

Working with deaf people who have committed sexual offences against children: The need for an increased awareness

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Abstract *Little research is available on the assessment and treatment of deaf people who commit sexual offences. Most studies provide statistical information on offenders or medical discussion on the causes of violence among deaf people. Sex offender treatment programmes for deaf people are rare internationally and only two such groups exist in Europe. The first of the European treatment programmes was set up at the National Centre for Mental Health and Deafness (NCMHD) in Manchester, United Kingdom. This paper reviews the literature around deaf people and forensic mental health needs, describes the sex offender treatment programme based at the NCMHD, discusses distinguishing characteristics of a deaf sex offender, why treatment should be specialized for deaf offenders and why current treatment should be researched.*

Keywords *Deafness; violence; mental health; sexual offender*

Introduction

The purpose of this paper is to provide a description of a sex offender treatment programme (SOTP) specifically for British sign language (BSL)-using deaf people in the north west of England. The paper also provides a review of the literature around forensic and deaf mental health issues, and how the gaps in services for this client group have led to the process of setting up the first SOTP for deaf people in Europe.

First, the context of deafness is discussed in terms of population, cultural variations and language. The paper then provides a brief overview of deafness and mental health and deaf people in the criminal justice system. Thirdly, the paper focuses specifically on sexual offending behaviour in the hearing population and deaf people who have committed sexual offences. The paper then provides a description of the first SOTP that was set up in Europe for deaf people and explores how this established treatment group has progressed, and provides a conclusion that will support the development of a specific SOTP for deaf people.

In the United Kingdom there are four specialist NHS Mental Health services for deaf people. These are based at Manchester, Birmingham, London and Nottingham. The first

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three services are open units; the Nottingham-based service is a high-security unit. There is also an independent-sector medium-security facility based at Bury, Lancashire.

The National Centre for Mental Health and Deafness (NCMHD) admits clients who use sign language as their preferred method of communication; it does not usually serve clients who have become deafened, as these two groups are culturally different and their mental health needs may be too diverse. The NCMHD provides a comprehensive service for deaf people with mental health needs, including inpatient, day patient, outpatient and community patients. The service accepts people with mental health needs who have criminal convictions.

A service review in May 1998 found that there was an increase in the number of clients being referred to the service who had committed sexual offences against children. Unlike hearing offenders, who have been able to access specifically designed services through either prison programmes or National Health Service (NHS) groups, no such treatment programme existed for deaf people.

Deaf people cannot access such services because of the cultural and linguistic implications of their deafness. The NCMHD identified the gap in provision with this client group (through referrals received for work on an individual basis) and formulated a group treatment programme aimed specifically at assessing and treating deaf people who have committed sexual offences against children. This group was the first BSL-led SOTP for deaf people in Europe (SOTPs for deaf people are in existence in the United States, but not in Europe).

Throughout the paper, it should be borne in mind that any service user should have their mental health needs identified and assessed, and should be offered effective treatments that include specialist services (National Service Framework for Mental Health; Department of Health, 1999).

Deafness

In the United Kingdom there are over eight million people who have hearing loss. The majority lose their hearing as a consequence of ageing (Royal National Institute for Deaf People, 1998). It is estimated that the number of people in the United Kingdom who use BSL as their first, preferred or only language range from 62,000 to 70,000; these people will identify themselves as part of a "Deaf Community" (British Deaf Association, 1999).

To understand this community, the capital "D" in "Deaf" signifies an inclusion in this culture, a sense of pride and empowerment that is not experienced in the hearing world. Deaf people do not see themselves as having a disability that requires treatment, although some hearing parents may seek ways of "treating" their child's deafness (Marshall, Fernandez, Hudson & Ward, 1998). The deaf community regards itself as a distinct cultural group with its own history, traditions, social structure and behavioural norms (Ladd, 1998).

Prelingual deafness refers to deafness that occurs prior to the age of three years, where hearing cannot be used to learn language. These deaf people are likely to have constricted vocabularies and poor English and literacy skills (Vernon & Raifman, 1997).

