NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

University of Alberta

Sex Education for Persons with Disabilities

by

Patricia D. Missall

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE **DEGREE OF MASTER OF EDUCATION**

IN

SPECIAL EDUCATION (SEVERE DISABILITIES)

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1991

ISBN 0-315-70013-0

University of Alberta
Edmonton
Canada T6G 2G5

Department of Educational Psychology
Faculty of Education
6-102 Education North. Telephone (403) 492-5245
Fax (403) 492-1318

11 July 1991

Patricia Missall
Department of Educational Psychology
University of Alberta

Thank you for your request to use the "ecological model of abuse of people with disabilities" figure in your thesis. You certainly have my permission to use this figure. Please cite the source.

Thank you.

Sincerely,

Dick Sobsey
Professor

University of Alberta

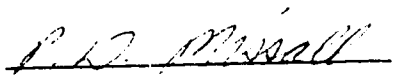
Release Form

Name of Author: **Patricia D. Missall**

Title of Thesis: **Sex Education for Persons with Disabilities**

Degree: **Master of Education**

Year This Degree Granted: **1991**



Patricia D. Missall
5304 - 103 A Avenue
Edmonton, Alberta
T6A 0W6

Date: *Aug. 1, 1991*

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **"Sex Education for Persons with Disabilities"** submitted by Patricia D. Missall in partial fulfilment of the requirements for the degree of **Master of Education** in **Special Education (Severe Disabilities).**

R. Sobsey (supervisor)

L. McDonald

K. Willson

Date: July 18, 1991

DEDICATION

To my mother,
who has shared all those umbrellas and rainbows with me.

Abstract

The purpose of this study is to examine possible contents of sex education curricula for persons with disabilities. The study is a partially independent part of a survey done by the University of Alberta Sexual Abuse and Disability Project. Experts knowledgeable in the field were asked to rank clusters of possible elements for client training according to their perceived usefulness in preventing abuse. They could also identify elements thought to be harmful or of no use. Comparisons were made of the rankings given by the subgroups of persons with disabilities and nondisabled service providers.

Friedman tests on the data were computed on each subgroup to determine their priorities. In this computation, those cases with missing values and those rated as harmful or worthless were dropped from each cluster, leaving only those with complete data utilized in the analysis. The percentage of respondents who considered each element in a cluster to be harmful, or of no effect, was separately computed.

The main findings of the study were that the within-cluster rankings of elements were similar between the two subgroups. Of all the elements rated, sexual abstinence as a lifestyle was most considered by both groups to be potentially harmful or of no use. Many different elements were recognized as being a part of sex education. The elements validated were then used to refine prevention factors related to the sexual abuse and exploitation of persons with disabilities.

ACKNOWLEDGEMENTS

This work would never have been completed without the special support of many people:

- A sincere "thank you" to Dr. Dick Sobsey, whose depth of help over the years has far exceeded his office as my advisor.
- Glenda Murphy, for the multitude of things that she has rescued from wastebaskets.
- My children, who coped with my frequent absences, both physical and mental.
- Bonnie Fyfe, for the sharing of her materials.
- Lisa Mutch, my next generation typist.
- And finally, my husband Bryce, for always being there.

Data analyzed in this study was collected under a project funded by National Health Research and Development Program, Health and Welfare Canada, under project number 6609-1597FV. Findings and opinions expressed in this thesis are the opinions of the author and not necessarily those of the Department.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF TABLES (CONTINUED)

LIST OF FIGURES

CHAPTER 1
INTRODUCTION

Why Sex Education?

Sex education is a term which usually generates an immediate reaction from anyone within hearing range. Nevertheless, a large majority of parents, students, teachers, and the general public favour the teaching of this subject (Arcus, 1986; Marsman & Herold, 1986). There are a number of reasons why this is an important topic for teaching. Today, many people favour this education because it may help prevent unwanted teenage pregnancies, the spread of sexually transmitted diseases, and the sexual abuse and exploitation of children. It may also help disseminate information which will help young people develop their total personality and prepare for adult roles in society.

Prevention is one of the first associations many people make with sex education. It comes in several different forms. Probably the most basic of these is the hope of preventing unwanted teenage pregnancies and the spread of sexually transmitted diseases (STD). Appropriate knowledge of these subjects can lead to a heightened concern and more responsible behaviour, in addition to giving basic "how-to" or "how-not-to" information. Most cases of teenage pregnancy and STD are caused by risk-taking, accidents, or ignorance (Brown & Fritz, 1988; Corcoran, Plante, & Robbins, 1984; Gordon, 1981; Herz, Reis, & Barbera-Stein, 1986). While education often does little about the first two problems, it can alleviate ignorance.

Another prevention concern has been growing for at least the last two decades. The sexual abuse and exploitation of children is becoming

recognized as a major social problem (Kolko, Moser, & Hughes, 1989; Nibert, Cooper, & Ford, 1989). Some adults who were victims say that they may have been spared, if they had known that their abuser's behaviour was not appropriate. There is also a need for children to learn some self-protective skills. Often, even if the victimized children speak to parents, these parents are reluctant to seek help. Thus, available treatment programs can assist fewer victims than these programs otherwise might help (Wurtele, 1987). Successful prevention eliminates the need for treatment.

Sex education is also considered important for young people for the more general information it imparts. Children of all ages get sexually stimulating messages from popular media. They often do not communicate well with their parents and instead seek information from their peers. That knowledge is frequently composed of misinformation and myths. Children need to learn that sex is normal and an important part of their personality and growing selves. They need this information to prevent their fears from damaging their self-esteem. Young people who have a greater self-knowledge are better armed to resist sexual exploitation and the problems of unwanted pregnancy or sexually transmitted diseases (Hofstein, 1978; Johnson, 1981; Silverstein & Buck, 1986; Wurtele, 1987).

Sex Education for Persons with Disabilities

The purpose of sex education for persons with disabilities is basically the same as it is for those who are not disabled. All young people have many similar needs, and some individual needs. Most of the

individual needs are related to the range of human differences, not necessarily to the presence of disability. Teenagers with disabilities need to be educated about how to prevent unwanted pregnancies and sexually transmitted diseases. They, too, are subject to sexually stimulating and confusing messages from the media, and misinformation from their peers. They, too, need someone to give them correct information.

Possible sexual abuse and exploitation of individuals with disabilities is not limited to a few isolated occurrences. It seems to be a very widespread problem in today's society (Sobsey & Doe, in press). Knowledge can help protect these people who generally have less control over their daily lives, and more contact with caregivers who may attempt to manipulate them.

Finally, individuals with disabilities have the right to know and develop themselves, to the best of their abilities, as sexual beings. They have the right to self-esteem, and to information that may help them make decisions in their lives (Cornelius, Chipouras, Makas, & Daniels, 1982). In short, they have the same right to receive sex education as anyone who is not disabled.

Curriculum Content Issues

The basic issue in almost any discussion of content in sex education curricula is simply what to teach. For people with disabilities, the question is sometimes whether they should be taught sex education at all (Elgar, 1985). This issue is usually brought up by those who feel that individuals with disabilities are asexual and have

no need to learn about themselves (Monat, 1982). Another theory is that persons with special needs cannot have "normal" sex and thus do not require sex education. Of course, no one has yet established a reliable definition of what "normal" is (Johnson & Kempton, 1981).

There are several other issues surrounding curriculum content for sex education for individuals with disabilities. Should the course include teaching self-help skills or should people rely more on the services of caregivers. Should there be guidance about socially acceptable behaviour and public and private behaviour, or should persons with disabilities simply be told that certain behaviour is wrong at any time (Brown, 1983). An equally strong issue is whether to encourage choice-making skills and assertiveness, to give individuals with disabilities more general control over their own lives. Different people will look at any question from different viewpoints, and some subjects appear to evade agreement.

This study is part of a survey done by the University of Alberta Sexual Abuse and Disability Project. The respondents, considered to be experts knowledgeable in the field, were asked to rank clusters of possible elements for client training according to their perceived usefulness in preventing abuse. They could also identify items thought to be harmful or of no use. Comparisons were made of the rankings of several sample subgroups (e.g., disabled, caregivers, male, female). The validated elements were then used to refine prevention and treatment factors related to sexual abuse and exploitation of persons with disabilities.

CHAPTER 2
LITERATURE REVIEW

Importance of Sex Education for Persons with Disabilities

Sex education is both a right and a need for people with disabilities. Most persons with disabilities, like everyone else, will develop sexually at their own internal rate. They are neither "oversexed" nor "undersexed" in relation to their nondisabled peers (McKowan & English, 1986). Because individuals may have a problem in one physical or cognitive area does not necessarily mean they have problems in all other areas of their lives. The only sexual differences from their nondisabled peers may occur in their means of expression, since persons with disabilities can have some unique sexuality concerns related to their physical and/or mental challenges. Because they have more difficulties, they need more, not less, formal help to understand their natural physical and emotional changes (Schuster, 1986; Segal & Craft, 1983; Tallor, 1985). Individuals with disabilities may not be able to get the information they need from books, or they may have special communication problems. They may have few friends to ask, or friends who provide them with poor information. They may also simply not know whom or how to ask for help, and thus may attempt to learn through perceived observations (Johnson & Kempton, 1981). People with disabilities are going to learn about sex somehow, as everyone does, but they should be given proper education on the subject.

Today, more individuals with disabilities are learning to live in the community at large: in group homes, in family or extended family homes, or independently. Leaving a more sheltered home setting for the

general society is posing new needs for some of these people, needs that can be met through social/sexual education. Often, individuals with disabilities may have had limited opportunities for social interaction, and may base their ideas of what is accepted on the distorted views presented by the media (Graff, 1983). Having had backgrounds with little personal privacy, they can find their actions or themselves labelled as bad. They can be told they are doing something wrong, when they are simply doing spontaneously and openly what others of their own age do privately. This may result in feelings of confusion and guilt. They need guidance to learn what is considered socially acceptable behaviour and how they can fit into that context (Monat, 1982; Smiglielski & Steinmann, 1981). Most importantly, individuals with disabilities need to be taught the meaning of and the times for privacy by caregivers who respect their clients' rights and basic integrity. Service providers do a great disservice by not teaching appropriate social interactions and modelling a variety of ways to express affection (McClennen, 1988).

Chapman and Pitceathly (1985) comment that it is unrealistic for society to insist on responsible sexual behaviour from people who have never been taught what responsible sexual behaviour is. This is further complicated because few behavioral norms are agreed upon by any given populace at any given time (Brown, 1983). Even "proper" sexuality is often defined differently according to the disability a person has. For example, some members of society believe that persons with mental handicaps should not have children, and thus should not engage in sexual activities which might lead to conception (Giami, 1987). It is

important for individuals with disabilities to learn appropriate basic everyday social skills in the context of sex education. They need to understand how to start a conversation, how to fit in, and how to comfortably meet and associate with others of the opposite sex (Cornelius et al., 1982). People can be socially effectively achieving what they want in a social setting. They can scream, swear, or use other disruptive behaviour to force others to leave them alone or to gain attention, but this type of behaviour will not endear them to the rest of the population. It is important for individuals with disabilities to learn appropriate and acceptable skills for dealing with others (Foxx, 1985).

Barmann and Murray (1981) added a sex education course to their behavioral procedure for eliminating inappropriate sexual behaviour. The subject in this study was taught that the public aspect of his behaviour was unacceptable. This course assisted in maintaining the treatment gains for at least six months. Hamre-Nietupski and Ford (1981) were involved in setting up a series of sex education and related skills programs for individuals with severe disabilities. There were five major content areas: (1) bodily distinctions, (2) reproduction and birth control information, (3) family life, (4) self-care, and (5) social manners and interactions. Over seven years the students' changing needs were met with a frequently revised curriculum, used to teach appropriate behavioral alternatives in order to eliminate problem behaviours. Based on data gathered from those involved, many of the skills learned were generalized and should facilitate more adult functioning in a variety of less restrictive environments.

Douglas (1989) reminds us that the sex of a person is an integral part of their personality. People almost always ask the gender of a new baby. The answer affects the way people will behave toward the child, as well as the role that the child will be expected to play in future years. People with disabilities need to understand the inherent changes that occur in their social/sexual roles, as well as the actual physical changes that will occur. They need to develop a healthy attitude about their bodies and the function of those bodies. Puberty, alone, brings physical changes that often cause fear and confusion about how to live with and care for that body (Dixon, 1988; Pueschel & Scola, 1988). Teaching a basic skill such as menstrual care can make an individual with disabilities more independent, and relieve the burden of responsibility from family or caregivers. The need to provide such care has often led to the performance of inappropriate medical solutions, such as a hysterectomy (Richman, Reiss, Bauman, & Baily, 1974; Varnet, 1984). Persons with disabilities also need basic sexual information to make informed decisions about receiving appropriate medical treatment. Without proper preparation, something as necessary as a woman's first pelvic exam can become a thing of fear leading to avoidance (Shapiro & Sheridan, 1985) and, hence, increased risk for serious illness.

