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Review article

Sexual abuse involving children with an intellectual disability (ID): A narrative review☆

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ABSTRACT

The current paper provides a narrative review of the literature on sexual abuse, involving children with Intellectual Disability (ID). The thirteen articles that were found and met our criteria vary in their definitions of sexual abuse and in how ID was determined. Still, they do paint a general picture concerning (1) the extent of sexual abuse, (2) the nature of the sexual abuse, and (3) the institutional reactions following sexual abuse of children with ID. Our findings confirm the greater vulnerability of children with ID to become involved in sexual abuse both as a victim and as a perpetrator, and we discuss ways to help strengthening prevention and intervention methods. Nevertheless, more research is needed, as it is still a rather unexplored topic, which is striking in light of the high vulnerability of this group.

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1. Introduction

After several international reports on sexual abuse of children by Catholic priests, nuns and members of Roman Catholic orders (in Canada, Ireland, the United States, the Netherlands and throughout the world) and of incidents of sexual abuse by youth care workers and other significant adults in the life of children, it was clear that more knowledge was needed about sexual abuse of children within institutions and of children who receive youth care and foster care. The current study was conducted to present a narrative review of the literature on sexual abuse involving children with an intellectual disability (ID) and was funded by the Dutch government (Committee-Samson, 2012). Following the definition of the World Health Organization (2014), an ID is defined as '*a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development*'.

Several authors indicate that individuals with disabilities are more likely to be maltreated than individuals without disabilities, and that individuals with ID are especially at risk (Horner-Johnson & Drum, 2006). Moreover, it seems that this risk is even higher in the case of sexual abuse (besides other types of maltreatment) (Khemka, Hickson, & Reynolds, 2005). A few studies specifically focused on children with ID and also indicated that they seemed more vulnerable for sexual abuse (e.g., Furey, Granfield, & Karan, 1994; Sullivan & Knutson, 2000). Despite this vulnerability, not much is known about the extent and nature of sexual abuse in children with ID and the institutional reactions following sexual abuse of these children. In a broader research project encompassing the current study, sexual abuse was defined as 'sexual contact of (young) adults with children younger than 18 years old. These hands on contacts are against the will of the child or without the possibility of the child to refuse these contacts. Perpetrators use emotional pressure towards the child, force the child or, by their greater power, the child is afraid to say no when approached' (Committee-Samson, 2012, p. 49; Wissink, Moonen, Van Vugt, Stams, & Vergeer, 2012). Because many of the children with ID receive youth care, it was considered important to also include abuse committed by children living in the same youth care institution, group home or (foster) family, because children should be protected against such types of sexual abuse as well (Committee-Samson, 2012).

In DSM-5, intellectual disability is considered to be the case when the IQ of a child is approximately two standard deviations or more below the population mean, which equals an IQ score of about 70 or below (American Psychiatric Association, 2013). Despite a lack of precision about the prevalence of *children* with ID, partly caused by inconsistent and changing definitions, early studies indicated that people with ID in general are at increased risk for sexual abuse (Furey et al., 1994).

The current study reviews the literature on sexual abuse of children with ID both as victims and perpetrators. Children with ID are believed to have a higher risk of becoming a victim of sexual abuse, because some of their characteristics are thought would make them especially vulnerable (among others: dependency, need to belong, naivety, lack of knowledge regarding sexuality) (Wissink et al., 2012). Children with ID are also believed to be more at risk of becoming a perpetrator as they are less able to adequately interpret social situations and understand intentions and emotions of others (Balogh et al., 2001; Firth et al., 2001; Hofstede, 1995; Lindsay & Taylor, 2005; Timms & Goreczny, 2002). Moreover, children with ID can sometimes take images quite literally (Janssens, Schakenraad, Lammers, & Brants, 2009) so that, for instance, pornographic material might function as a frame of reference for sexual relationships (Gesell, Maris, Van Berlo, & Van Haastrecht, 2010). Finally, children with ID as perpetrators may have been victim of abuse themselves, which makes them more at risk for becoming a perpetrator. In the literature, therefore, the blurred distinction between victims and offenders has been described (Kramer, Janssens, Cinibulak, & Cense, 2007).

The current literature review focuses on empirical studies, published between 1998 and 2014 (1st of July, 2014) concerning the topic of *sexual* abuse involving *children* with an *ID*. The general aim of this narrative review study was to review the scientific literature on the extent and nature of sexual abuse involving children with ID and on the reactions following the abuse. The specific research questions that directed the literature search were: Based on the literature, what can be said concerning (1) the extent of sexual abuse involving children with ID, (2) the nature of sexual abuse involving children with ID (such as victim characteristics, perpetrator characteristics, abuse characteristics), and (3) what were the reactions following the sexual abuse involving children with ID?

2. Materials and methods

Several databases (PsycINFO, Web of Knowledge, GoogleScholar and Google) were used to search for relevant publications. Different terms were used in this search to find as many publications as possible from different disciplines and scientific backgrounds. Hereby, we took into consideration the different terms that have been used over the years both for ID and for sexual abuse. Additionally, we specifically searched for publications about sexual abuse involving children in foster care. The keywords used in the search are displayed in Table 1. In addition, reference lists of retrieved publications were

Table 1
Used search terms.

Intellectual disability	Sexual abuse
- Mentally disabled children	- Sexual abuse
- Mental retardation	- Maltreatment
- Mild mental retardation	- Sexual maltreatment
- Learning disabilities	
- Mild learning disabilities	
- Intellectual disability	
- Mentally disabled children	

Note. All terms were also combined in searches.

examined and we searched for 'cited by' publications. Finally, we contacted several experts in the field for relevant publications.

