by institutional precedents (a smaller institution ‘in the community’ is still an institution, whatever advantages it may have over a large, isolated long-stay hospital; geographical integration does not necessarily result in social integration). The institutionalised processes of punctualisation that package up aspects of shared experience and render

them memorable as composite shared events will, for obvious reasons, emphasise relatively banal occasions with an ostensibly positive affective tone: royal weddings, Christmas, the birthdays of staff members and service users. By contrast, incidents such as an abuse inquiry will not typically be formally punctualised: rendering them, and the abuse associated with them, collectively less accessible.

Further issues arise when we consider the duration or lived time of people with learning disabilities. Middleton and Brown (2005, p. 81) note that whilst our duration is always conjoined with those of others in 'an irreducible mix of co-existing planes of experience', it is when our own duration fails to coincide with others that we become most aware of its character. More so than the rest of us, the lives of people with learning disabilities are subject to temporal regimes over which they have little or no control: day centre opening hours, the schedules of institutional living, the timetables of training, working rotas, appointments with various professionals. Moreover, cognitive impairments may obstruct their comprehension of the relatively abstract patterns of clock and calendar time, and might even impair the ability to effectively partition experience into the dynamic categories of 'past' and 'present', 'then' and 'now'. Similarly, visual impairments and poor reading skills may make it difficult to use watches, clocks or calendars. The issue here is not that the lives of people with learning disabilities are not experienced as duration, as lived time. Rather, their facility for sensibly relating this lived time to other frames may be limited because the ways in which their prior experience is 'cut out' and reinserted into the present may be somewhat unconventional, frequently driven by affects, or by the partially-known temporal regimes of others. An interview study of trauma in people with mild intellectual disabilities found that questions involving judgements about

time and age were particularly difficult for participants (Mitchell et al., 2006), and clinical experience shows that trauma can be re-experienced by people with learning disabilities as flashbacks and incomplete memories (Hollins & Sinason, 2000).[p.169]

Clearly these features will impact upon successful remembering generally, but may have particular consequences for memories of abuse. One possibility is that the enforced precedence of institutional time may mean that memories of abuse more readily get tied to elements of the institutional schedule than the lived experience of the person concerned. In Mary's case, for example, it did not seem that being alone in her bedroom prompted her self harm, nor getting undressed: rather, it seemed to be the institutional routine of 'getting ready for bed' that occasioned her difficulty.

However, an alternate possibility is that lived time gets thoroughly disconnected from institutional time, which may mean that memories of abuse play themselves out apparently randomly, inappropriately, with no obvious connection to the circumstances and situations the person occupies. In such circumstances the effects of abuse may more readily get construed as 'challenging behaviours' than meaningful, if somewhat obscure, responses to life events: people with learning disabilities who have been abused are significantly more likely to be described as having challenging behaviours than matched, non-abused controls (Sequeira et al., 2003).

Of course, these social and material influences are not the only impediments to people with learning disabilities remembering incidents of abuse in coherent ways. We have emphasised these factors in our discussion so far because they are more-or-less generally applicable, and because they draw attention to influences upon remembering that are both rarely considered and, in many cases, potentially capable

of transformation. However, as Middleton and Brown acknowledge, memories also have an affective or felt dimension. This means they can get enrolled in emotional dynamics which may further problematise them, although the particular ways in which this occurs for people with learning disabilities are poorly understood. Indeed, Arthur (2003) claims that the emotional lives of people with learning disabilities have generally been neglected, despite their having significantly higher levels of emotional difficulties and disturbance than the general population. What research there is frequently characterises the social relations and emotional lives of people with learning disabilities using such terms as loss, grieving, mourning, bonding and attachment difficulties (Bicknell, 1983; Clegg & Lansdall-Welfare, 1995). Psychiatric research suggests that rates of emotional disturbance are higher in people with learning disabilities, both generally and amongst those who have been abused (Sequeira & Hollins, 2003; Sequeira et al., 2003). Stokes & Sinason (1992) suggest that people with learning disabilities may be highly emotionally responsive despite their cognitive impairments, and that this sensitivity can render them painfully subject to the damaging responses of parents and others. Parental failures of separation, their grief responses for the 'normal' child they did not have, and familial tendencies to attribute their problems to the learning disabled member, all provide a potentially toxic affective dynamic within which children with learning disabilities develop. In conjunction with the prejudice and discrimination of the wider world, it is claimed that such dynamics may [p.170] foster the development of 'secondary handicaps', the defensive adoption of a stance of relative stupidity in order to avoid engagement with a difficult reality.

