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SEXUAL ABUSE AND PEOPLE WITH DISABILITIES

BY

SHEILA MANSELL

A PAPER FORMAT THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION

IN COUNSELLING PSYCHOLOGY

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19 AUGUST 1993

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Dear Sheila:

I am writing to provide a formal record of my consent for your use of any or all articles that we have coauthored for your thesis. I also grant permission for you to include a copy of the Sexual Abuse and Disability Study Data Collection form in your thesis.

Sincerely,

Dick Sobsey
Professor

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THE UNDERSIGNED CERTIFY THEY HAVE READ, AND RECOMMEND TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH FOR ACCEPTANCE, A THESIS ENTITLED SEXUAL ABUSE AND PEOPLE WITH DISABILITIES SUBMITTED BY SHEILA MANSELL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF EDUCATION IN COUNSELLING PSYCHOLOGY.

Dr. P. Calder

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Dr. P. Jacobs

Date: August 19, 1993

ABSTRACT

This thesis presents three papers based on the results of research of the Sexual Abuse and Disability Project at the University of Alberta. The first paper concerns the survey findings from 208 sexual abuse and sexual assault victims with disabilities from Canada, New Zealand, and the United States. The reported patterns of sexual abuse and sexual assault from these countries were analyzed. Results indicate sexual abuse and assault are frequently repeated and chronic often resulting in significant harm to the victim. Incidences of abuse are rarely reported to child welfare or law enforcement authorities; consequently, charges and convictions are rare. Many offenses are committed by paid service providers and occur in disability service settings, although other offenses occur in the same situations as sexual abuse and assault of victims without disabilities. Victims with disabilities often experience difficulty in obtaining accessible and appropriate treatment services. Implications for sexual abuse prevention and treatment are discussed. The second paper presents selected results concerning access, availability and appropriateness of sexual abuse treatment from 119 sexual abuse victims with developmental disabilities. Results indicate sexual abuse treatment services are typically inaccessible, unavailable and inappropriately adapted. Inadequate treatment services appear to be due to the paucity of qualified professionals in the area of sexual abuse and developmental disabilities coupled with the slow development of appropriate sexual abuse treatment approaches. The application of adapted therapy approaches for people with developmental disabilities and examples of adapted sexual abuse treatment for children and women are presented. Treatment issues for the developmentally disabled are discussed for practitioners' consideration. The third paper concerns sexual abuse prevention strategies for people with disabilities.

Strategies focus on sexuality and self-protection education, increasing social skills, assertiveness, and access to social relationships. Staff strategies include introducing policies on abuse, detection training and reporting procedures. Greater care in the use of drugs, behavior management programs and restraints is recommended. Administrative strategies include screening staff, and taking greater responsibility for safety of individuals in their care. Additional strategies concern increasing sexual abuse treatment services, and changing damaging attitudes about disability.

ACKNOWLEDGEMENT

I thank Dr. Dick Sobsey for his support throughout my involvement in this project. I also thank my thesis advisor, Dr. Peter Calder, for his encouragement and guidance throughout the writing of the treatment article and the thesis. I thank Dr. Phil Jacobs for his involvement as a member of my thesis committee. Portions of the project that provided the basis for these articles were funded by National Health Research and Development Program, Health and Welfare Canada under projects 6609-1465 CSA and 6609-1597 FV and by The Social Sciences and Humanities Research Council of Canada under project 410-911665.

The findings and opinions expressed are those of the authors and not necessarily those of of the funding agencies.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

This thesis includes three published papers that cover various aspects of the sexual abuse of people with disabilities. The three areas addressed in these articles include international patterns of sexual abuse, prevention strategies and treatment for sexual abuse victims with developmental disabilities. The published works in the paper thesis include two articles and one book chapter. They are:

Sobsey, D., & Mansell, S. (in press). An international perspective on patterns of sexual abuse and sexual assault. In E. Chigier (Ed.), International aspects of sexuality and disability. Tel Aviv: Freund Publishing House Ltd.

Sobsey, D., & Mansell, S. (1990). The prevention of sexual abuse of persons with developmental disabilities. Developmental Disabilities Bulletin, 18 (2), 51-65.

Mansell, S., Sobsey, D., & Calder, P. (1992). Sexual abuse treatment for persons with developmental disability. In Professional Psychology: Research and Practice, 23 (5), 404-409.

These published papers are based on research conducted as part of the Sexual Abuse and Disability Project in the Department of Educational Psychology at the University of Alberta. All three papers were co-authored with Dr. D. Sobsey, the principle researcher of the Sexual Abuse and Disability Project. I played a substantial role in conducting the research for the project. I was involved in the collection, analysis and interpretation of the data in the victims' study. I also played a substantial role in the writing of the three articles with Dr. Sobsey.

The first paper co-authored with Dr. D. Sobsey is titled an international perspective on patterns of sexual abuse and sexual assault. This paper is soon to be published as a book chapter and was originally presented by myself at the Israel Rehabilitation Society sponsored

International Seminar on Sexuality and Disability, on March 4, 1992 in Tel Aviv, Israel. This paper draws heavily upon the data from the study of sexually abused victims with disabilities. The survey form used for the data collection in the study is located in the Appendix. In the paper the patterns of victimization from the data from Canada, United States and New Zealand are presented and discussed.

The second article is titled the prevention of sexual abuse of persons with developmental disabilities. It was co-authored with Dr. D. Sobsey and was originally published in the Developmental Disabilities Bulletin (1990). This article draws on existing literature on prevention of sexual abuse of people with disabilities and presents a variety of current and potential sexual abuse prevention strategies for people with developmental disabilities. This article does not directly examine the research findings of the Sexual Abuse and Disability Project but presents the literature relevant to project's findings concerning abuse and disability.

The third article is titled sexual abuse treatment for persons with developmental disabilities and was originally published in Professional Psychology: Research and Practice (1992). I am principle author of this article and have as co-authors Dr. D. Sobsey and Dr. P. Calder. This article draws from the data of the victims' study. The focus for this article however is more specific than in the international patterns of abuse chapter. The presented data focus on the sexual abuse victims with developmental disabilities with an emphasis on the effects of the abuse, the availability, access to and appropriateness of treatment. The article discusses a variety of concerns and issues surrounding sexual abuse treatment for people with developmental disabilities.

These three published works constitute the paper format thesis. The patterns chapter and the treatment article both draw heavily upon data from the victim's study. Each paper uses data from different stages in the

data collection and the focus differs for the two papers. The treatment article focuses on developmental disabilities and the accessibility and availability of treatment; the patterns chapter is a general presentation of the data along national lines. The data in each of the two articles is presented at different stages of collection and the methodology, procedures and results from the victim's study are presented in each paper and shall not be covered here. The prevention strategies article draws less heavily upon project data but more upon the existing literature on prevention of sexual abuse of people with disabilities and addresses current and potential sexual abuse prevention strategies for people with disabilities as it relates to project findings and other literature concerning sexual abuse and disability.

The three papers were written during my position as research assistant with the Sexual Abuse and Disability Project as a student in the Masters' Counseling Psychology Program in the Department of Educational Psychology at the University of Alberta.

Sexual Abuse and Disability Project

The Sexual Abuse and Disability Project has been in operation since 1987; with Dr. D. Sobsey as the principle investigator. Since its beginning the research of the project has examined a variety of issues associated with abuse and disability. Research areas that have been examined include incidence of abuse (Sobsey & Varnhagen, 1988), professionals' attitudes towards prevention strategies (Sobsey, Mansell & Wells, 1991), prevention strategies (Sobsey & Mansell, 1990), patterns of abuse as determined by a victims' study (Sobsey & Doe, 1991; Sobsey & Mansell, in press) and most recently sexual abuse treatment (Mansell, Sobsey & Calder, 1992).

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An International Perspective on Patterns of Sexual Assault and Abuse of People with Disabilities

by

Dick Sobsey & Sheila Mansell

Sexual Abuse and Disability Project

University of Alberta

Presented at the International Seminar on Sexuality and Disability, Tel Aviv, Israel, March 3, 1992

Sobsey, D., & Mansell, S. (in press). An international perspective on patterns of sexual abuse and sexual assault. In E. Chigier (Ed.), International aspects of sexuality and disability. Tel Aviv: Freund Publishing House Ltd.

For both adults and children with disabilities, there is an increased risk of sexual assault and sexual abuse (Sobsey, Gray, Wells, Pyper, & Reimer-Heck, 1991). For example, research on women with a variety of disabilities found that they were about 1.5 times as likely to have been sexually abused as children as non-disabled women (Doucette, 1986). Research on children with disabilities reveals similar findings. Sullivan, Vernon, and Scanlan (1987) cite several studies that suggest 54% of deaf boys and 50% of deaf girls are sexually abused as children. Compared to the presented norms for sexual abuse in the general population of 10% of boys and 25% for girls, these figures suggest the rate of sexual abuse for deaf children is doubled for girls and five times as high for boys. Other studies of children with disabilities present even higher rates of abuse (e.g., Brookhouser, Sullivan, Scanlan, & Garbarino, 1986; Stimpson, & Best, 1991). Many additional studies have linked both physical and sexual abuse to disability (Westcott, 1991).

Although the increased risk for abuse is well documented, little research describes sexual abuse and assault as it affects people with disabilities (Tharinger, Burrow-Horton, & Millea, 1990). Research of the Sexual Abuse and Disability Project of the University of Alberta has addressed the incidence of sexual abuse in people with disabilities (Sobsey, & Varnhagen,1988), sexual abuse prevention strategies (Sobsey, & Mansell,1990) and sexual abuse treatment (Mansell, Sobsey, & Calder,1992). The Project research also included a survey of sexually abused people with disabilities (Sobsey, & Doe, 1991). A clearer picture of the nature of abuse was obtained by collecting and analyzing the data drawn from reports from victims and their advocates. The results of this research are presented and the implications for sexual abuse prevention strategies and treatment are discussed.

Sexual Abuse and Disability Project Survey

In the survey's twenty-one questions, a variety of aspects of sexual abuse were evaluated. Survey questions included the attributes of offenders and victims, offender's relationship to the victim, the number and nature of abuse episodes, charges, reports, convictions, impact for abuse victims, and victim treatment services. The questionnaires used in the study complied with APA ethical standards and received approval by the Research and Ethics Committee of the Educational Psychology Department of the University of Alberta in Canada and the Otago Area Health Board in New Zealand. The questionnaires were sent to advocacy groups, service agencies, and sexual assault centers in the United States, New Zealand, and Canada and were completed by client advocates and victims with disabilities.

Cases included in this survey do not represent a random sample of sexual abuse and assault victims with disabilities. People that choose to report may not represent those who choose not to report in the survey. Some of the data collected in this survey were direct reports made by the individuals who experienced abuse. In other cases, third party reports from family members, service providers, or other "advocates" were made for the abused person. Third party reports provide valuable data about the abuse though they may not accurately reflect the victim's perspective of the abuse. At the time of writing, this research sample is the largest of its kind available.

Subjects

There were 208 questionnaires returned to the Sexual Abuse and Disability Project by mail and telephone between 1987 and 1992. The offenses described in these reports took place between 1960 and 1992. Most of the offenses took place between 1986 and 1990, but some older cases were included because disclosure was delayed.

