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

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ABSTRACT

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

1. Introduction

The concept of intellectual disabilities (ID) is defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) as a combination of limitations in intellectual functioning and adaptive behavior (Schalock et al., 2021). Adaptive functioning, in terms of practical domains, refers to the potential difficulties that individuals may encounter in achieving personal independence and social responsibility (Patel et al., 2020). Consequently, individuals with ID require varying degrees of support to carry out everyday activities such as self-care, personal hygiene, eating, communication, social interaction, money management, and accessing community and health services (Patel et al., 2020; Schalock et al., 2021). This population is also prone to the presentation of

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other concomitant physical and mental health problems (Maulik et al., 2011; Mazza et al., 2020), which may increase the need for assistance. The role of caregiver may fall on relatives or on other direct support professionals. The primary caregivers of individuals with ID are frequently family members, such as parents, siblings or partners (Saxton et al., 2001; Vilaseca et al., 2017). These are known as informal caregivers since they are not professionally paid for their support and assistance. The population in question may also receive the services of professional caregivers, either at home, in a day care center or in residential care.

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

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

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

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

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

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

2. Method

2.1. Participants

The study sample comprised 260 adult men and women with an ID diagnosis who were recruited in collaboration with a federation of social organizations that provide a range of services, including care, education, employment and leisure activities for individuals with ID throughout Catalonia. The participants had a mean age of 41.7 years (SD = 12). The main sociodemographic characteristics of the participants are shown in Table 1.

2.2. Procedure

This study is part of a project in collaboration with a federation of entities from Catalonia that work with people with ID. Twenty-three entities participated in the study. The overall objective was to explore the experiences of victimization in people with ID. This general project resulted in various studies exploring different violence against people with ID, such as lifetime victimization (Codina & Pereda, 2022), sexual victimization (Codina, Pereda & Guilera, 2022), bias victimization (Díaz-Faes et al., 2023) or unobserved victimization clusters (Díaz-Faes et al. (2024). Once project obtained the approval of the University's bioethics committee, a collaboration agreement was signed with the federation, making them responsible for disseminating the study information among their partner centers to recruit users interested in participating. Subsequently, an easy-to-understand document was created to ensure that participants fully understood the study's purpose and was used to obtain their informed consent. The only exclusion criteria were being under 18 and being unable to comprehend the study's objectives, provide informed consent, or effectively communicate their thoughts and experiences to the interviewer. Consequently, this criterion excludes individuals with the most severe difficulties.

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

2.3. Measures

Participants' personal information was obtained through a sociodemographic data sheet, as detailed in Table 1. Most of this data

Table 1
Sociodemographic information.

	Total	
	n	%
Gender		
Men	154	59.2
Women	106	40.8
Legal guardianship[a]		
Institution	64	39.5
Family members/relatives	88	54.3
Others	10	6.2
Place of residence		
Non-residential care	151	58.1
Residential care	109	41.9
Regular contact with relatives		
No	19	7.3
Yes	241	92.7
Type of support needed[b]		
General	17	7.8
Extensive	47	21.5
Limited	75	34.2
Intermittent	80	36.5
Secondary disability diagnosis[c]		
No	86	33.1
Yes	174	66.9
Type of secondary diagnosis		
Physical disability	74	42.5
Mental health disability	68	39.1
Both	32	18.4

[a] Among those who have been declared legally disabled ($n = 162$), a person needs to be judicially named to assist the person with their duties, obligations and needs.
[b] Degree of support required to carry out daily activities and self-care.
[c] Another diagnosed disability that coexists with intellectual disability.