Everyone needs to have high self-esteem. Obiaker and Stile (1989) noted that a person's behaviour will be consistent with his or her self-concept of self-esteem. Tuttle (1987) found that in visually impaired students, self-esteem determined their attitudes toward themselves and others. If they valued themselves and felt in control of situations, then they could more easily make decisions or choices regarding events

in their lives.

Individuals with disabilities find self-esteem harder to acquire because they are often obviously different from both media presentations and many of the people they meet. They need to gain an awareness and realistic image of their particular selves, in order to reduce any shame in a body that is different from those of others. Low self-esteem can lead to feelings of unworthiness which can in turn lead to the acceptance of sexual abuse or exploitation (Dixon, 1988). Another boost to increased self-esteem is learning how to make decisions which effect their lives. Individuals feel less helpless when they gain more control over their lives (Cornelius et al., 1982).

Prevention of sexual abuse and exploitation is a particularly important reason for training in sex education for people with disabilities. Those who lack knowledge of basic prevention or protection measures cannot defend themselves. As well, those who have been taught indiscriminate compliance, and must depend on others for their basic needs, are often seen as easier victims (Haseltine & Miltenberger, 1990; Martin & Forchuk, 1987; Robinson, 1984; Watson, 1984). Williams, Walker, Holmes, Todis and Fabre (1989) found in their recent study that the most needed social skill by persons with disabilities, according to teacher ranking, was compliance. Since most persons with disabilities spend a considerable amount of time in schools, it follows that they are learning a great deal about being compliant.

People who do not know the rules for the correct behaviour of others can become more easily exploited, particularly if they lack

experience or more highly developed judgement skills (Craft & Craft, 1981). Many women, disabled or not, believe the myth that sexual intercourse is supposed to hurt the female, and so have endured unpleasant or painful sexual experiences (Pitceathly & Chapman, 1985).

Although sex education is important for persons with disabilities for several reasons, the two most important ones are: (1) the increased chances of normalized social experiences, and (2) the help in avoiding more destructive experiences (Kempton & Stiggall, 1989). It is the right of individuals with disabilities to be enabled to live their lives to the fullest. Sex education for these people should be individualized and constantly evolving, but it should exist.

Elements of Sex Education

Although most people agree that sex education is a good thing, everyone seems to have a somewhat different idea about what should be included in the curriculum. There is even disagreement about the subject heading. Regardless of whether their students have disabilities or not, some educators want to teach sex education, while others want family life education (Arcus, 1986; Herz et al., 1986). Douglas (1989) would integrate sex education into health education. Martin and Forchuk (1987) also felt sexuality needs belong under health education, with everything taught from body parts and functions, to emotions, to social rules and assertiveness.

Physical Aspects

In sex education, individuals with disabilities should learn about

the human body and how it works and feels. They should study maturation and body changes, anatomy and what defines privacy, birth control, masturbation, sexually transmitted diseases, and parenting and marriage (Monat, 1982). Tabeek and Conroy (1981) focus on the student's own personal awareness for those who have physical disabilities. They stress individual physical problems, concerns, and limitations. In their initial program development, they found that most of their students wanted to know about birth, the prenatal time, and child growth.

Schultz and Adams (1987) see family life education for mildly mentally disabled adolescents as basic nutrition, teenage pregnancy, sex education, the developmental tasks of adolescents (i.e. accepting changes in life, getting along with the opposite sex), marriage and parenthood, and planning and decision making. Robinson (1984) added the topics of homosexuality, alcohol and drugs, and community risks and hazards in her sex education program.

Relationships

Evans and McKinlay note that menstruation and masturbation (or the care of) are the two best covered areas in most sex education curricula, which proves a crisis-oriented approach. Instead, instructors should be teaching adolescents with disabilities to understand themselves and their relationships. These authors would rather see sex education in the context of family life, and the relationships people have with their family, their friends, and with strangers. These would be taught along with biological information, although they worry about the legality of

teaching masturbation.

Champagne and Walker-Hirsch (1982) use their Circle Concept to discuss the more physical aspects of human sexuality, from how to say "no" to a hug, to how to decide when to increase intimacy in a relationship. This concept has been proposed to teach persons who are developmentally disabled. The key idea, again, is relationships, this time taught through the medium of ever-widening circles.

Penny and Chataway (1982) evaluated a sex education program conducted by a family planning group. It had a strong emphasis on the human relationships base of sexual activity. Still, the students with disabilities were evaluated on the basis of their knowledge of specific sexual words in a vocabulary test.

Individuals with disabilities need to learn and understand the standards for social behaviour. This is done through teaching about sexual norms and customs. Persons with disabilities need to know how to cope with and manage day-to-day anger and problems (Cornelius et al., 1982). This is the relationships side of sex education; learning about one's feelings, about self in relation to others, and how to express one's feelings appropriately (Monat, 1982).

Social Skills

Duncan & Canty-Lemke (1986) believe that sex education should be considered a part of social skills training, not as something separate. Persons with disabilities often have problems discerning what are considered public versus what are considered private acts, as well as how to behave toward a friend versus a stranger. Education which does

not teach these distinctions is not helpful. Griffiths, Quinsey & Hingsburger (1989) agree that it is a social context in which sexual expression occurs. They feel that many inappropriate expressions of sexuality by individuals with disabilities are the result of a lack of training with regard to the time and place for such things. These researchers have found that individuals with disabilities are as a group more vulnerable, and are more likely to engage in sexually inappropriate behaviour because they lack training or are abused by others.

Communications Skills

Another skill that people feel should be taught as part of sex education/social skills is communication. Tabeek and Conroy (1981) maintain that individuals who depend on service providers must be supplied with greater means of communication. Persons with disabilities need these skills so they can demand respect, indicate choices, and seek guidance from those who care for them.

Haseltine and Miltenberger (1990) studied the use of a curriculum for teaching self-protection skills to adults with mild mental handicaps, to help prevent their being involved in sexually abusive situations. These skills were found to be important to teach but difficult to assess. Incident reporting was the most difficult skill for the clients to learn.

Kempton and Stiggall (1989) found that reports indicate a high incidence of sexual abuse for persons with handicaps. They feel that a critical component of any sex education program is to strengthen the students' abilities to protect themselves. This includes teaching

assertiveness skills. LaBarre, Hinkley, and Nelson (1986), in their resource book on sexual abuse information for the hearing impaired, reinforce the rights all persons with disabilities have to be safe, to be protected, to feel good, and to say "no".

Other Considerations

In 1979, Edmonson, McCombs, and Wish, conducted a study on what adults with mental handicaps believe about sex. Their results indicated that even severely mentally disabled persons can acquire facts and attitudes about sex. If taught, these become part of more independent and responsible behaviour. Segal and Craft (1983) feel that basic sex education is a part of self-understanding and a complete life. It should be incorporated along with social skills, self-care skills, language, and home living skills.

Adams, Tallon, and Alcorn (1982) also concluded that the curriculum should be incorporated into the daily living setting, while Goodman, Budner and Lesh (1971) feel that parents need to be involved in all parts of planning.

Whatever content is taught, it must be adapted to the age, disability, background, maturity, and handicaps of the students (Martin & 1987; Penny & Chataway, 1982).

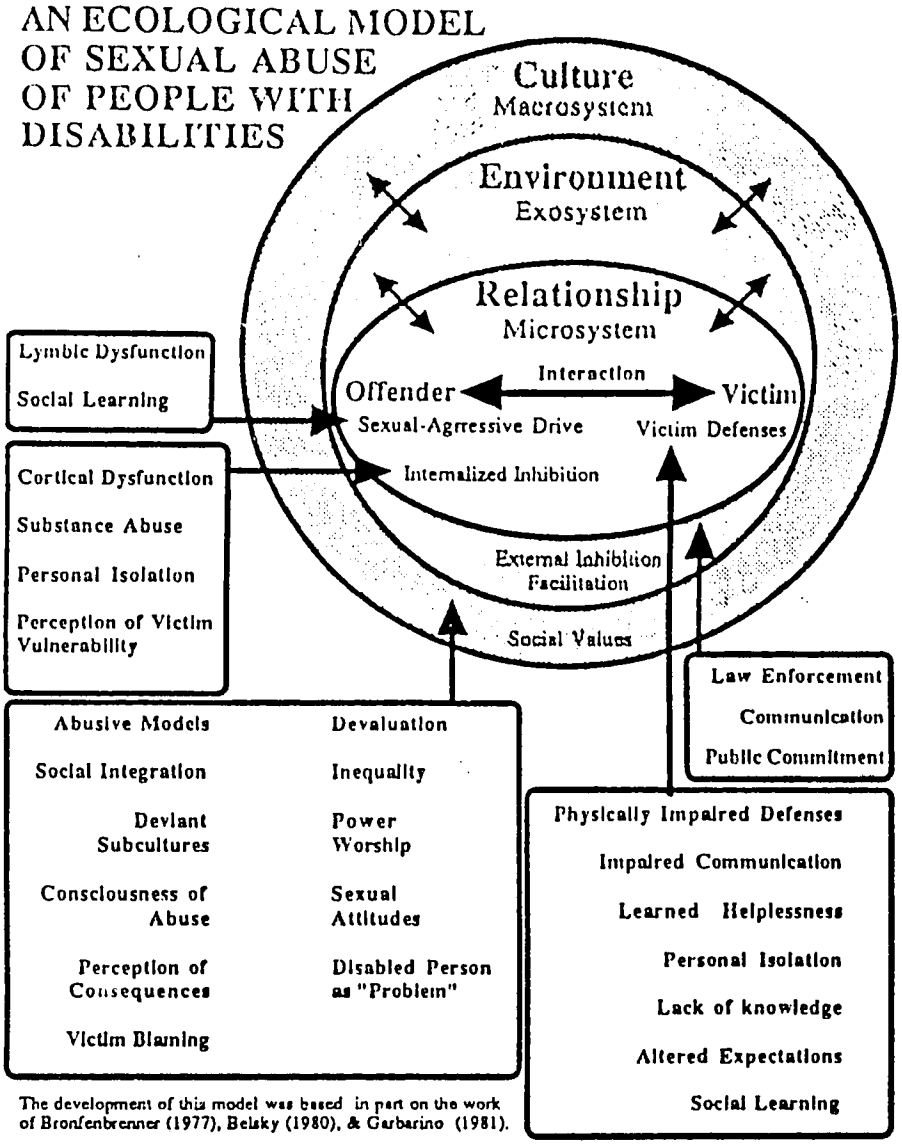
An Ecological Model of Sexual Abuse

One of the major motives for offering sex education to students, who do or do not have disabilities, is to help prevent sexual assault and exploitation. Sobsey and Varnhagen (1989) cited evidence that while

any person can become a victim, individuals with disabilities experience much greater risk and higher incidence of this problem. Because the topic of sexual abuse, like that of sex education, involves many different opinions, a model was needed to incorporate all the information gathered.

Over the years, there have been a number of theories concerning the etiology of abusive behaviour. They have been based on models from psychiatry, sociology, social-situations, and Bronfenbrenner's ecological model of human development (Zirpoli, Snell, & Loyd, 1987). Belsky (1980) took the work of Bronfenbrenner (1977), with its concern for the context in which abuse takes place, and developed what he felt was a useful tool to help understand child abuse factors. Garbarino (1977) found this model a useful one for integrating several divergent viewpoints. Belsky used the Bronfenbrenner framework to show the causative role of various factors identified as influential in abuse: individual, family, community, and cultural. He felt his model served as a guide for basic research, and showed the interrelationships needed for the design of prevention strategies.

The University of Alberta Sexual Abuse and Disabilities Project used a form of this model to demonstrate the roles and interactions of individuals and society, in investigating abuse prevention strategies (see Figure 1). The microsystem includes the relational interactions of the victim and offender. The exosystem includes the environment where these interactions take place, and the macrosystem includes the collection of influential cultural values and beliefs that effect the other two systems. These three systems continually interact and form



Note. From "General Abuse of Individuals with Intellectual Disability" by D. Sobsey, in press. In A. Craft (Ed.), Practice Issues in Sexuality and Intellectual Disability. Adapted by permission.

