

The Journal of Forensic Psychiatry & Psychology
Vol 15 No 3 September 2004 494-510

BrunnerRoutledge 

Characteristics of deaf sexual offenders referred to a specialist mental health unit in the UK

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ABSTRACT Sexual offences have been acknowledged by society to be a significant problem. Given the relative lack of empirical information on deaf sexual offenders, this paper reports on the findings of a case file review of a cohort of 137 (1969-2002) deaf sex offenders, referred to the National Centre for Mental Health and Deafness, a specialist mental health service for deaf people. The findings suggest deaf sex offenders are primarily male, single, have child victims and have low rates of major mental disorders. This cohort had high rates of mental impairment, poor communication with caregivers, little sex education, and a history of sexual offences in public places. Further research is needed to better delineate the characteristics of deaf sex offenders.

Keywords: deaf, sex offender, sex offending behaviour

DEAFNESS AND THE SCOPE OF THE POPULATION

The Royal National Institute for Deaf People (1998) estimates that in the UK there are over 8 million people with some degree of hearing loss. It

The Journal of Forensic Psychiatry & Psychology
ISSN 1478-9949 print/ISSN 1478-9957 online © 2004 Taylor & Francis Ltd
<http://www.tandf.co.uk/journals>
DOI: 10.1080/14789940410001703291

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is estimated 1/1000 people are born deaf (European Society for Mental Health and Deafness, 1999). However, the term 'deafness' encompasses many conditions and the degree and age of onset are important determinants of the consequences of deafness. Deafness is divided into profound and partial deafness, and hard of hearing. People, who are hard of hearing, have a mild/moderate hearing loss that occurs following the acquisition of speech and verbal language especially in later life. While people with profound deafness have little or no use of words, partial deafness ranges from mild to severe hearing loss and use of words. Verbal language may be internalized and some benefit can be gained from lip reading, in those with partial deafness.

A further distinction can be made based on speech acquisition. Pre-lingual refers to deafness prior to speech acquisition while post lingual post-dates the acquisition of speech. Deafness from birth (prelingual) results in significant difficulties in the acquisition of speech and verbal language.

Most deaf children used to receive special education where oral/aural methods are used for communication. However, British Sign Language (BSL) is officially recognized as the natural language of deaf people and was recently introduced into teaching methods (Gregory, 1996). According to the Health Advisory Service report (BSMHD, 1998), in Britain an estimated 50,000 people use BSL as their preferred language. However, a significant number do not have the facility to use BSL because the majority of deaf children are born to hearing parents (Department of Health, 2002). Hearing parents are rarely encouraged to learn BSL when their deaf child is young and communication difficulties and delayed language development are the norm (Hindley, 2000).

An estimated 5-10% of deaf children are born to deaf Parents (BSMHD, 1998).

FORENSIC SERVICE PROVISION FOR DEAF PEOPLE

At present, forensic service provisions for deaf people are inadequate (The Department of Health, 2002). The strategic framework for commissioning and delivering specialized services is based on a four-tier model of service provision for both adults and children (BSMHD, 1998). Currently, only Mayflower Hospitals in Bury, in collaboration with the Bolton, Salford and Trafford NHS Trust, provide medium secure facilities for deaf mentally disordered offenders. The National Centre for Mental Health and Deafness (NCMHD), in conjunction with Mayflower Hospitals, provide a pioneering sex offender treatment programme in BSL.

SEX OFFENDING BEHAVIOUR IN THE HEARING

There has been increasing concern that rates of sexual offending, compared with other offences, have increased steadily in the last decade (Gordon and Porporino, 1990; Motiuk and Belcourt, 1996). In the US the estimated risk of sexual offending is around 20% of the total offender population (Motiuk & Belcourt, 1996). United Kingdom criminal statistics for 2000 (Home Office, 2001) noted that sex offences represented 10.4% of all offences.

The literature on sexual offenders suggests that they form a heterogeneous group in terms of their personal histories, victim preferences, levels of violence, and risk of recidivism (Gordon and Porporino, 1990). It is recognized that sexual offending behaviour tends to begin early in life, is usually repetitive and associated with other criminal behaviours (McElroy *et al.*, 1999; Dolan, Holloway, Bailey and Kroll, 1996). The majority of perpetrators are single (Hanson, Steffy and Gauthier, 1993) and women and children are the most frequent victims of sexual assaults (Hall, 1995).