Our searches flagged more than a thousand sources that we subsequently screened for appropriateness. Hereby, the following inclusion criteria were used:

(1) the articles had to focus on *children*
(2) specifically with *ID* (complete group, subgroup or majority of the subjects)
(3) specifically on *sexual* abuse (extent, nature and/or reactions)
(4) being published in the years between *1998* (January) and *2014* (July)
(5) concern original empirical studies (including meta-analyses, but excluding review studies)
(6) being written in the English language
(7) being published in international academic journals

Several studies were excluded because these studies were review studies (mostly with a broader scope) and did not bring forward new, original material (Halter, Brown, & Stone, 2007; Horner-Johnson & Drum, 2006; Lindsay & Taylor, 2005; McEachern, 2012; Morano, 2001; Rushbrooke, Murray, & Townsend, 2014; Skarbek, Hahn, & Parrish, 2009; Stalker & McArthur, 2012; Timms & Goreczny, 2002). The findings in these studies did not add to the original studies specifically focusing on the topic we were interested in (and which were included). As meta-analyses do provide new results, these were included (e.g., Jones et al., 2012). A few studies were excluded because no differentiation was made between the type of disability (Hershkowitz, Lamb, & Horowitz, 2007) and/or between the form of child abuse: e.g. sexual abuse/physical abuse, etcetera (Agnew, Powell, & Snow, 2006; Cuevas, Finkelhor, Ormrod, & Turner, 2009). In other words, these publications could not be used to answer our research questions about *sexual* abuse of children with an *intellectual* disability. A few studies focused on adults instead of on children (Keilty & Connelly, 2001; Khemka, Hickson, & Reynolds, 2005), or on other related topics outside our research questions (Phasha & Myaka, 2014). Finally, four sources were excluded because they were written in the Dutch language and had not been published in international academic journals (Deelstra, Van der Molen, Niessen, & Ponsioen, 2001; Janssens, Felten, & Frans, 2010; Spanjaard, Haspels, & Roos, 2000; Vermeulen, Jansen, & Feltzer, 2007).

Our search and screening resulted in a selection of thirteen relevant scientific publications on the extent, nature, and/or reactions on sexual abuse of children with (mild) ID (see Table 2). Following Stalker and McArthur (2012) we employed the approach of Arksey and O'Malley (2005) for registering the data and collating, summarising and reporting the results. Accordingly, we collected standard information on each study using a form in Microsoft Word. This enabled us to systematically collect information of all the studies about the background, aims, samples, location, analyses conducted, key results and other relevant information. An overview of several main characteristics of the articles collected during this stage is provided in Table 3. For the final stage of collating, summarising and reporting the results, we employed the approach of Stalker and McArthur (2012) and subsequently present the findings around different themes (following our research questions) as a 'narrative account' (Arksey & O'Malley, 2005). It should be noted that as a result of the different methods that have been used to determine sexual abuse involving children with ID (retrospective data, analysis of case files, self-reports, interviews) the results we present should always be understood within the framework of the original studies.

3. Results

3.1. Extent of sexual abuse

Few researchers specifically mentioned to have determined the prevalence of sexual abuse involving children with ID. Jones et al. (2012) conducted a meta-analysis of studies on the violence against children with disabilities and they presented prevalence figures for several subgroups. They included 17 studies (combined total of 18.374 children) and based on 8 studies involving 6.522 children they concluded that the prevalence of sexual violence in children with mental or intellectual disabilities was 15%. However, they added that there was substantial heterogeneity between the values (varying from 7.1% to 24%). Additionally, based on 4 studies they computed odds ratios (OR) and found that the risk of sexual violence was 4.6 times higher in children with mental or intellectual disability than in children without disabilities. Here as well, substantial variation was found (varying from 2 to 10 times higher). Balogh and colleagues (2001) reported that 14% of all children of a

Table 2
Included literature sources.

Authors	Year	Title	Source
(1) Akbas, S., Turla, A., Karabekiroglu, K., Pazvantoglu, O., Keskin, T., & Boke, O.	2009	Characteristics of sexual abuse in a sample of Turkish children with and without mental retardation, referred for legal appraisal of the psychological repercussions.	Sexuality and Disability, 27, 205–213.
(2) Balogh, R., Bretherton, K., Whibley, S., Berney, T., Graham, S., Richold, P., e.a.	2001	Sexual abuse in children and adolescents with intellectual disability.	Journal of Intellectual Disability Research, 45, 194–201.
(3) Bottoms, B.L., Nysse-Carris, K.L., Harris, T., & Tyda, K.	2003	Jurors' perceptions of adolescent sexual assault victims who have intellectual disabilities.	Law and Human Behavior, 27, 205–227.
(4) Briggs, F.	2006	Safety issues in the lives of children with learning disabilities.	Social Policy Journal of New Zealand, 29, 43-59.
(5). Cederborg, A.-C., La Rooy, D., & Lamb, M.E.	2008	Repeated interviews with children who have intellectual disabilities.	Journal of Applied Research in Intellectual Disabilites, 21, 103–113.
(6). Cederborg, A.-C., Danielsson, H., La Rooy, D., & Lamb, M.E.	2009	Repetition of contaminating question types when children and youths with intellectual disabilities are interviewed.	Journal of Intellectual Disability Research, 53, 440–449.
(7) Cederborg, A.-C., Hultman, E., & La Rooy, D.	2012	The quality of details when children and youths with intellectual disabilities are interviewed about their abuse experiences.	Scandinavian Journal of Disability Research, 14, 113–125.
(8) Firth, H., Balogh, R., Berney, T., Bretherton, K., Graham, S., & Whibley, S.	2001	Psychopathology of sexual abuse in young people with intellectual disability.	Journal of Intellectual Disability Research, 45, 244–252.
(9) Jones, L., Bellis, M.A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T., & Officer, A.	2012	Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies.	Lancet, 380, 899–907.
(10) Kvam, M.H.	2000	Is sexual abuse of children with disabilities disclosed? A retrospective analysis of child disability and the likelihood of sexual abuse among those attending Norwegian hospitals.	Child Abuse & Neglect, 24, 1073–1084.
(11) Reiter, S., Bryen, D. N., & Shachar, I.	2007	Adolescents with intellectual disabilities as victims of abuse.	Journal of Intellectual Disabilities, 11, 371–387.
(12) Spencer, N., Devereux, E., Wallace, A., Sundrum, R., Shenoy, M., Bacchus, C., & Logan, S.	2005	Disabling conditions and registration for child abuse and neglect: A population-based study.	Pediatrics, 116, 609–613.
(13) Sullivan, P. M., & Knutson, J. F.	2000	Maltreatment and disabilities: A population-based epidemiological study.	Child Abuse & Neglect, 24, 1257–1273.

psychiatric division for people with ID presumably had been a victim of sexual abuse. The authors indicated that this percentage was probably an underestimation of the real figures, as only file data and information from team members were used. Using self-reports, Briggs (2006) indeed found a higher percentage of 32% sexual abuse victimization among girls with learning disabilities (i.e. three or more years behind their peers in all aspects of the curriculum) in special education schools. For boys, the sexual abuse was described to be equally common.