Figure 1 - An Ecological Model of Sexual Abuse Views the Interaction Between the Offender and Victim in the Context of the Environments they Share and the Cultural Beliefs that Shape the Environment

what is sometimes seen as the mesosystem (Sobsey, in press; Sobsey & Doe, in press).

Grounded Theory Approach

The University of Alberta Sexual Abuse and Disability Project was compiled through a modified grounded theory approach (Glaser & Strauss, 1967) to research. In this method, the researcher collects data relevant to a particular sociological problem, then inspects it to discover whether any theory can be developed directly from the patterns found in the data. The data are sorted into preliminary conceptual categories. The contents are then constantly compared within each category and across categories. As the concept in each category is refined, the researcher explores whether several concepts are related to each other, and thus can form the basis for a theory (Tesch, 1990).

A form of triangulation was devised for validation. In research, triangulation includes using diverse methods of data to support the same conclusion (Fielding & Fielding, 1986). The expert rankings in the survey from which this study came were used for triangulation and validation.

A modified grounded theory seemed the most logical method of research to use for this topic. This method is sensitive to everyday facts and relationships, and uses a variety of data collection strategies (Marshall & Rossman, 1986). Sexual abuse involves the relationships of people in conflict. The resulting reactions and personal, and, as such, often require a sensitivity in handling to gain the needed information. With any subject that involves human beings, a

variety of viewpoints will likely give a more complete picture. A strictly quantitative method of research would not have taken into consideration the very human factors of this subject.

Summary

In summary, sex education is an important curriculum component for all students. It is particularly important for people with disabilities, partially because it may help to reduce their risk for being sexually abused. The precise elements recommended for a sex education program for people with disabilities vary. No universal set of components has yet been identified for sexual abuse prevention. This study attempts to validate the rankings of sex education curriculum elements by experts in abuse prevention. The study also compares the rankings of two subgroups within the larger group that was surveyed.

Research Questions

1. Are the within-cluster rankings of sex education elements similar or different between persons with disabilities (service providers or not) and service providers without disabilities?
2. Are any of the cluster items of sex education elements considered potentially harmful, with attitudes similar or different between persons with disabilities (service providers or not) and service providers without disabilities?
3. Are any of the cluster items of sex education elements considered potentially worthless, with attitudes similar or different between persons with disabilities (service providers or not) and service

providers without disabilities?

Hypotheses

Based on the research questions these hypotheses were formulated:

1. Regarding experts' attitude toward the rankings of elements in sex education, there is no significant difference among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider.
2. Regarding experts' attitude toward the potential harmfulness of elements in sex education, there is no significant difference among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider.
3. Regarding experts' attitude toward the potential lack of effect of elements in sex education, there is no significant difference among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider.

CHAPTER 3
METHOD

Method

Information for this study has been gathered as a partially independent component of a survey designed to identify means of preventing sexual abuse of children and sexual assault of adults with disabilities (Sobsey, Mansell, & Wells, in press). The sections used are those on client training, under the general topic of sex education.

Sample

A sample consisting of 220 experts was surveyed, with a return of 112, or 51% These people are considered to be experts because they are knowledgeable about sexual abuse prevention and/or about services for people with disabilities. They include social workers (2), counsellors (10), advocates (22), law enforcement officers (5), teachers (7), researchers (19), administrators (11), people with disabilities (23), health care providers (5), lawyers (4), residential service providers (3), child protection workers (2), parents of children with disabilities, and victims of abuse. Of those returning the survey, 84% indicated they had been involved directly with cases of sexual abuse or assault. Many of the respondents had also been involved with alleged cases of neglect (78%), physical abuse (77%), and/or psychological abuse (73%). Sixty-six (59%) had been involved in cases as the reporter of abuse. Only eight (7%) of the respondents indicated that they had no direct experience with abuse cases. Most of the subjects do not have a disability, but 23 (21%) indicated that they do have some form of

disability. They reside mostly in Canada, but also in the United States, England, Australia, New Zealand, and Germany. Appendix A lists the names, affiliations, and geographic locations of 79 (71%) of the respondents who chose to have their names listed. The remaining 33 (29%) chose to remain anonymous or did not indicate either preference.

For the sections used in this study, the survey participants have been divided into two groups: (1) those who identify themselves as disabled (60% of whom consider themselves service providers), and (2) those who identify themselves as nondisabled service providers. These subjects are not a random sample because they were identified as both knowledgeable and likely to respond before the survey was mailed out. They were identified because they had corresponded with the University of Alberta Sexual Abuse and Disability Project in the year prior to the distribution of the survey, and indicated interest and involvement in various aspects of sexual abuse prevention for people with disabilities.

Instrument

The full survey is part of work done by the University of Alberta Sexual Abuse and Disability Project and compiled during 1990 and 1991 (Sobsey et al., in press). The components of that project have been combined through a modified grounded theory approach (Glaser & Strauss, 1967). Information from victims reports, an extensive literature review, confidential notes, a survey of sexual assault centres, and other sources have been used to develop a model of abuse. This model was then used to help identify or develop possible prevention methods. These possible prevention methods form the basis for the survey. The

responses given by the subjects will be used to adjust the prevention methods and the model itself. A copy of the survey instrument is included in Appendix B.

The surveys were mailed with stamped, self-addressed envelopes included, in the Canadian mailings. Self-addressed envelopes and Universal Postal Union return mail coupons were included in mailings to non-Canadians. The survey was mailed in November, 1990, and responses were received and tabulated until February, 1991.

Respondents were asked to participate on a voluntary basis. They were requested to fill in answers in a survey form including eight demographic questions, and 39 clusters of prevention items for ranking. Each cluster included between 2 and 12 items for ranking. The respondents were asked to rank all clusters on which they wished to have input. The items within each cluster were to be ranked 1, 2, 3, and so on, with 1 indicating the item of greatest importance. If an item was felt to have no value, it was ranked 0. If it was deemed more harmful than helpful, then it was ranked X. Respondents were requested to rank every item within a cluster, and to complete those clusters felt to be the most important if there was not time to do them all. The time required to complete the survey was about one hour, with some respondents indicating that several hours were required.

Many respondents indicated that they had difficulty ranking items within clusters. Comments, such as "hard to rank because all equally important", and "almost all of this is important", and "almost all of this is essential: hard to choose 'more important' items", were frequent.

Since the purpose of this study is to examine the possible contents of sex education curricula for persons with disabilities, only certain sections of the survey are examined. The demographic information identifies the two groups of subjects whose responses are of most interest. The information clusters examined are: (1) training components, (2) client training, (3) sex education for people with disabilities, (4) sexual lifestyle choices for people with disabilities, (5) social skills training for people with disabilities, (6) abuse prevention education for people with disabilities, (7) assertiveness training for people with disabilities, (8) choice-making education for people with disabilities, (9) personal rights education for people with disabilities, and (10) communication skills training for people with disabilities.

Data Analysis

The data gathered was keyed into a microcomputer. Statistical tests involved the computation of a Friedman test, a nonparametric equivalent test of order of ranked data (Marascuilo & McSweeny, 1977) using a StatView II software program (Abacus Concepts, 1987) on a MacIntosh IIx microcomputer. In the computation of the Friedman statistic, those cases with missing values and those with "X" (harmful) or "0" (worthless) were dropped from each cluster, leaving only those with complete data utilized in the analysis.

Friedman tests were computed for the total sample to determine the overall priorities of the group. Friedman tests were also performed on subgroups (e.g., people with disabilities, people without disabilities,

females, males) to determine priorities of these separate groups.

The Friedman test statistic, chi-square, tests the null hypothesis that the distribution of rankings within a cluster is identical. It is a less sensitive measure than a classical F test, but is more appropriate for ranked data because of the interdependence of rankings.

The percentage of respondents who considered each item in a cluster to be harmful (X), or of no effect (0), was separately computed. Criteria were set in order to identify items in a cluster which might cause concern. If more than 5% of the respondents regarded an item to be possibly harmful, if more than 8% regarded an item to have no use, or if the combined total of these two rankings exceeded 10% (X's & 0's), these items were identified as being areas of concern. These criteria were set to identify concerns that were not interpretable from the numerical rankings of importance.

CHAPTER 4
RESULTS

Results

The results have been organized under survey question clusters, with the responses noted that were given by persons with disabilities, including some who considered themselves service providers, and by service providers without disabilities. The information includes within-cluster rankings, and percentages of elements considered to be harmful or of no effect.

Question 11 on the survey asked respondents to rate Training Program elements for people with disabilities. For the 22 disabled respondents who rated all four items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 6.491 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

TABLE 1A - Disabled Expert Rankings of Training Program Elements for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.909	Client Training	0.0 %	0.0 %
2	2.591	Public Education	0.0 %	0.0 %
3	2.682	Service Provider Training	0.0 %	0.0 %
4	2.818	Family Training	0.9 %	0.0 %

Table 1A indicates the mean rankings for the elements of Training Programs for people with disabilities, as rated by disabled respondents.

The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Client Training, but Public Education, Service Provider Training, and Family Training also received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 61 nondisabled service provider respondents who rated all four items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 16.281 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 1B - Nondisabled Service Provider Expert Rankings of Training Program Elements for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.016	Client Training	0.0 %	0.0 %
2	2.369	Service Provider Training	0.0 %	0.0 %
3	2.762	Family Training	0.0 %	0.0 %
4	2.852	Public Education	0.0 %	0.0 %

Table 1B indicates the mean rankings for the elements of Training Programs for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest

priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Client Training, but Service Provider Training, Family Training, and Public Education also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects or to have no effect. Thus, 100% of the nondisabled service provider respondents considered all of these elements to be potentially helpful. In summary, respondents with disabilities and service providers both ranked the element of Client Training programs as the highest priority.

Question 12 on the survey asked respondents to rate Training elements for people with disabilities. For the 20 disabled respondents who rated all seven items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 22.686 (df=6), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

Table 2A indicates the mean rankings for the elements of Training for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Assertiveness Training, but Personal Rights and Sex Education also received high rankings. Choice Making, Abuse Prevention, Communication, and Social Skills were all ranked as helpful but assigned lower priorities than the other elements. Less than 1% of the respondents

TABLE 2A - Disabled Expert Rankings of Training Elements for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.550	Assertiveness Training	0.0 %	0.0 %
2	3.100	Personal Rights	0.0 %	0.0 %
3	3.575	Sex Education	0.0 %	0.0 %
4	4.400	Choice-Making	0.0 %	0.0 %
5	4.475	Abuse Prevention	0.9 %	0.0 %
6	4.900	Communication	0.0 %	0.0 %
7	5.000	Social Skills	0.0 %	0.9 %

considered any of these elements to have potentially harmful effects, or to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 59 nondisabled service provider respondents who rated all seven items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 11.684 (df=6), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

Table 2B indicates the mean rankings for the elements of Training for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Assertiveness Training, but Sex Education, Personal Rights, Abuse Prevention, Social Skills, Choice Making, and

TABLE 2B - Nondisabled Service Provider Expert Rankings of Training Elements for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	3.492	Assertiveness Training	0.0 %	0.0 %
2	3.585	Sex Education	0.0 %	0.0 %
3	3.873	Personal Rights	0.0 %	0.0 %
4	4.008	Abuse Prevention	0.0 %	0.0 %
5	4.144	Social Skills	0.0 %	0.9 %
6	4.288	Choice-Making	0.0 %	0.0 %
7	4.610	Communication	0.0 %	0.0 %

Communication also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects, and less than 1% of the respondents considered any of these elements to have no effect. Thus, more than 99% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Question 13 on the survey asked respondents to rate the elements of a Sex Education program for people with disabilities. For the 12 disabled respondents who rated all seven items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 11.786 (df=6), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less that five in one-hundred cases ($p \leq .05$).

Table 3A indicates the mean rankings for the elements of a Sex Education program for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular

TABLE 3A - Disabled Expert Rankings of Elements of a Sex Education Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.917	Body Parts	0.0 %	0.0 %
2	3.167	Sexual Vocabulary	0.0 %	0.0 %
3	3.500	Love and Sex	0.9 %	0.0 %
4	4.000	Physical Affection	0.0 %	0.0 %
5	4.250	Puberty	0.0 %	1.8 %
6	4.917	Hygiene	0.9 %	6.3 %
7	5.250	Lifestyle Choices	0.0 %	0.0 %

elements would be harmful or have no effect. Respondents gave the highest priority to Body Parts, but Sexual Vocabulary, Love and Sex, Physical Affection, Puberty, Hygiene, and Lifestyle Choices also received high rankings. Less than 1% of the respondents considered these elements to have potentially harmful effects, and less than 2% of the respondents considered any of these elements to have no effect, with the exception of the 6.3% who thought Personal Hygiene would have no effect. Thus, more than 98% of the disabled respondents considered all of these elements to be potentially helpful, with the exception of Personal Hygiene.