A number of researchers have attempted to develop typologies and models to explain sexual offending behaviour (e.g. Barbaree Seto, Serin, Amos and Preston, 1994; Knight and Prentky, 1990; Hall and Hirshman, 1991). Traditionally, child sex offenders are classified according to their degree of fixation with children, social competence, level of contact, injury to victims and presence/absence of sadistic fantasy (Knight and Prentky, 1990). By contrast, rapists have been characterized into 'opportunistic', 'pervasively angry', 'vindictive' and 'sadistic/non sadistic sexual type' (Knight and Prentky, 1990).

Studies examining psychiatric morbidity in sex offenders indicate some associations with substance abuse, antisocial personality/conduct disorders, paraphilias and mood disorders (Langevin and Watson, 1996). Others report that schizophrenia or intellectual deficits may be associated with sexual offending (Hoyer, Kunst and Schmidt, 2001).

Studies examining personality factors in sex offenders have noted associations with introversion (Gudjonsson and Sigurdsson, 2000), poor social skills (Segal and Marshall, 1985; Knight and Prentky, 1990), anger and hostility (Barbaree *et al.*, 1994), lack of intimacy, poor sexual identity, devalued self-esteem and unassertiveness (Lang, Lloyd and Fiqia, 1985). Salter (2003) described the differences between rapists and child molesters: Rapists are more angry/assertive, more opportunistic and have higher prevalence rates of personality disorder and substance abuse. Child molesters, by contrast, are older, they plan their offences and their fantasies are more neurotic and sexually deviant.

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POPULATION

Only a few studies have examined offending and, in particular, sexual offending in deaf cohorts. Of the available studies there is some evidence that sex offending is over-represented in deaf offenders seen for psychiatric evaluations (Harry, 1984; Klaber and Falck, 1963; Denmark, 1985). It has been suggested that a number of factors distinguish deaf from hearing paedophiles even though comparisons between deaf and hearing offenders are difficult (Vernon and Rich, 1997). Dennis and Baker (1998) discussed the role of deaf culture and the influence of the deaf community on the incidence, and treatment of deviant sexuality and sexual offences. However, all of the above studies have methodological weaknesses.

RATIONALE FOR THE CURRENT STUDY

As there have been no published reports on deaf sex offenders in the UK, we examined the psychosocial characteristics of deaf sex offenders referred to the NCMHD between 1969–2002. This is primarily a descriptive study, however, we discuss some of the findings in relation to the hearing literature.

METHOD

Setting

The NCMHD in the NW region is one of the three specialist mental health services for deaf people in the UK. It provides a service for deaf people, who have mental health problems or exhibit challenging behaviour. Referrals are accepted from Northwest and Northern England regions as well as Wales and Scotland. The in-patient unit has 22 beds for assessment and treatment. The outreach service provides clinics in Manchester, Preston, Northern Ireland and Scotland. The unit routinely collates data on all referrals, including admissions for assessment and treatment, and referrals to the outreach clinics.

Procedure

The study was approved by the Local Research and Ethics Committee. A pre-coded pro-forma was designed for data collection from case files on all deaf sex offenders referred to the service between 1969 and 2002. The

information on socio-demographic details, personal and family psychiatric history, sexual abuse, previous offending and index offence was coded in a present/absent format similar to that used in a previous case file study in adolescent sex offenders (Dolan *et al.*, 1996). Additional items were included on the aetiology of deafness (e.g. information on cause, degree, and nature of deafness), means of communication, health issues, information on sex education, social skills, and physical appearance. Data was collected from case files, which included pre-trial reports, depositions, psychiatric and court reports. Only cases where there was sufficient information to complete the proforma were included.

Cohort/sample

A total of 140 deaf sex offenders, who had been referred to the NCMHD between 1969 and 2002, were identified from hospital records. Of these, 137 were considered to have enough detailed information to complete the key domains on the pro-forma. The data was entered into SPSS 10.0 and the descriptive statistics reported.

