"You Can Change Your Mind About Who You Trust": People with Intellectual Disability's Understanding About Healthy and Unhealthy Relationships

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Abstract: This qualitative study explores people with intellectual disability's understanding of healthy and unhealthy relationships and potential actions to prevent abusive or exploitative relationships. A total of 109 women and men with varying levels of intellectual disability participated in responding to pre and post-video vignette interview questions based on scenarios of healthy and unhealthy relationships. Researchers used conventional content analysis to examine responses. Five themes emerged including agency to solve a problem, identifying unhealthy relationships, identifying healthy relationships, staff roles versus friend roles, and blaming the victim. In addition to addressing compliance and rule-based behaviors, the LEAP intervention design provides real-world examples of unhealthy relationships and a safe place for exploring nuances within the relationships.

People with disabilities are disproportionately vulnerable to physical and mental abuse and exploitation, which can have a profound and long-lasting impact on their quality of life (Hughes et al., 2012). People with intellectual disability (ID) are even more at risk to experience abuse compared to people with other disabilities (Office of Justice Programs, 2018). The forms of abuse that people with ID might experience include physical, sexual, emotional, financial, restrictive actions, among others (Araten-Bergman, et al., 2017; Beadle-Brown et al., 2010). For people with ID, abuse typically starts in childhood and persists throughout their lives (Catani & Sossalla, 2015). Most perpetrators of abuse are known to the victim with ID, and often include people on whom the victims are reliant for care and support, such as paid staff (Harrell, 2017; Stevens, 2012). People with ID who live in residential settings are at an exceptionally high risk of abuse, which may be compounded by the fact that people with ID are generally not taught to recognize and report abuse (Araten-Bergman et al., 2017).

Structural barriers to help-seeking and help-receiving, along with stigmatization of and paternalism toward people with ID and abuse victims, create additional challenges for abused people with ID (Hughes et al., 2012; McGuire & Bayley, 2011). Sobsey (1994) suggested that the key to understanding the victimization of people with ID is their lack of autonomy over their lives. Sobsey contended that people with ID lack the opportunities and the support to decide how

they can live their lives. They often must rely on others, over whom they have little or no control, to meet their physical, psychological, or economic needs. People with ID want to have friendships and close relationships with others (Hurd et al., 2018; Scott & Havercamp, 2018); yet, people in their circle, including family members and staff, frequently control access to potential friendships and close relationships and can make it challenging to maintain connections with others (Scott & Havercamp, 2018). Research further suggests that for people with ID, the service system has a history that systematically reinforces compliance. Compliant behavior is an additional risk factor when people with ID comply with requests that result in abuse (Mazzucchelli, 2001; Saxton et al., 2001).

Abuse Prevention Programs for People with ID

In recognition of the abuse risk for people with ID and the need for programs that are tailored to their experiences and learning needs, a number of abuse prevention programs have been developed and evaluated, as demonstrated by systematic and scoping literature reviews of abuse prevention programs for people with ID (Araten-Bergman & Bigby, 2020; Araten-Bergman et al., 2017; Barger et al., 2009; Doughty & Kane, 2010; Lund, 2011; Mikton et al., 2014). These reviews show that most abuse prevention programs for people with ID are geared toward males and females with mild to moderate ID and are grounded in a theoretical model. Sociodemographics of program participants besides ID level and gender are largely missing. Most programs use in-person sessions facilitated by people who do not identify as having a disability, and the sessions incorporate verbal and textual modes of knowledge transmission. Some of the programs involved people with disabilities in the development of their curricula. They generally do not include or report ways that the curricula have been adapted, such as for participants who communicate in ways other than verbally or for participants with varying support needs. The curricula can be grouped into cognitively-based, behaviorally-based or psychoeducational, and they typically include strategies to enhance participants' skills to avoid or respond to abusive situations.

The most typical evaluation designs reported in the systematic and scoping reviews noted above (Araten-Bergman & Bigby, 2020; Araten-Bergman et al., 2017; Barger et al., 2009; Doughty & Kane, 2010; Lund, 2011; Mikton et al., 2014) were pre-post quantitative assessments, primarily of attitude and knowledge changes although some of the studies included a measure of skills acquisition. Some of the studies reported in the reviews incorporated follow-up assessments, ranging from 1 week to 3 months after the intervention. Randomized control studies have been rare as have been measures of actual abuse incidents or frequency. Even though implementation fidelity has been raised as an important component to community-based interventions (Breitenstein et al, 2010), the systematic and scoping reviews typically did not report on whether implementation fidelity was assessed in the studies. Additionally, the reviews typically did not involve an assessment of the validity of the measures for people with different levels of ID; this is an issue because of barriers to full participation in research by people with ID due to inaccessible consent processes and measures, for example (Dryden et al., 2017; Kidney & McDonald, 2014).

Qualitative Studies on Abuse Prevention for People with ID

In one of the few qualitative studies of abuse prevention with people with ID, Ottmann et al. (2016) asserted that abuse-oriented safety training "should focus on situations that are less readily identifiable" (p. 47). The nuances in some situations of potential abuse and exploitation can be difficult to identify and respond to. The authors noted that common strategies presented in abuse-focused safety training, such as disclosing or reporting the abuse to someone, were typically not the strategies that their participants reported (12 male and female Australians with mild to moderate intellectual disability). Rather, most participants engaged in behavioral strategies to avoid or leave an encounter that felt unsafe and they did not report the encounter to authorities. The majority of participants, however, did report that they would engage the assistance of family caregivers or service providers when needed to enact their safety strategies. The authors conclude that people with mild or moderate ID should be involved in assessing risk and making their own decisions about situations that they may face in their daily lives. Additionally, because some study participants did not have trusted persons in their circle, people with ID may need to reach out to formal support systems when familial and other informal support persons are not available.