Spencer et al. (2005) claimed to have conducted the first whole-population-based study on the relationship between disability and abuse registration and analysed the registrations of 119.729 children born in the West Sussex area (UK) between 1983 and 2001 (19-year birth cohort). They found that children with moderate or severe ID (using the UK term 'learning difficulties', referring to an IQ < 70), had an 8 times increased risk for sexual abuse registration. Also after controlling for birth weight, gestational age, maternal age and SES these children had a 6 times higher risk for sexual abuse. Only the children with conduct disorder showed a larger increased risk for sexual abuse (respectively 10 times and 7 times higher).

Table 3
Main study characteristics.

Study	Type	*N*	Setting	Def. sexual abuse	Def. ID	Sample	Age	Source	Country
1. Akbas etal. (2009)	Quantitative	$N_{\text{mental retardation}}$ = 20 (12mild; 8moderate); $N_{\text{typical growing}}$ = 20sexually abused children; 90% girls.	Victims were referred to outpatient clinic for psychiatric evaluation.	–	WISC-R $\leq$ 70.	Victims	7–16 (M = 12.35)	Psychiatric assessment and physical examination.	Turkey
2. Balogh etal. (2001)	Quantitative	N = 43in-patients with ID; 23boys; 20girls.	Specialist child and adolescent psychiatry department for young people with ID.	Derwent Initiative guidance (Graham, 1996); Modification of Turk & Brown's (1992) classification.	Admittance to a specialist child and adolescent psychiatry department for young people with ID.	Victims (n = 21) and perpetrators (n = 6); 16were both victim and perpetrator.	9–21	Retrospective case-note review.	UK
3. Bottoms etal. (2003)	Quantitative	N = 160jury-eligible US citizins.	Mock-trial study.	Sexual abuse = the defendant committed an act of sexual conduct with the alleged victim. Sexual conduct = any intentional or knowing touching or fondling by the accused, either directly or through the clothing, of the sex organ of the victim, for the purpose of sexual gratification or arousal of the victim or the accused.	The victim was portrayed as either having 'average intelligence' or as being 'mildly mentally retarded'.	Victim	16	Experimental data; 2 (disability status; intellectually disabled or nondisabled) $\times$ 2 (juror gender) between-subjects design.	USA
4. Briggs (2006)	Quantitative and qualitative	N = 161; 55boys; 61girls.	Special education students with 'learning disabilities'. Some were diagnosed as having ADD or ADHD, one with Down Syndrome, and one was brain damaged as a result of physical abuse in infancy. Some had minor intellectual disabilities.	–	Special education students who had been identified as 3or more years behind their peers in all aspects of the curriculum.	Victims	11–17 (M = 13.8)	Interviews with children and questionnaire.	New Zealand

5. Cederborg etal. (2008)	Quantitative and qualitative	*N* = 20interviews with alleged victims with ID.	Forensic setting: Interviews with alleged victims with ID were studied (prosecutors in all Swedish districts were asked to provide as much information as possible about recent cases in which children with ID were interviewed about suspected abuse). Because ID is not necessarily recorded in case files, the resulting data are influenced by the prosecutors' and police officer's memories of whether or not children were disabled (selective dataset).	(all but one child had allegedly experienced sexual abuse or both sexual and physical abuse)	Mild developmental difficulties (DD) = IQ of 50–55–70; Moderate DD = IQ 35–40–55; Severe DD = IQ < 35–40.	Victims	4.7–18 (*M* = 10.3)	Quantitative analysis of interviewer utterances and of information reported in the repeated interview; analysis of suggestive information in the repeated interview.	Sweden
6. Cederborg etal. (2009)	Quantitative and qualitative	*N* = 33case files and transcripts of interviews with children and youth with ID and possible sexual abuse (25girls and 9boys; 31sexual abuse).	Forensic setting: transcribed real-life forensic interview, documents from the police investigations and court files.	–	Mild developmental difficulties (DD) = IQ of 50–55–70; Moderate DD = IQ 35–40–55; Severe DD = IQ < 35–40.	Victims	5.3–19.1 (*M* = 12.1)	Quantitative analysis of interview utterances and qualitative analysis of quality of repeated option-posing and suggestive prompts and of substantial event information.	Sweden
7. Cederborg etal. (2012)	Qualitative	*N* = 32first formal investigative interviews with children and youth with ID and abused.	Forensic setting: transcribed police officers' first formal investigative interviews.	–	Differentiation in developmentally delayed (22) mild ID (9), unspecified degree of ID (13), autism spectrum disorder (4), diagnosed ID (7) combined with ASDs (1).	Victims	5.3–22 (*M* = 12.9)	Inductive review of all documents (transcribed interviews, documents from the police investigations and court files).	Sweden

Table 3 (*Continued*)

Study	Type	*N*	Setting	Def. sexual abuse	Def. ID	Sample	Age	Source	Country
8. Firth etal. (2001)	Quantitative and descriptive	*N* = 43; 23boys; 20girls.	Case material was drawn from 43patients of a regional psychiatric service for children and adolescents with ID. All subjects had been involved in sexual abuse (∼Balogh etal., 2001 data).	Derwent Initiative guidance (Graham, 1996); Modification of Turk & Brown's (1992) classification; probable or proven victimization.	Admittance to a specialist child and adolescent psychiatry department for young people with ID.	Victims (*n* = 21) and perpetrators (*n* = 6); 16were both victim and perpetrator.	9–21	Retrospective case-note review.	UK
9. Jones etal. (2012)	Meta-analysis of prevalence	*N* = 6522children (8studies) for pooled prevalence sexual violence estimates; *N* = 503 (4studies) for pooled odds ratios for risk of sexual violence.	Meta-analysis.	Sexual violence = unwanted sexual touch, forcing to touch someone sexually, forced sexual intercourse, attempted rape, flashing or sexual exposure, verbal sexual harassment, sexual intercourse before 12years of age.	Mental or ID: Combined categories of intellectual or mental disabilities, or developmental disabilities not otherwise specified.	Victims	Age ≤ 18	Studies	UK
10. Kvam (2000)	Quantitative	*N* = 1293 (*n* = 83disabled; *n* = 20mental retardation).	Children who were medically examined in hospitals for suspected sexual abuse.	The least serious sexual abuse excludes physical contact, for instance showing pornography and witnessing masturbation. More serious is kissing, fondling, or being made to touch the perpetrator and other forms of physical contact without penetration.	Mental retardation: IQ < 80.	Victims	Mean age total sample = 7.8; Mean age mental retardation sample = 8.6.	Chief pediatric doctors of 26hospitals filled in questionnaires.	Norway
11. Reiter etal. (2007)	Quantitative	*N* = 100 (*n* = 50adolescents with mild ID and other disabilities (25girls; 25boys); *n* = 50adolescents of regular schools).	Students in special education schools and students in regular schools.	Sexual abuse = unwanted sexual touch, forcing to touch someone sexually.	–	Victims	Mean age ID sample: 16.58; Mean age non-ID sample: 16.10.	Students filled in 'Ending the Silence' questionnaire.	Israel