Definition of a sex offender

For the purposes of this study, a subject was considered a sex offender if they had been charged with, or convicted of, a sexual offence. Sexual offences included rape, sexual intercourse with a minor (e.g. younger than 16), buggery, indecent assault and non-contact offences, e.g. exhibitionism. Sexual offences were classified into non-contact (exhibitionism, exposure, performance of sexual acts alone, etc.) and contact offences (rape, assault, genital or oral handling, etc.). To be classified as a paedophile, subjects younger than 16, had to be at least 5 years older than their victims. A total of 31 juvenile sex offenders were included in this sample.

RESULTS

General characteristics

All subjects ($N=137$) were male. The mean age of the cohort was 29 years (range 9–66 years). The majority (102, 73.9%) were single, or separated/widowed. Only 26 (18.8%) were married or co-habiting at the time of the offence. All but one sex offender was British born and the majority (125, 90.6%) were Caucasian. Only a third (45, 32.6%) had a stable history of employment. Eight (5.8%) perpetrators were described as having an unusual physical appearance. Eighty-eight per cent (121) had poor social skills.

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Deafness

The majority of cases (115, 83.3%) were profoundly deaf. Twenty-two (15.9%) were partially deaf. Over half the population (95, 68.8%) used BSL as their preferred primary means of communication and the remainder used oral methods. In fifty-one cases (37%) specific causes for deafness had been detected. The causes were attributed to rubella (22, 15.9%), meningitis (14, 10.1%) or measles (5, 3.6%). Ushers Syndrome was a primary cause of deafness in two cases (1.4%), whilst the remainder were acquired due to trauma. In just over a quarter of cases (37, 26.8%), deafness was associated with intellectual impairment. Psychological assessments indicated that 21 (15.2%) had average or above average IQ.

Developmental/educational history

The records indicated that 13 (9.4%) had obstetric difficulties at birth. Delayed achievement of developmental milestones was documented in 20 (14.5%) cases. Only 12 (8.7%) subjects attended mainstream schools. The remainder attended schools for deaf children, special needs or residential schools. Almost half the subjects (63, 45.7%) were recorded as having difficulties at school. Of these, 27 (19.6%) were expelled; 3 (2.2%) truanted and 13 (9.4%) were bullied. A further 18 subjects (13.1%) had engaged themselves in bullying, aggressive or disruptive behaviour at school. Engagement in disruptive behaviour at home was high at 36.2% (50).

Sexual history/sexual abuse

The majority (108, 78.8%) were heterosexual. Twenty-eight (20.4%) were sexually active under the age of 16. Nineteen per cent (26) had admitted to the use of pornography or fantasized about children. In 13.9% (19) of cases a strong or uncontrollable sex drive was recorded. Only one (0.7%) sex offender had received sexual education.

Information from records indicated that 35 (25.5%) of the perpetrators had been subject to sexual and/or physical abuse themselves. In most cases (33, 94.3%) the abuse occurred under the age of 10. Twenty-seven (77.1%) of the abused perpetrators went on to abuse children.

Family background

In all but one case, subjects were born to hearing parents. Only 19 (13.8%) were brought up by caregivers using the same form of communication. Approximately one-third (45, 32.8%) of the sample had suffered parental loss below the age of 10 years. In most cases this was due to maternal (16,

11.7%) or paternal (18, 13.1%) abandonment. A family history of criminality, substance abuse or psychiatric disorder was recorded in 21 (15.3%) cases.

Index offences

The sexual offences were committed between 1944 and 2000. Social Services had been involved in 104 (75.9%) cases. The mean age at onset of offending was 26 years (range 10–63 years). This included 31 (22.6%) sex offenders younger than 18 years.

In 10 cases (7.3%) there was evidence that the perpetrator had been employed in a position that made victims accessible.

With respect to the number of offences committed, almost half of the offenders (60, 43.8%) had committed up to four offences; 50 (36.5%) more than five offences. Only 14 (10.2%) were non-contact offences. In all remaining cases contact offences were recorded.

Ninety-two subjects (67.2%) denied the offence, while 20 (14.6%) accepted responsibility for the offence. Although the sexual recidivism rate was relatively high (87, 63.5%) 48 subjects (35%) did not sexually re-offend following their index/first conviction.