In a qualitative study on sexuality, sexual abuse, and self-protection skills, Eastgate et al. (2011) explored how nine women with ID understood sex, relationships, sexual abuse, and preventive actions. Findings indicated that most women with ID reported their understanding of sex was limited, had experienced unwanted or abusive sexual experiences, and lacked the self-protection strategies and the skills to obtain appropriate support independently.

In sum, few studies have explored people with ID's conceptual understanding of both healthy and unhealthy relationships and potential abuse prevention actions. The Ottmann et al. (2016) study is one of the few that offers insight into people with ID's perceptions on what they can do to keep safe from abuse and neglect and what others can do to help them stay safe. The authors of this study pointed out that the participants' responses, "grounded in their own lived experience" illustrate that they have the "capacity to develop strategic responses to perceived risk" (p. 58).

Further exploration is needed on the ways in which adults with ID understand healthy and unhealthy relationships and the potential strategies that they would enact to prevent or respond to abuse (Mikton et al., 2014). Additionally, there were no qualitative studies that the authors found that specifically address ways abuse prevention programming can impact participants' understanding of healthy and unhealthy relationships and their potential help-seeking strategies. By listening to people with ID's understanding of healthy and unhealthy relationships and potential help-seeking strategies, researchers and practitioners will be better able to develop and evaluate abuse prevention programs for this population that will be in tune with their lived realities, including presenting relationship scenarios that embody the nuance and ambiguity that people with ID face in their relationships with others.

In this article, we present findings from a study of people with a range of levels of ID, who participated in a four-session abuse prevention program, which was assessed at pre and posttest using quantitative and qualitative methods. The authors present the findings from the qualitative data.

About Leadership for Empowerment and Abuse Prevention (LEAP)

LEAP, *Leadership for Empowerment and Abuse Prevention,* is an evidence-based healthy relationships program designed for adults with mild, moderate, and severe intellectual disability. The LEAP Training Program was developed with input from people with disabilities along with a multidisciplinary team of professionals and family members. LEAP also employs people with disabilities as co-trainers in its presentation. The training is held in four highly interactive sessions. Families and staff who support participants of the LEAP Training Program are given access to an online partner guide and video-based summary of each LEAP session.

Theoretical Framework for LEAP

Bandura's (1978) Social Cognitive Theory (SCT) is the theoretical framework that informed the development of the LEAP curriculum. In SCT, self-efficacy is related to people's beliefs about their capabilities, which then influences their motivation and actions. People's self-efficacy beliefs can be enhanced when they have experiences where they are able to master an activity and through social modeling. When people believe they will be able to perform an activity successfully, they feel greater self-efficacy and are more motivated to engage in that behavior (Bandura, 1997).

Self-efficacy of people with ID, as related to health promotion activities, is connected to fostering motivation at the individual, contextual, and interactional levels (Michalsen et al., 2020). On the individual level, motivation to engage in the health promotion activity is enhanced when the activity is viewed as fun and is done in a social setting or incorporates technology. On the interactional level, motivation increases when the activity is done with others and when rewards are available for participation. On the contextual level, involvement of support persons in the activity as well as the ways in which the activity is presented can impact motivation. Support persons can increase or decrease motivation depending on their level of involvement or lack thereof (Michalsen et al., 2020). Thus, motivation for people with ID needs to be viewed as a relational experience influenced by contextual factors, which can support or deter individual involvement in health promoting activities. Self-efficacy beliefs of people with ID can also be enhanced through positive feedback and enjoyment (Nota et al., 2010).

Building on the tenets of SCT, the LEAP intervention offers opportunities to build individual capacity to recognize and respond to unhealthy relationship scenarios through the use of engaging, multimodal, group-based teaching and learning strategies. Participant learning is reinforced by observing and practicing desired behaviors. The LEAP Power Statement builds confidence and self-efficacy among participants and is reinforced in every session and through LEAP bracelets, which are given to participants as a visual cue from the program. Certificates of completion are also given to participants. Recognizing the importance of staff and other support persons in their role of reinforcing the core concepts of the curriculum (see Table 1), the project developed a companion guide, which is designed to complement the key points of the LEAP curriculum and to support LEAP participants in using their new knowledge and skills.

Method

Aim

This study aims to explore participants' responses before and after the LEAP intervention when presented with video vignettes (see Table 2) on healthy or unhealthy relationship scenarios.