For the 52 nondisabled service provider respondents who rated all seven items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 19.525 (df=6), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 3B - Nondisabled Service Provider Expert Rankings of Elements of a Sex Education Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	3.231	Love and Sex	0.0 %	0.0 %
2	3.673	Physical Affection	0.0 %	0.0 %
3	3.788	Puberty	0.0 %	0.9 %
4	3.808	Body Parts	0.0 %	1.8 %
5	4.183	Sexual Vocabulary	0.0 %	0.0 %
6	4.471	Lifestyle Choices	0.0 %	0.9 %
7	4.846	Hygiene	0.0 %	2.7 %

Table 3B indicates the mean rankings for the elements of a Sex Education Program for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Love and Sex, but Physical Affection, Puberty, Body Parts, Sex Vocabulary, Lifestyle Choices, and Hygiene also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects, and less than 3% of the respondents considered any of these elements to have no effect. Thus, more than 97% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Question 14 of the survey asked respondents to rate the elements of a Sexual Lifestyle Choices program for people with disabilities. For the 10 disabled respondents who rated all five items in the cluster, a nonparametric Friedman test of the significance of rankings was applied.

This yielded a corrected chi-squared value of 19.04 (df=4),suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 4A - Disabled Expert Rankings of Elements of a Sexual Lifestyle Choices Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.500	Birth Control	0.0 %	0.0 %
2	2.600	Sexual Alternatives	0.9 %	0.0 %
3	3.100	Pregnancy	0.0 %	0.0 %
4	3.300	Parenting	0.0 %	0.0 %
5	4.500	Abstinence	4.5 %	4.5 %

Table 4A indicates the mean rankings for the elements of a Sexual Lifestyle Choices program for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Birth Control, but Sexual Alternatives, Pregnancy, Parenting, and Abstinence also received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect, with the exception of the 4.5% who considered a section on Abstinence to have a potentially harmful effect, or to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful, with the exception of Sexual Abstinence.

For the 35 nondisabled service provider respondents who rated all

five items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 73.6 (df=4), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 4B - Nondisabled Service Provider Expert Rankings of Elements of a Sexual Lifestyle Choices Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.771	Sexual Alternatives	0.0 %	0.9 %
2	1.829	Birth Control	0.0 %	1.8 %
3	3.371	Pregnancy	1.8 %	1.8 %
4	3.714	Parenting	0.9 %	1.8 %
5	4.314	Abstinence	8.0 %	10.7 %

Table 4B indicates the mean rankings for the elements of a Sexual Lifestyle Choices program for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Sexual Alternatives, but Birth Control, Pregnancy, Parenting, and Abstinence also received high rankings. Less than 2% of the respondents considered any of the elements to have potentially harmful effects, with the exception of the 8% who considered a section on sexual Abstinence to be potentially harmful. Less than 2% of the respondents considered any of the elements to have no effect, with the exception of the 10.7% who considered a section on sexual Abstinence would have no effect. Thus, more than 98%

of the nondisabled service provider respondents considered all of these elements to be potentially helpful, with the exception of sexual Abstinence.

Question 16 on the survey asked respondents to rate the elements of a Social Skills program for people with disabilities. For the 21 disabled respondents who rated all five items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 16.267 (df=4), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 5A - Disabled Expert Rankings of Elements of a Social Skills Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.952	Friendship Interaction Skills	0.9 %	0.0 %
2	2.810	Dating Interaction Skills	0.0 %	0.0 %
3	3.048	Family Interaction Skills	0.0 %	0.0 %
4	3.381	Client-Service Provider Interaction Skills	0.0 %	0.0 %
5	3.810	Stress Management	0.9 %	0.9 %

Table 5A indicates the mean rankings for the elements of a Social Skills program for people with disabilities, as rated by disabled respondents. The elements are listed from highest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect.

Respondents gave the highest priority to Friendship Interaction Skills, but Dating Interaction Skills, Family Interaction Skills,

Client-Service Provider Interaction Skills, and Stress Management also received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, or to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 55 nondisabled service provider respondents who rated all five elements in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 80.175 (df=4), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 5B - Nondisabled Service Provider Expert Rankings of Elements of a Social Skills Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.709	Friendship Interaction Skills	0.0 %	0.0 %
2	2.436	Family Interaction Skills	0.0 %	0.0 %
3	3.036	Dating Interaction Skills	0.0 %	0.9 %
4	3.855	Client-Service Provider Interaction Skills	0.0 %	0.9 %
5	3.964	Stress Management	0.0 %	3.6 %

Table 5B indicates the mean rankings for the elements of a Social Skills program for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Friendship Interaction Skills, but Family

Interaction Skills, Dating Interaction Skills, Client-Service Provider Interaction Skills, and Stress Management also received high rankings. None of the respondents considered any of these elements to be harmful. Less than 1% of the respondents considered any of these elements to have no effect, with the exception of the 3.6% who thought Stress Management would have no effect. Thus, more than 99% of the nondisabled service provider respondents considered all of these elements to be potentially helpful, with the exception of Stress Management.

Question 17 on the survey asked respondents to rate the elements of an Abuse Prevention program for people with disabilities. For the 19 disabled respondents who rated all nine items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 34.888 (df=8), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 6A - Disabled Expert Rankings of Elements of an Abuse Prevention Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	3.526	Situations to Avoid	0.0 %	0.0 %
2	3.579	Good/Bad Touch	0.9 %	0.0 %
3	3.763	Risks	0.0 %	0.0 %
4	4.474	When To Say "No"	0.0 %	0.0 %
5	4.658	How To Say "No"	0.0 %	0.0 %
6	5.605	Seeking Help	0.0 %	0.0 %
7	5.842	Seeking Advice	0.9 %	0.0 %
8	6.421	Disclosure	0.0 %	0.0 %
9	7.132	Seeking Help Persistently	0.0 %	0.0 %

Table 6A indicates the mean rankings for the elements of an Abuse Prevention program, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Situations to Avoid, but Good/Bad Touch, Risks, When to Say "No", and How to Say "No" also received high rankings. Seeking Help, Seeking Advice, Disclosure, and Seeking Help Persistently were all ranked as helpful but assigned lower priorities than the other components. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 45 nondisabled service provider respondents who rated all nine elements in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 114.992 (df=8), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

Table 6B indicates the mean rankings for the elements of an Abuse Prevention Program, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Good/Bad Touch, but When to Say "No", Risks, Situations to Avoid, and How to Say "No" also received high rankings.

TABLE 6B - Nondisabled Service Provider Expert Rankings of Elements of an Abuse Prevention Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.922	Good/Bad Touch	0.0 %	2.7 %
2	3.844	When To Say "No"	0.0 %	0.9 %
3	3.911	Risks	0.0 %	0.9 %
4	3.933	Situations To Avoid	0.9 %	0.9 %
5	4.044	How To Say "No"	0.0 %	0.0 %
6	6.278	Seeking Help	0.9 %	1.8 %
7	6.467	Disclosure	0.0 %	0.0 %
8	6.733	Seeking Advice	0.0 %	0.9 %
9	6.867	Seeking Help Persistently	0.0 %	0.9 %

Seeking Help, Disclosure, Seeking Advice, and Seeking Help Persistently were all ranked as helpful but assigned lower priorities than the other elements. Less than 1% of the respondents considered any of these elements to have any potentially harmful effects, and less than 3% of the respondents considered any of these elements to have no effect. Thus, more than 97% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Question 18 on the survey asked the respondents to rate the elements of an Assertiveness Training program for people with disabilities. For the 16 disabled respondents who rated all three elements in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 8.375 (df=2), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

TABLE 7A - Disabled Expert Rankings of Elements of an Assertiveness Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.438	Protesting	0.0 %	0.0 %
2	2.125	Requesting	0.0 %	0.0 %
3	2.438	Self-Defense	0.0 %	2.7 %

Table 7A indicates the mean rankings for the elements of an Assertiveness Training program, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Protesting, but Requesting and Self-defense also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects, and less than 3% of the respondents considered any of these elements to have no effect. Thus, more than 97% of the disabled respondents considered all of these elements to be potentially helpful.

For the 51 nondisabled service provider respondents who rated all three items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 23.216 (df=2), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

Table 7B indicates the mean rankings for the elements of an Assertiveness Training program , as rated by nondisabled service provider respondents. The elements are listed from highest to lowest

TABLE 7B - Nondisabled Service Provider Expert Rankings of Elements of an Assertiveness Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.686	Protesting	0.0 %	0.0 %
2	1.765	Requesting	0.0 %	0.0 %
3	2.549	Self-Defense	4.5 %	2.7 %

priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Protesting, but Requesting and Self-defense also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects or no effect, with the exception of the 4.5% who considered Self-defence to have a potentially harmful effect and the 2.7% who considered Self-defence to have no effect. Thus, 100% of the nondisabled service provider respondents considered all of these elements to be potentially helpful, with the exception of Self-defence. In summary, respondents with disabilities and service providers both ranked the elements of assertiveness training programs in the same order of priorities.

Question 19 on the survey asked respondents to rate the elements of a Choice-Making program for people with disabilities. For the 22 disabled respondents who rated all three items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of .342 (df=2), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

Table 8A indicates the mean rankings for the elements of a

TABLE 8A - Disabled Expert Rankings of a Choice-Making Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.909	Problem Solving	0.9 %	0.0 %
2	2.023	Exploring Alternatives	0.0 %	0.0 %
3	2.068	Decision-Making	0.0 %	0.0 %

Choice-Making program for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Problem Solving, but Exploring Alternatives and Decision-Making also received high rankings. Less than 1% of the respondents considered any of the elements to have potentially harmful effects, or to have no effect. Thus more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 59 nondisabled service provider respondents who rated all three elements in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of .812 (df=2), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

Table 8B indicates the mean rankings for the elements of a Choice-Making program for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents

TABLE 8B - Nondisabled Service Provider Expert Rankings of a Choice-Making Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.932	Exploring Alternatives	0.0 %	0.0 %
2	1.983	Problem Solving	0.0 %	0.9 %
3	2.085	Decision-Making	0.0 %	0.9 %

gave the highest priority to Exploring Alternatives, but Problem Solving and Decision-Making also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects, and less than 1% of the respondents considered any of these elements to have no effect. Thus, more than 99% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Question 20 on the survey asked respondents to rate the elements of a Personal Rights program for people with disabilities. For the 20 disabled respondents who rated all four items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 12.668 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

Table 9A indicates the mean rankings for the elements of a Personal Rights program for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Values, but Self-concept, Human Rights, and

TABLE 9A - Disabled Expert Rankings of a Personal Rights Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.775	Values	0.0 %	0.0 %
2	2.300	Self-Concept	0.0 %	0.0 %
3	2.850	Human Rights	0.9 %	0.0 %
4	3.075	Private Behaviour	0.0 %	0.0 %

Private Behaviour also received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 56 nondisabled service provider respondents who rated all four elements in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 44.138 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 9B - Nondisabled Service Provider Expert Rankings of a Personal Rights Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	1.625	Values	0.0 %	0.9 %
2	2.402	Self-Concept	0.0 %	0.0 %
3	2.875	Private Behaviour	0.0 %	0.9 %
4	3.098	Human Rights	0.0 %	0.0 %

Table 9B indicates the mean ranking for the elements of a Personal Rights program for people with disabilities, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Values, but Self-concept, Private Behaviour, and Human Rights also received high rankings. None of the respondents considered any of these elements to have potentially harmful effects, and less than 1% of the respondents considered any of these elements to have no effect. Thus, more than 99% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Question 21 on the survey asked respondents to rate the elements of a Communication Skills program for people with disabilities. For the 22 disabled respondents who rated all four items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 8.891 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than five in one-hundred cases ($p \leq .05$).

Table 10A indicated the mean rankings for the elements of a Communication Skills program for people with disabilities, as rated by disabled respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to Expressing Feelings, but General Communication Enhancement, Saying "No", and Describing Experiences also

TABLE 10A - Disabled Expert Rankings of Elements of a Communication Skills Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.136	Expressing Feelings	0.9 %	0.0 %
2	2.227	General Communication Enhancement	0.0 %	0.0 %
3	2.455	Saying "No"	0.0 %	0.0 %
4	3.182	Describing Experiences	0.0 %	0.0 %

received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect. Thus, more than 99% of the disabled respondents considered all of these elements to be potentially helpful.