In the majority (122, 89%) of cases the index offence/behaviour was exclusively a sex offence. Sixty-two (45.3%) sex offenders, however, had also committed other non-sex crimes, with homicide (2, 1.5%) representing the most extreme additional offence.

Previous offences

The majority (135, 98.5%) of subjects had previous convictions for a variety of offences. Looking at prior disposals, 31 (22.6%) had been in prison, 28 (20.4%) had been placed on probation and 17 (12.4%) had been sectioned under the Mental Health Act 1983. Only six (4.4%) had received a conditional discharge.

Victims/site of offence

The majority of victims were children (95, 69.3%). Victims were exclusively female in 34 (24.8%) of cases.

Perpetrators offended mostly (83, 60.6%) in public places. However, 43 (31.4%) of the victims had been abused in the perpetrator's home. A small minority (23, 16.8%) of victims had been abused in their own homes.

Physical violence was noted in 51 (37.2%) cases and threats/coercion in a further 17 (12.4%). Seventy-five (54.7%) had been abused by either a

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relative or an acquaintance. In 60 (43.8%) of cases the sexual abuse had been committed by a stranger.

Psychiatric/medical history

At the time of the initial psychiatric evaluation/assessment, only one quarter (34, 24.8%) were considered to be suffering from a mental disorder within the meaning of the Mental Health Act, 1983. The most frequent (64, 46.7%) being depression, followed by pervasive developmental disorder (8, 5%) and schizophrenia/psychosis (8, 5%).

No mental disorder was diagnosed in the majority (79, 57.7%) of sexual offenders. However, 66 (48.2%) had a documented past psychiatric history, which included schizophrenia/psychosis in 13 (9.5%), personality disorder in 25 (18.2%) and alcohol abuse in 26 (19%) cases.

Fifty-five (40.1%) had a documented past medical history, seven (5.1%) of whom had suffered a head/brain injury.

Following the referral assessment, 41 (29.9%) of the sexual offenders received psychotherapy, either individual or group. Thirty-nine (28.5%) received medication (anti-libidinal suppressants and/or psychotropic drugs) alone, and a further 12 (8.8%) received a combination of psychotherapy and pharmacotherapy.

DISCUSSION

To our knowledge this is the first British study to describe in detail the characteristics of deaf sex offenders referred to a Specialist Mental Health Service from a large geographical area in Britain. We recognise that the tertiary nature of the service means that the findings cannot be generalized to community samples of deaf sex offenders, but consider the data important, since there are few other services available for the assessment of deaf sex offenders.

We also recognize that there may be some limitations on the reliance on case file review for detailed assessments in offender samples. However, the files were comprehensive and included sufficient information to rate key items. Although we are confident about the victim/offence typologies as we could cross check this data through court depositions, other variables, e.g. the prevalence/ extent of prior sexual abuse, exact age of onset of offending and use of pornography may be less reliable as the information is largely based on what offenders reported when they were undergoing a pre-trial assessment when offenders may minimise the level of their dysfunction. In addition, little information was available on deviant sexual fantasies and behaviours. In this study our reliance on case records also assumed that the

person had not committed another sexual offence, if no record had been made within 5 years of a reported sexual offence.

The demographic characteristics of the sample were similar to previous reports in the hearing population that the majority of sex offenders are male, under the age of 30 years and have child victims (Motiuk and Belcourt, 1996; Greenfield, 1997; Henn, Herjanic and Vanderpearl, 1976; Hanson and Brussiere, 1998).

Our finding that half our sample experienced difficulties at school and/or were unemployed following full-time education fits with previous reports that the educational levels of the deaf people are lower than those in the hearing community (Dye, Kyle, Allsop, Denmark, Drury and Ladd, 2000; Meadows-Orlands and Erting, 2000). They also support the notion that deaf people are more likely to be unemployed than hearing people (Klein and Kitson, 2000).

A number of studies suggest that deaf people are over-represented in mental health institutions (Denmark, 1966; Cornforth, 1972) and that they have longer lengths of stay than hearing samples (Timmermans, 1989).