Table 1. *LEAP session core concepts*

Session title	Key concepts
People in your life	The meaning of respect, what it means to deserve respect, internal and external strength The meaning of trust and how it relates to the relationships each person has/ encounters - using a map to show levels of relationships The different relationships in the participant's world - very good friends, trusted family members, friends, paid staff, acquaintances, strangers, love interests, and those who people no longer wish to have in their lives Exploration of the question: "Are all staff your friends?"
Healthy relationships	Reinforcement of the key concepts from session one Characteristics of healthy, unhealthy, or confusing relationships Correct names for private body parts and why it is necessary to use them Rules surrounding consent and the meaning behind "saying yes", "saying no", or "saying nothing" Experiential activities to model the complexities of consent and practice different ways to deny consent
Healthy touch	Reinforcement of the key concepts from sessions one and two The meaning of healthy, unhealthy, or confusing touch Activities that allow participants to practice distinguishing between the different types of relationships and touch through example scenarios Rules for healthy touch are explained
How and when to get help	Reinforcement of the key concepts from the three previous sessions How to get help if someone is in an unhealthy or confusing relationship How to get help if someone is in immediate danger of abuse Who to contact in confusing and unhealthy situations

Additionally, researchers wanted to better understand what participants identified as next steps when viewing an unhealthy scenario.

Design and recruitment of participants

This is a qualitative study that used a conventional content analysis approach as detailed by Hsieh and Shannon (2005) and other scholars (see, for example, Vaismoradi et al., 2013). The present research is part of a larger efficacy study conducted in one mid-Atlantic state that received approval from the supporting university's Institutional Review Board. This study used purposive sampling techniques and recruited participants from 15 community, day and residential support agencies that serve people with ID. These agencies provided the physical space for the larger research project that included the following: consent, pretest, four 90-minute LEAP sessions, a posttest and a 3 month follow up posttest. For the current study, qualitative responses to the pretest and posttest were included in the analysis.

The LEAP intervention, vignettes, and open-ended pre/posttest questions were created in partnership with adults who have a disability, family members, community and university professionals in fields including health, domestic violence, child advocacy, and social services.

Data collection procedure

To be included in this study, participants had to complete the consent process, pretest, four LEAP sessions, and the posttest. Participants

Table 2. *LEAP vignette descriptions*

Vignette storyline	Core concepts	Questions
Supervisor yells at an employee.	Trust, respect, boundaries	1) If someone makes you feel bad you should tell someone you trust? Yes/no? Why?
Assistant asks permission to help a person with counting money.	Difference between staff and friends, trust, respect, ask permission	1) Does Jamal have a healthy relationship with Fred? Yes/no? Why? 2) What should they do next?
Van driver sexually assaults person.*	Trust, unhealthy touch, ask permission, respect,	1) Is it Tomika's fault that Bill tried to kiss her because she rode in the front seat of the van? Why? 2) What should Tomika do next?
Friend betrays trust.	Trust, respect, boundaries	1) Is it ok for Nicole to change her mind about who she can trust? Why? 2) What should she do next?
Person is denied transportation to physical therapy as punishment.	Trust, respect	1) Is it alright that Lisa will not take Rodney to his appointment? Why? 2) What should he do next?
Staff respectfully supports a person putting away dishes.	Difference between staff and friends, respect	1) Staff are always my friends. Yes/no? Why?

* Example of vignette dialogue, "Bill is a van driver. One day, Bill asked Tomika if she would like to sit in the front passenger seat for the ride home. Tomika said 'yes'. When the van got to Tomika's house, Bill leaned over to open the door for her, and his arm rubbed against Tomika's breast. The next day, when Bill reached over to open the van door, he tried to kiss her. Bill told Tomika not to tell anyone because she would get in trouble for riding in the front of the van."

received no compensation for participating in the research.

Research data were collected before and after the LEAP intervention. The pretest and posttest included six-video vignettes presented on a tablet to participants (see Table 2). Each vignette lasted approximately 40 seconds and were offered to research subjects two times. After viewing a vignette, a participant was asked one or two predetermined open-ended questions about the vignette. Each pre and posttest was completed in an area of the agency that provided the most privacy for the participant. The data collection took approximately 25 to 90 minutes per participant to complete, depending on their level of ID and use of a communication device.

To be included in the research, eligible participants had to be 18-65 years old, have an ID diagnosis reported by a community agency, legal guardian, or a family member. The participants either provided informed consent or their legal guardian provided informed consent. Participants with legal guardians provided assent to participate in the study to ensure they understood the study description and risks. All participants were informed they could stop at any time during the research process.

Study participants

The study focused on 109 participants (56 females, 52 males, one missing) who were diagnosed with mild (*n*=49), moderate (*n*=33), severe (*n*=3), unspecified (*n*=4) or "no diagnosis" (*n*=20) level of intellectual disability. Within the study, 67.9% of participants were their own decision makers compared to participants (*n*=35) who had a legal guardian. Participants had a range of housing types, from independent living

(*n*=9), parent or relative's home (*n*=57), host/sponsored home (*n*=8), agency with one or two residents (*n*=2), agency with three to six residents (*n*=29) or an agency with seven to twelve residents (*n*=4). The majority of participants were identified as White (50.5%) and Black (38.5%) in addition to 2.8% being identified as Asian, 4.6% "two or more races," 0.9% Hispanic and 4.3% of participants did not have a specified race listed. The mean age of participants was 34.3 (SD=13.5) years old.

Data Analysis

This study used conventional content analysis to analyze the data from the pre and posttest. The methodological approach was inductive and followed patterns within the specific data (Graneheim et al., 2017; Vaismoradi et al., 2013). Data were analyzed using Graneheim et al. (2017)'s inductive content analysis technique.