was self-reported by the participants. When self-reporting was not possible, caregivers provided the missing information afterward (21.5 % of the sociodemographic collected data). To collect the victimization experiences, an adaptation of the Juvenile Victimization Questionnaire, Adult Retrospective Version (Finkelhor et al., 2005) was used (Pereda et al., 2018) under the consent of the original authors. In this adaptation, the question statements were enhanced with personalized cards containing pictograms corresponding to each question and accompanied by illustrative examples. An example of these pictograms is available in the supplementary materials. The questionnaire comprises 28 specific victimizations grouped into five modules: conventional crimes, caregiver victimization, sexual victimization, witnessing and indirect victimization, and electronic victimization. The reliability of the JVQ in this study was good (α = .827). An overview of general results for all modules can be found in Codina, Pereda, and Guilera (2022). The frequency of victimization was measured in a four-point Likert scale (never, one time, sometimes, many times). The six items in the caregiver victimization module were examined for the current paper. These items refer to victimizations perpetrated by individuals who provide care or support to the participant, such as family members or professional caregivers, while carrying out their caregiving responsibilities. The number of items on this adaptation expand Pereda's et al. (2018) version, in order to reflect the most noteworthy forms of victimization experimented by those with ID in the hands of caregivers. For a description of each of the six specific victimizations, see Table 2.

When participants reported affirmatively to any of the six caregiver victimization items, they were asked to recall the last time it happened. To obtain the details of the victimization experiences, a series of specific follow-up questions were asked (e.g., how old were you when it happened?; Was the person who did this to you a man or a woman?; Did you explain what happened to anyone, such as your parents, siblings, relatives, friends, staff members, or the police, after it happened?). The information gathered with these questions refers to the age of the victim at that time, their relationship to the offender, the offender's gender, the location of the incident, whether they reported the victimization and to whom, and the physical and psychological consequences that they experienced. These follow-up questions were also accompanied by pictograms.

2.4. Data analysis

A descriptive analysis of the sociodemographic and victimization data was performed. Then a bivariate analysis was conducted to examine the association between the study variables. Two levels or groups of analysis were created to analyze the victimization experiences: gender (men = 0, women = 1) and place of residence (non-residential care = 0; residential care = 1). The category 'non-residential care' includes those who live with family members, their partner, alone, or in independent shared housing. Meanwhile, the category 'residential care' refers to those living in facilities specializing in the care of individuals with ID.

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

Table 2
Description of the items in the caregiver victimization module.

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

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

3. Results

More than half of the sample (59.2 %; $n = 154$) have experienced at least one type of caregiver victimization. Of those who experienced caregiver victimization, 43.5 % were women and 56.5 % men. Within the caregiver victimization module (see Table 3), the most reported victimizations were physical abuse (37.3 %) and verbal abuse (24.6 %), followed by neglect (19.5 %) and the denial of personal rights (18.4 %). There is a significant difference between the place of residence and the experience of caregiver victimization ($\chi^2[df] = 5.510[1], p = .019$). People living in a residential care setting are at greater risk for caregiver victimization than those not living in a residential care setting ($OR = 1.89$, 95 % CI [1.11, 3.22]). By type of victimization, those living inside residential care settings are at a significantly greater risk for neglect ($\chi^2[df] = 6.01[1]$; $p = .014$; $OR = 2.17$, 95 % CI [1.16, 4.06]) and denial of personal rights ($\chi^2[df] = 7.50[1]$; $p = .006$; $OR = 2.44$, 95 % CI [1.27, 4.68]). There were no significant gender differences in the prevalence of caregiver victimizations in general, except for verbal abuse ($\chi^2[df] = 6.81[1]$; $p = .009$), for which women face double the risk of their men counterparts ($OR = 2.12$, 95 % CI [1.20–3.76]).

However, when analyzing gender with respect to residential status we find significant differences in the experience of caregiver victimization ($\chi^2[df] = 5.239[1]$; $p < .022$), with women living outside of a residential care setting facing double the risk ($OR = 2.08$, 95 % CI [1.11, 3.91]). By contrast, those living inside residential care settings show non-significant gender differences.

Accounting for sum and variety scores, Table 4 demonstrates that individuals living in a residential care setting experienced significantly more caregiver victimization incidents and a broader range of victimization forms compared to their counterparts not living in residential care, underscoring the consistency of the results, regardless of whether the sum or variety scores are considered. The results on gender for both measures show significant differences between men and women, with women having greater sum and variety scores than men.