Despite the psychiatric nature of the service, we found the prevalence of major mental disorders was relatively low at 24.8%. This figure is similar to studies on psychiatric morbidity in hearing sex offenders (Marshall, 1996; Hanson and Bussiere, 1998) and deaf sex offenders (Vernon and Rich, 1997). We found a lower rate of antisocial personality disorder than has been reported in the deaf (Vernon and Rich, 1997) and hearing sex offender literature (Moore, Bergman and Knox, 1999; McElroy *et al.*, 1999; Prentky, Cohen and Seghorn, 1985; Henn *et al.*, 1976) but this may be due to the lack of systematic recording of this diagnosis. Although it has been reported that deaf people are more likely to be diagnosed as having a personality disorder, or adjustment or behavioural problems (Health Advisory Service, 1998) there have been few studies specifically examining this issue in deaf samples and systematic psychiatric assessment of deaf people is still in its infancy (Kitson and Thacker, 2000).

Approximately one-fifth of our sample had comorbid alcohol abuse. To date, there are no studies specifically looking at substance misuse rates in deaf offender and non-offender samples so comparisons are difficult (Guthmann and Blozis, 2001). However, the hearing literature in sex offenders indicates co-morbid substance abuse in hearing sex offenders is relatively common (Seto and Barbaree, 1995; Bruckner and Johnson, 1987; Dimock, 1988; Krug, 1989; McGrath, 1991; Rada, Kellner, Laws and Winslow, 1978).

We found high rates of intellectual impairment, rubella, meningitis and measles. Comparison with the hearing literature is difficult as there is comparative data on the prevalence of rubella, meningitis and measles in hearing sex offenders.

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Congenital rubella syndrome (CRS), in particular, has been associated with brain damage, intellectual impairment and severe behaviour disorders (Krugman, 1980). CRS affects 1/100,000 births (March of Dimes Perinatal Data Center, 2000). The relatively high rates of congenital disorders in this sample may be related to the fact that the sample includes offenders who were born before immunization programmes were introduced.

Approximately 5% of this sample had a traumatic brain injury. This figure is much lower than the 35% reported by Vernon and Rich (1997) in their cohort of deaf paedophiles. The higher rate in the latter study may be due to the fact that Vernon and Rich (1997) only studied paedophiles and there is some evidence that organic brain syndromes are more prevalent in child sex offenders than rapists (Henn *et al.*, 1976). The association between traumatic brain injury and sexually inappropriate behaviour is well documented (Achte, Jarho, Kyykka and Vestereinen, 1991; Miller, Cummings, McIntyre and Ebers, 1986; Sabhesan and Natarajan, 1989; Langevin, Wortzman, Dickey, Wright and Handy, 1988; Hucker *et al.*, 1988). It is likely that the co-morbidity of deafness and brain injury contributes to the difficulties in developing appropriate sex offender treatment programmes for deaf offenders.

In over one-quarter of our sample deafness was associated with intellectual impairment and only 15.2% had an average or above average IQ. Psychiatric disorders in children with hearing impairment are particularly associated with low IQ and low communication ability (Carvill, 2001). These findings fit with reports that 30% of deaf children are intellectually impaired (Schein, 1975). It has been reported that the performance IQ of deaf sex offenders is compatible to those of the overall prison population (Miller and Vernon, 2003). However, over 60% of the latter study's sample had literacy levels that were lower than levels for deaf adults who remained in education until they were 18 years old. It has also been suggested that high IQs in the deaf community are associated with genetic rather than traumatic causes of deafness (Vernon and Rich, 1997). We found only a minority of cases had hereditary factors as an aetiological factor which might account for the lower mean IQ of the sample. However, it is also possible that the lower IQ may be accounted for by a variety of other factors including co-morbid organic syndromes, limited educational opportunities and poor social/rearing environment. A review of 208 studies involving 171,517 deaf people, carried out in the USA (Braden, 1994), indicated that those born to deaf parents had higher performance IQs than other groups. In general, deaf children born to deaf parents are in a better position to communicate and do better academically than those born to hearing parents (Department of Health, 2002). Hearing parents are rarely encouraged to learn BSL when their child is young. This may result in delayed language development, low self-esteem and

communication difficulties in these children making them more vulnerable to mental health problems (Hindley, 2000).