One LEAP research member entered all the semi-structured interview responses into Microsoft Word then added them to a data management tool, Dedoose (2021). Data were then reviewed to identify emerging themes. Data were read in entirety by one author, making notes of similarities (Hsieh & Shannon, 2005) prior to dividing the data into "meaning units," which were then combined into initial codes (Graneheim et al., 2017). Once initial codes were identified, a second researcher reviewed the codes and assisted in re-organizing and condensing the codes. At this time, codes were compared between the pretest and posttest and placed into 28 categories. The two researchers immersed themselves in the data for approximately 10 months, which allowed for constant reflection and the ability to discuss the identified categories and revisit the data to continue to condense and edit accordingly as recommended by Elo et al. (2014). Throughout the reflection period the categories were discussed with the LEAP team for further input on the identified categories. Finally, through the lumping and sorting process, the categories were reduced to 14 and five themes emerged from the data.

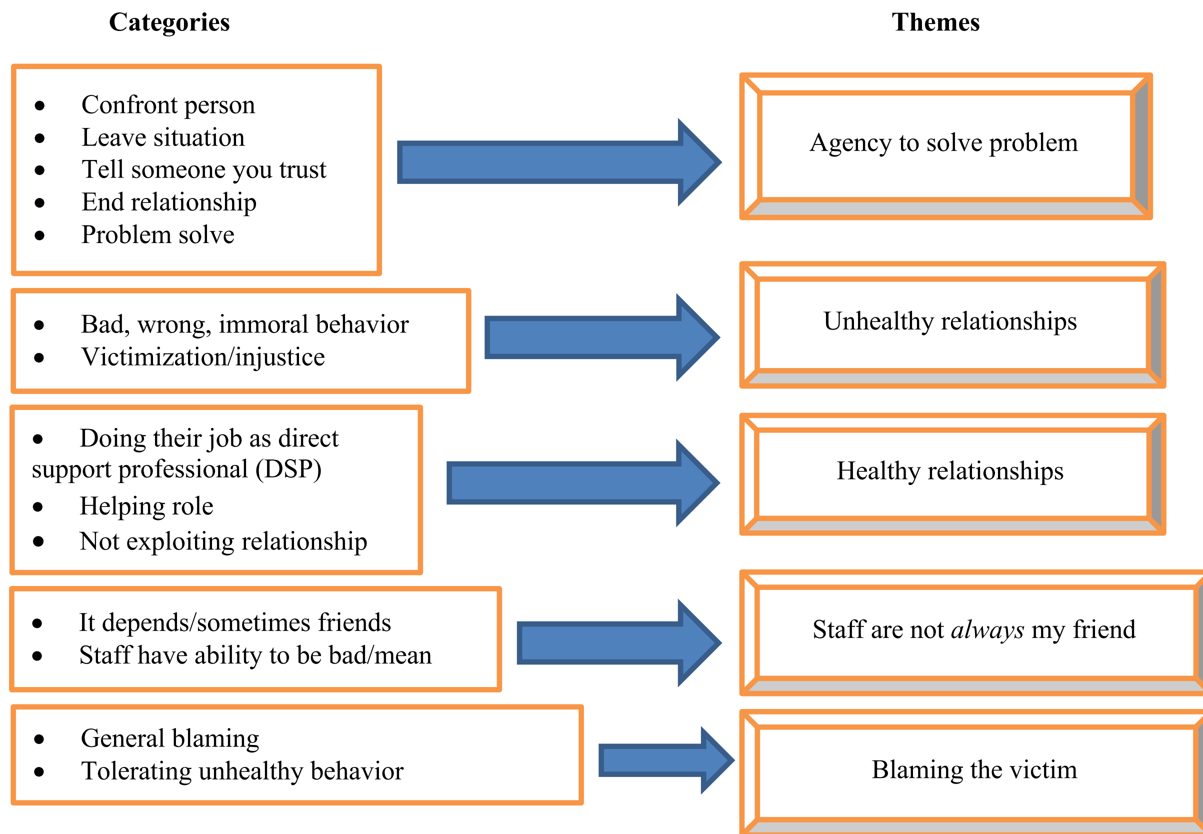
Trustworthiness and credibility

Conducting a conventional content analysis was best suited for this study as it allowed the research team to discover meanings within the data to create the categories instead of using theory to direct the analysis (Hsieh & Shannon, 2005; Lincoln & Guba, 1985). To increase trustworthiness or rigor of the study, the research team incorporated numerous credibility strategies such as member checking, peer debriefing, prolonged engagement, and persistent observation (Hsieh & Shannon, 2005; Lincoln & Guba, 1985). Prior to starting research, people with disabilities were included in the creation of the LEAP curriculum, video vignettes, session implementation and data collection. Member checking did not occur with the participants themselves, but with trainers of the LEAP sessions. The analysis of the data occurred over a 10 month period encouraging prolonged engagement and consistent peer debriefing, which occurred on a weekly basis. Peer debriefing included discussions of the conceptualization and reorganizing of codes, consistency between both coders, and also reflection on any issues of confirmability where there may be researcher bias (Lincoln & Guba, 1985).

Results

This study had five themes emerge from the data, summarized in Figure 1. The themes are agency to solve a problem, identifying unhealthy relationships, identifying healthy relationships, staff are not always my friend, and blaming the victim. A description will be provided for each theme and the categories that fell under each theme. Number of occurrences for each category at pre and posttest is

Figure 1. Summary of the analysis



provided. Illustrative quotes from LEAP participants are included.