3.1. *Characteristics of the last incident and the perpetrator*

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

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

3.2. *Consequences and disclosure*

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

Eighty-three percent of the victims reported having some type of negative psychological consequence as a result of their victimization. However, the gender differences were not significant. The most commonly reported consequences were feelings of distress

Table 3
Caregiver victimization and odds ratio by place of residence and gender.

	Total ($N =$ 260)		Place of residence			Gender		
	n	%	% Non-residential care	% Residential care	*OR*	% Men	% Women	*OR*
Any caregiver victimization	154	59.2	41.6	58.4	1.89 * [1.11, 3.22]	56.5	43.5	1.32 [0.80, 2.20]
Financial abuse	30	11.6	63.3	36.7	1.04 [0.47, 2.29]	53.3	46.6	1.30 [0.61, 2.80]
Verbal abuse	64	24.6	64.1	35.9	1.01 [0.56, 1.82]	45.3	54.7	2.12 ** [1.20, 3.76]
Psychological abuse	36	13.9	52.8	47.2	1.77 [0.87, 3.59]	50	50	1.53 [0.76, 3.11]
Neglect	50	19.5	50.0	50.0	2.17 * [1.16, 4.06]	54	46	1.32 [0.71, 2.45]
Physical abuse	94	37.3	59.6	40.4	1.47 [0.86, 2.42]	52.1	47.9	1.63 [0.97, 2.73]
Denial of personal rights	46	18.4	47.8	52.2	2.44 ** [1.27, 4.68]	56.5	43.5	1.17 [0.61, 2.23]

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

Table 4
Comparison of caregiver victimization means between sum and variety scores by residential group and gender.

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

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

Table 5
Percentages of perpetrator and location of the victimization by place of residence.

	Total	Residential care	Non-residential care	Statistics	
	%	%	%	$\chi^2(df)$	*p-value*
Gender of perpetrator				1.13 (*2*)	.568
Men	32.1	27.9	33.3		
Women	26.5	24.6	27.8		
Multiple of both genders	42.4	47.5	38.9		
Relationship with perpetrator				10.42 (*3*)	.015 *
Family member/relative	63.4	54	70		
Care staff/professional	13.7	23.8	6.7		
Acquaintance/friend/neighbor	3.3	1.6	4.4		
Multiple perpetrators[a]	19.6	20.6	18.9		
Location of incident				22.87 (5)	<.001 ***
Home	57.8	44.6	67		
Residential care setting	17	33.9	5.1		
Occupational/educational center	8.2	10.7	6.3		
Other care services[b]	3.7	3.6	3.8		
Public places[c]	4.4	3.6	5.1		
Multiple scenarios[d]	8.9	3.6	12.7		

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

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

[c] Refers to street, park, etc.

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

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

(38.6 %), anxious-depressive symptoms (24.2 %) and anger reactions (15.2 %). Other participants reported feeling fear (10.6 %) or helplessness and shame (8.3 %). These experiences were revealed to someone after they happened in 59.7 % of the cases, while the remaining 40.3 % disclosed them for the first time to the interviewers in the present study. Among those who had previously made a disclosure to someone, the most common confidants were staff or professional caregivers (37.8 %), followed by parents (25.6 %) and other family members like siblings (19.6 %). Those living in a residential care setting disclosed the incident more to parents than those living inside ($\chi^2[df] = 5.747[1]; p = .017$). Only 9.8 % of victims reported the incident to the police.

4. Discussion

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

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

The conformity to gender-role norms and expectations may influence different caregiver practices and behaviors that needs to be examined in the context of gender differences. Intersectional approaches can also contribute to better comprehending experiences of women with ID by addressing the confluence of multiple stigmatized identities that can operate in different ways when it comes to vulnerability to violence (Codina et al., 2023). However, due to its complexity and the endurance of traditional narratives, the intersections of ID with other cultural identities are barely explored and could be benefit from critical perspectives arising from social psychological theories (Dirth & Branscombe, 2018).