Deaf people in the criminal justice system

Diversity in deaf language use can be divided into those who are proficient in sign-language use and those who have minimal language skills (MLS). Those with MLS may give inappropriate responses to questions, may "nod" when they have not understood, may not have adequate vocabulary, may have impoverished socialization and may not understand

abstract concepts. In this respect, these communication barriers present specific challenges. Within the criminal justice system (CJS) and forensic treatment programmes, deaf people are often unable to understand legal terminology or concepts: for example, “rape”, “indecent exposure”, “victim” or “assault”. In court procedures deaf suspects are, therefore, vulnerable and disempowered (Miller & Vernon, 2002).

With regard to the NCMHD forensic client population studied by Young, Howarth, Ridgeway and Monteiro (2001), 84 (41.2%) were classified as having “communication difficulties”.

It is a common misconception on the part of hearing people that speechreading is an effective form of communication. Speechreading depends on the skill of the speechreader, does not work when the speaker is out of range and is ineffective, as two-thirds of spoken English is not visible on the speaker’s lips (Marshall et al., 1998).

Deafness and mental health

Profoundly deaf people suffer from mental disorders more than their hearing counterparts, due first to causes of deafness, and secondly to social exclusion factors (Department of Health, 2005).

The NCMHD accepts patients with a wide range of mental health difficulties, including those with severe and enduring mental illness, behaviour and adjustment problems, patients with mild learning difficulties and those with forensic backgrounds.

Clients referred to the NCMHD are not a homogeneous group, and there have not been clear admission criteria in terms of clinical need; the unit has therefore tended to offer mental health services to people who are deaf with a variety of complex needs. It is difficult, therefore, to distinguish between a prison population of deaf sex offenders and those clients who have committed sexual offences who have come through the mental health system.

The SOTP for deaf people is a clinical population that does not reflect the wider deaf community. People who are offered treatment within the SOTP are subject to acceptance criteria that will be referred to later.

Young et al. (2001) conducted research into the nature of forensic referrals to the Manchester, Birmingham and London services. For the Manchester unit, from 1968 to 1999, the total number of clients referred was 3,364; 325 clients had a previous criminal conviction. Greenfield (1996) refers to a high correlation between significant hearing loss and violence, where violence is defined as:

the intentional and malevolent physical injuring of another without adequate social justification.

Young, Monteiro and Ridgeway (2000) found that of 77 individual forensic referrals that were audited, 89 offences were recorded in connection with the referral. Twenty-five offences were of violence (e.g. assault and attempted murder), and 39 were sexual offences (including sexual assault, rape, attempted rape and unlawful sexual intercourse). A later study by Young et al. (2001) showed that a high proportion of forensic referrals to the Manchester, Birmingham and London services had been convicted of/were currently charged with sexual and violent offences; almost one-fifth had been charged with sexual offences.

Deaf people and violent crime

The majority of deaf people cope with the day-to-day frustrations of living in a hearing world non-violently, and adjust reasonably well to their circumstances (Lane, 1992). However, for some who leave school poorly educated, poorly adjusted and without adequate employment, frustrations can lead to violence. This is supported by Vernon and Greenberg (1999), who suggest three causal factors that influence violent behaviour among deaf people. These are educational, communicative and vocational limitations; an increased rate of brain damage among deaf people; and a higher rate of learning disabilities. Brain damage, when coupled with substance misuse, can lead to an increase in violent behaviour. Causes of hearing loss that are also linked with brain damage include trauma, premature birth, meningitis, prenatal rubella and genetics (Braden, 1994). Research has shown brain damage, neurological and biochemical factors to be precipitants of violence (Hickey, 1997). The most common diagnosis in Vernon, Steinberg and Montoya's (1997) study on deaf homicides was antisocial personality disorder. Educational and communication difficulties, an increase in the rates of brain damage, higher rates of unemployment, social isolation and lower incomes are some of the contributors to a higher rate of violence in deaf people that must be taken into account.

In 1895, Lombroso (cited in Harry & Dietz, 1985) was regarded as the "father of criminology" and pioneered biological explanations for criminal behaviour, also known as "atavism". He referred to the hearing of "born" criminals as being dulled. Glueck and Glueck (1950) found "no strong association between delinquency and deafness".