For the 60 nondisabled service provider respondents who rated all of the four items in the cluster, a nonparametric Friedman test of the significance of rankings was applied. This yielded a corrected chi-squared value of 30.763 (df=3), suggesting that differences of this magnitude in the mean ranking could be expected by chance in less than one in one-hundred cases ($p \leq .01$).

TABLE 10B - Nondisabled Service Provider Expert Rankings of Elements of a Communication Skills Training Program for People with Disabilities

Rank Order	Mean Rank	Elements	Harmful	No Effect
1	2.058	General Communication Enhancement	0.0 %	0.0 %
2	2.192	Expressing Feelings	0.0 %	0.0 %
3	2.508	Saying "No"	0.0 %	0.0 %
4	3.242	Describing Experiences	0.9 %	0.0 %

Table 10B indicates the mean rankings of the elements of a Communication Skills program, as rated by nondisabled service provider respondents. The elements are listed from highest to lowest priority, along with the percentage of people who indicated that particular elements would be harmful or have no effect. Respondents gave the highest priority to General Communication Enhancement, but Expressing Feelings, Saying "No", and Describing Experiences also received high rankings. Less than 1% of the respondents considered any of these elements to have potentially harmful effects, and none of the respondents considered any of these elements to have no effect. Thus, more than 99% of the nondisabled service provider respondents considered all of these elements to be potentially helpful.

Summary

This chapter has detailed the results of the survey question clusters on client training, under the general heading of sex education. The two respondent groups examined were experts with disabilities and service provider experts without disabilities. The main findings were that the within-cluster rankings of elements were similar between the two subgroups. Of all the elements rated, Sexual Abstinence as a lifestyle was most considered by both groups to be potentially harmful or of no worth. The teaching of Personal Hygiene was felt by many experts with disabilities to have no effect. In general, most of the elements in the clusters were considered to be potentially helpful.

Hypotheses

1. Regarding experts' attitude toward the rankings of elements in sex education, there was little difference among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider.

2. Regarding experts' attitude toward the potential harmfulness of elements in sex education, there were some differences among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider. More service providers without disabilities felt that teaching abstinence as a lifestyle and teaching self-defense were potentially harmful.

3. Regarding experts' attitude toward the potential lack of effect of elements in sex education, there were some differences among experts due to their having a disability (and perhaps being a service provider), or not having a disability and being a service provider. More service providers without disabilities felt that teaching abstinence as a lifestyle and teaching stress management would potentially have no effect. More experts with disabilities felt that teaching hygiene was potentially of no use.

CHAPTER 5
DISCUSSION

Introduction

This study took part of the information from a survey asking experts to rank elements deemed useful in preventing the sexual abuse of individuals with disabilities. The question clusters examined were those thought to be possible topics for sex education curricula. In this chapter, the research outcomes are discussed, limitations noted, and implications suggested.

Discussion

The results of this study demonstrated that both the respondents with disabilities and the nondisabled service provider respondents considered almost all of the elements in the clusters examined to be potentially helpful. This information was consistent with the beliefs of many of the previously cited authors (i.e. Hamre-Nietupski & Ford, 1981; Penny & Chataway, 1982; Segal & Craft, 1983). They all felt that there are many content areas which could and should be included in sex education.

There were a few exceptions noted in the survey results. Teaching abstinence as a sexual lifestyle choice earned the greatest overall reaction. Respondents with disabilities answered 4.5% that this would be potentially harmful, while 8% of the nondisabled service provider respondents agreed. This was followed by a rating of potentially no effect by 4.5% of the respondents with disabilities and 10.7% of the nondisabled service provider respondents. Since such a significant number of persons, both with and without disabilities, felt that

abstinence is not helpful, there is again a demonstrated need for comprehensive sex education programs. If individuals with disabilities are going to have a sexual lifestyle, they must be taught what is socially acceptable behaviour, as noted by Monat (1982), and Smigelski and Steinmann (1981).

It was felt by 6.3% of the respondents with disabilities and 2.7% of the nondisabled service provider respondents that teaching hygiene had potentially no effect. This is an interesting reaction by the persons with disabilities in particular, to an element that is generally considered a basic part of sex education curricula. It is consistent with the tendency of more authors to want to teach from a relationships point of view (i.e. Champagne & Walker-Hirsch, 1982; Evans and McKinlay, 1989).

Less than 1% of the respondents with disabilities felt that stress management would potentially have no effect, but 3.6% of the nondisabled service providers felt it would have no effect. This implies that either a percentage of the individuals with disabilities had already found stress management helpful, or that they would find it potentially helpful. Equally important is the implication that the nondisabled service providers fail to detect some of the stress levels in their clients. In a situation where service providers often must speak for their clients, this suggests powerful conflict in the mutual understanding of needs.

Service providers must always seek to interpret exactly what is required by those they assist. In order to help meet this essential function, persons with disabilities must be taught clear means of

communication so they can explain their needs and desires. This belief concurs with Tabeek & Conroy's (1981) assessment of the necessity for communication skills.

The final cluster element that rated a strong reaction was the teaching of self-defence for people with disabilities. While both groups implied that it would potentially have no effect, the nondisabled service provider respondents considered by 4.5%, that this education could have a potentially harmful effect. This reaction may reflect the history of many service providers, particularly school teachers, in teaching indiscriminate compliance to those with whom they work. Although all children are taught to comply with the instructions of a responsible adult, children with disabilities learn to generalize that compliance to inappropriate situations (Sobsey & Varnhagen, 1989). Some service providers, accustomed to usually immediate compliance to their wishes, might see teaching self-defense to their clients as a means of making their own work harder or more unpleasant.

In school settings, some requests initiate activities that are less fun than others. These displeasing requests may encourage escape-motivated behaviour from some of the students. These students and their teachers sometimes become engaged in an escalating interaction in which the student becomes increasingly more resistant. The teacher insists more as the student resists more. Finally, the student may tantrum, become self-abusive, or aggressive. These unpleasant interactions have been documented in both school and home environments (Singer, Singer & Horner, 1987). Some service providers may consider that teaching self-defense will only make these types of interactions more difficult.

The issue of generalized compliance by individuals with disabilities has been commented on indirectly in other rankings. Assertiveness is the opposite of compliance, and both respondent groups agreed that the highest priority of training for persons with disabilities was assertiveness training. Further, both groups assigned the same rank order to the elements of an assertiveness training program. The ability to protest was given the highest priority. As noted earlier, actually teaching assertiveness and the ability to protest may make some service providers feel they are working against themselves.

Perhaps the issues of compliance and assertiveness training need to be addressed within specific situations. There are times in school and other settings (i.e. during the teaching of a skill or in an emergency) when compliance to requests is necessary. There are other times when assertiveness, and protest in particular, is wanted. Aside from situations of danger, persons with disabilities need the ability to demonstrate preferences. Indicating choices, if only through protest, allows people to gain better control of their everyday lives and raises their self-perception (Houghton, Bronicki & Guess, 1987). One of the main issues of compliance/assertiveness should thus be that of teaching how to discriminate which reaction is appropriate in a given situation.

Friendship interaction skills as an element of a social skills training program for persons with disabilities was also given the highest priority by both respondent groups. Friendships are important to all people for many reasons, and individuals with disabilities are not excepted. Many authors felt friendship cultivation was an important

component to teach as part of sex education (i.e. Duncan & Cantry-Lemke, 1986; Evans & McKinlay, 1989).

People who are without friends are often lonely, and may become victims because they indiscriminately seek companionship. They can also accept improper behaviour from a companion if they do not understand what friendship means or if they fear losing that companion. If people are involved in an abusive situation, they will often confide in their friends for help. As well, people with disabilities, like those without, need friends to care about and watch over them. Access to friendships is the right of every human being, and if individuals with disabilities need skills to develop friendships, that is also their right.

Limitations

The limitations of this study revolve around the respondents. The sample was not random, even considering that it was devised for a specialized field. The survey was mailed to those who had previously shown an interest in the subject. Many respondents indicated that they found the survey items difficult to rank, and the entire survey time-consuming to complete. While this demonstrates the importance they attached to the information, it also implies some respondents may have been tired and not fully attending when doing their ranking.

Another limitation involves the respondents being asked what components would be useful as abuse prevention methods for persons with disabilities. They were not asked about sex education elements in general. The clusters considered by this survey as those potentially

included in sex education were examined.

Finally, the respondents in this survey were considered to be experts, and their opinions may differ in various ways from those of people living and working in everyday situations. Experts often have good ideas, but poor firsthand knowledge of situational, staffing, monetary, or other complications. Experts say what "should" work, while the others experience what "will" work.

Implications

The most specific implication to come from this study is that sex education for persons with disabilities is important, and includes many different elements. It is necessary for several reasons, to teach about the act of sex, relationships, and how to behave. Probably the most important reason for teaching this subject is to help prevent sexual abuse and exploitation. The respondents to this survey were asked to rank the clusters in reference to the use of each in preventing sexual abuse. Almost all of the within-cluster items were highly ranked and considered potentially helpful.

Parents and guardians, teachers, counsellors, residential staff, and other service providers of individuals with disabilities should all be made aware of the importance of sex education. They must ensure that it is taught at home, in school, and is taught and/or reinforced by service providers. Those who will do the instructing will need their own training (Flinn, 1982; Graff, 1983; Walker 1982). Instructors who are prepared to teach sex education may hesitate when first asked to teach students with disabilities. Just because parents have a special

needs child does not make then experts, or even comfortable, in handling sex-related questions. Finding and providing good research personnel is imperative.

Sex education for persons with disabilities encompasses much more than the traditional teaching about body parts, adding the elements of communication, assertiveness, making friends, and self-esteem. Sex education should also involve developing problem-solving and decision-making skills (Caster, 1988; Vernon & Hay, 1988). Having and using these skills gives individuals more control over their lives.

This study reflects that differences in ranking for a variety of educational elements are, on the whole, only minor. Sex education is a part of life and should not be taught in the isolation of a classroom. The wide range of topics validated in this survey are useful in every part of a person's life. Parents, teachers, and other service providers must look closely at what training each individual requires, and then see to it being provided.

There are many possibilities for further research in this field. Course content must be more distinctly defined, for different age groups and to address the needs of individuals with many different disabilities. Those with a greater cognitive disability require a much different curriculum from those who have a mainly physical disability. Other aspects must also be taken into account, such as personal levels of maturity, behaviour, and social ability. Even the environments an individual frequents are of importance.

Functional teaching methods must be devised and adapted to meet the requirements of specific clients and situations. Who should teach,

what exactly will they teach, how should it be taught, and at what age should it be started? Various means of evaluation must also be researched. Teaching sex education to persons with disabilities required so many varieties of individuality that the means of assessing the outcomes may also have to be unique.

Certain long-held social theories about what a person may or may not be, may or may not do, need to be examined. Individuals with disabilities are also sexual beings, and as such, have the right to sex education. Service providers must stop demanding the immediate indiscriminate compliance that may lead to victimization, and instead encourage independence (Sobsey, in press; Sobsey & Varnhagen, 1989). The principle of normalization which promotes the movement of persons with disabilities into the community, specifies that these individuals should be encouraged and aided in making their own choices, and expressing their own preferences (Perrin & Nirje, 1985). As more people with special needs take their places in society, society's views must change to include them as full and equal citizens. As we empower others, so are we more empowered ourselves.

Conclusion

This study looked at the opinions of people with disabilities and service providers without disabilities, and how they ranked elements of sex educational programming. The information was gained from a component of a survey designed to identify means of preventing sexual abuse of individuals with disabilities. The within-cluster rankings of items were similar between the two groups. Of all the elements rated,

abstinence as a lifestyle was most considered by both groups to be potentially harmful or of no effect. Sex education was considered a potential means of preventing sexual abuse and exploitation of persons with disabilities, and many different elements were recognized as part of that education.

References

Abacus Concepts Inc. (1987). StatView II. Berkeley, CA: Author.

Adams, G.L., Tallon, R.J., & Alcorn, D.A. (1982). Attitudes toward the sexuality of mentally retarded and nonretarded persons. Education and Training of the Mentally Retarded, 17, 307-312.

Arcus, M. (1986). Should family life education be required for high school students?: An examination of the issues. Family Relations, 35, 347-356.

Barmann, B.C., & Murray, W.J. (1981). Suppression of inappropriate sexual behaviour by facial screening. Behaviour Therapy, 12, 730-735.

Belsky, J. (1980). Child maltreatment: An ecological integration. American Psychologist, 35, 320-335.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American Psychologist, 32, 513-531.