One of the strengths of the present study lies in its analysis of abuse forms that are unique to individuals with disabilities in the specific population. This is crucial for bringing visibility to the existence of disability-related abuse and preventing such specific forms of victimization from being wrongly grouped under general categories of violence. In this respect, being assaulted by a stranger on the street and being subjected to physical abuse by a professional caregiver may share certain characteristics, but they are distinct phenomena. The denial of personal rights is also a unique form of victimization that is especially relevant for those living in residential care settings. From a human rights model of disability, the denial of personal rights impairs equality and emphasizes discrimination (Degener, 2016). These results underscore the need to explore the types of victimization that are often used as a strategy to control or limit some aspects of the life of people with ID under the false pretense of care or risk prevention.

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

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

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

Finally, most of the participants disclosed their victimization to someone, but only a small number made a report to the police even though fully a third of the cases resulted in physical injury. Downplaying the importance of abuse, together with the barriers discussed by Lund (2021) and Saxon et al. (2001) as well as other limitations related to communication, knowledge or awareness of their rights, the inadequacy of the authorities' response, and erroneous assumptions about capacity and credibility in the testimony of victims (McGilloway et al., 2020), may contribute to an underreporting of victimization incidents and should be kept in mind when analyzing official victimization rates in this specific population. Yet, it appears that this type of victimization has higher rates of reporting to authorities compared to other types of victimization such as sexual victimization (Willott et al., 2020). A possible explanation would be that forms of abuse by caregivers have comparatively lower levels of stigma and fear associated with reporting. Future research should better analyze the levels of reporting for these types of victimizations.

5. Limitations

This is a cross-sectional non-probabilistic study, which limits the generalizability of its results to the general ID population. The individuals in the sample present generalized support needs to a greater or lesser extent. They also present multiple physical and mental health disabilities that increase their dependency. However, some valuable characteristics, such as the degree of disability or any specific secondary diagnoses, were unavailable. Individuals with severe cognitive or communicative difficulties were excluded from the study because they could not meet the inclusion criteria. Individuals not receiving external support or services were not among the federation users, so they are not represented in the study. As a result, more vulnerable and isolated victims may have been overlooked. Also, since the responses to the survey are self-reported, the rates of abuse must be interpreted with caution. Recall bias may lead to underreporting or overreporting depending on the capacities and memory of each respondent, as well as their awareness, knowledge, or understanding of the abuse. Although the questionnaire was adapted, participants presented some difficulties in recalling the details of the victimizations, in particular frequencies and time lags were difficult to obtain. While some participants were able to give explanations with greater or lesser detail, some barely responded with yes, or no, pointing to the supporting pictograms or with single words.

6. Conclusions

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

What this paper adds?

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

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CRediT authorship contribution statement

Pereda Noemí: Funding acquisition, Project administration, Supervision, Writing – review & editing. **Codina Marta:** Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Díaz-Faes Diego A.:** Conceptualization, Methodology, Writing – original draft, Writing – review & editing.

Declaration of Competing Interest

This work is original and has not been published elsewhere, nor it is currently under consideration for publication elsewhere. We report no conflict of interest.

Data Availability

Data will be made available on request.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ridd.2024.104689.

References

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., & Whelton, B. (2010). Adult protection of people with intellectual disabilities: Incidence, nature and responses. *Journal of Applied Research in Intellectual Disabilities, 23*(6), 573–584. https://doi.org/10.1111/j.1468-3148.2010.00561.x

Codina, M., Díaz-Faes, D. A., & Pereda, N. (2023). Women with intellectual disabilities: Unravelling their victim–offender status. In S. Banwel, L. Black, D. K. Cecil, Y. K. Djamba, S. R. Kimuna, E. Milne, L. Seal, & E. Y. Tenkorang (Eds.), *The Emerald International Handbook of Feminist Perspectives on Women's Acts of Violence* (pp. 109–123). Emerald Publishing Limited. https://doi.org/10.1108/978-1-80382-255-620231008.