12. Spencer etal. (2005)	Quantitative	$N = 119729$ ($n = 1067$learning dis; $n = 246$sexual abused).	All children born with addresses in the West Sussex area and complete data (1983–2001); 19-year whole-population cohort.	Sexual abuse that has actually occurred or if there is a known offender in the household.	Learning disability (IQ < 70); ICD-9.	Victims	–	File data of health conditions (ICD-9) were merged with file data of the child-protection register.	UK
13. Sullivan and Knutson (2000)	Quantitative	$N = 50278$ (n mental retardation = 248; n mental retardation & sexual abuse = 91).	All children enrolled in the Public (OPS) and Archdiocese schools of Omaha, Nebraska during the 1994–1995 year.	Interagency task force on research definitions of maltreatment.	Mental retardation combined all degrees of mental retardation from mild to profound.	Victims	0–21	An electronic merger of school records with Central Registry, Foster Care Review Board, and police databases was followed by a detailed record review of the circumstances of the maltreatment.	USA

Sullivan and Knutson (2000) conducted an epidemiological study using data of official reports regarding a group of school-going children in the US, and their results showed that children with ID had a 4 times greater risk for sexual abuse than children without ID. Sullivan and Knutson (2000) also found that, of the total group of abused children with a disability (including other types of abuse), the percentage of children with an ID was relatively high (25%). Actually, the children with an ID and the children with a behaviour disorder were the two largest groups of the different groups of abused children with a disability. Purely focusing on the children who had been *sexually* abused, they found that only 4% of these children had an ID (21 of the 497 children). An important explanation for this lower-than-expected percentage in their sample was that sexual abuse in this group of children was described as not coming to light easily, possibly caused by a deficient registration by institutes that were responsible for investigating and responding on the suspected abuse.

Indeed, the results of Kvam (2000) revealed a higher percentage when they reported that of the total group of children with disabilities who had been examined for sexual abuse, a substantial percentage (24% i.e. 20 of the 83 children) had an ID. The results of Akbas et al. (2009) revealed an even higher percentage: they found that of 122 children who were victims of sexual abuse and referred for psychiatric evaluation to a clinic, 23 had a WISC-R score between 71 and 85 (i.e. borderline intelligence) and 41 were clinically diagnosed with ID. This adds to a total of 64 of the 122 children, which brings along a percentage of 52% of the evaluated victims of sexual abuse had an ID. Finally, the selected publications also indicated that, in the group of children with ID, *more serious* types of sexual abuse occurred, often repeated in nature (Reiter, Bryen, & Shachar, 2007).

Despite the heterogeneity in findings, it is evident that children with ID are at risk for sexual abuse and that of all children with disabilities (in itself already a risk factor), children with ID seem to be among the groups with the highest risks for sexual abuse/maltreatment. In the next section, we elaborate on the explanations for this higher risk as we present what the studies showed concerning the nature of the sexual abuse (i.e., characteristics of the victims, of the perpetrators, and of the sexual abuse itself).

3.2. Nature of the sexual abuse

3.2.1. Victim characteristics

In the introduction of the studies only a few authors specifically addressed why children with *ID* are vulnerable for *sexual* abuse; most of them focused on children with disabilities in general, or on abuse in general. Akbas et al. (2009, p. 206) was one of the exceptions and summarized that in the 1990s it was emphasized that 'there was growing recognition that individuals with ID (here: mental retardation) are particularly vulnerable to sexual abuse due to multiple factors, including life-long dependence on adults for care, trained compliance, social isolation, lack of education about sexuality and sexual abuse, and a societal view that devalues people with disabilities'. Additionally, Akbas et al. (2009) described that children with ID often would not realise that the behaviour of perpetrators is a form of 'sexual abuse', and that it is punishable.

Briggs (2006) mentioned that children with ID (using the UK term 'learning disabilities') were the ones least likely to have had any conversations with their parents about personal safety issues surrounding abuse, including sexual abuse. This lack of education is also reflected in Briggs' (2006) findings that 7% of the children with ID she questioned thought it was 'OK' for adults to use children for sex and 10% were not sure. Some children suggested that sex between adults and children was acceptable if the children were of a certain age, but these ages were never within the appropriate legal boundaries. Additionally, 1 out of every 5 boys could not explain why sexual abuse by adults was inappropriate and only a few showed an understanding of the abuse of power. Also, 13% of the children indicated that it was OK for boys to force girls to have sex, and 15% were unsure. Moreover, even if boys indicated that it was not appropriate for boys to force girls to have sex, they often added 'unless it's your girlfriend' (Briggs, 2006). So, there seem to be ample opportunities for educational intervention efforts to try to improve children's knowledge and skills, and to reduce the risks.

3.2.1.1. Gender of the victims. In the literature included, it was sometimes mentioned that girls have a higher risk for becoming a victim of sexual abuse than boys (Reiter et al., 2007). Other sources indicated that boys are at the same or even higher risk for sexual abuse as girls (Briggs, 2006). According to Briggs (2006) the boys she included in her study were much less knowledgeable than the girls about all sex-related issues and abuse and they were uncertain about adults' rights to use children for sex and their own rights to force girls into sexual activity, especially regarding their 'girlfriends'. This would also make them more vulnerable for becoming a perpetrator.

3.2.1.2. Age of the victims. A few authors paid attention to the age of the children when being abused. Sullivan and Knutson (2000), for instance, found that for children with a non-intellectual disability, children between 0 and 5 years old (the very young group) were more at risk, whereas for children with ID, the abuse was visible in all age groups (0–5, 6–9, 10–13, 14–20 years old). However, a limitation of this large-scale study was that with this age-specific information, no differentiation was made between the different kinds of abuse: sexual, physical, and emotional. Balogh et al. (2001), including 43 children and adolescents (7–12, 13–18, 19–21 years old) in their study, did specifically address *sexual* abuse and found the highest percentage of victims of sexual abuse among the children with ID aged between 13 and 18. In addition, Balogh and colleagues showed that the risk for becoming a victim of sexual abuse was particularly high for adolescent girls. It should be noted however, that these subgroups were quite small and that therefore, this source cannot substantiate firm conclusions about the age of victims of sexual abuse with ID.