A wide range of disabilities were in this sample as shown in Table 1. Three additional reports did not specify the nature of the victim's disability adequately for placement in any of these categories and do not appear in the table. The total number of disabilities exceeded the number of victims because many victims had multiple disabilities. Of the 152 individuals identified as having intellectual impairment, 18.4% (N=28) were identified as having a mild disability, 15.8% (N=24) were identified as having a moderate disability, 26.3% (N=40) were identified as having a severe, and 5.3.0% (N=8) were identified as having a profound disability. The remaining 34.2% (N=52) with intellectual impairment had no level specified. Although, the numbers in various disability categories are important to describe the sample, relative frequencies should not be interpreted to indicate relative risk or incidence since the sample was not random.

Table 1. Number of People with Specific Disabilities of Victims in Sample.

	Intellectual	Mobility	Hearing	Psychological	Visual	Neurological	Autism	Learning Disability
Canada	100	32	23	18	5	4	3	4
U.S.	24	4	2	0	4	4	0	0
N.Z.	28	8	4	5	0	4	2	0

Ages of victims ranged from 1 to 57 years old, with a mean age of 19.1 years. Most victims in this sample were adults. Subjects who were 21 years and over constituted 40.0% of the sample and those 18 through 20 years constituted another 8.8%. Younger victims included 21.0% that were 13 through 17 years and 30.2% that were younger than 13 years old. A more restrictive criterion was used for inclusion of adults and adolescents. There had to be clear evidence of coercion or harm in these reports, while this was not required for inclusion of reports involving children 12 and under.

Similar to other sexual offenses, these offenses largely were committed by men against women. Most victims were women (80.1%), and most offenders were men (91.2%), although male victims (19.9%) and female offenders (8.8%) were reported in smaller but significant numbers. Turk and Brown (1992) report only about 2.5% female perpetrators among their British sample, but Sullivan, Brookhouser, Scanlan, Knutson, and Schulte (1991) report 11.5% female perpetrators in their American sample. As in the general population, the predominance of female victims was weaker among younger victims.

Data Analysis

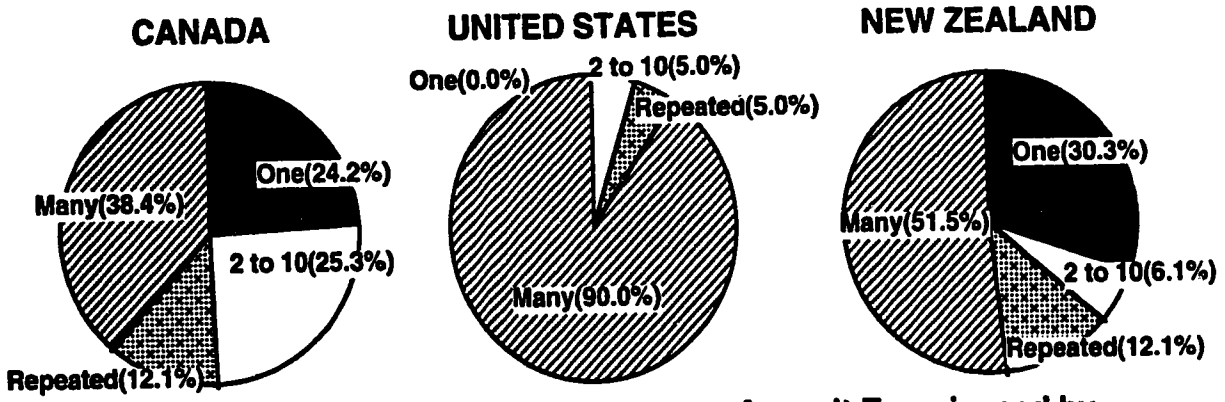
Data were categorized and tabulated. The researchers completed Chi-square analysis of the tabulated data to test for differences among the three countries. Post-hoc cell contributions based on z-scores were generated using a Statview II software program in order to determine which countries differed on which response categories. A similar but independent study, "Sexual Abuse of Adults with Learning Disabilities" has been conducted in England by Turk and Brown (1992) using different case finding and reporting strategies. Relevant results of this study are provided for contrast as a further indicator of validity and to provide an additional international comparison.

Results

As illustrated by Figure 1, most victims experienced abuse on more than one occasion. Single offenses were reported in about one fifth (22.4) of the cases. Sullivan and colleagues (1991) report 17.4% of their U.S. sample involved single-episode offenses. Another 18.4% of reports described two to ten incidents. The largest group (48.0%) disclosed abuse on "many" (greater than 10) occasions, and although they did not specify enough information for further categorization, the remaining 11.2% described abuse as repeated. Chi-square analysis revealed

significant differences among the three countries (p=.0008). Post hoc analysis of cell contributions suggests that cases from the United States were significantly more likely to involve chronic abuse and significantly less likely to involve single episodes of abuse than cases from Canada or New Zealand.

Figure 1.



Number of Episodes of Sexual Abuse or Assault Experienced by Victims with Disabilities in Samples from Three Countries

About half (50.8%) of the reports of sexual offenses against people with disabilities revealed physical harm, which ranged from minor bruising to death. Minor injuries typically not requiring treatment were reported in 21.4% of cases, and more severe injuries requiring treatment were reported in 20.3%. A small number of pregnancies (2.1%) and sexually transmitted diseases (7.0%) were also reported. These percentages are very likely low estimates because report forms did not specifically inquire about pregnancy or sexually transmitted diseases, and many respondents may not have included these in their definition of physical harm. Canadian cases were least likely to involve physical injury, while serious injury was most common in the U.S. cases, and sexually transmitted diseases were most frequently reported in the New Zealand cases.

Emotional, behavioral, and social consequences appeared to be universal (97.9%). Although 2.1% of reports indicated no emotional harm was apparent, these were third party reports of victims with severe communication deficits, suggesting the possibility that these cases may reflect the inability to communicate distress rather than a lack of effect. Uncategorized emotional distress was expressed in varying degrees by 47.7% of the victims. In addition, withdrawal was reported among 21.6% of victims. Another 20.5% exhibited aggression, non-compliance, inappropriate sexual behaviour, and other "behaviour disorders." These behavior problems often resulted in secondary harmful consequences such as punishment or intrusive treatment of the victim. Secondary harmful consequences also occurred when victims were removed from their homes (4.2%) or programs (3.9%) as a method of controlling the abuse. Victims with intellectual disabilities were less likely to be reported as exhibiting withdrawal, but lost placements (e.g, residential, vocational) were much more common in this group (Sobsey, in press). The lower rate of reporting of withdrawal among victims with intellectual disabilities may reflect a difference in response, but it may also reflect caregivers' inability to recognize withdrawal in this group since these included many third party reports. In addition, withdrawal may also be masked by communication impairment. The American cases were significantly more likely to describe lost placements as a result of abuse.

In 53.4% of the cases, abusers had a relationship to the client that was similar to those commonly found among offenders and non-disabled victims of abuse. Acquaintances (e.g., neighbors, family friends) comprised 17.0%, natural family members comprised 16.1%, paid generic service providers (e.g., babysitters) comprised 7.6%, strangers comprised 6.8%, dates comprised 3.4%, and step-family members comprised 2.5% of the abusers.

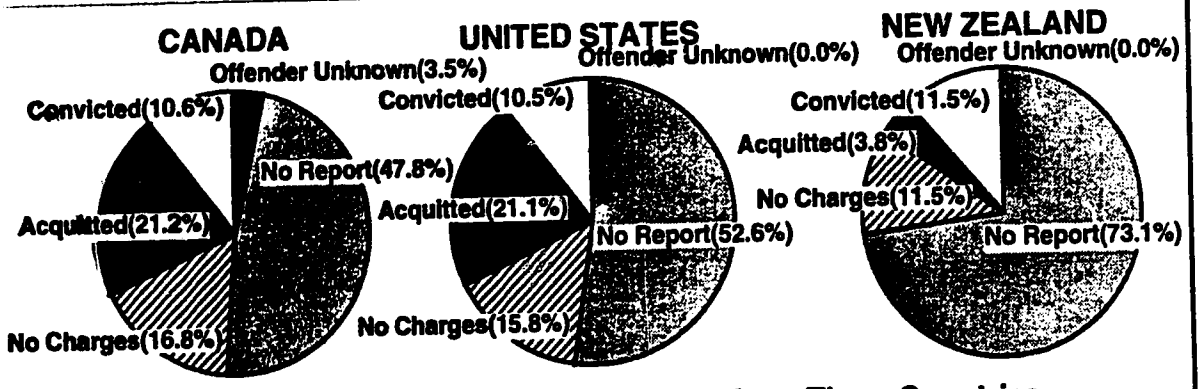
In another 46.6% of the cases, abusers had a relationship with the victim that appeared to be specifically related to the victim's disability. Disability service providers (e.g., personal care attendants, psychiatrists, residential care staff) comprised 26.3% of the abusers, specialized foster parents comprised 6.0%, and specialized transportation providers comprised 5.1%. Another 9.3% of abusers comprised other disabled individuals, typically clustered with the victim in a specialized program.

The New Zealand sample included significantly more cases of abuse in foster care (15.8%), while the U.S. sample included significantly more cases by paid "disability" services providers (44.4%) and paid generic service providers (25.0%). Turk and Brown (1992) report many more offenses committed by other people with disabilities (41.7%) from their British sample, but other reported categories of offenders are similar to those found in the present research. Sullivan and colleagues (1991) report 18.6% of perpetrators in their U.S. sample to be peers. Based on the percentage of offenders that are associated with specialized services in this sample, it would be reasonable to expect risk to increase by an additional 86% due to exposure to the "disabilities service system" alone. The extent of this elevation of risk would be adequate to explain most of the findings of increased incidence among individuals with disabilities.

Figure 2 illustrates outcomes for offenders. Although the offender was known in 93.2% of cases , only 22.1% of the offenders described in these reports were charged with the offense, and only 8.2% (37.1% of those charged) of them were convicted. Sullivan and colleagues (1991) report 97.2% of offenders were known to the victims prior to the offense. In some cases, failure to charge the offender resulted from refusal to press charges by the police (18.0% of cases that did not result in charges) or prosecutors (4.1% of cases that did not result in charges). In other cases, courts dropped charges at a preliminary hearing (1.6%).

Nevertheless, the most frequent reason for failure to lay charges was that the victims and their advocates did not report these crimes to law enforcement agencies (68.0% of cases that did not result in charges).

Figure 2.



Outcomes for Offenders in Samples from Three Countries

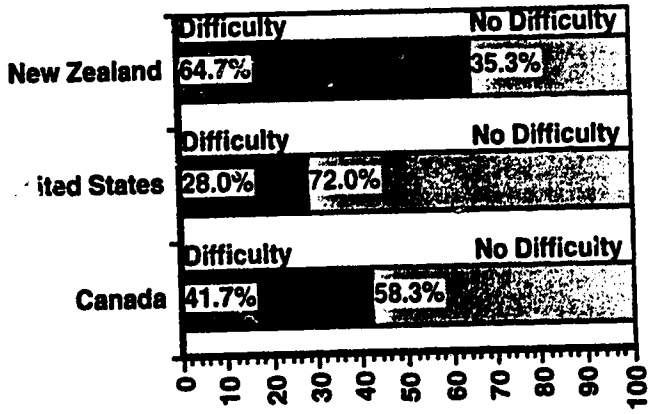
Many of the victims and their advocates indicated that they did not report abuse because they felt it was useless or because they feared retribution from the offender or interruption of services as a consequence of reporting. The experiences of those among this sample and elsewhere who reported abuse to authorities suggest that such fears are often justified. Chi-square analysis revealed no differences among the three countries in the charges or convictions. Turk and Brown (1992) report 18.5% of cases resulting in prosecution or disciplinary action and 48.2% resulting in no consequences for the offenders among their British sample.