Brown, H. (1983). Why is it such a big secret? Sex education for handicapped young adults. In A. Craft and M. Craft (Eds.), Sex education and counselling for mentally handicapped people (pp 131-146). Tunbridge Wells, Kent: Costello.

Brown, L.K., & Fritz, G.K. (1988). AIDS education in the schools: A literature review as a guide for curriculum planning. Clinical Pediatrics, 27, 311-315.

Caster, J.A. (1988). Sex education. In G.A. Robinson (Ed.), Best practices in mental disabilities (vol. 2, pp. 352-383). Des Moins: Iowa State Department of Public Instruction.

Craft, A., & Craft, M. (1981). Sexuality and mental handicap: A review. British Journal of Psychiatry, 139, 494-505.

Craft, A., Davis, J., Williams, Maldwyn, & Williams, Marjorie. (1983). A health and sex education programme: Curriculum and resources. In A. Craft and M. Craft (Eds.), Sex education and counselling for mentally handicapped people (pp. 148-185). Tunbridge Wells, Kent: Costello.

Champagne, M.P., & Walker-Hirsch, L.W. (1982). Circles: A self-organization system for teaching social/sexual behaviour to mentally retarded/developmentally disabled persons. Sexuality and Disability, 5, 172-174.

Chapman, J.W., & Pitceathly, A.S. (1985). Sexuality and mentally handicapped people: Issues of sex education, marriage, parenthood, and care staff attitudes. Australia and New Zealand Journal of Developmental Disabilities, 10, 227-235.

Corcoran, K.J., Plante, C., & Robbins, S.P. (1984). Another look at sex education in schools: An empirical analysis. School Social Work Journal, 8, 98-107.

Cornelius, D.A., Chipouras, S., Makas, E., & Daniels, S.M. (1982). Who cares? A handbook on sex education and counselling services for disabled people (2nd ed.). Baltimore: University Park Press.

Dixon, H. (1988). Sexuality and mental handicap. London: The Trinity Press.

Douglas, J. (1989). Health, sex, and hygiene in special education. Journal of Visual Impairment and Blindness, 83, 125-126.

Duncan, D., & Cantry-Lemke, J. (1986). Learning appropriate social and sexual behaviour: The role of society. The Exceptional Parent, 16(3), 24-26.

Edmonson, B., McCombo, K., & Wish, J. (1979). What retarded adults believe about sex. American Journal of Mental Deficiency, 84, 11-13.

Elgar, S. (1985). Sex education and sexual awareness building for autistic children and youths: Some viewpoints and considerations. Journal of Autism and Developmental Disorders, 15, 214-216.

Evans, A.L., & McKinlay, I.A. (1989). Sex education and the severely mentally retarded child. Developmental Medicine and Child Neurology, 31, 98-107.

Fielding, N.G. & Fielding, J.L. (1986). Linking data. Gage University Paper series on Quantitative Research Methods (vol. 4). Beverly Hills, CA: Gage.

Flinn, S. (1982). Preparing teachers of the deaf to teach sex education. Sexuality and Disability, 5, 230-2[illegible].

Foxx, R.M. (1985). Social skills training: The current status of the field. Australia and New Zealand Journal of Developmental Disabilities, 10, 237-243.

Garbarino, J. (1977). The human ecology of child maltreatment: A conceptual model for research. Journal of Marriage and the Family, 39, 721-736.

Giami, A. (1987). Coping with the sexuality of the disabled: A comparison of the physically disabled and the mentally retarded. International Journal of Rehabilitation Research, 10, 41-48.

Glaser, B.G. & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine.

Goodman, L., Budner, S., & Mesh, B. (1971). The parents' role in sex education for the retarded. Mental Retardation, 9, 43-45.

Gordon, S. (19 1). Preteens are not latent, Adolescence is not a disease. In L. Brown (Ed.), Sex education in the eighties (pp. 83-99). New York: Plenum Press.

Graff, D. (1983). Teacher preparation: The key to effective sex education for the mentally retarded. Health Education, 14(3), 25-27.

Griffiths, D.M., Quinsey, V.L., & Hingsburger, D. (1989). Changing inappropriate sexual behaviour. Baltimore: Paul H. Brookes.

Hamre-Nietupski, S., & Ford, A. (1981). Sex education and related skills: A series of programs implemented with severely handicapped students. Sexuality and Disability, 4, 179-193.

Haseltine, F., & Miltenberger, R.G. (1990). Teaching self-protection skills to persons with mental retardation. American Journal on Mental Retardation, 95, 188-197.

Herz, E.J., Reis, J.S., & Barbera-Stein, L. (1986). Family life education for young teens: An assessment of three interventions. Health Education Quarterly, 13, 201-221.

Hofstein, S. (1978). Talking to preteenagers about sex. New York: Public Affairs Committee.

Houghton, J., Bronicki, G.J.B., & Guess, D. (1987). Opportunities to express preferences and make choices among students with severe disabilities in classroom settings. Journal of the Association for People with Severe Handicaps, 12, 18-27.

Johnson, J.M. (1981). Sex education and family planning. In L. Brown (Ed.), Sex education in the eighties (pp. 43-49). New York: Plenum Press.

Johnson, W.R., & Kempton, W. (1981). Sex education and counselling of special groups: The mentally and physically disabled, ill, and elderly (2nd Ed.). Springfield, Ill: Charles C. Thomas.

Kempton, W., & Stiggall, L. (1989). Sex education for persons who are mentally handicapped. Theory Into Practice, 28, 203-210.

Kolko, D.J., Moser, J.T., & Hughes, J. (1989). Classroom training in sexual victimization awareness and prevention skills: An extension of the red flag/green flag people program. Journal of Family Violence, 4, 25-45.

LaBarre, A., Hinkley, K.R., & Nelson, M.F. (1986). Sexual abuse! What is it? An informational book for the hearing impaired. St. Paul, MN: St. Paul-Ramsey Foundation.

Marascuilo, L.A., & McSweeney, M. (1977). Nonparametric and distribution - free methods for the Social Sciences. Belmont, CA: Wadsworth Publishing.

Marshall, C. & Rossman, G.B. (1989). Designing qualitative research. Newbury Park, CA: Gage.

Marsman, J.C., & Herold, E. (1986). Attitudes toward sex education and values in sex education. Family Relations, 35, 357-361.

Martin, M., & Forchuk, C. (1987). Sexuality and the developmentally handicapped: Health education strategies. Canadian Journal of Special Education, 3, 181-189.

McClennen, S. (1988). Sexuality and students with mental retardation. Teaching Exceptional Children, 20, 59-61.

McKown, J.M. (1986). Disabled teenagers: Sexual identification and sexuality counselling. Sexuality and Disability, 7(12), 17-27.

Monat, R.K. (1982). Sexuality and the mentally retarded. San Diego: College-Hill Press.

Nibert, D., Cooper, S., & Ford, J. (1989). Parent's observations of the effect of a sexual-abuse prevention program on preschool children. Child Welfare, 68, 539-545.

Obiakor, F.E. & Stile, S.W. (1989). Enhancing self-concept in students with visual handicaps. Journal of Visual Impairment and Blindness, 83, 255-257.

Penny, R.E.C., & Chataway, J.E. (1982). Sex education for mentally retarded persons. Australia and New Zealand Journal of Developmental Disabilities, 8, 204-212.

Perrin, B. & Nirze, B. (1985). Setting the record straight: A critique of some frequent misconceptions of the normalization principle. Australia and New Zealand Journal of Developmental Disabilities, 69-74.

Pitceathly, A.S., & Chapman, J.W. (1985). Sexuality, marriage and parenthood of mentally retarded people. International Journal for the Advancement of Counselling, 8, 173-181.

Puesche, S.M., & Scola, P.S. (1988). Parents' perceptions of social and sexual function in adolescents with Down's Syndrome. Journal of Mental Deficiency Research, 32, 215-220.

Richman, G.S., Reiss, M.L., Bauman, K.E., & Bailey, J.S. (1984). Teaching menstrual care to mentally retarded women: Acquisition, generalization, and maintenance. Journal of Applied Behaviour Analysis, 17, 441-451.

Robinson, S. (1984). Effects of a sex education program on intellectually handicapped adults. Australia and New Zealand Journal of Developmental Disabilities, 10, 21-26.

Schultz, J.B., & Adams, D.U. (1987). Family life education needs of mentally disabled adolescents. Adolescence, 22, 221-230.

Schuster, C.S. (1986). Sex education of the visually impaired child: The role of the parents. Journal of Visual Impairment and Blindness, 80, 675-680.

Segal, S., & Craft, A. (1983). Sexuality and mental retardation: A review of the literature. In A. Craft and M. Craft (Eds.), Sex education and counselling for mentally handicapped people (pp. 1-37). Tunbridge Wells, Kent: Costello.

Shapiro, E.S., & Sheridan, C.A. (1985). Systematic assessment and training of sex education for a mentally retarded woman. Applied Research in Mental Retardation, 6, 307-317.

Silverstein, C.D., & Buck, G.M. (1986). Parental preferences regarding sex education topics for sixth graders. Adolescence, 21, 971-980.

Singer, G.H., Singer, J., & Horner, R.H. (1987). Using pretask requests to increase the probability of compliance for students with severe disabilities. Journal of the Association for People with Severe Handicaps, 12, 287-291.

Smiglelski, P.A., & Steinmann, M.J. (1981). Teaching sex education to multiply handicapped adolescents. The Journal of School Health, 51, 238-241.

Sobsey, D. (in press). Sexual abuse of individuals with intellectual disability. In A. Craft (Ed.), Practice issues in sexuality and intellectual disability. London: Routledge.

Sobsey, D., & Doe, T. (in press). Patterns of sexual abuse and assault. Sexuality and disability.

Sobsey, D., Mansell, S. & Wells, D. (in press). Sexual abuse of children with disabilities and sexual assault of adults with disabilities: Prevention strategies. Edmonton: University of Alberta, Sexual Abuse and Disability Project.

Sobsey, D., & Varnhagen, C. (1989). Sexual abuse of people with disabilities. In M. Csapo & L. Gougen (Eds.), Special education across Canada: Challenges for the 90's (pp. 199-218). Vancouver: Centre for Human Development and Research.

Tabeek, E.S., & Conroy, M.G. (1981). Teaching sexual awareness to the significantly disabled school-age child. Psychiatric Nursing, 7, 21-25.

Taylor, M.E. (1985). Qualitative and quantitative strategies for exploring the progress of sex education for the handicapped. Health Education, 16(3), 16-22.

Tesch, R. (1990). Qualitative research: Analysis types and software tools. Bristol, PA: The Falmer Press.

Tuttle, D.W. (1987). The role of the special education teacher - Counsellor in meeting students' self-esteem needs. Journal of Visual Impairment and Blindness, 81, 156-161.

Walter, E. (1982). Continuity of sexuality education in programs serving people with mental handicaps. Sexuality and Disability, 5, 9-13.

Watson, J.D. (1984). Talking about the best kept secret: Sexual abuse and children with disabilities. Exceptional Parent, 14(6), 15, 16, 18-20.

Williams, S.L., Walker, H.M., Holmes, D., Todis, B., & Fabre, T.R. (1989). Social validation of adolescent social skills by teachers and students. Remedial and Special Education, 10(4), 18-27.

Wurtele, S.K. (1987). School-based sexual abuse prevention programs: A review. Child Abuse and Neglect, 11, 483-495.

Varnet, T. (1984). Sex education and the disabled - Teaching adult responsibilities. The Exceptional Parent, 14(4), 43-46.

Vernon, A. & Hay, J. (1988). A preventative approach to childhood sexual abuse. Elementary School Guidance and Counselling, 22, 306-312.

Zirpoli, T.J., Snell, M.E., & Loyd, B.H. (1987). Characteristics of persons with mental retardation who have been abused by caregivers. Journal of Special Education, 21, 31-41.

Appendix A
List of Respondents

PROJECT CONSULTANTS

The following project consultants were among those who served on the panel of experts for the prevention components validation study. These 79 consultants represent 71% of the total 112 respondents. Expert consultants were asked to indicate if they wished their names and affiliations to be listed in the report and only those who responded affirmatively are included here. The remaining 29% indicated that they did not wish to have their names and affiliations listed or did not indicate either preference.