3.2.2. Perpetrator characteristics

In several studies attention was paid to the perpetrators of sexual abuse in which a child with an ID was a victim. Different researchers stated that the perpetrators are often from within the immediate or extended family, for instance (foster) parents and (foster) brothers/sisters (immediate family) and grandparents and uncles (extended family). Akbas et al. (2009) found that children with ID were more often sexually abused by a relative (50% versus 10% in control group). Of the children with ID who had been abused repeatedly, the perpetrator was most often a family member as well. Balogh et al. (2001) also described that the sexual abuse most frequently occurred within the close or extended family (living in the same house), however, complex and varied home circumstances of the victims precluded more detailed analysis by these researchers. Cederborg, La Rooy and Lamb (2008) studied interviews with victims of 20 abuse cases in Sweden (19 cases of sexual abuse, 1 physical abuse only) with varying types of 'ID' and reported that 12 of the 20 (60%) alleged perpetrators were familiar to the children, eight (40%) were immediate family members, and two (10%) were unfamiliar. In a later study, Cederborg, Danielsson, La Rooy and Lamb (2009) reported that most of the suspected perpetrators of the 33 cases they studied were well known or familiar to the children and youths (3% relative; 40% immediate family; 37% familiar; 20% unfamiliar). Briggs (2006) specifically mentioned stepfathers, but also older brothers, mothers' boyfriends, an uncle and a girlfriends' brother as perpetrators in case of the girls. For boys, perpetrators were also older females, males, and a babysitter. However, Briggs (2006) described that older youths were reported to be responsible for sex offences in the majority of the cases (54%), and almost a quarter of the studied children reported that 'kids at school' had used force or tricks to involve them in underage sex.

The large-scale quantitative research of Sullivan and Knutson (2000) on sexual abuse showed that in less than half of the cases (47%) persons from outside the family were perpetrators. In one study, drivers of special transport services were specifically mentioned (Reiter et al., 2007). Besides, clergymen, teachers, coaches, neighbours, friends of the family and professional caregivers were mentioned as perpetrators. Reiter et al. (2007) showed that the perpetrators of sexual abuse of individuals with disabilities were often professional caregivers. Regarding sexual abuse by professional caregivers, Balogh et al. (2001) suggested that underreporting was probably the case.

To summarize, it is not simple to outline a straightforward profile of perpetrators of sexual abuse of people with ID, as very different cases of perpetrators are described in the literature depending on the data sources used (case files, self-reports, official registrations, examinations). However, in the majority of the cases the perpetrator was a male (for instance, see Balogh et al., 2001) and a family member or an acquaintance of the victim or somebody the victim trusted (Akbas et al., 2009; Reiter et al., 2007). Several authors, however, also pointed at perpetrators of a person in the same age or living in the same facility: peers or group mates (Balogh et al., 2001; Briggs, 2006; Firth et al., 2001), and this perpetrator group could receive more attention (please see next section).

3.2.2.1. Perpetrators with ID. Some researchers mentioned that the distinction between victims and perpetrators of sexual abuse with ID is not very sharp, and that many perpetrators, especially girls, have been sexually victimized themselves in the past (Balogh et al., 2001; Firth et al., 2001). According to Balogh et al. (2001) if the victim of sexual abuse had an ID, the perpetrator most likely had an ID as well. The literature also indicated that powerlessness is often seen as a characteristic of perpetrators with ID (Firth et al., 2001). Controlling behaviour, bullying and abusing other children can be a reaction to powerlessness as a result of own experiences with sexual abuse and/or physical abuse. This can be described as a process that starts with being a victim of abuse, which results in feelings of powerlessness and aggression and the need for retaliation, which in turn can lead to the abuse of others, also called the cycle of abuse.

3.2.3. Abuse characteristics

Based on most publications no reliable conclusions could be drawn about characteristics of the abuse, such as the type, location and duration of the sexual abuse. Akbas et al. (2009) summed details of the type of sexual abuse of both children with ID and a control group, and found that in case of children with ID the sexual abuse more often concerned vaginal penetration (50% of children with ID versus 15% of children without ID). Other details of the nature of the sexual abuse were not significantly different for children with and without ID. The study of Reiter and colleagues (2007) provided some information about the location: most cases were committed in the direct surrounding, for instance, at home, in the neighbourhood, in public spaces, or during the transfer from home to school. Regarding the duration of the sexual abuse, as already mentioned, Reiter et al. (2007) indicated that the abuse within the ID group was more often repeated in nature (Reiter et al., 2007). Akbas et al. (2009) reported that among the children who were abused more than once, the mean duration was 11.41 months. However, there was a large variation (12.36 months), and the mean duration in the control group was even higher (16.50 ± 18.71 months). There were also suggestions in the literature that children in residential institutions are more often victim of repeated sexual abuse (Reiter et al., 2007).

3.3. Reactions to the abuse

3.3.1. Prevention

Several authors emphasized the importance of sex education and defensive or self-protection techniques for children with ID to prevent them from being sexually abused or revictimized (Briggs, 2006; Reiter et al., 2007). In that way children with ID could be taught to recognize potentially dangerous situations, could be empowered, may become more assertive, and learn to defend themselves, with the final goal of being able to resist perpetrators of sexual abuse. Nearly all of the students in

special education schools with learning disabilities in the Briggs' (2006) study indicated that personal safety skills should be taught in schools to protect children against the risk of sexual abuse. According to Briggs (2006) training programs could be used to improve children's knowledge of their rights.

More attention should be paid as well to the development of specific expertise of professionals. Briggs (2006) and the children she questioned advised that police education officers played a role in education. Specialist forces could relieve other professionals directly involved with the children (like teachers and youth care workers) of having to develop yet another set of professional competencies. In the discussion section, Briggs (2006) provided some suggestions, such as using exploration through a variety of means (DVD's, role-play), frequent reassurance, repetition with minor modifications, use of information broken into small segments, daily practises and parental involvement. A specific programme that was mentioned is the Keeping Ourselves Safe programme (see Briggs, 2006).

3.3.2. Reports

Based on the literature, the risk of children with ID to be sexually abused seems additionally heightened by difficulties children with ID can have with reporting the abuse they have experienced. Like children without ID, children with ID have to overcome certain thresholds to report the abuse, like overcoming feelings of guilt, fear of being abandoned or separated of family and of possible loss of affection and rewards/gifts (Akbas et al., 2009). However, for children with ID there are additional obstacles. That is, as already indicated, these children do not always realise that they are being abused, and sometimes they do not have the right words to report about it, depending on their level of intellectual and other disabilities. Balogh et al. (2001) mentioned that children with more severe levels of ID probably have more difficulties with disclosing the sexual abuse, and that this could explain the higher percentage of children with a milder level of ID (as opposed to children with more severe levels of ID) in their group of victims and perpetrators of sexual abuse. It seems that the level of ID is a factor in disclosing and reporting about the abuse.