The most frequent service sought for the victims of these offenses was counselling (44.6%). Medical services (16.3%) and various services or support from current caregivers (12.9%) were also frequently required or provided. Protective (7.9%) and legal services (7.5%) were sought in a smaller but still considerable number of cases, while abuse prevention education was sought in only a small number of cases (2.9%). Although the victims and/or their caregivers attempted to access more than one category of service in a number of cases, no attempt was made to secure any treatment or support in 11.5% of all cases.

Medical services and assistance from current caregivers was less frequently sought for individuals with intellectual disabilities than for victims with other disabilities (Sobsey, in press). Also, legal intervention, abuse prevention education, and protective services were more frequently sought for victims with intellectual disabilities.

Figure 3 illustrates the difficulties experienced accessing services in the three countries. Many victims (43.8%) experienced difficulty obtaining required treatment services. Although significantly more victims from New Zealand (64.7%) had difficulty accessing services ($p \leq .01$), 41.7% of the Canadian victims and 28.0% of American victims also had difficulty accessing services.

Figure 3.



Percent of Individuals Experiencing Difficulty Accessing Treatment in Samples from Three Countries

Even when services were successfully located, they often failed to meet the victim's needs. Most of the services (51.5%) failed to accommodate the special needs of the individual with a disability. Another 22.8% were viewed as inadequate in meeting the special needs of these victims. Nevertheless, 20.4% were viewed as adequately accommodating the special needs of the victims, and the generic services provided to other victims were considered appropriate in 5.4% of cases. In no case were services rated as making unnecessary modifications. These findings were similar for victims from all three countries.

Although sexual offenses committed against people with disabilities appear to be different in some respects, they are not entirely unique. In most respects, they are similar to other sex crimes (e.g., predominantly male offenders and female victims, similarity of relationships of offenders to victims, underlying dynamic of abuse of power), and differences appear to exist as extremes on a continuum such as increased incidence. For the subjects in this survey, offenses tended to be severe and often were repeated or chronic. Many offenders were paid caregivers, and many offenses took place in rehabilitation service environments. Services for victims with disabilities were often difficult to access, especially for those with severe disabilities. Yet even when services were found, they often failed to meet the individual needs of people with disabilities. The general patterns of abuse revealed by this study suggest a number of possibilities for abuse prevention strategies and the importance of developing accessible and appropriate treatment programs for people with disabilities who have been sexually abused.

PREVENTION STRATEGIES

Training can be an important component in reducing the risk of sexual abuse. Training potential victims to avoid or resist abuse has been the standard approach to sexual abuse prevention. Unfortunately, abuse prevention training programs may have the unintentional but detrimental effect of focusing responsibility for sexual abuse and assault prevention on potential victims and failing to assign ultimate responsibility for sexual victimization to offenders (Trudell & Whatley, 1988; Gilgun, & Gordon, 1985). It is unrealistic to expect that any program that places sole responsibility for abuse prevention on potential victims will adequately protect them. Despite some problems associated with abuse prevention training programs, there are several training approaches which appear to be useful in addressing the needs of people with disabilities.

Sexuality education is an important resource in abuse prevention, yet the pervasive myths surrounding disability and sexuality continue to influence both societal perceptions and treatment of people with disabilities (Warnemuende,1986). For example, myths portraying people with disabilities as "asexual" have been extremely influential. These infantilizing and erroneous beliefs not only deny the sexuality of disabled people, but have justified denying sex education and sexual expression to people with disabilities (Abramson, Parker, & Weisberg, 1988). Denying access to sex education may increase the vulnerability of people with disabilities to possible pregnancy, venereal diseases, and potential abuse by those who will exploit their lack of knowledge about sexuality. Appropriate sexuality education that is both individually tailored to developmental level and part of an ongoing program is essential for sexual abuse prevention.

Sexual abuse prevention training may include teaching different social skills such as learning to recognize and avoid dangerous situations, becoming aware of personal feelings of discomfort (Watson, 1984), and learning how to seek advice and help when necessary to prevent situations from escalating to abuse. Abuse prevention education programs, however, are not the only educational interventions that can help prevent sexual abuse of people with disabilities.

Assertiveness training, choice-making, and personal rights education are essential educational content for people with disabilities. Unfortunately, special education programs have often focused on generalized compliance, and compliance training has effectively trained students to be victims of psychological, sexual, and physical abuse. Education should aim at teaching students to discriminate between appropriate times appropriate times for compliance and for asserting their personal rights.

A critical, protective element for many people with disabilities is learning enhanced communication skills. Individuals who cannot communicate their feelings or describe what has happened to them may

be more vulnerable to abuse because offenders seek victims they perceive as vulnerable and unable to seek help or report the abuse (Lang, & Frenzel, 1988). Communication skill deficits may contribute to an offender's perception of victim vulnerability and to the selection of potential victims. For example, deaf children experience a greater incidence and risk for sexual abuse than hearing children (Sullivan, Vernon, & Scanlan, 1987). Improved communication skills probably decrease the perception of vulnerability and increase the risk of sexual abuse. Also, the development and enhanced access to appropriate social and sexual relationships can reduce vulnerability to more abusive relationships (Shaman, 1986). Programs that attempt to isolate or de-sexualize people with disabilities are likely to increase the likelihood of abuse.

Disabled children and adults may clearly benefit from educational interventions; however staff members who are providing educational, vocational, residential, and other related services can also benefit from training (Sundram, 1984). Staff should be trained to recognize and respond appropriately to early signs of abuse and have an early introduction to a clear policy regarding abuse and sexual behaviour. It is critical in abuse prevention that staff members have a clear understanding of standards of conduct and boundaries regarding appropriate and inappropriate behavior with their clients.

Staff need to know not only the procedures for reporting abuse, but also receive training to detect sexual abuse. The presence of effective prevention and reporting systems can have powerful deterrent effects on offenders. Potentially abusive staff members who believe that others are unlikely to detect and report them are likely to become active abusers. Staff members who believe that they are likely to be detected and reported may have their potentially abusive behavior inhibited. Inadequate reporting and detection procedures ensure that abuse is allowed to continue. Most abusers typically have numerous victims

before being apprehended. Cases of abuse that are both undetected and unreported allow more people to be victimized. Detection and reporting may protect victims from repeated and prolonged abuse.

Sexual abuse often takes place in the "disability service delivery system", and abusers are often paid caregivers (Sobsey & Doe, 1991). These findings indicate that system reform is an essential part of abuse prevention. There are several administrative reforms that can be implemented with potentially powerful effects in sexual abuse prevention for people with disabilities.

In a number of cases that have come to our attention, known sex offenders have taken jobs providing personal care to people with disabilities in institutions, group homes, and private residences. Although the number of previously convicted and currently charged applicants is small, the number of victims that each will likely have if allowed into the system is quite large (likely over 100). Therefore, careful and thorough reference and police checks are essential to the screening process (Musick, 1984). These strategies may be of limited use due to both the under reporting of abuse and employee dismissal practices that prevent charges from being laid against the alleged offender. Employers in the service delivery system need to be both sensitive to the problems produced by sexual abuse of people with disabilities and conscientious about screening staff to prevent it.

A particularly problematic area for abuse prevention concerns administrative dismissal policies that allow many abusers to resign from an agency rather than facing charges for their offenses. Administrative dismissal policies appear to be fueled by fears of negative publicity and potential loss of program funding, but ultimately, these policies provide irresponsible, short-sighted solutions that ensure the perpetuation of sexual abuse. Dismissal policies do not treat abuse as a serious crime and effectively prevent offenders from being stopped, charged, and convicted for their crimes and effectively reduce the likelihood that they

will receive treatment. Unfortunately, following dismissal, many offenders move on to another service delivery setting and continue to abuse people in their care. It is imperative that whenever possible charges be laid and convictions obtained to prevent the possibility of abusers moving from agency to agency.

Other potential abusers may include people living in the institution or residence. Many institutional settings cluster potentially sexually aggressive and vulnerable people together with little attention to violence prevention. Institutionalization of dangerous individuals may improve safety in the community, but without adequate safeguards to protect vulnerable people living in institutions, they will be put at great risk for victimization. Although institutions cannot entirely eliminate risk for residents, they do have a responsibility to provide a level of safety that is not substantially worse than in the community. Institutional staff have a responsibility to take reasonable precautions to reduce the risk of abuse for residents, and a similar level of responsibility needs to be established for contract staff. For example, many schools and other programs contract for transportation services to convey students with disabilities to specialized programs. Once schools and other service providers have knowledge of this risk, they have a responsibility to control it.

Some researchers suggest the risk of being sexually abused within an institutional setting is two to four times as high for being sexually abused in the community (Rindfleisch, & Rabb,1984; Crossmaker,1986). Therefore, serving more people with disabilities within the community and fewer in institutions may be a powerful prevention strategy. For individuals who continue to be served in institutional settings, however, reducing the isolation of this service delivery system may have similar preventive effects (Crossmaker, 1986).

The extensive use of psychotropic drugs for behavior control of people with developmental disabilities may also increase vulnerability to abuse. In some cases, the same people who recommend, prescribe, or

administer these mind altering drugs are also the offenders who sexually abuse their drugged victims. Drugs may be used deliberately to reduce the victim's resistance or to interfere with the victim's ability to protest or complain. Also drugs may be prescribed and administered by treatment team members who are unaware of the real cause of the non-compliant or other "inappropriate" behavior.

Similarly, intensive and aversive behavior management programs are sometimes used to control non-compliant, aggressive, sexually inappropriate, or other problem behavior of people with disabilities. Unfortunately, these programs are often employed with little attention to the discovery of the cause of the inappropriate behavior. In many cases, the cause of the behavior turns out to be the abuse. Suppressing this behavior through behavioral control may take away the victim's last defence against abuse and silence their only way of letting people know that they are being abused. It is essential that attempts be made to identify the real cause of "behavior problems" before caregivers attempt to eliminate them through the intrusive use of drugs or punishment procedures (Sobsey, 1990).

The processes of detection, reporting, prosecution, and treatment of sexual abuse are essential components of prevention programs. Many sexual abuse prevention policies are problematic because administrators fail to recognise the importance of implementation. Inadequate detection, reporting, and prosecution results in repeated offenses against the same victims and the victimization of others. It is the perception that these crimes go unreported and unpunished that encourages potential offenders to act out their impulses (Sundram, 1984).