Agency to solve problem

In this research, agency to solve a problem was interpreted to mean a participant's ability to proactively find a solution to the vignette scenario. This theme included five categories (see Table 3). For all results' tables, the category with the greatest percentage increase in number of occurrences and the category with the greatest percentage decrease in number of occurrences are noted.

Confront person

This category emerged from participant responses stating a person in the vignette scenario needs to directly interact with a person who caused them harm. There was a slight decline in *confront the person* responses from the pretest to posttest. However, the pretest responses were considerably simpler in how to confront someone that was causing harm. For example, in the scenario where a van driver tries to sexually assault a client, a participant stated, "slap him" compared to a posttest response of "Tell him to 'back off', [and] not to kiss her. She doesn't like it."

Leave situation

Leaving a situation included responses that described hiding, walking away, or avoidance of the situation. The number of responses slightly increased from the pretest to posttest. Sample responses in this category were "walk away" and "they should run" on the preset to answers that suggested things like making new friends and ending unhealthy relationships in the posttest.

Tell someone you trust

This category had significantly more responses on the posttest compared to the pretest. The responses ranged from telling anyone to a parent, legal guardian, case manager or the police. For this theme, participants' responses often got more specific starting with "tell someone" at pretest to "tell somebody who they can trust, an adult or someone they know who can talk about it and fix the problem" after the invention at posttest.

End relationship

Ending a relationship had three main subcategories including stopping a relationship (friend or staff), replacing the relationship (friend or staff), and changing your mind about who you trust. The last concept about changing your mind on who to trust was introduced in the LEAP intervention and this category significantly increased in number or responses at posttest. During the posttest, one participant reported "Not everyone is going to be your friend, some people will be friends, some people won't, and we can change our minds [about them being our friend]."

Problem Solve

The category, "problem solve" had twice as many responses for the posttest. Language in this category described trying to find a solution or negotiating a tenuous situation. In a video vignette that depicted an aide yelling at a person with ID for making a mess and telling him she would not take him to therapy, responses included, a suggestion to "find another aide" on the pretest to suggestions that he could clean up after his therapy session on the posttest.

Unhealthy relationships

The second theme that emerged was identifying unhealthy relationships. This theme had two categories, identifying *bad, wrong, or immoral behavior* and identifying victimization/injustice in scenarios (see Table 4). Both categories had a slight increase in identifying unhealthy relationships on the posttest.

Bad, wrong, immoral behavior

This category included descriptions of identifying unhealthy behavior from staff and friends who were yelling, sharing private information, refusing to take a client to treatment, or identifying sexual assault as abuse. As mentioned, the number of incidences for this category were only slightly higher on the posttest; however, responses were vastly different in the depth of detail after experiencing LEAP. A common series of responses on the pretest for a scenario where a staff member refuses to take their client to a doctor's appointment was "she should take him" or "she should help him out" compared to a posttest response of "Because she's yelling at him, and he has special needs. She's being abusive.

Table 3. *Agency to solve problem (n=109)*

Category	Pretest (# of occurrences)	Posttest (# of occurrences)
Confront person *	58	45
Leave situation	19	26
Tell someone you trust	175	240
End relationship	42	41
Problem solve **	27	67

* = category with greatest percentage decrease pretest to posttest; ** = category with greatest percentage increase pretest to posttest

She needs to be nicer to him and know [the] needs of [a] person with down syndrome." For the scenario with the van driver who tried to kiss the client, the posttest had more responses where participants were able to identify abusive behavior, such as "...it was the guy's fault cause he's being abusive and taking advantage of her."

Victimization/injustice

The second category in this theme was identifying victimization or injustice in the vignette scenarios. Participants did this by focusing on the victim's experience of being innocent and identifying when a scenario had components of people being deceived. The incidences on the pretest and posttest were similar with a slight increase on the posttest. As mentioned before, the depth of response was greatly different on the posttest. For example, a response on the pretest was that the victim did not want to receive a kiss from her van driver, versus an acknowledgement that the victim did not do anything to deserve the assault on the posttest. A participant during the posttest stated, "She didn't say anything, she just got in the van. He's the one who told her to ride in the front seat and trying to use her sexually."

Healthy relationships

This theme allowed participants to discern between healthy relationships with staff and friends. This third theme included three categories, staff appropriately doing their job, helping, and not exploiting (see Tables 5, 6, and 7).

Table 4. *Unhealthy relationships (n=109)*

Category	Pretest (# of occurrences)	Posttest (# of occurrences)
Bad, wrong, immoral behavior	198	209
Victimization/injustice**	18	24

Note. ** = category in this theme with greatest percentage increase pretest to posttest.