In early common law, deaf people were presumed to lack criminal responsibility and have been linked historically to mentally disordered offenders. Prelingually deaf people, therefore, not uncommonly experience problems within the CJS. Paternalistic attitudes to deaf people within the CJS can lead to leniency and a lack of consequences for the offender who evades the criminal justice process. This can only serve to reinforce pro-criminal attitudes and behaviours.

Deaf people with the aforementioned minimal language skills have been referred to previously as having a "primitive personality disorder" or "surdophrenia" (*sic*). In such cases, the deaf defendant may be regarded as incompetent to stand trial and may, if regarded as high risk, be subject to assessment at a specialist mental health unit for deaf people. Vernon and Raifman (1997) refer to mental health units acting as "warehouses" in such instances.

Of the forensic clients studied by Young et al. (2001), 49% had received probation supervision (despite a distinct need for this service to address its lack of deaf awareness and adequate BSL skills), and 24.5% had had or were serving custodial sentences. It is also known that deaf people who are serving custodial sentences are vulnerable to mental health deterioration due to lack of communication and social isolation; this may explain the prevalence of depression and suicidal attempts in deaf offenders (Miller & Vernon, 2002) mentioned previously.

Klaber and Falek (1963) suggested that deaf people are treated more leniently at the point of arrest and through court procedures, although they noted that the prevalence of prelingually deaf people among defendants at pretrial was five times greater than the prevalence of prelingually deaf people in the general population. This figure also reflects those prelingually deaf people represented in mental health hospitals.

Within the CJS, a greater awareness of the needs of deaf people has occurred. The Police and Criminal Evidence Act (HMSO, 1995) and the Code of Practice to the Mental Health Act 1983 (HMSO, 1999) both refer to the linguistic and cultural needs of deaf people (Young et al., 2001).

Causes of sexual offences

A primary sexual interest in children is both illegal (when acted upon) and a “sexual deviance” (Araji & Finkelhor, 1986). According to Becker (1994), 58–80% of adults who commit sexual offences against children began their deviant behaviour as juveniles. Difficulties in childhood relationships can result in low self-esteem and are risk factors for sexual offending. Other possible contributory psychosocial problems include lack of social confidence, social incompetence, loneliness and poor capacity for intimacy. Burgess et al. (1986) suggest that if a child has received little parental support or an early traumatic experience (i.e. abuse or bullying), this can lead to the development of violent fantasies or distorted thinking, possibly becoming sexualized once puberty has been reached. All these factors can be present with deaf sexual offenders in terms of social isolation, sexual immaturity and prolonged separation from their families if they are in residential schools, which can be sexually segregated dormitories (Harry, 1984).

Often, deaf people who attend residential schools meet, for the first time, other deaf people and have an opportunity to interact with others. Many deaf sex offenders report sexual activity in school with other peers, older children and teachers, and only become aware that their experiences were abusive when they become involved in mental health services and through SOTPs. This abuse often goes unreported or undetected, and Sullivan, Vernon and Scanlon (1987) state that deaf children are far more likely to experience sexual abuse than hearing children. In this respect, when working with adult offenders (deaf or hearing), it is important to acknowledge these experiences and assist the offender to explore these issues in terms of understanding themselves. This must be balanced with the offender also accepting responsibility for his actions and not projecting blame onto these experiences.

Previous studies have highlighted the relatively high numbers of deaf people who commit sexual offences (Young et al., 2000, 2001). More research should be conducted in this area, as comparisons with hearing offenders may only partially explain this issue. In this respect, single theories are insufficient and too general to apply to this population. Language barriers experienced by deaf children impede socialization and may affect their ability to learn social constructs (Schneider, 1997). This supports the need for more emphasis to be placed on sex education for deaf children and treatment programmes to be developed further for deaf sexual offenders.

Rainer, Altshuler, Kallman and Deming (1963) studied the link between deafness and crime; the deaf offenders whose offences were of a sexual nature were described as “immature”, uneducated and “ill equipped to cope with the complexities of society or the courtroom”. This view was supported by Rainer (1969), who referred to deaf sexual offenders as having difficulties in understanding social rules and responsibilities, and experiencing problems with regard to a lack of sexual information. Miller and Vernon’s (2002) study of deaf sex offenders in a prison population found depression and suicide attempts to be common, and a history of substance misuse was acknowledged.