Detection of sexual abuse of people with disabilities has often been hampered by several different factors. Society's de-sexualized image of people with disabilities often results in professionals' failure to recognize the possibility of sexual abuse of children and adults with disabilities

(Shaman,1986; Mansell, Sobsey, & Calder, 1992). Greater public understanding of the frequency of this crime is necessary in order for people to recognize and react to its symptoms. Just as people with disabilities are often stereotyped, caregivers are often viewed as patient, dedicated figures who are beyond reproach. Nevertheless, we cannot afford to dismiss suspicious events or behavior because of these beliefs. An additional obstacle to successful detection is symptom-masking. Many of the symptoms of sexual abuse may be easily attributed to the victim's disability and overlooked (Sobsey, in press).

Sexual abuse of people with disabilities currently goes unreported for several reasons. Many service consumers are intimidated by the abuser or are afraid of disruption of essential services and are unable to discuss their abuse because of their disability or because their isolated living situation prevents them from having free communication with someone they can trust. Many service providers fail to report abuse for fear of direct retaliation by the abuser or administrative retaliation from authorities who are embarrassed by reports of abuse within the service delivery system for which they have responsibility.

"Whistleblower" or complainant protection legislation is an essential component in deterring abuse and has been adopted in some states. Provisions of this legislation vary, but generally, they include legally mandated reporting of suspected abuse and protection from legal action taken by the alleged abuser if the charges are not supported. Legislative protection may ensure that people with disabilities will not face service interruption or more restrictive placement and service providers will not face administrative harassment or other consequences as a result of reporting. Good investigation and prosecution procedures are essential to prevention because failure to convict perpetrators of these crimes allows abusers to continue their abuse and encourages others to believe that they can also become abusers without the fear of punishment. There are several abuse prevention strategies which may be helpful, however,

it is also important to ensure that victims with disabilities have access to appropriately adapted treatment programs in order to address the consequences of sexual abuse (Tharinger, Burrows-Horton, & Millea, 1990).

Many community sexual abuse and assault programs remain inaccessible to people with disabilities or offer programs that are inappropriate to their needs. Physical accessibility, alternative telephone devices, provision of translating services, and non-print alternatives are among the basic accommodations required. For example, many sexual abuse treatment centers across Canada have acknowledged the existing gap in their services and are making progress toward ensuring accessible services for people with disabilities (Sobsey, Mansell, & Wells, 1991). Nevertheless, increased physical and resource accessibility of sexual abuse treatment centers has not yet been accompanied by the development of available or appropriate therapies for people with disabilities.

The physical and resource accessibility of sexual abuse treatment centers has increased for persons with a wide variety of disabilities; however, these advances do not suggest that appropriate therapies are widely available. Lack of appropriate treatment resources persists because of ignorance about disability and the inadequate training and experience of many professionals in the area of developmental disability (Tanguay, & Szymanski, 1980).

Insufficient experience and/or knowledge about the strengths, abilities, special needs, and limitations of persons with developmental disabilities are apparent in the training of many professionals (Tanguay, & Szymanski, 1980). The resulting lack of confidence working with persons with developmental disabilities prevents many professionals in sexual abuse treatment programs from providing treatment services to this vulnerable population. Treatment availability will continue to be problematic as long as professionals in sexual abuse treatment are

isolated from persons with developmental disabilities in their training and practice. Providing professionals with experience and training with this population may give them the necessary confidence, knowledge, and skills to work with this population and increase the availability of sexual abuse treatment for persons with disabilities. Also, experience and training may improve the attitudes of professionals toward persons with disabilities (Talbot, & Shaul, 1987) and heighten awareness of the treatment concerns of persons with disabilities.

Professionals' ignorance about the sexual abuse of people with disabilities has been influential as is evidenced by the low priority that the development of appropriate sexual abuse therapy approaches has had in research. Professional training in the area of disability and sexual abuse education may promote acknowledgment of the sexual abuse treatment needs of this population. For example, although researchers have reported success with adapting a variety of therapies for people with developmental disabilities including individual counseling and psychotherapy (Szymanski,1980; Rubin, 1983; Spackman, et. al., 1990), and group therapy (Szymanski, & Rosefsky,1980; Monfils, & Menolascino, 1984; Monfils, 1985); there is scant literature on sexual abuse treatment adaptations (Cruz, Price-Williams, & Andron,1988; Sullivan, Scanlan, Knutson, Brookhouser, & Schulte,1992).

Cruz, et al. (1988) suggest that conventional forms of sexual abuse treatment need only be modified and adapted to meet the needs of sexually abused people with disabilities. Mansell, Sobsey, and Calder (1992) suggest that greater professional liaison between professionals in the fields of abuse and disability and the use of adapted sexual abuse therapy may help ensure that sexual abuse therapy becomes both more available and appropriately adapted for people with disabilities who have been sexually abused.

Clearly, the cultural myths surrounding sexual assault and abuse (Sundberg, Barbaree, & Marshall, 1991) and the devaluing attitudes about people with disabilities (e.g., Yuker, 1988) contribute to their

disempowered position and vulnerability to sexual abuse. Greater advocacy involvement that works toward changing negative attitudes toward persons with disabilities may be an important, encompassing and long-term empowerment and sexual abuse prevention strategy. A more immediate objective for sexual abuse prevention, however, is to address attitudes of professionals working with people with disabilities (Sundram, 1984; Crossmaker, 1986) and to provide greater education on sexual abuse.

Heightening professionals' awareness of sexual abuse may encourage research on sexual abuse treatment adaptations, advocacy for funding sexual abuse treatment program, and professional liaisons in the areas of sexual abuse and disability. Sexual abuse education may improve professionals' detection skills, encourage sexual abuse reporting, and promote implementing sexual abuse prevention strategies (Westcott, 1991). In addition, professional training and liaison in the areas of sexual abuse and disability may help ensure that sexual abuse and offender treatment for people with disability is both available and appropriate.

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Sexual Abuse Treatment For Persons With Developmental Disabilities

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Running head: SEXUAL ABUSE TREATMENT

Mansell, S., Sobsey, D., & Calder, P. (1992). Sexual abuse treatment for persons with developmental disability. In Professional Psychology: Research and Practice, 23 (5), 404-409.

Testimony presented by Dunn (1991) on behalf of the APA's Division of Rehabilitation Psychology and Committee on Disability Issues in Psychology states that "the prevention and treatment of physical and sexual abuse of people with disabilities is an urgent need for increased study " (p.6). Dunn also recommends that research and dissemination in this area " be a top priority in the coming decade" (p.8). In this chapter, results from a survey of the treatment experiences of sexually abused people with developmental disabilities are presented; issues associated with providing accessible, appropriate sexual abuse treatment to this population are discussed; and adapted therapy approaches for people with developmental disabilities and examples of their application in sexual abuse treatment are presented. In addition, sexual abuse treatment issues for the developmentally disabled are presented for practitioners' consideration.

People with disabilities are at an increased risk for both sexual assault and sexual abuse (Sobsey, Gray, Wells, Pyper, & Reimer-Heck, 1991). Davis (1989) reported that 75-80% of mentally retarded women from a variety of community residences were sexually assaulted. A comparison of community and institutional reports of abuse suggests that sexual abuse incidents were almost four times as common in institutional settings than in the community (Blatt & Brown, 1986).

Previous research by the Sexual Abuse and Disability Project studied the incidence of sexual abuse in people with disabilities (Sobsey & Varnhagen, 1988), and sexual abuse prevention strategies (Sobsey & Mansell, 1990). More recent research involved a survey of sexually abused people with disabilities.

Sexual Abuse and Disability Project Survey

The survey's twenty-one questions were aimed to evaluate a variety of aspects of sexual abuse and asked about attributes of offenders and

victims; offender's relationship to the victim; the number and nature of abuse episodes; charges, reports, convictions; the impact for abuse victims; and victim treatment services. The questionnaires used in the study received approval by the Research and Ethics Committee of the Educational Psychology Department of the University of Alberta and complied with the APA's ethical standards. Researchers sent the questionnaire to advocacy groups, service agencies, and sexual assault centers. The questionnaires were completed by client advocates and victims with disabilities in both Canada and the United States. There were 170 questionnaires returned to the Sexual Abuse and Disability Project by mail and telephone between 1987 and 1990. At the time of this writing this research sample is the largest of its kind available.

The survey respondents included 119 sexual abuse victims with developmental disabilities and 51 victims with other sensory and motor disabilities. We present in this article only the survey data concerning the developmentally disabled respondents; survey data concerning respondents with other disabilities will be addressed by us in future articles.

Developmental disabilities are a group of neurological deficits that cause impaired functioning in areas such as intelligence, motor abilities, and personal-social interaction (Godschalx, 1983). These disabilities are attributable to mental retardation, autism, cerebral palsy, epilepsy and other conditions closely related to retardation in adaptive and intellectual problems (Horejsi, 1979). The term *sexual abuse* shall be used in this article to refer to both child sexual abuse and sexual assault. Survey reports involving sexual contact with children 12 years old and younger, and reports involving coercive sexual contact between adolescents and adults constituted sexual abuse.

The cases included in this survey do not represent a random sample of sexual abuse and assault victims with disabilities. People that choose to report may not represent those who choose not to report in the survey. Some experiences collected in this survey were direct reports made by the individuals who experienced abuse. In other cases, third-party reports from family members, service providers, or other "advocates" were made for the abused person. Third party reports provide valuable data about the abuse, though they may not accurately reflect the victim's perspective on the abuse.

The survey results reported do not include comparison data from victims without disabilities. Although previous studies document the increased vulnerability of people with disabilities to physical and sexual abuse and assault. Sobsey and Varnhagen (1991) reviewed several studies pointing out that the "risk for individuals with disabilities appears to be substantially greater than the risk for their nondisabled age peers" (p.206). The Disabled Women's Network study, comparing the incidence of sexual abuse of women with disabilities, found that women with disabilities were more vulnerable to sexual and other forms of abuse than were the control group of women (Doucette, 1986).

Results

The mean age of the 119 victims with developmental disabilities was 20.2 years (range = 1.5-51 years, SD = 10.4). Victims were primarily female (80.2%), close to twenty percent (19.8%) of victims were male. The mean age of offenders was 33.4 years (range = 14-80 years, SD = 13.8). Primarily, offenders were male (90.8%), but there were some female offenders (9.2%). The mean date of offenses was 1986 (range = 1978-1990, SD = 2.26).

The average number of episodes of abuse was addressed in the survey. Of the survey's respondents 19.2% indicated they had been abused once; 16.7%, that they had been abused 2 to 10 times, 10.3%, that they had been abused repeatedly; and 53.8%, that they had been abused on many occasions. It appears that for many people with developmental disabilities abuse occurred repeatedly, and often over protracted periods of time.

The locations in which abuse took place and the offenders' relationship to the victim were also determined by the survey. People with developmental disabilities experienced abuse in several different environments. Private homes (57.3%), vehicles (10.3%), group homes (8.5%), institutions (7.7%), public places (7.7%), other settings associated with rehabilitation services (4.3%), other (2.6%), and hospitals (1.7%) were environments where abuse took place. Offenders included paid caregivers providing services related to their victims' disabilities (26.3%), natural family members (17%), neighbors or acquaintances (13.5%), service providers for services unrelated to their victims' disabilities (10.5%). Other offenders included strangers (9.0%), disabled peers (8.3%), transportation providers (6.0%), foster family members (4.5%), dates (3.0%), and step-relatives (1.5%). From the survey's results, it appears that many sexually abused people with developmental disabilities are abused by workers in the service delivery system.