Table 5. *Healthy relationships (n=109)*

Category	Pretest (# of occurrences)	Posttest (# of occurrences)
Doing their job as direct support professional (DSP)**	8	27
Helping role	44	73
Not exploiting relationship	43	53

Note. ** = category in this theme with greatest percentage increase pretest to posttest

Table 6. *Staff are not always my friend (n=109)*

Category	Pretest (# of occurrences)	Posttest (# of occurrences)
It depends/sometimes friends	10	15
Staff have ability to be bad/mean**	5	11

Note. ** = category in this theme with greatest percentage increase pretest to posttest

Table 7. *Blaming the victim (n=109)*

Category	Pretest (# of occurrences)	Posttest (# of occurrences)
General blaming	97	76
Tolerating unhealthy behavior*	59	19

Note. * = category in this theme with greatest percentage decrease pretest to posttest

Doing their job as a direct support professional (DSP)
This category highlighted the expectation staff would complete their paid work regardless of how the client is behaving. Not many pretest responses fell into this category of being able to identify and acknowledge that it was the professional responsibility of the DSP to carry out specific tasks. Two varied examples are “it is their job” and “blanket statement, don't know if you like him or not, it’s a professional relationship, not a personal one.” Posttest responses included specific duties of a paid support staff, for example, “The staff [are] there to get paid and help with independent living, manage money or shopping and stuff …”

Helping role
This category had almost twice as many occurrences on the posttest and highlights the nuance between staff serving in a helping role versus being a friend. Sample responses on the pretest included themes that acknowledged that staff are helpful, “they help you out when you need them,” whereas the posttest responses included more detail about staff assisting with problem solving, for example, “Because you can go to staff if you need help or a situation goes on in the community or in the house.”

Not exploiting the relationship
The third category within this theme had slightly more incidences on the posttest; however, responses were similar in depth. In this category, participants recognized that staff had an opportunity to exploit someone, but instead proved trustworthy. For example, asking someone to take money from their wallet to pay for something and counting the change with them rather than stealing from them was seen as a healthy relationship because they did not steal money.

Staff are not always my friend
This theme was an advanced concept for participants to report due to the nuance of helpfulness commonly being associated with friendship. This theme had a low occurrence rate, for both the pretest and posttest; however, the depth of responses in the posttest are highlighted below.

It depends/sometimes friends
This category captured the confusing nature of being kind, helpful and still being a paid support. Participants recognized that staff work cooperatively and could develop true friendships with them, but not all staff would. An example of this was on the posttest, “Because staff works with you and are in charge of you. Some are friends but not all. They are paid to support you, not be your friend.”

Staff have ability to be bad/mean
Some posttest responses highlighted the realization that paid support have the capacity to be unkind, with replies that recognized that staff could be untrustworthy and not treat people as they should, for example, “they could say stuff to others and break trust, not treat people like they should be treated.”

Blaming the victim

The fifth theme, *blaming the victim*, included responses where individuals in the scenarios were blamed for being sexually assaulted because they broke rules or did not stand up for themselves. It also included blaming individuals who were in unhealthy relationships and encouraged victims to either be quiet and suffer or tolerate the behavior. This theme declined in occurrences from the pretest to the posttest.

General blaming

General blaming of the victim was higher in the pretest than posttest. This category had a high number of responses in both the pretest and posttest that reported victims could have prevented abuse if they would have followed rules. Examples of pretest responses suggested that the victim broke a rule by sitting in the front seat and could have avoided the assault had she obeyed the rules, "I think that she should have stayed in the backseat to avoid sexual assault and rape." A response on the posttest that suggested that the victim should have set limits on the perpetrator is "cause it's wrong if you let him kiss [you]. You didn't say anything to stop him, didn't do anything, he's doing his job."

Tolerating unhealthy behavior

Responses that indicated the victim needed to stay in the unhealthy situation drastically decreased from the pretest to posttest. On the pretest, a participant stated that the victim should allow herself to be assaulted by following the perpetrator into his house so that he could "do what he wants to do with her." Similarly, on the posttest, a respondent stated that it was the victim's fault for trusting someone who did not behave honorably.

Discussion

The LEAP intervention was developed to support people with ID in distinguishing the differences between healthy and unhealthy relationships/situations, understanding how unhealthy relationships may lead to being a target of abuse, and knowing how to respond when in an unhealthy relationship/situation. We believe this information is essential for decreasing their risk of abuse and exploitation.

In some post-intervention responses, people with ID demonstrated an ability to understand the nuances between healthy and unhealthy relationships. As highlighted by Ottmann and colleagues (2016), it is critical that abuse prevention programs address complex scenarios that mirror real-world, often unclear scenarios that people with ID often encounter with unhealthy relationships.

In other responses, research subjects focused on organizational rule-based behaviors that took precedence over affirming that a relationship was unhealthy or abusive. Reliance on compliance or rule-based behaviors and actions may pose a barrier to people with ID developing deeper understandings of abusive and exploitative relationships and their ability to change their behaviors and take action when presented with abusive situations (Mazzucchelli, 2001; Saxton et al., 2001). Abuse prevention intervention designs need to acknowledge and address the issue of compliant or rule-based behaviors directly so that people with ID are exposed to and empowered to take action when confronted with challenging and often confusing unhealthy situations.

After completing the LEAP sessions, participants began to adopt the language and tools presented in the training to describe and address healthy and unhealthy relationships. The LEAP training provided a framework and vocabulary for characterizing relationships and specific tools that can be used when confronting unhealthy relationships/situations. For example, "tell

someone on her trust card" was reported by multiple individuals as a way to solve a problem. The "trust card" was provided during the first LEAP session and included participant-completed and general emergency contact information for quick reference in case of a questionable or unhealthy situation. Promoting an abuse prevention vocabulary (e.g., "tell someone you trust") and providing concrete tools for practicing that vocabulary and action like completing a "trust card" seemed to be an effective strategy for reinforcing the core concepts of the curriculum.