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

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

Daigle, L., Snyder, J., & Fisher, B. (2016). Measuring victimization: Issues and new directions. In B. M. Huebner, & T. S. Bynum (Eds.), *The Handbook of Measurement Issues in Criminology and Criminal Justice* (pp. 249–276). Wiley-Blackwell. https://doi.org/10.1002/9781118868799.ch12.

Degener, T. (2016). Disability in a human rights context. *Laws, 5*(3), 35. https://doi.org/10.3390/laws5030035

Dembo, R. S., Mitra, M., Akobirshoev, I., & Manning, S. E. (2021). Symptom sequelae following violence against youth with disabilities. *Journal of Interpersonal Violence, 36*(21–22), NP11555–NP11576. https://doi.org/10.1177/0886260519889928

Díaz-Faes, D. A., Codina, M., & Pereda, N. (2023a). Experiences of bias victimization among people with intellectual disabilities. *Journal of Interpersonal Violence, 38* (15–16), 9423–9437. https://doi.org/10.1177/08862605231165772

Díaz-Faes, D. A., Codina, M., & Pereda, N. (2024b). Identifying victimization clusters across people with intellectual disabilities: A latent class analysis. *Disability and Health Journal*. https://doi.org/10.1016/j.dhjo.2023.101573

Emerson, E., Kiernan, C., Alborz, A., Reeves, D., Mason, H., Swarbrick, R., … Hatton, C. (2001). The prevalence of challenging behaviors: A total population study. *Research in developmental disabilities, 22*(1), 77–93. https://doi.org/10.1016/S0891-4222(00)00061-5

Finkelhor, D., Hamby, S. L., Ormrod, R., & Turner, H. (2005). The juvenile victimization questionnaire: Reliability, validity, and national norms. *Child Abuse & Neglect, 29*(4), 383–412. https://doi.org/10.1016/j.chiabu.2004.11.001

Fisher, M. H., Baird, J. V., Currey, A. D., & Hodapp, R. M. (2016). Victimisation and robosocial vulnerability of adults with intellectual disability: A review of research roboextending beyond Wilson and Brewer. *Australian Psychologist, 51*(2), 114–127. ⟨https://doi.org/10.1111/ap.12180⟩.

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., & Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet, 379*(9826), 1621–1629. https://doi.org/10.1016/S0140-6736(11)61851-5

Hughes, R. B., Lund, E. M., Gabrielli, J., Powers, L. E., & Curry, M. A. (2011). Prevalence of interpersonal violence against community-living adults with disabilities: A literature review. *Rehabilitation Psychology, 56*(4), 302–319. https://doi.org/10.1037/a0025620

Lund, E. M. (2021). Disability-related abuse in people with intellectual and developmental disabilities: Considerations across the lifespan. *International Review of Research in Developmental Disabilities, 61*, 77–97. https://doi.org/10.1016/bs.irrdd.2021.07.006

Lund, E.M., Sabey, C.V., Thomas, K.B., & Bouchard, L.M. (2017). Physical abuse of people with intellectual and other developmental disabilities in residential care. The Wiley handbook of violence and aggression (pp. 1–13). https://doi.org/10.1002/9781119057574.whbva105.

Maulik, P. K., Mascarenhas, M. N., Mathers, C. D., Dua, T., & Saxena, S. (2011). Prevalence of intellectual disability: A meta-analysis of population-based studies. *Research in Developmental Disabilities, 32*(2), 419–436. https://doi.org/10.1016/j.ridd.2010.12.018

Mazza, M. G., Rossetti, A., Crespi, G., & Clerici, M. (2020). Prevalence of co-occurring psychiatric disorders in adults and adolescents with intellectual disability: A systematic review and meta-analysis. *Journal of Applied Research in Intellectual Disabilities, 33*(2), 126–138. https://doi.org/10.1111/jar.12654