The 119 victims with developmental disabilities included 38 victims with severe and profound disabilities, 42 with mild and moderate disabilities, and 39 with an unspecified degree of intellectual impairment. A comparison of the survey results of the 38 victims with severe and profound developmental disabilities and 42 victims with mild and moderate developmental disabilities was conducted. The other 39 victims were excluded from this analysis because respondents did not specify the degree of intellectual impairment.

Chi-square contingency tables provide the probabilities of differences of distributions between the mild/moderate and severe/ profound groups. The category of mild and moderate developmental disabilities included people with mild (N=23) and moderate (N=19) intellectual impairment. The category of severe and profound developmental disabilities included people with severe (N=29) and profound (N=7) intellectual impairment, and people with moderate intellectual impairment, sensory, and motor disabilities (N=2). In this article the comparative analysis of the survey results focuses on the sexual abuse sequelae, and sexual abuse treatment accessibility and appropriateness. The results of the survey are in greater detail in Sobsey and Doe (1991).

In the survey sexual abuse sequelae were evaluated through questions about whether the sexually abused person experienced any social, emotional, or behavioral injury, and if so, about the nature and extent of the trauma. The limitations of third party reports are particularly relevant to results concerning abuse sequelae. Reports that may suggest withdrawal or an absence of emotional sequelae may suggest an inability to communicate instead of an actual absence of negative effects (Sobsey & Doe, 1991). Most sexually abused people in both groups suffered negative effects, and the difference between victims with milder and more severe disabilities was not statistically significant (p =.07).

Of the respondents, 9.8% of those with mild and moderate disabilities and 17.7% of those with severe and profound disabilities, reported that they experienced withdrawal. Of the respondents with mild and moderate disabilities and those with severe and profound disabilities, 19.6% and 31.1% respectively reported that they developed aggressive and/or other behavioral problems such as inappropriate sexual behavior. Reports of experiencing no emotional or social

problems came from 3.9% of the respondents with mild and moderate disabilities and 0 respondents with more severe disabilities. Reports of being moved out of home came from 2.0% of respondents with mild and moderate disabilities and 11.1% of respondents with severe and profound disabilities. Reports of losing program placement came from 7.8% of respondents with mild and moderate disabilities and 4.4% of respondents with severe and profound disabilities. Of the respondents with mild and moderate disabilities and severe and profound disabilities, 56.8% and 35.5% respectively reported unspecified emotional distress as abuse sequelae.

The accessibility of sexual abuse treatment was addressed through questions about whether disability made it difficult to obtain treatment services for the abuse victim. Many (54%) respondents suggested having difficulty obtaining treatment, but people with severe and profound disabilities were significantly more likely to have difficulty when seeking services ($p < .01$). Of respondents with mild and moderate disabilities, slightly over half (53.4%) obtained treatment without difficulty, and (46.6%) suggested that they had difficulty obtaining treatment. In contrast, only one sixth (16.7%) of the people with more severe disabilities obtained treatment services without difficulty, whereas most of these respondents (83.3%) had difficulty obtaining treatment services.

The appropriateness of the sexual abuse treatment for the respondent's individual needs was evaluated. A few respondents with mild and moderate disabilities (5.7%) received the same services as nondisabled clients and required no special treatment modifications. None of the more severely disabled people received appropriate treatment through these services. A little over a quarter of clients with moderate and mild disabilities (28.5%) received services that adequately met their needs. Yet fewer clients (7.4%) with more severe disabilities received specialized or individualized services. There were attempts to

meet the special needs of clients with disabilities, but these were considered inadequate for 22.8% of the respondents with mild and moderate disabilities and for 14.8% of respondents with severe and profound disabilities. Many respondents with mild and moderate disabilities (42.8%) and most of the respondents with severe and profound disabilities (77.7%) required accommodations to their special needs that were not available to them. More than half the people with developmental disabilities (51.1%) were in this category, but this included significantly more people with severe disabilities ($p<$ .01). None of the survey's respondents suggested that there were unnecessary accommodations made for them.

Discussion

For people with developmental disabilities who have been sexually abused, there has been prolonged denial of their sexual abuse, inadequate access to treatment services, and a paucity of appropriately trained professionals. Similarly, development of appropriate treatment approaches for people with developmental disabilities has been a low priority in both research and program funding. The inadequacy of treatment services may suggest the desensitizing impact of myths and devaluing attitudes toward people with developmental disabilities (Cushna, Szymanski, & Tanguay, 1980; Spackman, Grigel, & MacFarlane, 1990).

Attitudes Toward Disability

Pervasive attitudes surrounding disability are often negative and consist of myths that portray people with disabilities as helpless, damaged, inhuman, asexual, and insensitive to pain (Sobsey & Mansell, 1990). Myths and devaluing attitudes toward disability can encourage desensitization to the plight of the disabled. Unfortunately, when professionals develop these attitudes,their disabled clients may suffer

negative consequences (Cushna et al., 1980; Crossmaker, 1991). Myths about "asexuality" and "insensitivity to pain" of the developmentally disabled may have been particularly influential in the acknowledgment of sexual abuse being delayed and the continuing inadequacy of sexual abuse treatment services

Misconceptions surrounding the "asexuality" of people with developmental disabilities have been particularly influential and damaging. The infantilization of people with developmental disabilities and the resulting denial of their sexuality clearly overlooks the inherent sexuality of all people. Nevertheless, this myth has justified denying both sexuality education and sexual expression to the developmentally disabled (Kempton & Kahn, 1991; Abramson, Parker & Weisberg, 1988). Denying the developmentally disabled access to sexuality education increases their vulnerability to possible pregnancy, venereal diseases and abuse by persons exploiting their inadequate knowledge about sexuality (Shaman, 1986). Sexuality education that includes teaching self-protective behavior and assertiveness may be an important sexual abuse prevention strategy (Sobsey & Mansell, 1990). Notions about asexuality prevented many caregivers from acknowledging potential sexual abuse risk and delayed the implementation of abuse prevention strategies, such as educating staff to be able to detect sexual abuse. Caregivers overlooking the possibility of sexual abuse ensured that abuse continued undetected and prevented people from being protected and receiving help.

The inaccurate belief about the' insensitivity to pain' stems from the reasoning that because developmentally disabled people do not understand what has happened to them, they do not suffer pain (Crossmaker, 1986; Sobsey & Mansell, 1990). There is no evidence to support the notion that the developmentally disabled experience different

emotional abuse sequelae than individuals without disabilities (Varley, 1984; Sullivan, Scanlan, Knutson, Brookhouser, & Schulte, in press; Cruz, Price-William, & Andron, 1988). Beliefs about pain insensitivity may have been influential in contributing to the inaccessibility of treatment services. Professionals erroneously believing that the developmentally disabled are asexual and insensitive to pain may have hindered acknowledgement, detection and prevention of sexual abuse and contributed to the inaccessibility of treatment services.

Treatment Accessibility

Treatment access for people with disabilities may be problematic because of insufficient resource materials and inadequate accommodations for physical access to treatment. For example, not all sexual assault treatment centers have ramps or elevators for physical access or important resources such as telephone devices, translation services, or non-print alternatives for reading materials. Despite problems related to resources and physical access, many sexual abuse treatment centers have made considerable progress in ensuring accessibility (Sobsey, Mansell, & Wells, 1991); however, increased access of sexual abuse treatment centers has not yet been accompanied by appropriate or available therapies for people with developmental disabilities.

Treatment Availability

Lack of available treatment persists because of many professionals' inadequate training and experience in the developmental disability field (Tanguay & Szymanski, 1980) and inadequate program funding. It is apparent that the training of many professionals provided insufficient experience and knowledge about the abilities, special needs, and limitations of the developmentally disabled (Tanguay & Szymanski,

1980). This inadequacy may effectively prevent many sexual abuse treatment centers from providing treatment services to this population. Providing professionals with more experience may give them the confidence, knowledge and skills to provide services and may improve attitudes toward people with disabilities (Talbot & Shaul, 1987). Heightening professionals' awareness and sensitivity to disability treatment issues may promote advocacy for funding treatment programs and research.

Appropriate Treatment

Development of appropriate therapy approaches for people with developmental disabilities has been a low priority in research. Many proponents of psychotherapy approaches suggested that people with developmental disability were unsuitable candidates for traditional insight-oriented therapies because of their limited language and abstract-conceptual abilities (Monfils & Menolascino, 1984). Level of intelligence is often considered an important determinant of success in and suitability for insight-oriented therapies. Professionals' exaggerated pessimism about disability (Rubin, 1983) and therapy efficacy with this population (Spackman et al., 1990) probably prevented many practitioners and researchers from questioning these assumptions about therapy suitability, and the emphasis on intelligence may have hindered the development of more appropriate treatment approaches.

Therapy Adaptations

A few researchers and practitioners have challenged the importance of intelligence as the primary determinant of suitability for therapy by adapting existing therapeutic techniques and using more relevant indicators of ability to participate in therapy (Szymanski &

Rosefsky, 1980; Monfils & Menolascino, 1984). Using relevant indicators such as a client's level of development, ability to form relationships, and social adaptability may help practitioners choose appropriate therapeutic techniques for clients (Rubin, 1983). Adapted therapy techniques are similar to conventional therapeutic approaches but require that a practitioner adapt the techniques to the person's level of understanding, developmental level and social adaptability. Researchers report success with adapting a variety of therapies for people with developmental disabilities, including individual counseling and psychotherapy (Szymanski, 1980; Rubin, 1983; Godschalx, 1983; Spackman et al., 1990), group therapy (Laterza, 1979; Szymanski & Rosefsky, 1980; Monfils & Menolascino, 1984; Monfils, 1985) and sexual abuse treatment (Cruz et al., 1988).

Spackman et al., (1990) suggest that both psychotherapy and counseling are adaptable for people with developmental disabilities. They note that for practitioners willing to learn and use client's receptive language, symbolic communications, visual imagery, tactile, and kinesthetic interactions in therapy, there are many therapeutic approaches. They report the use of therapeutic adaptations including psychodynamic techniques such as direct and indirect suggestion, therapeutic metaphor, paradoxical and experiential interventions. Also, behavioral techniques; cognitive approaches; non-verbal techniques similar to play and art therapies; verbal techniques such as reassurance, support, directed discussion, reflection and clarification of feelings, and interpretation are therapeutic adaptation possibilities (Spackman et al., 1990).

Szymanski (1980) recommended the use of directive approaches that set limits, maintain structure and focus, and allow flexibility for the expression of thoughts and feelings. Also, verbal and nonverbal

techniques such as play therapy and concrete activities such as modeling and nonverbal communication are useful when clients have language deficiencies (Szymanski, 1980).

Laterza (1979) recommended the use of eclectic group therapy adaptations such as action-oriented group work, adapted modeling techniques, transactional analysis techniques, and behavior contracts. Monfils (1985) recommended a theme centered group using relaxation techniques, modeling, and role-playing. For group therapy, each potential group member is assessed individually for motivation to change, verbal expression abilities, and the degree to which a client will benefit from group structure.