For several scenarios, participants focused on irrelevant details instead of the core component presented in the scenario. In those instances, many participants did not answer the question asked, but instead focused on the immaterial details within the story, which seemed to derail them from being able to assess the more relevant aspects regarding the relationships in question. Another issue that evoked ongoing comprehension problems was confusion regarding pronouns. Responses were recorded verbatim, and therefore could not be coded because the researchers were unclear about whom the participant was describing.

Given these challenges, future researchers are encouraged to balance rigor in their study data collection protocols with flexibility to ask probing or follow up questions based on participant responses. Building in the flexibility to probe and ask follow up questions may increase data quality, allow research participants to focus their attention on the key elements of study rather than on extraneous details, and help to clarify responses that are unintelligible without further explanation.

Limitations

Recruitment for participants in our study was through formal ID service systems (agencies that provide ID support & advocacy organizations). As a result of our recruitment methods, people who are not connected to formal ID support systems were not included in the study. Future research is needed to better understand the experiences of this group of people, the relationships in their lives, and if interventions such as LEAP are able to improve their understanding of healthy and unhealthy relationships.

Additionally, the study relied heavily on communication to understand how people with ID view healthy and unhealthy relationships. While we provided visual aids and some individuals used communication devices, our only window into understanding the perspectives of people with ID was through responses from research participants. Many people with ID who are victims of abuse, neglect, and exploitation do not have communication systems. While people with ID with limited communication can and should be included in abuse prevention interventions, we still know little about the benefits of abuse prevention interventions, like LEAP, for this group.

Finally, the theoretical framework of LEAP is predicated on the idea that changes in beliefs will influence self-efficacy and action. For this study, the way that we examined participant changes in understanding and action was through responses to vignette scenarios. We did not include abuse incidence rates or data collection on how participants reacted to real-life unhealthy encounters after the LEAP intervention as outcome measures. Since the central purpose of LEAP is prevention of abuse, our research team, and others examining outcomes of abuse prevention interventions may want to consider direct follow-up measures on incident reduction to evaluate impact.

Implications

Although participants in the LEAP intervention had improved outcomes regarding responses to questions about a video-based scenario, there is much work to be done regarding complex conversations surrounding abuse, neglect, and exploitation. It's important to note that the participant's responses improved after a relatively short intervention of just four 90-minute LEAP sessions. Further conversations about these complex and nuanced issues should be held regularly with trusted support providers. Furthermore, special attention should also be focused on the avoidance of teaching people with disabilities compliance based behaviors, such as obediently following verbal commands from paid staff, which may inadvertently be reinforcing requests to comply with demands that result in sexual assault (Kim, 2016). It is critical that we provide safe environments and set aside time so that people may discuss complex feelings and relationships with peers and support staff.

Although support staff may develop close relationships and develop reciprocal friendships over years of supporting a person with a disability, many with little history or experience step into their care provider role with the expectation of immediate trust and friendship. This lack of professional boundaries and inaccurate assumption may foster ongoing confusion for people using support services regarding whom should be trusted. Although the current health pandemic has caused many to be lonely and isolated, it is essential that people with disabilities develop community connections with others who are not paid staff or family members.

Further qualitative research is needed to understand how abuse prevention interventions impact people with disabilities as revealed in their own words and responses, which would typically not be captured in quantitative studies. Qualitative research posits itself to empower individuals who are considered marginalized by giving voice to their experience (Hash & Cramer, 2003).

Lastly, the LEAP intervention was provided to adults, many of whom disclosed abuse that had occurred earlier in their lives. To truly address prevention of abuse, information regarding the core concepts of LEAP should be instructed at a younger age so that youth and adults are equipped with strategies to undertake steps to accessing help that will be well rehearsed and practice

References

Araten-Bergman, T., & Bigby, C. (2020). Violence prevention strategies for people with intellectual disabilities: A scoping review. *Australian Social Work*, 1-16. https://doi.org/10.1080/0312407X.2020.1777315

Araten-Bergman, T., Bigby, C., & Ritchie, G. (2017). *Literature review of best practice supports in disability services for the prevention of abuse of people with disability. Report for the Disability Services Commissioner.* Living with Disability Research Centre, La Trobe University. http://hdl.handle.net/1959.9/562870

Bandura, A. (1978). Self-efficacy: Toward a unifying theory of behavioral change. *Advances in Behaviour Research and Therapy, 1*(4), 139–61. https://doi.org/10.1016/0146-6402(78)90002-4

Bandura, A. (1997). *Self-efficacy: The exercise of control*. Worth Publisher.

Barger, E., Wacker, J., Macy, R., & Parish, S. (2009). Sexual assault prevention for women with intellectual disabilities: A critical review of the evidence. *Intellectual and Developmental Disabilities, 47*(4), 249-262. https://doi.org/10.1352/1934-9556-47.4.249

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

Breitenstein, S. M., Gross, D., Garvey, C. A., Hill, C., Fogg, L., & Resnick, B. (2010). Implementation fidelity in community-based interventions. *Research in Nursing & Health*, *33*(2), 164-173. https://doi.org/10.1002/nur.20373

Catani, C., & Sossalla I. M. (2015). Child abuse predicts adult PTSD symptoms among individuals diagnosed with intellectual disabilities. *Frontiers in Psychology, 6*(1600), 1-11. https://doi.org/10.3389/fpsyg.2015.01600

Dedoose. (2021). *Web application for managing, analyzing, and presenting qualitative and mixed method research data* (Version 9.0.15). SocioCultural Research Consultants, LLC www.dedoose.com.