Diana Andriashek, Clinical Physician
Millbourne Health Centre
Edmonton, Alberta

Nora J. Baladerian
Mental Health Consultants
Culver City, California

Harry Beatty, Senior Legal Educator
Advocacy Resource Centre for the Handicapped (ARCH)
Toronto, Ontario

Lee Ann Bourcier, Special Services Supervisor
Multnomah County Developmental Disabilities Program
Portland, Oregon

Hilary Brown, Senior Lecturer in Mental Handicap
University of Kent
Canterbury, Kent, England

Frank Caparulo, Sex Therapist (Special Populations)
Caparulo Associates
Orange, Connecticut

Shelly Carver, Consultant of the Deaf
Cloverdale, British Columbia

Bruce Cassidy, Director
Camp Tamarack
Grande Prairie, Alberta

Sandra S. Cole, Professor and Director
Sexuality Training Center

Department of Physical Medicine and Rehabilitation
University of Michigan Medical Center
Ann Arbor, Michigan

Dr. Ann Craft, Lecturer
University of Nottingham Medical School
Nottingham, England

James Creechan, Assistant Professor
Sociology Department
University of Alberta
Edmonton, Alberta

Ceinwen Cumming, PhD
Cross Cancer Institute and University of Alberta
Edmonton, Alberta

Steve DeMaio, Emergency Services Specialist
Aroostook Mental Health Centre
Presque Isle, Maine

Dr. Len Denton, Director
Atlantic Behavioural Science Application
Truro, Nova Scotia

James N. Docherty, Private Social-Services Consultant
Toronto, Ontario

Parin A. Dossa, Visiting Professor of Anthropology
University of Alberta
Edmonton, Alberta

J. Kenneth Duncan, Counselor
Center for Accessible Living
Louisville, Kentucky

Derek Eaves, Executive Director
Forensic Psychiatric Services Commission
Burnaby, British Columbia

Suzanne Frank, Coordinator
University of Alberta On Campus Program

Edmonton, Alberta

Dianne A. Funk, Director
Calgary Action Group of the Disabled
Calgary, Alberta

Karin Goldberg, Public Education Assistant
Sexual Assault Centre of Edmonton
Edmonton, Alberta

Sharmaine Gray, Researcher
Sexual Abuse & Disability Project
Montréal, Québec

Frances Harley, Pediatrician
University of Alberta Medical School
Edmonton, Alberta

Pierre Hébert, National Director
Disabled Victims of Violence Program
Ottawa, Ontario

Thomas Hess, Family & Children's Services Specialist
New York State Department of Social Services
Albany, New York

Valdine Huyghebaert, Coordinator of Psychology
St. Amant Centre
Winnipeg, Manitoba

Pat Israel, Chairperson
Disabled Women's Network Canada
Toronto, Ontario

Harley Johnson, Ombudsman
Province of Alberta
Edmonton, Alberta

Sue Johnson, Empowerment Trainer
Wesley School
Muskegon , Michigan

Jane Karstaedt, Executive Director
Sexual Assault Centre of Edmonton
Edmonton, AB

Sandra Keating, Psychologist
Glenrose Rehabilitation Hospital
Edmonton, Alberta

Margaret Kennedy, National Co-ordinator Keep Deaf Children Safe Project
Nuffield Hearing & Speech Centre
London, England

Diane Kieren, Associate Vice President
University of Alberta
Edmonton, Alberta

Pamela McDermid King, Project Officer
Ministry of Community & Social Services
Toronto, Ontario

Barbara Ludlow, Associate Professor
West Virginia University
Morgantown, West Virginia

Susan Ludwig, RN, Consultant
Keswick, Ontario

Kim Lyster, Community Support Consultant
B.C. Association for Community Living
Vancouver, British Columbia

Scott McArthur, Manager, Training & Development
Ontario Federation for Cerebral Palsy
Toronto, Ontario

Patricia McGillicuddy, MSN (Social Work)
College St. Womens Centre
Toronto, Ontario

Katrine McKenzie, Director, Office for the Prevention of Family Violence
Alberta Family & Social Services
Edmonton, Alberta

Andrea McLean, Coordinator, Employment/Options
Alberta Vocational Centre
Edmonton, Alberta

Cathy McPherson, Co-ordinator, Education & Development
Advocacy Resource Centre for the Handicapped (ARCH)
Toronto, Ontario

Robynanne Milford, Physician
DSAC (Doctors for Sexual Abuse Care)
Auckland, New Zealand

Kenneth R. Miller, Clinical Professor of Pediatrics
University of Alberta & Grey Nuns' Hospital
Edmonton, Alberta

Martina Müller, Scientific Assistant
Wurzburg, Germany

Linda Page, Program Coordinator
Association for Hearing Handicapped
Edmonton, Alberta

Berré Patenaude, Co-ordinator Family Life Education
Health Promotion Section, Community Health and Standards Division
Government of the Northwest Territories Department of Health
Yellowknife, Northwest Territories

Jim Peakman, RPN, CSW, Executive Director
Regina & District Branch, Saskatchewan Association for Community Living
Regina, Saskatchewan

Marie-Josée Piché, Educational Counsellor
Malaspina College
Powell River, British Columbia

Valerie Plata, Researcher
McMaster University
St. Catharines, Ontario

Diane Pyper, Researcher

Edmonton, Alberta

Kapri Rabin, Toronto Regional Director
The Canadian Hearing Society
Toronto, Ontario

Debbie Reid, Director, Outreach Services
Calgary Outreach Services
Calgary, Alberta

Karen Rodgers, Coordinator
Family Violence Program/Canadian Council on Social Development
Ottawa, Ontario

Rix Rogers, Executive Director
Canadian Child Welfare Association
Ottawa, Ontario

Norman W. Rosema, School Social Worker
Wesley School
Muskegon, Michigan

Edward Rowe, Detective Inspector
Ontario Provincial Police
Toronto, Ontario

Howard Sapers, Executive Director
The John Howard Society of Alberta
Edmonton, Alberta

Lisé K. Schwartz, Mental Retardation Facilities Inspector
East Hartford, Connecticut

Karin Melberg Schwier, Communications Coordinator
Saskatchewan Association for Community Living
Saskatoon, Saskatchewan

Judith H. Seifer, RN, PhD, Certified Sex Educator, Counselor & Therapist
Associate Clinical Professor, Departments of Psychiatry & OB-GYN AASECT
Wright State University School of Medicine
Dayton, Ohio

Charlene Y. Senn, Researcher
York University, Psychology Dept
North York, Ontario

Ellen J. Shaman, Private Consultant
Seattle, Washington

Brenda Smaniotto, Community Outreach Worker
Calgary Alternative Support Services
Calgary, Alberta

Ruth Soult, Program Manager
Skills Training & Support Services Association
Edmonton, Alberta

Bonnie Spence-Vinge, Assistant Director
Special Education Branch, Ministry of Education
Victoria, British Columbia

Patricia Spindel, Professor
Humber College
Etobicoke, Ontario

Sheila Stangier, Client Advocate
Michener Centre, Family & Social Services
Red Deer, Alberta

Liz Stimpson, Chairwoman
Disabled Women's Network-Toronto
Toronto, Ontario

Joan Stradiotti, Director
Department of Sexual Health Services, G.F. Strong Centre
Vancouver, British Columbia

Patricia M. Sullivan, Director
Center for Psychological Services & Abused Handicapped Children
Boys Town National Research Hospital
Omaha, Nebraska

Sister Agnes Sutherland, Writer-Researcher
Fort Smith Society for Disabled Persons

Fort Smith, Northwest Territories

Patricia Sutherland
Edmonton, Alberta

Bonnie E. Thiessen, Director of Special Education
River East School Division #9
Winnipeg, Manitoba

Bruce Uditsky, Consultant
Bruce Uditsky & Associates
Edmonton, Alberta

Connie K. Varnhagen, Assistant Professor of Psychology
University of Alberta
Edmonton, Alberta

John Warden, Detective
Edmonton Police Services
Edmonton, Alberta

Nancy K.Williams, Researcher
Department of Health Education, Southern Illinois University
Carbondale, Illinois

Thomas Zirpoli, Associate Professor
University of St. Thomas
St. Paul, Minnesota

Appendix B
Survey Form

26 November 1990

«Data Protocols Mailing 1»
«FirstN» «LastN»
«Title»
«Affiliation»
«Address1»
«Address2»
«City», «Province» «PC» «Country»

Dear «FirstN»:

I am writing to ask your help on a research project designed to help set an agenda for prevention of sexual abuse of children and sexual assault of adults with disabilities. The project is being conducted by the University of Alberta and is sponsored by the Family Violence Division of The National Health Research and Development Program of Health and Welfare Canada.

Through a comprehensive review of the literature and an analysis of case reports we have identified some measures that may help reduce the risk of abuse for people with disabilities. As the next step, we need help in establishing priorities for this prevention agenda. To accomplish this, we have identified a group of potential consultants who are knowledgeable about sexual abuse prevention or services for people with disabilities. I am writing to request your help with this task.

Please take 30 minutes to an hour sometime in the next two weeks to fill out the enclosed form and return it to me with your rankings of program components. Of course your participation would be voluntary and you have the right to refuse participation for any reason. Your responses will be completely confidential and we will not determine or keep data on who provided any specific answers.

I know that time is valuable and the project cannot compensate you for your time. Nevertheless, I believe that this project is important and your contribution to the project will be valuable. If you would like a report of our findings, we will be glad to share it with you. Please let us know if you want this report by filling in the separate cover sheet and returning it to us. Please also indicate on this form if you wish to be listed as a member of the consultant advisory group.

For the purpose of this study, ***"disability" refers to any disturbance of normal sensory, motor, perceptual, cognitive, emotional, or behavioral function that results in special needs or in being perceived by others as handicapped in some way.*** If you believe that any of your responses to survey items would depend on the nature of the disability of the individual, please respond based on the individuals and the disabilities with which you have the greatest experience.

I look forward to receiving your response and thank you for considering this request.

Sincerely,

Dick Sobsey
Professor & Project Leader

Sexual Abuse Prevention Survey
Cover Sheet
Please do not include this sheet with inner survey form.
Return of this sheet is optional.

Name: _____

Title: _____

Affiliation: _____

Address: _____

_____

City: _____

Province / State: _____

Postal Code: _____

Would you like to receive a copy of the results of this survey?

☐ **YES** **NO** ☐

Would you like to be listed as a consultant to our sexual abuse prevention project in our report to Health and Welfare Canada?

☐ **YES** **NO** ☐

Cover sheet data will be kept separately from survey responses. Your individual responses will remain confidential and unknown to the investigators.

Return to: Sexual Abuse Prevention Survey/ c/o Dick Sobsey/ 6-102 Ed. North/ University of Alberta/ Edmonton, AB T6G 2G5/ CANADA

Instructions:

Please rank the items within clusters by putting a number in the box next to each item.

1. Rank all clusters that you wish to have input on.
2. Rank 1,2,3,4,5, an so on...until all items in cluster are ranked
3. Use each ranking only once in any cluster
4. 1 indicates greatest importance, the highest number in any cluster indicates the least importance
5. Number of items in cluster determines highest ranking
6. Rank Ø for any item you believe would have no value
7. Place **X** next to any category you believe would be harmful
8. Please feel free to add any comments that you may have

Place completed form in small envelope and seal

- Place small envelope in larger one
- If you wish include cover sheet with name and address in larger envelope. *If so, we will share results of study with you*

Seal and mail large envelope

Example:

1. Cluster title:

☐ item you consider 3rd most important

☐ item you consider to be be more harmful than helpful

☐ item you consider most important

☐ item you consider 2nd most important

☐ item you consider least most important

☐ item you consider 4nd most important

☐ item you consider to have no value

☐ Other (Please Specify) *Something we left out, but you wish to add*

Demographic Information:

Your responses to these questions are optional, but would be helpful.

Please check the following that apply to you:

1.

☐ I do not have a disability

☐ I have a disability (please specify nature of your disability)

2.

☐ I am a woman

☐ I am a man

3.

☐ I have not been a direct service provider to people with disabilities

☐ I have been a direct service provider to people with disabilities for less than 5 years

☐ I have been a direct service provider to people with disabilities for more than 5 years

If a service provider, what kind of services do you provide (e.g., teacher, residential aide, vocational guidance, etc.)?

If a service provider, what is the nature of the disabilities of the clients you serve (e.g., hearing impairment, intellectual impairment, mobility impairment, etc.)?

4.

☐ I have personal knowledge of individuals with disabilities that have experienced sexual abuse or assault

☐ I have personal knowledge of individuals with disabilities that have experienced physical abuse or assault

☐ I have personal knowledge of individuals with disabilities that have experienced neglect

☐ I have personal knowledge of individuals with disabilities that have experienced psychological abuse

☐ I do not have personal knowledge of any individuals with disabilities that have experienced abuse, neglect, or assault.

5

☐ I live and work in an community of less than 3,000 people

☐ I live and work in an community of 3,000 to 30,000 people

☐ I live and work in an community of more than 30,000 people

6.