Reiter et al. (2007) found that 67% of the children with disabilities who had been sexually abused (self-reports) disclosed to a family member, and 33% to a professional. If children do disclose about sexual abuse, Akbas et al. (2009) described that they were well able to tell about the abuse. Briggs (2006) found that in 62% of the sexual abuse cases the child reported the abuse to a trusted adult and that boys were less likely to report the abuse. Remarkably, the children indicated that some adults ignored reports or defended the perpetrators. Sometimes, 'nothing happened' after a report was made to the police. Also important is the finding that no cases involving older youths were said to have gone to court. Children considered it difficult to report sexual misbehaviour involving these older youths, because of fear of violent retribution, embarrassment, being disbelieved and stigma related to (implied) homosexuality. Reiter et al. (2007) and Akbas et al. (2009) mentioned that more than half of the cases of sexual abuse of children with a disability were never reported and that, when a case was reported, it was often settled administratively and not judicially. They concluded that it is therefore important to encourage children to be open and tell about whatever abuse they experience. As already mentioned, Sullivan and Knutson (2000) suggested that one of the possible reasons for the lower percentage of children with ID among sexual abuse victims they found was a deficient registration by institutes that were responsible for investigating and responding on the suspected abuse.

Overall, the general idea is that many cases of sexual abuse involving children with ID are not reported. When there is a report, there is also less confidence within the justice system in reports and testimonies of people with ID, and these reports are sometimes not or taken less seriously (Reiter et al., 2007). It is often very difficult to determine with certainty if what happened indeed should be considered as a case of sexual abuse. Balogh et al. (2001) mentioned that in only 16% of the cases they examined (7 out of 43), the sexual abuse was proven or very likely to have happened. In the other cases it was less clear. The uncertainty of whether or not sexual abuse took place also seems to increase with the level of the ID, and an unclear conclusion was less common for children without ID.

Cederborg and colleagues (2008) studied 34 interviews of police officers with real abuse victims (31 cases sexual abuse) with varying types of ID. They concluded that repeated interviews are valuable when children with ID are interviewed following (sexual) abuse accusations. Repeated interviews improved the information children with ID provided. However, they also mentioned the poor interviewing techniques they came across and that people who interviewed children with ID needed to be specifically trained to elicit reliable and accurate information. In 2009, Cederborg and colleagues also warned against the use of repeated focused questions by police officers. Such repeated questions would affect the consistency of responding. That is, children changed their answers when a question was asked repeatedly, which would make it difficult to understand what really happened. This could lead investigators to question the credibility of the children. In other words, the children were not given the opportunity to report in a reliable way, because they were asked potentially contaminating questions repeatedly. In 2012, Cederborg, Hultman and La Rooy concluded that most of the questions asked by the police investigators only required short answers and if open questions were asked, the children with ID seemed to report less information compared to children without ID. All in all, Cederborg and colleagues (2009) stated that police officers should give priority to interview strategies that allow them to obtain the most accurate and complete information from the child victims.

In contradiction with the general view, we should also mention the findings of Bottoms, Nysse-Carris, Harris and Tyda (2003). They asked 160 jury-eligible US citizens to make judgments following documentation and video-taped excerpts of a sexual abuse case involving a 16-year old victim and found that, when the victim was presented as 'mildly mentally retarded' by an experimental manipulation, she was considered *more* credible and honest, and less capable of fabricating the sexual

abuse accusation compared with a victim who was presented as 'having average intelligence'. The researchers suggested that adults perceive teenagers with ID like young children, judging them to be honest, trustworthy, innocent and lacking the capacity to fabricate sexual abuse allegations. The defendant was judged to be less credible in case of a mildly mentally retarded victim. The results of Bottoms et al. (2003) showed that 41.5% of the mock jurors judged the sexual abuse defendant to be guilty in case of a mildly retarded victim, compared to only 23.5% in case of a victim without ID, all other things held equal. Thus, jurors seem to trust the narratives of victims who have ID, and they seem particularly likely to convict the suspected perpetrators.

Nevertheless, according to Balogh and colleagues (2001) *real* convictions of perpetrators are still extremely rare in case of abuse of children with ID. Additionally, there are suggestions that if perpetrators are convicted, the punishment is less severe in case of abuse of persons with disabilities (Reiter et al., 2007). Putting everything together, several aspects seem to additionally heighten the risks for this already vulnerable group, and it is therefore important to take away potential barriers for reporting abuse and bringing it to court as much as possible.

Finally, several authors emphasized that there should be more coordination and communication between the parties who possibly know of sexual abuse, such as social workers, child protection agencies, schools, teachers, parents, personnel of work homes, police and staff working in residential facilities (Reiter et al., 2007). Furthermore, attention is paid to the fact that, when there is a report of abuse and subsequent inquiry, the responsible parties should register the reports properly and should conduct the necessary steps in a systematic way. This is often not the case now. Moreover, all reports on sexual abuse are recommended to be combined in systematic registrations or national datasets (Sullivan & Knutson, 2000) and large-scale research on this type of datasets should be conducted to be able to find starting points for prevention, intervention and treatment programs aiming at the diminishment of the risk of sexual abuse (Reiter et al., 2007).

3.3.3. *Policies*

As a final point regarding the reactions on sexual abuse of children with ID the literature paid attention to policy. An explicit policy concerning how to deal with sexuality and sexual abuse within institutions, including schools, is very important according to Reiter et al. (2007). They indicated that this should not only be put down in writing, but also be translated into concrete behavioural guidelines for professionals working in the institute, containing information about every person's responsibilities including, for instance, appointing key figures with certain responsibilities. Additionally, professionals in institutions should regularly speak about these guidelines and there should be formal and informal ways to deal with complaints and reports (Reiter et al., 2007). A conscious, alert and broadly shared institutional culture was considered very relevant according to these authors. Institutions themselves ought to bear responsibility to provide information about their policy and procedures in case of actual sexual abuse in their facilities. Better knowledge of professional guidelines and sanctions could further diminish the prevalence of abuse.