McGilloway, C., Smith, D., & Galvin, R. (2020). Barriers faced by adults with intellectual disabilities who experience sexual assault: A systematic review and meta-synthesis. *Journal of Applied Research in Intellectual Disabilities, 33*(1), 51–66. https://doi.org/10.1111/jar.12445

McNally, P., Taggart, L., & Shevlin, M. (2021). Trauma experiences of people with an intellectual disability and their implications: A scoping review. *Journal of Applied Research in Intellectual Disabilities, 34*(4), 92–7949. https://doi.org/10.1111/jar.12872

Nevill, R. E., Istvan, E. M., & Havercamp, S. M. (2022). The effects of aggression subtypes on burnout and caregiver instability in direct support professionals. *Journal of Positive Behavior Interventions, 24*(2), 99–109. https://doi.org/10.1177/10983007211013794

Patel, D. R., Cabral, M. D., Ho, A., & Merrick, J. (2020). A clinical primer on intellectual disability. *Translational Pediatrics, 9*(Suppl 1), S23–S35. https://doi.org/10.21037/tp.2020.02.02

Pereda, N., Gallardo-Pujol, D., & Guilera, G. (2018). Good practices in the assessment of victimization: The Spanish adaptation of the Juvenile Victimization Questionnaire. *Psychology of Violence, 81*(1), 76–86. https://doi.org/10.1037/vio0000075

Platt, L., Powers, L., Leotti, S., Hughes, R. B., Robinson-Whelen, S., Osburn, S., Ashkenazy, E., Beers, L., Lund, E. M., Nicolaidis, C., Hughes, R. B., Powers, L. E., Nicolaidis, C., Katz, M., Oschwald, M., Larson, D., Plourde, E., Raymaker, D., & Lund, E. M. (2017). The role of gender in violence experienced by adults with developmental disabilities. *Journal of Interpersonal Violence, 32*(1), 101–129. https://doi.org/10.1177/0886260515585534

Ryan, C., Bergin, M., & Wells, J. S. (2021). Work-related stress and well-being of direct care workers in intellectual disability services: A scoping review of the literature. *International Journal of Developmental Disabilities, 67*(1), 1–22. https://doi.org/10.1080/20473869.2019.1582907

Saxton, M., Curry, M. A., Powers, L. E., Maley, S., Eckels, K., & Gross, J. (2001). Bring my scooter so I can leave you" a study of disabled women handling abuse by personal assistance providers. *Violence Against Women, 7*(4), 393–417. https://doi.org/10.1177/10778010122182523

Schalock, R.L., Luckasson, R. and Tassé, M.J. (2021) Intellectual disability: Definition, diagnosis, classification, and systems of supports. 12th ed. American Association on Intellectual and Developmental Disabilities.

Skirrow, P., & Hatton, C. (2007). Burnout' amongst direct care workers in services for adults with intellectual disabilities: A systematic review of research findings and initial normative data. *Journal of Applied Research in Intellectual Disabilities, 20*(2), 131–144. https://doi.org/10.1111/j.1468-3148.2006.00311.x

Strand, M., Benzein, E., & Saveman, B. I. (2004). Violence in the care of adult persons with intellectual disabilities. *Journal of Clinical Nursing, 13*(4), 506–514. https://doi.org/10.1046/j.1365-2702.2003.00848.x

Vilaseca, R., Gràcia, M., Beltran, F. S., Dalmau, M., Alomar, E., -Adam Alcocer, A. L., & Simó-Pinatella, D. (2017). Needs and supports of people with intellectual disability and their families in Catalonia. *Journal of Applied Research in Intellectual Disabilities, 30*(1), 33–46. https://doi.org/10.1111/jar.12215

Willott, S., Badger, W., & Evans, V. (2020). People with an intellectual disability: Underreporting sexual violence. *The Journal of Adult Protection, 22*(2), 75–86. https://doi.org/10.1108/JAP-05-2019-0016