SOTP for deaf people

The SOTP for deaf people was set up as a direct result of findings from the service review, which concluded that there was an increase in this client group (25% of the inpatient population during 1998) who were being seen by individual members of the multidisciplinary team. These team members were often searching for appropriate resources or in consultation with hearing SOTP facilitators. For this reason, previously discussed theories were considered and this led to the SOTP for deaf people.

For assessments or treatments, few instruments have been validated for deaf people. For the NCMHD SOTP, evaluations, modifications and interventions are based on the facilitators' and group members' experience of "what works and what does not". Facilitators have needed to adapt existing hearing and learning disability tools and to work in a more creative way to overcome the problems of language, concrete thinking or difficulties in abstract concepts. This is supported by Marshall et al. (1998), who state that clinical staff need to frame questions in a more concrete way and use more visual and experiential forms of assessment and treatment. In this respect, the use of role-play with deaf people is more effective; for example, an offender may only start to appreciate the wider effects and impacts for a victim of their offending if role-play is used in victim issues/empathy blocks. This can be supported by the training received by SOTP facilitators, following the Ashworth Hospital national sex offender therapy training programme.

It is important when working with deaf people who have committed sexual offences that assumptions are not made about their ability to understand these social norms and processes, due to differing language skills, psychosocial development and the separate nature of their culture.

Due to language differentials, culture and, in some cases, lack of knowledge, deaf offenders may use "slang" terms for body parts and may describe their offences in graphic detail. SOTP facilitators need to be aware that this can be overwhelming and issues of concern must be raised in group or clinical supervision.

Common experiences of SOTP facilitators suggest that deaf offenders benefit from more visual communication to partly overcome communication and abstract thinking difficulties. Additional to sign language, mime, drawings, pointing, gestures, experiential exercises and role-play are found to be beneficial.

Marshall et al. (1998) also comment that deaf people may use their deafness and language deficits defensively to avoid accepting responsibility. Deaf people in treatment have also blamed their offending behaviour on previous experiences of abuse, their lack of education or their inability to maintain a relationship with a hearing partner. While all these factors may have contributed to their offending it is important, as stated previously, that the offender acknowledges these and is assisted to explore them in terms of their own behaviours. When assessing an offender's denial or evasiveness, other members of the multidisciplinary team should offer an opinion on how well or openly the offender performed in less threatening therapeutic interventions.

The SOTP facilitators have found that a multidisciplinary, deaf/hearing, male-female approach is vital when working with deaf people who have committed sexual offences against children, as insight into the offender's self-esteem, degree of social isolation, deaf identity and development of social skills are relevant to planned future treatment and their response to that treatment.

The treatment programme for deaf people is now a well-established and valued component of the NCMHD service at Bolton, Salford and Trafford NHS Mental Health Trust (BSTMHT), and has received an "Improving Working Lives" staff award for outstanding achievement for client care. Staff have also been trained and accredited under the national SOTP.

The HM Prison Service-adapted sex offender treatment programme (Home Office, 2001) takes 170 hours to complete over a course of 2-3 years. A similar timescale can be applied to the deaf SOTP, although difficulties in referral procedures, preparation for the client prior to the group and probation orders being completed before clients are ready to progress towards more advanced programmes are some of the many reasons why this programme has been difficult to research and structure as effectively as hearing programmes.

The groups have been run on a weekly, closed basis, but due to this being a limited resource, new members have been able to join established groups with preparation.

The treatment programme is based on a multimodal analysis (MMA) cognitive behavioural model in which cognitive distortions are challenged directly within the group setting. MMA offers an overall view of the offender's behaviour and provides therapists with a basis to offer a treatment plan to the offender. It also provides an opportunity to address the offence cycle, exploring triggers and consequences.

The distinct lack of clinical staff with the specialized skills to work in this area has also hampered the development of this programme. As research into this specific area is scant, the clinical team have had to rely on professional reflection and supervision discussions to develop the programme. As is the case with learning disabled sexual offenders, assessment tools and interventions have needed to be adapted by the clinical team involved.