Doughty, A., & Kane, L. (2010). Teaching abuse-protection skills to people with intellectual disabilities: A review of the literature. *Research in Developmental Disabilities*, *31*(2), 331-337. https://doi.org/10.1016/j.ridd.2009.12.007

Dryden, E. M., Desmarais, J., & Arsenault, L. (2017). Effectiveness of IMPACT: Ability to improve safety and self-advocacy skills in students with disabilities-follow-up study. *Journal of School Health, 87*(2), 83-89. https://doi.org/10.1111/josh.12474

Eastgate, G., van Driel, M. L., Lennox, N. G., & Scheermeyer, E. (2011). Women with intellectual disabilities--a study of sexuality, sexual abuse and protection skills. *Australian Family Physician*, *40*(4), 188-191.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open*, *4*(1), 1-10. https://doi.org/10.1177/2158244014522633

Graneheim, U. H., Lindgren, B. M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, *56*, 29-34. https://doi.org/10.1016/j.nedt.2017.06.002

Harrell, E. (2017). *Crime against persons with disabilities, 2009-2015 - Statistical table*s (NCJ 250632). U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/capd0915st.pdf

Hash, K. M., & Cramer, E. P. (2003). Empowering gay and lesbian caregivers and uncovering their unique experiences through the use of qualitative methods. *Journal of Gay & Lesbian Social Services*, *15*(1-2), 47-63. https://doi.org/10.1300/J041v15n01_04

Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., & 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

Hurd, C., Evans, C., & Renwick, R. (2018). "Having friends is like having marshmallows": Perspectives of transition-aged youths with intellectual and developmental disabilities on friendship. *Journal of Applied Research in Intellectual Disabilities: JARID*, *31*(6), 1186-1196. https://doi.org/10.1111/jar.12493

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Kidney, C. A., & McDonald, K. E. (2014). A toolkit for accessible and respectful engagement in research. *Disability & Society*, *29*(7), 1013-1030. https://doi.org/10.1080/09687599 2014.902357

Kim, Y. (2016). Evaluation of a sexual abuse prevention program for children with intellectual disabilities. *Behavioral Interventions, 31*(2), 195-209. https://doi.org/10.1002/bin.1439

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lund, E. M. (2011). Community-based services and interventions for adults with disabilities who have experienced interpersonal violence: A review of the literature. *Trauma, Violence, & Abuse, 12*(4), 171-182. https://doi.org/10.1177/1524838011416377

Mazzucchelli, T. G. (2001). Feel safe: A pilot study of a protective behaviours programme for people with intellectual disability. *Journal of Intellectual and Developmental Disability, 26*(2), 115-126. https://doi.org/10.1080/13668250020054431

McGuire, B. E., & Bayley, A. A. (2011). Relationships, sexuality and decision-making capacity in people with an intellectual disability. *Current Opinion in Psychiatry*, *24*(5), 398-402. https://doi.org/10.1097/YCO.0b013e328349bbcb

Michalsen, H., Wangberg, S. C., Anke, A., Hartvigsen, G., Jaccheri, L., & Arntzen, C. (2020). Family members and health care workers' perspectives on motivational factors of participation in physical activity for people with intellectual disability: A qualitative study. *Journal of Intellectual Disability Research*, *64*(4), 259-270. https://doi.org/10.1111/jir.12716

Mikton, C., Maguire, H., & Shakespeare, T. (2014). A systematic review of the effectiveness of interventions to prevent and respond to violence against persons with disabilities. *Journal of Interpersonal Violence, 29*(17), 3207-3226. https://doi.org/10.1177/0886260514534530

Nota, L., Ginevra, M. C., & Carrieri, L. (2010). Career interests and self-efficacy beliefs among young adults with an intellectual disability. *Journal of Policy and Practice in Intellectual Disabilities*, *7*(4), 250-260. https://doi.org/10.1111/j.1741-1130.2010.00274.x

Office of Justice Programs. (2018). *Crimes against people with disabilities*. U.S. Department of Justice, Office for Victims of Crime. https://ovc.ojp.gov/sites/g/files/xyckuh226/f iles/ncvrw2018/ info_flyers/fact_sheets/2018NCVRW_VictimsWithDisabilities_508_QC.pdf.

Ottmann, G., McVilly, K., & Maragoudaki, M. (2016). "I walk from trouble": Exploring safeguards with adults with intellectual disabilities–an Australian qualitative study. *Disability & Society*, *31*(1), 47-63. https://www.tandfonline.com/loi/cdso20

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

Scott, H. M., & Havercamp, S. M. (2018). Promoting wellness in people with intellectual and developmental disabilities through relationships. *Current Developmental Disorders Report, 5*, 150-156. https://doi.org/10.1007/s40474-018-0144-3

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance*? Paul H. Brookes Publishing.

Stevens, B. (2012). Examining emerging strategies to prevent sexual violence: Tailoring to the

needs of women with intellectual and developmental disabilities. *Journal of Mental Health Research in Intellectual Disabilities, 5*(2), 168-186. https://doi.org/10.1080/19315864.2011.608153

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398-405. https://doi.org/10.1111/nhs.12048

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