4. Discussion

The current narrative review study is the first specifically focused on sexual abuse of children with ID. A more specific aim offers the opportunity to explore a topic in a more profound manner, as opposed to covering more topics but at a more general level. Additionally, an update on the literature on this topic was in place. In 2006, it was suggested that there had been limited growth in the literature on maltreatment of victims with ID in the late 90s and following years (after main publications such as Sobsey, 1994) (Horner-Johnson & Drum, 2006; Petersilia, 2001). The current review shows that since then several new publications have appeared, even specifically focused on sexual abuse of children with ID, adding new findings to the existing literature and providing new material for the current review. Besides, the current review adds to the existing literature by not merely focusing on the prevalence or extent of abuse, but also on the nature of the sexual abuse (victim, perpetrator and abuse characteristics) and on the institutional reactions, hereby providing a more complete picture of the topic of sexual abuse of children with ID. As such, the current study affords insights that can further contribute to the prevention and intervention of this type of abuse of these already vulnerable victims. Below, we discuss the main findings of our examination of the literature on sexual abuse of children with ID following our research questions and we elaborate further on the topic.

First of all, however, we would like to mention that it is still not straightforward to draw general conclusions regarding sexual abuse of children with intellectual disability (ID), because of the many differences among the studies focusing on this topic, especially in the definitions of ID and of sexual abuse and the variety of methods used to measure these concepts. This is also confirmed by the substantial heterogeneity in results that was found in the meta-analysis of Jones et al. (2012) and these researchers also mentioned this 'ongoing challenge in the discipline' in the discussion. We agree with these authors that there is a need for greater consensus in terms of the definitions, types, and measures of disability and abuse. Therefore, we would like to emphasize that attention should be paid to possible differences in: (1) type of sample (clinical, school-going, residential), (2) respondents or informants (care-providers, case files, self-reports, teachers, doctors, parents), (3) used terms and definitions (for instance, sexual abuse, sexual deviant behaviour, sexual assault, sexual violence, sexual abusive behaviour, sexual harassment, sexual maltreatment, sexual victimization), (4) specificity of the disability (mild ID, ID in general, children with ID and children with other disabilities and/or ID, children with borderline intelligence), (5) how the ID was established (different IQ tests, clinical judgment, file reports), and (6) specificity of the age-group (children, adolescents,

specific age-groups). Furthermore, one should also consider the country in which the study has been conducted and the legal and care procedures in that specific country. Table 3 summarizes the main characteristics of each of the included studies.

4.1. Extent

In line with the mentioned differences between the studies, the results of the included studies concerning the extent of sexual abuse of children with ID showed quite some variation. The prevalence estimates ranged from 14 to 32% of the children with ID having experienced sexual abuse (Balogh et al., 2001; Briggs, 2006; Jones and colleagues' meta-analysis revealed a mean prevalence figure of 15%). The relative risk for sexual abuse was estimated to be 4–8 times higher for children with ID compared to children with average intelligence (Spencer et al., 2005; Sullivan & Knutson, 2000; Jones' meta-analysis computed a mean of 4.6 times greater risk). Finally, of children who had been sexually abused, between 4 and 52% were found to have an ID (Akbas et al., 2009; Kvam, 2000; Sullivan & Knutson, 2000).

Despite this heterogeneity in findings concerning the extent of the sexual abuse in children with ID, the results confirm that children with ID are very vulnerable and at a higher than average risk for sexual abuse. Actually, our findings confirm that of all children with disabilities, children with ID are among the highest risk groups for sexual abuse (Jones et al., 2012; Spencer et al., 2005; Sullivan & Knutson, 2000). There is some question about the causational path, however: although there is a widespread belief that children with ID are more vulnerable to sexual abuse, a reverse causation has also been discussed as a possibility (Firth et al., 2001; Spencer et al., 2005).

There are also some indications that children with milder levels of ID (including borderline intelligence) are more at risk for sexual abuse than children with severe and profound ID. For instance, Balogh et al. (2001) found that most of the children with ID involved in sexual abuse either as victim and/or perpetrator had a mild (44%) or moderate (37%) ID, and only a small percentage (7%) were severe or profound disabled. This is in line with the suggestion of Verdugo, Bermejo and Fuertes (1995) that children with milder intellectual disabilities are at greater risk for sexual abuse than children who have more obvious disabilities. However, as Balogh et al. (2001) mentioned, it is also possible that for children with severe or profound ID it is more difficult to disclose and a higher level of underreporting is likely. Nevertheless, Morano (2001) stated as well that, of all children with ID, the children with *mild* ID were probably at the highest risk for problems with sexual activities (sexual assent, assault and abuse), as these children generally are active participants in all aspects of society (school, work, and leisure time activities) and that they have more personal freedom and possibilities to come in contact with others.

4.2. Nature: victim, perpetrator and abuse characteristics

Not explicitly addressed in most of the empirical studies is the question of what makes children with *ID* especially vulnerable to *sexual* abuse. Akbas et al. (2009) and Briggs (2006) did describe the lack of knowledge of children with ID about what is acceptable sexual behavior. Other literature sources provide more information on the vulnerability of children with ID. Children with ID are said to develop sexually as do children without ID, but their technical knowledge and emotional and social skills are often not developed enough according to their chronic age to deal adequately with their sexuality (Wissink & Moonen, 2014; Wissink et al., 2012). Another important factor is that children with ID are dependent of care and caregivers and, therefore, more vulnerable and less combative. Children with ID often deeply trust caregivers as authority figures, which makes them even more inclined to do whatever they are asked to do. Moreover, as children with ID are used to express affection through physical contact, they can realize less quickly that boundaries are crossed. Also, physical contact is needed to provide good care, with the danger of abuse by caregivers. Besides these factors the wish to be accepted by others is a factor that contributes to the elevated risk. Especially persons with mild ID have a strong need to belong to the group of peers without an ID and to have friends in the 'normal' population. This makes that children in this group are especially vulnerable for coercion and seduction. These vulnerabilities add to existing challenges all children are confronted with, such as the presence of sexual stimuli and situations in daily life, while children with ID have less opportunities to understand their sexuality and to explore their sexual curiosity in a safe way. Finally, when sexually abused, the abuse seems to come to light less easily, and adults are thought to have less confidence in reports and testimonies of children with ID about the abuse experienced, which further contributes to their vulnerability (Wissink et al., 2012).

Remarkably, the available international studies also did not provide much systematic and convincing information concerning the abuse situation itself and the perpetrators. More large-scale research is needed to fill these gaps. What we did find is that in case of (same-aged) perpetrators with ID, powerlessness is an often seen characteristic (Firth et al., 2001). Children with ID who become perpetrators of sexual abuse often show aggressive behavior besides the inappropriate sexual behavior. Controlling behaviour, bullying and abusing other children can be a reaction to powerlessness as a result of own experiences with sexual and/or physical abuse (cycle of abuse).