Visual aids (such as timelines, the use of pictures, symbols, experiential learning and role-play) are necessary to allow group members to elaborate on their ideas, to explain their ideas to the group and make information more concrete.

For deaf people who have committed sexual offences, the MMA has been adapted to include areas where clients may need specific assessment and treatment; for example, sexual awareness (e.g. general knowledge, knowledge of the law, access to information, understanding terminology, developmental skills, sexual attitudes, relationships and social skills), psychosocial development (e.g. self-esteem, confidence, deaf identity, understanding of emotional concepts, ability to empathize/express emotions), intellectual ability (e.g. IQ, learning experience, ability to conceptualize, developmental disorders), educational background (e.g. oral/signed education, residential/day pupil, deaf/mainstream education, language support systems), family dynamics (e.g. relationships, other deaf family members, evidence of abuse, deprived environment), language development and communication and language skills. This additional information is needed for deaf people due to the diversity of their experiences and enables facilitators to build a holistic picture of the client and their needs.

Additional therapies that complement sexual offence work are often required, such as interpersonal skills, anger management, sexual education, confidence building and access to specific deaf issues groups and deaf peers. For the NCMHD, the multidisciplinary team that are involved directly or indirectly with SOTP, in addition to the SOTP facilitators, include speech and language therapists, cognitive behavioural therapists, occupational therapists, nurses, art therapists, psychologists, community nurses and medical staff.

The NCMHD SOTP is provided by two clinical staff, on a rotated basis, that have at least level 2 BSL skills and experience of working with sexual offenders. Marshall et al. (1998) suggest that if interpreters are used in individual sessions then a number of issues is raised; the deaf person can become confused with the triadic relationship and the therapeutic process is affected. Similar issues apply if a deaf person is assisted by an interpreter and is in group treatment; the pace of therapy may not suit the deaf person as s/he may require additional preparation, clarification of terminology, s/he may have limited literacy skills, etc. The role of the interpreter in this setting may also become confusing for both the hearing and deaf group members. The group facilitators attend group supervision on a monthly basis.

Clients within the SOTP have varying communication abilities, with specific language disorders (where narratives, question words and comparatives are difficult to understand), sign-supported English (SSE), BSL, limited vocabulary or difficulties in comprehension or expression. In such a diverse group, difficulties for the group members and facilitators arise due to these differing levels of sign language abilities and the group tends not to move on as a whole "unit" at the same pace.

The group requires a great deal of clarification and repetition in terms of communication, awareness of concepts and awareness of terminology that deaf people may not have encountered before. However, where deaf facilitators are involved they enhance clarification, meaning that the group members understand more and are less likely to be nervous when asking for clarification. Deaf facilitators can also present information in different ways. The group itself is held in a room away from the inpatient service to maintain confidentiality and a sense of “safety”.

Sometimes it is difficult for group members when they are trying to discuss abstract concepts or emotional topics (for example, the concept of “victim” or the difference between “guilty” and “wrong”), as they may not have the emotional vocabulary to express themselves. Role-play and visual aids enable the process of expression of group members’ own experiences. This is facilitated by the use of concrete examples initially and then more abstract examples are used, as more mature communications are established.

Group members have tended to have been diagnosed with mental disorders (F 60–69, ICD-10; WHO, 1992) as opposed to mental illnesses (F20–39, ICD-10; WHO, 1992), such as schizophrenia or bipolar affective disorder, Asperger’s syndrome, personality disorder and brain injury (ICD-10; WHO, 1992).

As stated in previous literature, deaf sexual offenders may have significant gaps in their education. They may have little awareness of the law or of the roles and responsibilities of adults or children; they may not have had sexual education and may have limited abilities in terms of communicating abstract or emotional concepts.

Group progress and development

The deaf SOTP was adapted specifically from hearing SOTPs to include a large educational module (legal knowledge, sex education and awareness, developmental knowledge, terminology, etc.). This material is useful in making a solid foundation on which to build, to learn about the individual’s offending behaviour and begin to develop alternatives to offending.