Adapted therapies appear to be promising therapy possibilities for people with developmental disabilities but they are not widely practice because of many professionals' negative perceptions of its efficacy. This perception may be a product of practitioners' pessimism about clients' success in therapy and unrealistic therapy goals for clients. In addition, many studies of therapeutic adaptations have methodological problems such as varying diagnosis, no control groups, no standardized treatment techniques and inadequate measures of therapy outcome (Szymanski & Rosefsky, 1980). Better evaluative research needs to be developed to determine the efficacy of adapted therapies.

Sexual Abuse Treatment

A few practitioners and researchers adapted sexual abuse treatment for handicapped children (Sullivan et al., 1990) and developmentally disabled women (Cruz et al., 1988) by using conventional sexual abuse treatment approaches.

Browne and Finkelhor's (1986) review of the child sexual abuse literature suggests that initial effects of child sexual abuse include fear, anxiety, depression, anger, and inappropriate sexual behavior. Long term effects include depression, self-destructive behavior, feelings of isolation and stigma, poor self-esteem, tendencies toward revictimization, substance abuse, difficulty trusting and sexual maladjustment (Browne & Finkelhor, 1986). Finkelhor and Browne (1985) created a model of traumagenic dynamics to explain the effects of child sexual abuse. The dynamics of traumatic sexualization, betrayal, powerlessness and stigmatization are important for trauma assessment and the development of treatment goals. It is essential that practitioners understand the impact of sexual abuse to address the psychological and behavioral effects (Sarnacki Porter, Canfield Blick & Sgroi, 1982). Sexual abuse treatment for the developmentally disabled requires that the effects of abuse are considered with disability issues (Cruz et. al., 1988).

Sullivan and colleagues (1990) reviewed literature on sexual abuse and combined it with their expertise about children with handicaps to adapt sexual abuse treatment. Sexual abuse treatment goals include alleviating guilt, regaining the ability to trust, treating depression, helping children express anger, teaching about sexuality and interpersonal relationships, teaching self protection techniques, teaching an affective vocabulary to label feelings, teaching sexual preference and sexual abuse issues when appropriate and treating secondary behavioral characteristics (Sullivan & Scanlan, 1987). Therapy techniques include directive and nondirective counselling, play and reality therapy, psychodrama and role-playing, transactional analysis, behavior therapy, didactic counselling, and generalization training (Sullivan & Scanlan, 1987).

Sullivan, Scanlan, Knutson, Brookhouser and Schulte (1992) studied the efficacy of these therapy adaptations by using The Child Behavior Checklist (CBC) before and after therapy on a sample of 72 sexually abused subjects from a residential school for the deaf. The sample included 51 boys and 21 girls between 12-16 years old, and therapy was conducted by a therapist fluent in sign language. The study included a nontreatment control group because half of the parents refused the offer of free psychotherapy services for their child. Before therapy, both the treatment and nontreatment groups had elevated CBC scores. Children receiving therapy had significantly fewer behavior problems after therapy than children not receiving therapy.

One year after therapy, girls in the treatment group had lower scores than girls in the control group on the Total, External, Depressed, Aggressive and Cruelty scales but there were no differences on the Internal, Anxious, Schizoid, Immature, Somatic and Delinquent scales. Boys in the treatment group had significantly lower scores than boys in the control group on Total, Internal, External, Somatic, Uncommunicative, Immature, Hostile, Delinquent, Aggressive and Hyperactive scales but there were no differences on the Schizoid and Obsessive scales. The research of Sullivan and colleagues (1992) shows considerable promise in developing adapted sexual abuse treatment for children with handicaps and determining its efficacy.

Another group of researchers adapted group therapy techniques including role-playing and group discussions in sexual abuse treatment for developmentally disabled women who experienced intrafamilial child sexual abuse (Cruz et al., 1988). They used a cotherapy approach, with one therapist with expertise in sexual abuse and another with expertise in developmental disability, in an adapted group approach to sexual abuse treatment. Cruz et al., (1988) have presented a promising example of adapted sexual abuse treatment for the developmentally

disabled. Emphasizing professional liaison through the cotherapist team with adapted sexual abuse treatment may help ensure availability and appropriateness of sexual abuse treatment. For practitioners providing sexual abuse treatment to the developmentally disabled, there are several personal and professional issues to consider.

Practitioners require considerable knowledge about disability, along with sensitivity to disability and sexual abuse issues. Positive and nonjudgmental attitudes toward mental retardation that promote personal rights and emphasize acceptance and potential for continued learning and growth are essential (Monfils & Menolascino, 1984). Cushna et al., (1980) have noted that many therapists have rejected clients with developmental disability because of frustration that therapy could not cure their client's mental retardation. Practitioners' creativity, flexibility and patience are crucial for developing realistic expectations and therapy goals and adapting therapy appropriately to clients' needs and abilities. In addition, practitioners must carefully consider the combined impact of clients' issues surrounding developmental disability and sexual abuse in treatment.

People with developmental disabilities often have poor coping skills, weak problem solving skills, and poor communication skills accompanied by low self-esteem, feelings of inadequacy, and isolation (Spackman et al., 1990). Cruz et al., (1988) noted that developmentally disabled women who were sexually abused as children have significant issues surrounding guilt, intimacy needs, lack of self-esteem, feelings of isolation, difficulty handling and expressing anger. Clients may have concerns and confusion about their sexuality and feelings about being "damaged goods" ; their dependency on others may exacerbate fears of retaliation and abandonment. Practitioners need to recognise that the

impact of these combined issues for the developmentally disabled person in sexual abuse treatment may be more complicated than for sexually abused people without developmental disabilities.

Conclusion

From the Sexual Abuse and Disability Project's survey of sexually abused people with developmental disabilities, it was evident that respondents had considerable difficulty obtaining accessible, available and appropriate sexual abuse treatment. Professional training in developmental disability and sexual abuse education may heighten awareness of sexual abuse treatment needs and encourage research on sexual abuse treatment adaptations. This also may result in greater advocacy for funding sexual abuse treatment programs and in forming professional liaisons between the fields of sexual abuse treatment and developmental disability treatment. Sexual abuse education may improve professionals' detection skills, encourage sexual abuse reporting, and promote the implementation of sexual abuse prevention strategies (Sobsey & Mansell, 1990). Professional training and liaison in the areas of sexual abuse and disability may help ensure that sexual abuse treatment is both available and appropriate.

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The Prevention of Sexual Abuse of People with Developmental Disabilities

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Running Head: Sexual Abuse Prevention

Considerable research demonstrates that both children and adults with disabilities experience a much greater risk of sexual abuse and sexual assault (Sobsey, Gray, Wells, Pyper & Reimer-Heck, 1991). The available information concerning prevention and treatment of sexual assault and sexual abuse for the disabled is scarce. This chapter examines some of the existing prevention programs and proposes alternate sexual abuse prevention strategies for disabled persons.

Some of the strategies discussed in this paper developed out of work completed by the University of Alberta Sexual Abuse and Disability Project. This project began in 1987 and completed a comprehensive review of the literature, (Sobsey, Gray, Wells, Pyper, & Reimer-Heck, 1991) and an analysis of more than 150 victims' reports (Sobsey, in press; Sobsey & Doe, in press). The current work of the project is designed to validate prevention components extracted from the two previous phases. Many of these prevention strategies are discussed in this chapter.

Abuse Prevention Strategies

Education and Training

Training can be an important component in a risk reduction program. Training potential victims to avoid or resist abuse has been the standard approach to sexual abuse prevention for some time. Nevertheless, it is unrealistic to expect that any program which places sole responsibility for abuse prevention on potential victims will adequately protect or serve the needs of the disabled.

Researchers suggest that prevention training programs also may produce several unwanted effects. Detrimental effects may result from prevention programs which focus responsibility for sexual abuse and or assault prevention on potential victims but fail to assign ultimate responsibility for sexual victimization to offenders (Trudell & Whatley, 1988; Gilgun & Gordon, 1985). For example, if potential victims fail to

prevent sexually abusive or assaultive situations, by implication they may be held responsible for the occurrence. Ironically, prevention training programs that intend to help potential victims protect themselves may ultimately contribute to victim blaming. Although many children and adults with disabilities possess adequate information and the will to avoid victimization, they still may be powerless to prevent abuse. Despite problems associated with training programs there are several types of training which appear to be useful in addressing the needs of the disabled.

Appropriate Sex Education

Everyone, whether disabled or not, needs appropriate education and training in sexuality. The culturally pervasive myths surrounding disability continue to influence both societal perceptions and treatment of the disabled (Wamemuende, 1986). These myths may also contribute to offender's rationalizations for sexually abusing disabled persons. For example, one myth portrays people with disabilities as non-sexual. This erroneous belief not only denies the sexuality of disabled persons, it also may be used to justify denying access to sex education to people with disabilities. Denying the disabled access to sex education, may produce several related consequences. It may increase the vulnerability of people with disabilities to possible pregnancy, and venereal diseases, but also to potential abuse by those who will exploit their lack of knowledge about sexuality. For example, in our own research of sexual abuse victims with disabilities, we found cases in which sexual abuse was rationalized by offenders as a form of sex education. This rationale for abuse is not unique to cases involving victims with disabilities, however, Marshall and Barrett report that many incest offenders and child molesters use the same type of rationalization (1990). Those who fail to receive an appropriate and healthy sex education may be condemned to

an inappropriate and brutal sex education at the hands of those who will exploit and abuse them. Appropriate sex education for the disabled clearly is an important resource in sexual abuse prevention.

Sex education programs for people with disabilities should be individually tailored to the person's age, environment, and communication skills. In sex education programs although it is necessary to impart explicit information about sexual behavior, choices, and risks. It is also important to reach beyond the biological and address the social and emotional aspects of sexuality.

A critical component in sexuality education is sexual abuse prevention. Several different skills may be involved such as learning to recognize and avoid dangerous situations and becoming aware of personal feelings of discomfort (Watson, 1984; Ryerson, 1981). Learning how to seek advice, and help when it is needed are also important skills. For example, students need to learn how to let others know something doesn't feel good, and that letting others know immediately, before the situation becomes more serious may prevent escalation to abuse. Sex education is not the only educational intervention that can help prevent sexual abuse of the disabled.

Other Educational Needs

Assertiveness training, choice making, and personal rights education are essential educational content areas for people with disabilities. Unfortunately, special education programs have often focused on generalized compliance as a goal for students. An unfortunate consequence of this approach is that our best students may have been effectively trained to be victims of psychological, sexual, and physical abuse (Sobsey,1988). Education must not aim at unquestioning compliance and generalization; rather it should aim at teaching students

to discriminate between appropriate times for compliance and for asserting personal rights. Education should emphasize an awareness of the range of lifestyles available and help students develop abilities to choose. The development and enhanced access to appropriate social and sexual relationships can reduce vulnerability to more abusive relationships (Shaman,1986). Therefore, the programs that attempt to isolate or de-sexualize people with disabilities are likely to increase the likelihood of abuse.