4.3. Reactions: signalling, prevention, intervention and reporting

Before we discuss the findings following our narrative review on the institutional reactions on the sexual abuse of children with ID, we would like to emphasize that it is important that professionals, like medical doctors, psychologists, care providers, teachers and other persons working with children with ID recognize signs of sexual abuse. Physical indicators of possible sexual abuse of children with disabilities are difficulties with sitting or walking, bruises or bleedings of the genitals,

vagina, or anal area, presence of sperm, venereal diseases, pregnancy, torn, bloody or smudged underclothes, pain or itch in the genital areas, repeated infections of the urinary passages and stricken hymen at a very young age. Indirect, behavioural signals are lack of appetite, sleeping problems, crying, nightmares, withdrawn behaviour, social isolation, running away, depression, suicide urges, apathetic behaviour, auto-mutilation, anxiety, hallucinations, not being able to speak about the incident, avoidance and blockade, bad peer relations, anger, verbal or physical aggression, delinquency, tempting, promiscuous or sexually deviant behaviour or knowledge of sexual behaviour that is inconsistent with the developmental level. Finally, for young children, preoccupation with their own and others' sexual organs could be a signal (Balogh et al., 2001). Possible signals of sexual abuse should not only be noticed, but should also be interpreted in the right way: are these signals of sexual abuse or of other nature that could or could not co-occur with the specific disability? Hereby, it is very important that professionals have the right knowledge of the typical behaviours of children with a certain age and/or disability.

Although the studies we reviewed did not pay attention to these signals, they did pay attention to other measures for prevention and intervention. All authors agreed that educating and training children with ID could reduce their vulnerability, although one should take into account the limited ability to learn of many of these children and their problems to apply things taught in other situations. Therefore, further investment in the development of training programs should be promoted, especially focused on both victims and perpetrators of sexual abuse with ID. One could think of sexual education, defensibility training, and therapeutic sessions dealing with abuse experiences. Talking about sexuality and taking the subject out of the secretive atmosphere could also help to prevent sexual abuse. Briggs (2006) warned that some organisations might be unwelcoming regarding new programmes focusing on protecting children from sexual abuse, as higher rates of sexual abuse reports have sometimes been understood as institutional failure rather than success. New programmes will also add to the already heavy work load of many professionals in youth care, and one should be sensitive to issues like these if one aims to implement new programmes. More specific examples of possibilities that Briggs (2006) mentioned are training the ability to recognize potentially dangerous situations, establishing rules about sexual behaviour of children and professionals and improving the understanding of children's rights in relation to sexual abuse (Briggs, 2006). In the Netherlands, following the broader research project that encompassed the current study, several measures were undertaken to protect the children, such as the development of an action plan called 'Children safe' which provides measures to prevent and stop child abuse, measures to signal child abuse at an earlier stage and to be able to limit the negative consequences, and a special taskforce child abuse was brought into being for attenuated attention for the development and observance of these measures.

As said, programs for children with ID should take into account the specific difficulties these children encounter. Because of problems with generalization one should work with concrete 'do-situations', work in small steps, with repetition, and have attention for putting the things taught into practice in other situations. The complete network around the children should also be included in these programs. Moreover, this should all be provided within a supporting, stimulating and structured context (De Wit, Moonen, & Douma, 2011).

It is also important to focus on the reports of suspected sexual abuse. The literature indicates that many cases of sexual abuse of children with ID are not reported by the victims themselves, but also not by their parents and care providers. This should be kept in mind when interpreting the statistics as well. If one assumes that the underreporting is even stronger in case of children with ID, compared to children without developmental difficulties, the elevated risks for children with ID may be even higher than the studies based on registrations suggest.

When a report is being made, it appears extremely difficult in many cases to prove that it really was 'sexual abuse'. This low evidential force is associated with the lack of experts, like doctors, psychologists, psychiatrist and police officers who have been trained to use specific techniques that are needed to talk about abuse with children with (mild) ID. For instance, professionals should avoid the use of repeated focused questions. Cederborg et al. (2009) discussed that focused questions encourage children with ID to respond even when they do not know the answer, leading them to respond inaccurately. Children with ID may have learnt to rely on others when they fail to remember or understand the questions asked, which increases their suggestibility. Therefore, professionals should be specifically trained to avoid techniques that lead to inaccurate answers and replace them with techniques that lead to more reliable and convincing reports with stronger evidential force (open-ended invitations or open directive questions) (Cederborg, Hultman, & La Rooy, 2012). Additionally, the findings of Bottoms et al. (2003) showed that the thought that victims with ID are perceived as incredible witnesses might not be grounded, as they showed that, if allowed to testify, victims with mild ID might not be necessarily be disadvantaged compared to witnesses without ID. According to them, the dismissal of allegations of children with ID as incredible does a disservice to a large, generally unrecognized group of sexual abuse victims, frustrating legal efforts that would offer them and their peers protection against sexual abuse and the needed youth care (Bottoms et al., 2003). Furthermore, in general, all information about child abuse should be collected accurately, and the information gained out of these reports should be registered on a national level.

4.4. Future research

Besides these new insights, there are still some caveats in the literature and in light of the heightened vulnerability of this group, more solid large-scale quantitative research is needed on both the extent, nature and intervention of sexual abuse of children with ID. Internationally, more uniform definition and measurement is greatly needed, and advanced research

designs and methods of analyses should be employed to further improve knowledge about sexual abuse of these vulnerable children. Also, at present not much is known about the effectiveness of different types of programs aiming at the prevention and intervention of sexual abuse involving children with a disability, both as victims and perpetrators (Skarbek et al., 2009).

Additionally, there is still much to learn about the sexual development and sexual behaviour of children with ID. Especially within the group of children with mild ID, it is difficult to differentiate behaviour designated as 'abuse' from behaviour that is part of their play repertoire and from their experimenting behaviour (Balogh et al., 2001). More information is needed for a correct delineation of behaviour.

And finally, most of the studies on sexual abuse of children with ID we found were quantitative in nature. Qualitative research could provide more information about the situation of the abuse itself, about what has happened, about how the abuse started and about the development from there, about how children report of being pressured or seduced or, in other words, about how the abuse could have happened. These qualitative descriptions could provide additional insight into how sexual abuse of children with ID can be prevented better in the future.

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