As the group moved on from an educational perspective, the group flowed more freely and discussion topics led to more insight and understanding among group members. One of the drawbacks of this was that group members sometimes seemed to focus upon irrelevant points and “run away” with this, requiring facilitators to “step in” and redirect the discussion.

After the group had been running for approximately 18 months, facilitators felt that during this period they did not have to steer the group as much as in the initial stage, as relationships were developing and the group members were more open, honest and far more likely to challenge each other. Directing the group members towards each other to question the validity of what was being communicated has facilitated this “challenging culture”. This has also had the effect of breaking down the perceived “power” held by the facilitators.

“Support”, “trust” and “safety” are reinforced regularly to reassure group members that they can disclose sensitive information; this “safe space” also allows other group members to recognize minimizing and lying behaviours more easily in their peers, so enhancing intergroup challenging.

Working with deaf clients is different to working with hearing clients in the way in which individuals are challenged. More direct questioning styles are used more often, but indirect/covert questioning can be effective when dealing with sensitive information. It is more

therapeutic for group members to challenge each other directly, as this may partly remove the staff/client or hearing/deaf power dynamic.

Group members also tend to “pigeonhole” the facilitators in terms of their abilities, “strictness”, communication skills, etc. Gender issues can also exist in terms of some clients accepting challenges from a male facilitator more readily than from a female facilitator. Specific to working with deaf offenders is the visual mode in which offence details are disclosed. At times, mental images of offence details can be distressing, due not only to the information that has been disclosed but also because of the medium of BSL being detailed and salient. Issues of this nature should be subject to facilitator debriefs and supervision arrangements.

Group work for deaf sexual offenders is very positive. It allows other people to learn via their own experiences, leading to change in their own cognitions about a specific topic or idea, meaning that a more natural, experiential learning occurs. Additional deaf-specific criteria for inclusion in group treatment include the ability to understand and abide by the group contract and being able to communicate in BSL. These factors are in addition to those standard criteria that exist for hearing treatment groups.

Services for deaf people with a mental illness or mental disorder are scant across the United Kingdom. The NCMHD has tended to accept referrals based on clients being deaf, and not as part of specific and clear admission criteria. This has led to an indistinct clinical population within the service and the need to provide a service for a forensic population, namely SOTP for deaf people.

Service users themselves refer to the value and support received through group therapy; the safety and confidentiality of the group enables open discussion and reflection. For many deaf clients, who are often socially and culturally isolated, the group is the only forum in which they are able to discuss anxieties and receive weekly support around lifestyle issues, high-risk thoughts, planning and developing coping strategies.

Conclusion

Diversity within the deaf community can be seen in terms of culture, identity, language proficiency and social structure (to name but a few). A percentage of this population suffers from mental disorders that may result in aggressive and violent behaviours, leading to entry into the CJS.

The experience of some deaf people through social isolation, educational experiences, early sexual experiences or language barriers contributes to existing factors when explaining causes of sexual offending behaviours among a deaf population. While some similarities exist between hearing and deaf sexual offenders, distinctions are apparent in a number of areas that reflect the need for a specific service and treatment structure for a deaf population. The NCMHD recognized this need and responded by setting up the first SOTP specifically for deaf people in Europe. The SOTP for deaf people has been adapted by facilitators to include areas that are pertinent to a deaf group such as sexual awareness, understanding terminology, deaf identity or emotional expression.

Research in this little-known area might usefully address the past and present deaf sex offender population exploring, for example, the type of abuse s/he may have experienced, the cause of deafness, educational experiences, issues related to the individual's deaf and sexual identity and their intellectual abilities. Attention should concentrate upon primary prevention and a need to understand the causes of sexual offending among such a diverse population.

There is a critical gap in the evidenced knowledge base for working with deaf people who have sexually offended; the NCMHD treatment programme currently utilizes existing hearing and learning disabled resources and research, but also practice-based evidence as opposed to evidence-based practice. Due to research being scant in this area, facilitators and group members are able to record and reflect on only what is effective and access training that is hearing-orientated. It is, therefore, crucial that this area of need is recognized and researched further to develop an evidence base.

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