A critical element for many people with disabilities is learning enhanced communication skills. Individuals who cannot communicate their feelings are more vulnerable to abuse. Researchers suggest that offenders may seek victims who they consider to be vulnerable and unable to seek help or report the abuse (Lang & Frenzel, 1988). Communication skill deficits may contribute to an offender's perception of victim vulnerability and to the selection of potential victims. Increased vulnerability of deaf children is clearly demonstrated by research that indicates deaf children experience a greater incidence and risk for sexual abuse than hearing children (Sullivan, Vernon, & Scanlan, 1987). Conversely, improved communication skills probably decrease the perception of vulnerability and the risk of sexual abuse.

Staff Training

Disabled children and adults can clearly benefit from some of the previously described educational interventions. Staff members who are providing educational, vocational, residential, and other related services could also benefit from training (Sundram, 1986). It is important for staff to have an early introduction to a clear policy regarding abuse and sexual behavior. Staff should be trained to recognize and respond appropriately to early signs of abuse, and to their own feelings of aggression or sexual attraction that may arise. Some researchers

suggest that many service providers occasionally experience feelings of sexual attraction to one or more clients (Pope, Keith-Spiegel, & Tabachnick, 1986). Most service providers, however, maintain appropriate standards of professional conduct. Frequently, the individuals who inappropriately act out their aggressive or sexual feelings have failed to anticipate the possibility of these feelings and have never developed strategies for appropriately dealing with them (Pope et al.,1986). Establishing both clear standards of conduct and boundaries between appropriate and inappropriate behavior, along with access to formal or informal counselling may help staff cope more appropriately with their feelings.

Staff need to know not only the procedures for reporting abuse but also be trained to detect the signs of sexual abuse. These prevention components may seem to be "after-the-fact" and perhaps too late to have any preventive effect. Nevertheless, there are several indicators that these can be powerful prevention strategies. The presence of effective prevention and reporting systems can have powerful deterrent effects on offenders. Potentially abusive staff members who believe that others are not only unlikely to detect but also unlikely to report them, are likely to become active abusers. Alternately, when they believe that they are likely to be detected and reported, their potential abuse is often effectively inhibited. Most abusers have many victims; child molesters may have on average about 70 victims before they are first apprehended (Barbaree & Marshall, 1988). Consequently both undetected and unreported cases of sexual abuse allow more people to be victimized. Therefore, while it may be too late to prevent the victimization of past victims, potential future victims may be protected. Also most victims do not appear to be sexually abused on only a single occasion (Sobsey & Doe, 1991). The abuser typically repeats the offense with the same

victim many times over periods of months or years unless the abuse is reported. Therefore, detection and reporting may protect victims from repeated and prolonged abuse.

Administrative Reform

Our research suggests sexual abuse often takes place in the "disability" service delivery system and abusers are often paid caregivers (Sobsey, in press). The implications of this finding suggest that system reform is an essential part of prevention. There are several administrative reforms that could be implemented in this system to have powerful effects in sexual abuse prevention for the disabled.

Staff Screening

In a number of cases that have come to our attention, known sex offenders have taken jobs providing personal care to people with disabilities in institutions, group homes, and private residences. Although the number of previously convicted and currently charged applicants is small, the number of victims that each will be likely to have if allowed into the system is large (likely 100 or more). Therefore careful and thorough reference and police checks are essential to the screening process (Musick, 1984). The interview process provides an employer with an important opportunity to determine the suitability of a prospective employee. Using open-ended situational questions may help an employer determine a prospective employee's attitudes towards the disabled and reactions to personal feelings of aggression, stress or arousal in providing personal care to the disabled. Employers in the service delivery system need to be both sensitive to the problems produced by sexual abuse of people with disabilities and conscientious about screening staff in order to prevent it.

In the past, many abusers have been allowed to resign from an agency rather than facing charges for their offenses. Unfortunately, many of these individuals move on to another service delivery setting and continue to abuse the individuals in their care. It is imperative that whenever possible charges be laid and convictions obtained to prevent the possibility of abusers moving from agency to agency. When employees leave an agency because of concerns over the nature of their interaction with service consumers, it is essential that this fact be included in any reference information provided to prospective future employers.

Agency Responsibility

Service providers must accept greater responsibility for the clients they serve. For example, when they fail to provide a reasonably safe environment, they must acknowledge their responsibility for the resulting harm done to the people in their care. Failure to adequately screen staff is one example of agency irresponsibility, but there are several others. Many institutional settings cluster potentially sexually aggressive and vulnerable people together with little attention to the prevention of violence. Institutionalization of dangerous individuals may improve safety in the community, but without adequate safeguards to protect vulnerable people living in institutions, such residents will be at great risk for victimization. Certainly, violence among residents is rarely condoned and typically some attempt is made to maintain order, but institutions have failed to recognise their legal obligation to maintain a level of personal safety similar to that of the general community.

Several recent court decisions suggest that this irresponsibility will no longer be tolerated. In at least three American cases, courts found that mental institutions did not protect residents adequately against

sexual assault from other residents (Sobsey, 1988). One American institution for people with developmental disabilities had federal funding withdrawn for the same reason (*School for the disabled loses...*, 1989). Canadian courts have also recognized this principle. For example, a recent case found a nursing home to be responsible for a physical assault by a resident (*Stewart v. Extendacare,* 1986). Staff were held responsible because they knew that the developmentally disabled resident was assaultive and failed to take appropriate action to prevent the assault.

Institutions cannot entirely eliminate risk for residents, but they do have a responsibility to provide a level of safety that is not substantially worse than the level currently available in the community. Institutional staff have a responsibility to take reasonable precautions to reduce the risk of abuse for residents. Responsibility also needs to be established for contract staff. For example, many schools and other programs contract for transportation services to convey students with disabilities to specialized programs. Our research has found many cases of these transportation providers sexually assaulting disabled students (Sobsey & Doe, 1991). Once schools and other service providers have knowledge of this risk, they have a responsibility to control it.

Integration and Reduction of Isolation

It is difficult to precisely compare the relative risks for sexual abuse in institutional and community environments. The available research suggests that the risk of being sexually abused within an institutional setting is two to four times as high for being sexually abused in the community (Rindfleisch, & Bean, 1988; Rindfleisch, & Rabb, 1984; Shaughnessy, 1984). Therefore, serving more people with disabilities within the community and fewer in institutions may be a powerful prevention strategy.

For individuals who continue to be served in institutional settings reducing the isolation of this service delivery system may have similar preventive effects (Crossmaker, 1986; Musick, 1984). The privacy of individuals living within institutions is both a legitimate and significant concern. Ironically many of the practices defended in the name of protecting the privacy of the individual, have resulted in the isolation of these individuals thereby increasing their risk for abuse.

Behavioral Control

Two other service reforms need careful consideration. The extensive use of psychotropic drugs for behavior control of people with developmental disabilities may also increase their vulnerability to abuse. In some cases the same people who recommend, prescribe, or administer these mind altering drugs are also the offenders who sexually abuse their drugged victims. The drug may be used deliberately to reduce the resistance of victims or to interfere with the victim's ability to make a complaint. Breggin (1983) has described widespread use of these drugs to control political dissenters, prisoners, and the elderly, in addition to people with intellectual and behavioral disabilities.. Animal and human studies reported in these studies document the effects of tranquilizers in suppressing escape and avoidance responses, interfering with the abilities required for self-protection. In some cases these drugs may be used with good intention but with equally damaging effects. For example, drugs may be prescribed and administered by treatment team members who are unaware of the cause of the behavior to control non-compliant or other "inappropriate" behavior. They may be unaware that the behavior that they are "treating" developed in response to abuse or that they are suppressing the victim's only available means of defense.

Similarly, intensive and aversive behavior management programs are sometimes used to control non-compliant, aggressive, sexually inappropriate or other problem behavior of people with disabilities. Unfortunately, these programs are often employed with little attention to the discovery of the cause of the inappropriate behavior. In many cases the cause of such behavior turns out to be abuse of the individual. Suppressing this behavior through behavioral control may take away the victim's last defence against abuse and silence their only way of letting people know that they are being abused. Abusers may even use such programs as a coercive tool to ensure silence from sexual abuse victims. It is essential that attempts be made to identify the real cause of "behavior problems" before caregivers attempt to eliminate them through the intrusive use of drugs or punishment procedures (Sobsey, 1990).

Various forms of restraint that are sometimes used to control people with atypical behavior also leave them vulnerable to abuse and assault. In our review of cases, we have also come across cases in which "therapeutic restraint" left victims vulnerable to abuse and assault. Whether restraint is accomplished physically, chemically, or through behavioral coercion, its use creates the extreme inequality of power that often leads to abuse. Packard (1875) in her classic description of her own experience as a patient in a 19th century insane asylum is suggesting that the "most heinous wrong of our present system consists in the fact that inmates of Insane Asylums are denied the primeval right of self defense" cited in Crossmaker and Merry (1990). Little has changed this fundamental fact in the last century. Only the new, more sophisticated methods of chemical and behavioral restraint have been added to supplement physical restraint. The use of any of these procedures is rarely if ever justified. If they are ever to be used, there must be more stringent controls in place to prevent abuse.

Detection, Reporting, Prosecution and Treatment

The processes of detection, reporting, prosecution and treatment of sexual abuse may appear to be activities that occur only after prevention has failed and therefore of little value in preventing sexual abuse. Yet these activities are essential components of prevention programs. Poor detection, reporting, and prosecution results in repeated offenses against the same victims and also to the additional victimization of others. The perception that these crimes go unreported and unpunished encourages potential offenders to act out their drives (Sundram, 1984). Treatment for victims and offenders is also important. Offenders who go untreated are likely to commit future offenses. There is also evidence that many adult sex offenders were victims of sexual abuse as children (Fagan & Wexler, 1988; Langevin, Wright & Handy, 1989; Finkelhor, 1984). Thus, by effective treatment of victims of child sexual abuse we may not only help the victim, but also decrease the chance that some victims will later become offenders.

Detection

Detection of sexual abuse of people with disabilities has often been hampered by several different factors. Society's de-sexualized image of people with disabilities often results in our failure to recognize the possibility of sexual abuse of children and adults with disabilities (Shaman,1986). A greater public understanding of the frequency of this crime is necessary in order for people to recognize and react to its symptoms. Just as people with disabilities are often stereotyped, caregivers are often viewed as patient, dedicated, quasi-religious figures, who are beyond reproach. Consequently, we may have difficulty believing that the same man who was honored by his international religious and fraternal organizations for his dedication in adopting handicapped children from the third world countries is now charged with

sexually abusing these children. It would be equally wrong, however, to stereotype all caregivers as merciless exploiters. Like individuals found in all segments in society caregivers are variable and complex individuals. We cannot afford to dismiss suspicious events or behavior simply because we believe some individuals are beyond reproach.

Special emphasis should be placed on teaching children and adults to recognise and respond to early signs of abuse. Caregiver-abusers often attempt to disguise their abuse as part of treatment and this ploy may be quite convincing especially at early stages. Symptom-masking is another obstacle to successful detection. Many of the symptoms of sexual abuse may be easily attributed to the victim's disability and thus overlooked (Sobsey, in press). For example, if a physician finds that an adolescent girl is not sleeping well, having difficulties in school, seems fearful of people, and resists physical examination, he should begin to wonder about the possibility that she is being abused. If that child has diagnosis of mental or emotional disability he may be likely to attribute the symptoms to her disability and thus be less likely to detect abuse.