Secondary handicaps may be particularly common amongst people with learning disabilities who have been abused (Sinason, 1986) since 'if knowing and seeing involve knowing and seeing terrible things, it is not surprising that not-knowing, becoming stupid, becomes a defence' (Stokes & Sinason, 1992 p.52). And abuse is indeed damaging, associated with challenging behaviours, relationship difficulties, sexualised behaviour, psychiatric diagnosis, self-harm, social withdrawal, aggression and low self-esteem (Sequeira & Hollins, 2003). However, despite such behavioural manifestations (and as we noted earlier), not all people with learning disabilities actually recognise their abuse as abuse. Moreover, the emotional reactions of people with learning disabilities to abuse occur both in tandem and in response to those of their parents and/or paid carers, who may themselves experience strong mixtures of conflicting emotions (see Brown, Hunt, & Stein, 1994; O'Callaghan et al., 2003). Additionally, the abilities to recognise abuse, recall abuse and deploy defensive emotional strategies of disavowal or denial that would impede remembering are not only productive of secondary handicaps, but also already dependent upon pre-existing levels of cognitive impairment. So, for people with learning disabilities, remembering abuse by is mediated by the social, relational and material factors we have described above, and simultaneously interpenetrated by affective dynamics that may serve both to invest memories with salience and force, and to render them less accessible because they are too threatening. Furthermore, as we have tried to show, these complex mixtures of social, material and affective influences are related to cognitive impairment in ways that not only interact with, but are also constitutive of, difficulties in recall.

Conclusion

In superficial ways the lives of people with learning disabilities, both in the UK and in many other developed nations, have changed dramatically over the past half century. In particular, the closure of long-stay hospitals has enabled people to become geographically, if not socially or economically, part of the mainstream. What has not changed, however, is their ongoing vulnerability to sexual abuse – a vulnerability which may derive in part from their cognitive impairments, but which is compounded and magnified by their devalued social position.

In the past decade there have been concerted efforts in the UK to enable people with learning disabilities to obtain justice following abuse. Considerable progress has been made on many fronts, including a requirement that all local authorities develop and implement adult protection procedures (Department of Health & Home Office, 2000); revised guidance on how to support vulnerable witnesses throughout the court process (Home Office, [p.171] 1998 & 2002) and a new Sexual Offences Act (2003). This Act not only rescinded the law (mentioned earlier) relating to ‘sex with a defective’, but also introduced a new sexual crime of ‘abuse of a position of trust’, which makes it an offence for any carer to have sexual relations with someone they are caring for.

However, while such legal and policy initiatives are to be welcomed, they are unlikely to be of immediate benefit to most people with learning disabilities – not least because they are concerned with intervening *following* abuse, rather than with the more difficult task of preventing abuse from occurring in the first place.

Profound changes, both within services and across society more broadly, are needed in order to both prevent and respond effectively to the abuse of people with learning disabilities. Current rhetoric, which in the UK (and elsewhere) emphasises the need for people with learning disabilities to be supported to achieve rights, independence, choice and social inclusion (Department of Health, 2001), is not of itself sufficient to challenge deeply enculturated social attitudes and practices. Moreover, a simplistic interpretation of complex notions such as ‘choice’ and ‘independence’ may lead to some already vulnerable people being made even more vulnerable (Fyson & Kitson, 2007). For example, remaining in an abusive or otherwise damaging situation can be presented as the ‘choice’ of a person with learning disabilities, with no recognition of how such a choice will already have been informed by previous life experiences and (lack of) knowledge about how things could be different. Moreover, structural or economic barriers, including limited financial and social capital or lack of availability of alternative support services, currently render meaningful choices of any kind difficult or impossible for most people with learning disabilities.

Those who plan and deliver services for people with learning disabilities have yet to develop an approach that takes into account the implications of working with a population that experiences such a high prevalence of abuse and for whom memories of abuse are so seldom validated or supported. There remains scant therapeutic support for individuals who have been abused in either hospital or community-based settings. At present, for many people with learning disabilities, this can result in a double jeopardy: first when they experience abuse and again when their memories of abuse are ignored, or when its behavioural manifestations are misinterpreted as irrational ‘challenging behaviour’ rather than as a rational response to a hostile world.

In such circumstances, it is difficult to say precisely what it would mean for people with learning disabilities to successfully integrate their memories of abuse such that they no longer cause ongoing distress. Nevertheless, our analysis suggests that services which actively seek to validate and support individual's life histories, and which provide suitable material, relational and (where appropriate) therapeutic support to do so, would be beneficial.

[p.172]**References**

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