In the literature on hearing sex offenders there are a number of reports of intellectual impairment and educational underachievement (Burgess, Groth, Holmstrom and Sgroi, 1978; Hayes, 1991). It has also been suggested that intellectually impaired sex offenders have a greater tendency to offend against male and younger children (Day, 1994). However, variation in the measures of IQ across samples makes comparisons difficult (Holland, 1991).

We found over half of this sample had prior convictions for sex offences. The figures are higher than that reported for hearing sex offenders (Hanson and Bussiere, 1998) but fit with studies indicating high rates of sex offending in deaf offenders (Miller and Vernon, 2003). Only 44% of our sample had a history of non-sexual crimes. This is much lower than the 76.9% found in a hearing sample (Motiuk and Belcourt, 1996) and suggests that deaf sex offenders may be less criminal than their hearing counterparts.

One-quarter of our sample had a history of sexual abuse. This figure is similar to that reported in the hearing (Freund, Watson and Dickey, 1990; Greenberg, Bradford and Curry, 1993; Hunter, Figuerdo, Malamuth and Becker, 2003) and deaf sex offender literature (Vernon and Rich, 1997; Miller and Vernon, 2003).

Sixty-seven per cent of deaf sex offenders in this cohort denied the offence. Denial and minimization are well recognized phenomenon in sex offender samples (Hunter and Figuerdo, 1999). It has been reported that deaf sex offenders tend to attribute their offending to their deafness, claiming that they were never taught appropriate sexual behaviour (Dennis and Baker, 1998). Interestingly, high levels of denial tend to be associated with recidivism (McGrath, 1991). In this sample we found both high levels of denial and high rates of recidivistic sexual offending behaviour. However, as this is a retrospective study, it is difficult to draw any firm conclusions from these findings.

We found lower recorded rates of pornography than is reported in the hearing literature (Marshall, 1988). It is possible that the denial of use of pornography is associated with denial over other issues associated with sex offending but this requires further exploration in prospective studies of deaf sex offenders.

In this sample, we found that a high proportion (88%) were recorded as having poor social skills. Poor social skills are also frequently reported in hearing sex offenders (Abel, Blanchard and Becker, 1978; Quinsey, 1977) but with lower frequency. Education difficulties (Vizard, Monck and Misch, 1995), social withdrawal/isolation (O'Callaghan and Print, 1995) and social maladaptation are also commonly reported in the hearing population, particularly those with intellectual impairments (Day, 1994).

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Very few of the deaf sex offenders had received formal sexual education and/or had an adequate awareness of sexual health issues. We also found that reports of inappropriate sexual activity as children in residential schools were high, again suggesting limited education in this area. Deaf children rarely understand sexual issues, even though they are intensely curious and highly naïve about sexual norms and values (Sullivan, Vernon and Stanlan, 1987). There is also a literature suggesting that intellectually impaired sex offenders lack appropriate sexual knowledge (Griffiths, Hingsburger and Christian, 1985; Furey and Niesen, 1994), are sexually naïve (Allam, Middleton and Browne, 1997) or display socially unacceptable sexual behaviour (Clarke, 1989). It is possible that the combination of deafness and intellectual disability compounds the difficulty in devising appropriate sex education programmes for this group.

SUMMARY AND CONCLUSIONS

This deaf sex offender sample share many characteristics with their hearing counterparts. For example, the majority are male, have child victims, deny their offence and have a history of repeated sex offending behaviour. The majority also do not suffer from major mental disorders but a substantial minority have a personality disorder and/or a history of alcohol abuse. Not surprisingly, the deaf cohort have high rates of mental impairment and disorders linked with hearing impairment. Our findings also suggest that lack of sex education and limited opportunities to develop intimate relationships may have contributed to an aberrant psychosexual development in our sample. Further studies are needed to investigate the similarities and dissimilarities between deaf and hearing sex offenders so that preventative and therapeutic approaches can be developed. Deaf people are disadvantaged in education, in gaining access to health and forensic mental health services, and in the criminal justice system. Further research is necessary to enable the development and delivery of appropriate and accessible services for this needy group.

ACKNOWLEDGEMENTS

We would like to thank Dr Sharon Ridgeway for her comments on the data collection sheet and the librarians at Prestwich library for their effort to obtain articles.

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