Reporting Abuse

Much of the sexual abuse of people with disabilities currently goes unreported for several reasons. Many service consumers are often intimidated by the abuser or afraid of disruption of essential services. Some service consumers are unable to communicate about their abuse because of their disability or because of their isolated living situation that prevents them from having free communication with someone they can trust. Many service providers fail to report abuse for fear of direct retaliation by the abuser or administrative retaliation from authorities who are embarrassed by the reports of abuse within the service delivery system for which they have responsibility.

Complainant protection legislation is essential to combat these obstacles and has been adopted in some states and provinces. Provisions of this legislation vary, but may include some combination of elements. First, there is a legally mandated requirement to report suspected abuse. Second, there is often protection from legal action taken by the alleged abuser if the charges are not supported. This protection against being sued by the alleged abuser is normally absolute except in the case where it can be proven that the report was made without grounds but rather with malice and intent to injure the accused. Service consumers may be protected against service interruption or withdrawal subsequent to making a report.

Similarly, service providers who report may be legally protected against administrative retribution. It is very important to have provisions to ensure that all reports go to authorities independent of the service delivery system involved, and that administrative investigation cannot be used as a substitute for law enforcement investigation appropriate to the reported crime. In some states and provinces independent advocates have been appointed to facilitate such reports since an employee of an institution or service system under investigation cannot be expected to act impartially.

Investigation and Prosecution

Good investigation and prosecution procedures are essential to prevention because failure to convict perpetrators of these crimes allows abusers to continue their abuse and encourages others to believe that they can also become abusers without the fear of punishment for these offenses. Currently many victims with disabilities are so severely disadvantaged in the criminal justice system that their rights to personal

security and equal protection of the law under sections 8 and 15 of the Charter of Rights and Freedoms are almost certainly violated. Legislation will be necessary to restore the balance of rights for disabled victims with those accused of abusing them.

Changes in evidentiary rules are required. At present many disabled victims are not allowed to testify in court because they are considered incompetent. Others are not allowed to utilize their most effective method of communication to testify. Every citizen who becomes a victim of a crime should have a right to present the best evidence they can in a manner that is most suited to their abilities.

Clarification of issues related to consent are also required in many countries. For example, in Canadian law, if an offender "honestly believes" that a victim is consenting, no crime has been committed. The law, however, is unclear regarding what constitutes reasonably honest belief in consent. The inability of an individual to fight off an attacker or to clearly communicate should be grounds for a finding of consent to sexual assault.

Complainant protection or "whistleblower" legislation is an essential component in a deterring abuse. People with disabilities should not be in jeopardy of service interruption or more restrictive placement as a result of reporting abuse. Service providers should not be in jeopardy of administrative harassment or other consequences that have occurred in response to their reports of abuse.

Treatment Programs

Many community programs that treat victims of sexual abuse or assault remain inaccessible to people with disabilities or offer programs that are inappropriate to their needs. Nevertheless, many treatment centres across Canada have acknowledged this gap in their services and are making excellent progress toward attaining appropriate

and accessible services for all. Physical accessibility, alternative telephone devices, provision of translating services, and non-print alternatives for reading materials are among the basic accommodations required. More work needs to be done to identify appropriate treatment alternatives for people with cognitive and communicative impairments that make traditional insight therapy difficult.

Attitudes About Disability

The myths surrounding sexual assault and sexual abuse combined with the cultural images of people with disabilities may act as powerful influences in the perpetuation of sexual abuse (Shaman, 1986). Most sexual offenders develop myths about their victims that they employ to both justify their own inappropriate behavior and reduce their behavioral inhibitions. For example, rapists often blame their victims describing them as "asking for it". We need to carefully examine the cultural myths surrounding people with disabilities to determine not only how these attitudes may contribute to abuse and also how changing attitudes may function as a sexual abuse prevention strategy. Five such attitudes are discussed here as examples, but there are several others.

The "Dehumanization" Myth

Sadly, people with disabilities are still portrayed and viewed as less than full members of our society. Labels such as "vegetative state" suggest an image of the person with a disability as not quite human. Such images allow offenders to fuel their existing justifications with the belief that their offenses are less problematic because the victim is not really a fellow human being. Since the offender sees himself as more human and therefore more valuable, he sees nothing wrong with exploiting the less valued individual to meet his own needs.

The "Damaged Merchandise" Myth

Closely associated with the dehumanization concept is the view of the disabled person as damaged merchandise. This is perhaps most clearly articulated by those who advocate for euthanasia of severely handicapped children. They argue that the "potential quality of life" for such a person is so poor that the child is better off dead than alive. Indeed, this myth allows society to kill handicapped children and provides the rationalization which asserts that it is ultimately in their "best interest". In fact, we have little reason to believe that the euthanasia advocates' presentation of so-called indicators of quality of life have any relationships to the individual's own perception of the quality of his or her own life.

The damaged merchandise myth asserts that because the life of the disabled person is worthless, they have nothing to lose in death. The sexual abuser may employ similar reasoning which allows him to regard his victim's life as worthless. Therefore it provides an offender with a rationalization not only for the choice of victim but also may alleviate any guilt or inhibition about exploiting a disabled person.

The "Feeling No Pain" Myth

People with disabilities, especially emotional disorders and mental handicaps are often described as immune to pain and suffering. In fact, there is no basis for this belief since these people are subject to experiencing the same range of feelings as any person. This myth allows offenders to believe that because some victims may not fully understand what is happening to them, they suffer less. Therefore, they rationalize their crime by saying that the victim really wasn't hurt by it.

Research shows that people with all kinds of disabilities suffer as much emotional trauma, physical injury, and social consequences of abuse as any other victim (Stuart & Stuart, 1981; Sullivan, Vernon & Scanlan, 1987).

The "Disabled Menace" Myth

People with disabilities have sometimes been portrayed and viewed as deviant menaces to society who are dangerous and unpredictable. For the offender, this view often contributes to rationalizations which blame the victim for the abuse. For example, caregivers who sexually abuse their clients may believe that the event occurred as a result of the sexual aggression of the victim. The reality is often the opposite. Sexually inappropriate behavior is often seen in victims of sexual abuse or sexual assault, but it often occurs as a result of their abuse, and should never be used as an excuse for the cause.

The "Helplessness" Myth

Even the portrayal of people with disabilities as vulnerable or helpless may contribute to their abuse. The perception of vulnerability is known to affect the selection of victims by sex offenders. This raises ethical concerns about exposing the frequency of sexual victimization of people with disabilities, since this exposure of vulnerability may encourage future victimization. However attempting to hide the problem, may produce worse problems because it protects abusers. The real answer to combatting the myth of helplessness is through the evolving empowerment of people with disabilities and developing positive, more realistic images appropriate to this empowerment. A more encompassing goal for the empowerment of people with disabilities involves promoting positive societal attitudes towards disability.

Changing Attitudes

Clearly society's attitudes about people with disabilities continues to contribute to their disempowered position and vulnerability to sexual abuse. Changing societal attitudes towards persons with disabilities may be an important, encompassing and long term empowerment and sexual abuse prevention strategy. A more relevant objective for sexual abuse prevention for persons with disabilities however is directly addressing the attitudes of professionals who work with persons with disabilities (Sundram, 1984).

Strategies including educational programs, contact with the disabled and disability simulation appear to be successful in promoting positive attitudes towards persons with disabilities (Westwood, Vargo, & Vargo, 1981). The results from studies attempting to alter attitudes toward persons with disabilities tend to be both conflicting, inconclusive and subject to methodological differences and problems (Westwood et al.,1981). Despite these methodological problems there may be important applications for use of these strategies in professional training programs. Ibrahim & Herr (1982) studied educational and role playing attitude change strategies in undergraduate students in helping professions and discovered role playing appeared to be more successful in altering attitudes towards the disabled. Professional training programs promoting positive attitudes toward people with disabilities, combined with increased employer awareness of sexual abuse issues and more rigorous employee screening may act together to help reduce the risk of sexual abuse for persons with disabilities.

Summary

People with disabilities experience increased risk for sexual assault and sexual abuse, however much of their excessive risk can be eliminated through appropriate abuse prevention strategies. Effective programs must consider the potential victims of abuse, potential offenders, and the settings where abuse often takes place. The problems of sexual abuse and sexual assault in our society are not unique to people with disabilities. The most effective forms of prevention must consider all members of society regardless of disability status.

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Sexual Abuse and Disability Study

Please fill out the following report as completely as possible. To ensure confidentiality, do not identify victim, offender, or reporter of criminal acts. Attach additional sheets if you wish. Report information related to only one victim on each form. Please provide as complete information as possible, but leave blanks or write "unknown" where the information available is incomplete. Copy or request additional forms if you wish to make more than one report. Return to **Abuse & Disability Project, 6-102 Ed North, University of Alberta, Edmonton, AB T6G 2G5, Canada.**

	Date	**Month**	**Year**
1. Date or approximate date of single offense:	— —	— —	— —

2. Approximate time of day: Hour __ __ A.M.or P.M. (Circle)

3. On how many occasions did this occur? _____

4. Specifically, where did the offense occur? (for example, victim's bedroom in home, school, institution or residential setting etc.)

_____

5. Please describe the offense briefly but clearly.

_____
_____
_____
_____
_____
_____
_____

6. How did you gain knowledge of the offense?

_____
_____
_____

7. Was the offender charged with the offense? ❒ **Yes** or **No** ❒ **(Check one)**

7a. If Yes, what was the charge?

_____

7b. If No, why not?

_____
_____

8. Was the offender convicted of the offense? ❒ **Yes** or **No** ❒ **(Check one)**

9. What were the offender's age & sex? **Years** ____ ❒ **Male** or **Female** ❒

10. Did offender receive treatment for offending? ❒ **Yes** or **No** ❒ **(Check one)**

11. If the offender was disabled what was the nature and extent of disability?

12. What were the age & sex of the victim? **Years** ____ ❒ **Male** or **Female** ❒

13. What was the relationship of the offender to the victim? (For Example, A Stranger, Parent, Teacher, Personal Care Attendant, etc.)

14. What were the nature and extent of the victim's disability (or disabilities)?

14a. In what way, if any, did the victim's disabilities contribute to vulnerability?

15. What was the nature and extent of physical injury to the victim (if any)?

16. What was the nature and extent of social, emotional injury to the victim (if any)?

17. What types of services were sought to treat or support the victim?

18. If treatment/support services were sought, was there difficulty in obtaining services for the victim because of the victim's disabilities? ❒ Yes or No ❒

18a. If Yes, what specific obstacles hindered access to treatment/support services for the victim?

_____
_____
_____
_____
_____
_____

18b. If services were obtained, did these services fully meet any special needs of the victim that resulted from the victim's disabilities? **(Check one)**

☐ The victim received the same service as others, no special services were required

☐ Services for the victim met the special needs of the victim's disabilities

☐ Services were altered to meet the special needs of this victim, but the alterations were not adequate

☐ No special services were provided, but they would have been helpful

☐ Special services were provided because of the victim's disabilities, but were not really necessary

19. Where did this incident occur? **(Check one)**

☐ Canada ☐ The United States

☐ Australia ☐ England

☐ New Zealand ☐ Scotland

☐ Other (please specify) _____

20. Other Comments:

_____
_____
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