Please indicate the province or state and nation that you live in:

Province or State: _____

Nation: _____

7.

Please indicate **one** descriptor below that you feel summarizes the primary way in which you are interested in sexual assault and abuse of people with disabilities:

☐ as an administrator
☐ as an advocate
☐ as a child protection worker
☐ as a counsellor
☐ as a health care provider
☐ as a law enforcement officer
☐ as a lawyer
☐ as a person with a disability
☐ as a residential service provider
☐ as a researcher
☐ as a social worker
☐ as a teacher
☐ as a vocational service provider

8.

Please indicate **all that apply.to you.**

☐ as an administrator
☐ as an advocate
☐ as a child protection worker
☐ as a counsellor
☐ as a health care provider
☐ as a law enforcement officer
☐ as a lawyer
☐ as a person with a disability
☐ as a residential service provider
☐ as a researcher
☐ as a social worker
☐ as a teacher
☐ as a vocational service provider

9. Program Components:

- ☐ Prevention
- ☐ Detection
- ☐ Reporting
- ☐ Investigation
- ☐ Prosecution
- ☐ Victims' treatment
- ☐ Offenders' treatment
- ☐ Research
- ☐ Other (Please specify below)

10. Prevention Components:

- ☐ Training
- ☐ Administrative reform
- ☐ Law reform
- ☐ Advocacy
- ☐ Social/cultural attitude change
- ☐ Other (Please specify below)

11. Training Components:

- ☐ Client training
- ☐ Service provider training
- ☐ Family training
- ☐ Public education
- ☐ Other (Please specify below)

12 Client Training

- ☐ Sex education
- ☐ Social skills training
- ☐ Abuse prevention programs
- ☐ Assertiveness training
- ☐ Choicemaking training
- ☐ Personal rights education
- ☐ Communication skill training
- ☐ Other (Please specify below)

13. Sex education

- ☐ body parts
- ☐ sexual vocabulary
- ☐ personal hygiene
- ☐ preparation for puberty
- ☐ relationship between love and sex
- ☐ physical affection
- ☐ sexual lifestyle choices
- ☐ Other (Please specify below)

14. Sexual lifestyle choices:

- ☐ abstinence
- ☐ sexual alternatives
- ☐ birth control
- ☐ pregnancy
- ☐ parenting responsibilities
- ☐ Other (Please specify below)

15. Sexual activity:

- ☐ abstinence
- ☐ masturbation
- ☐ petting
- ☐ heterosexual interaction
- ☐ homosexual interaction
- ☐ choices and risks
- ☐ Other (Please specify below)

16. Social skills training

- ☐ stress management
- ☐ family interaction skills
- ☐ friendships
- ☐ dating interaction skills
- ☐ client-service provider interaction skills
- ☐ Other (Please specify below)

17. Abuse prevention education

- ☐ risks
- ☐ situations to avoid
- ☐ good touching/ bad touching
- ☐ when to say "no"
- ☐ how to say "no"
- ☐ telling others
- ☐ seeking advice
- ☐ seeking help
- ☐ Other (Please specify below)

18. Assertiveness training

- ☐ Requesting
- ☐ Protesting
- ☐ physical self-defense
- ☐ Other (Please specify below)

19. Choicemaking education

- ☐ problem solving
- ☐ decision making
- ☐ Other (Please specify below)

20. Personal rights education

- ☐ values
- ☐ self-concept
- ☐ private behaviour
- ☐ basic human rights
- ☐ Other (Please specify below)

21. Communication skills training

- ☐ general communication enhancement
- ☐ expressing feelings
- ☐ saying "no"
- ☐ describing experiences
- ☐ Other (Please specify below)

22. Staff Training

- ☐ Introduction to policy
- ☐ Dealing with sexual or aggressive feelings
- ☐ Professional standards of conduct
- ☐ Recognizing and coping with potentially abusive situations
- ☐ Abuse definitions
- ☐ Seeking counselling
- ☐ Reporting abuse
- ☐ Preserving evidence of abuse
- ☐ Ethical behaviour
- ☐ Other (Please specify below)

23. Administrative reform

- ☐ Agency responsibility
- ☐ Employee screening
- ☐ Charges against abusers, not "allowed resignations"
- ☐ Establish guidelines for staff-client interactions (e.g., dating, intimacy)
- ☐ Establish safeguards for specialized transportation
- ☐ Provide for availability of staff counselling
- ☐ Agency mandate for protection from other service consumers
- ☐ Elimination of isolated services and focus on integration
- ☐ Encourage appropriate social and sexual alternatives
- ☐ Minimize the use of drugs (e.g., tranquilizers) that may increase vulnerability
- ☐ Other (Please specify below)

24. Agency responsibility

- ☐ Institutional responsibility for reasonable standard of individual security
- ☐ Prevention of clustering of offenders with vulnerable individuals
- ☐ Other (Please specify below)

25. Employee Screening

- ☐ Police checks for new service providers
- ☐ Reference checks
- ☐ Careful interview procedures
- ☐ Caregiver registry or certification
- ☐ Periodic review
- ☐ Agency records made available to future employers
- ☐ Caregiver registry or certification
- ☐ Other (Please specify below)

26. Thorough interview procedures

- ☐ Discussion of any past problems
- ☐ Caregiver registry or certification
- ☐ Discussion of power relationships
- ☐ Caregiver registry or certification
- ☐ Discussion of abuse policy
- ☐ Caregiver registry or certification
- ☐ Discussion of any gaps in employment history
- ☐ Other (Please specify below)

27. Advocacy group involvement

- ☐ Train families, caregivers in detection skills
- ☐ Train families, caregivers in reporting procedures
- ☐ Provide victims with independent advice
- ☐ Work to reform the justice system to encourage participation of people with disabilities
- ☐ Provide prevention and treatment programs
- ☐ Other (Please specify below)

_____

_____

28. Social and Cultural Change

- ☐ Increased integration of people with disabilities
- ☐ Greater valuation and empowerment of people with disabilities
- ☐ Elimination of view of disabled people as helpless
- ☐ Elimination of view of disabled people as insensitive encourage participation of people with disabilities
- ☐ Elimination of view of disabled people as dangerously deviant.
- ☐ Other (Please specify below)

_____

_____

29. Detection

- ☐ Teach signs abuse to people with disabilities
- ☐ Teach signs if abuse to families
- ☐ Teach signs of abuse to service providers
- ☐ Teach signs of abuse to health care providers
- ☐ Teach effects of disability in masking symptoms of abuse to all
- ☐ Develop a protocol for evaluating suspected abuse
- ☐ Mandated investigation of causes of behaviour problems

Train physicians in forensic examination procedures

- ☐ Other (Please specify below)

_____

_____

30. Mandated investigation of causes of behaviour problems

- ☐ non-compliance
- ☐ sexually inappropriate behaviour
- ☐ unexplained withdrawal
- ☐ fearfulness

☐ Other (Please specify below)

_____

_____

31. Reporting

- ☐ Reports must go outside agency or advocate
- ☐ Complainant Protection Act
- ☐ Require reporting of abuse involving all vulnerable people
- ☐ Waiver of confidentiality requirement
- ☐ Charges against abusers, not "allowed resignations"
- ☐ Require external reporting of potential abuse incidents
- ☐ Preservation of evidence
- ☐ Public Education on reporting requirements
- ☐ Professional education on reporting requirements
- ☐ Other (Please specify below)

_____

_____

32. Independent Advocates

- ☐ All reports of abuse in institutions and agencies must go to an independent advocate or agency
- ☐ All people living in institutional settings shall have availability to advocates that are not in the employ of the agency, department, or ministry which runs the institution
- ☐ Independent advocates shall have the right to visit institutions at any time and without prior notice
- ☐ Independent advocates shall work with police in investigating complaints of abuse
- ☐ Other (Please specify below)

_____

_____

33. Complainant Protection Act

- ☐ requirement to report
- ☐ waiver of confidentiality
- ☐ protection of consumer from service withdrawal
- ☐ protection of reporting service providers from administrative harassment
- ☐ right to report outside of agency
- ☐ protection of reporters and alleged victims from contact with alleged offenders
- ☐ specific immunity from civil action in unfounded cases except where malicious intent is demonstrated
- ☐ funding of court costs or provision of defense if civil action brought against reporter
- ☐ Agency commitment to complainant Protection Measures
- ☐ Other (Please specify below)

_____

_____

34. Protection of reporters and alleged victims from contact with alleged offenders

- ☐ police protection where appropriate
- ☐ court order for alleged offender to stay away from reporter and victim
- ☐ Other (Please specify below)

_____

_____

35. Require external reporting of potential abuse incidents

- ☐ Clearly define abuse
- ☐ Criminalize all patient client abuse
- ☐ Criminalize failure to report
- ☐ Criminalize failure to investigate or take action
- ☐ Determine sexual interaction between staff and client as abusive
- ☐ Criminal offenses to law enforcement
- ☐ All complaints to independent advocate
- ☐ Administrative Process shall not replace criminal investigation
- ☐ All allegations and evidence of of abuse must be recorded in the patients health care record
- ☐ Other (Please specify below)

_____

_____

36. Determine sexual interaction between staff and client as abusive

- ☐ Determine criteria for acceptable exceptions
- ☐ Other (Please specify below)

_____

_____

37. Investigation

- ☐ All reports shall be investigated
- ☐ Record every complaint
- ☐ no summary dismissals prior to investigation
- ☐ Use of dolls, puppets, drawings etc.
- ☐ No substitution of administrative process for police investigation
- ☐ Collaboration between police, social services, and special needs experts
- ☐ Provision of translators or alternative communication during investigation
- ☐ Use of polygraphs as investigative aid
- ☐ Other (Please specify below)

_____

_____

38. Prosecution

- ☐ All known offenders prosecuted
- ☐ Prosecution of those that aid or abet
- ☐ Justice and legislative system reform
- ☐ Other (Please specify below)

_____

_____

39. Justice System reform

- ☐ Review sentencing
- ☐ Use of directed sentencing
- ☐ Reporting of information regarding disability in standard crime reports
- ☐ Actively encourage reporting
- ☐ Protection of informants
- ☐ Legislative reforms
- ☐ Training for police officers
- ☐ Training for prosecutors
- ☐ Training for judges
- ☐ Joint witness training program with education
- ☐ Establish statistical reporting of crimes against people with disabilities
- ☐ Measures to encourage disabled consumer confidence and participation in the justice system
- ☐ Other (Please specify below)

40. Legislative reforms
(For Canadian Respondents Only)

- ☐ Modify "honest belief in consent" provisions
- ☐ Modify Canada Evidence Act
- ☐ Other (Please specify below)

41. Modify Canada Evidence Act
(For Canadian Respondents Only)

- ☐ Allow testimony of any victim; balance with expert testimony on credibility, if required
- ☐ Allow expert evaluation of victim credibility
- ☐ Allow the use of videotaped interview with vulnerable victims regardless of age
- ☐ Other (Please specify below)

42. Victims' Treatment Services

- ☐ Staffing
- ☐ Service Delivery
- ☐ Accessibility
- ☐ Appropriateness
- ☐ Other (Please specify below)

43. Victims' Treatment Services Staffing

- ☐ Staff must be trained in sexual assault counselling
- ☐ Staff must be trained in issues relevant to disability
- ☐ Includes consultants on special needs when appropriate
- ☐ Train specialized counsellors
- ☐ Other (Please specify below)

43. Victims' Treatment Services Service Delivery

- ☐ Victim is central focus
- ☐ Victim exercises choice and helps develop treatment program
- ☐ Focus on prevention of further abuse
- ☐ Focus on health related evaluation and treatment
- ☐ Focus on counselling
- ☐ Focus on education
- ☐ Based on models,guidelines, or protocols
- ☐ Includes family or significant others for victim
- ☐ Other (Please specify below)

_____

_____

43. Victims' Treatment Services Accessibility

- ☐ Shall be provided by accessible and appropriate generic community agencies
- ☐ Funding of model programs
- ☐ Service must be physically accessible to all
- ☐ Service must have provisions for translators and telephone alternatives for hearing impaired and deaf clients
- ☐ Services must be individualized to meet special needs
- ☐ Services must have policy of accepting all clients regardless of the nature or extent of disability
- ☐ Other (Please specify below)

_____

_____

44. Offenders' Treatment Services

- ☐ Establish treatment programs for disabled offenders
- ☐ Emphasis on habilitation
- ☐ Offenders barred form association with vulnerable people
- ☐ Notification of conviction to agencies
- ☐ Compulsory treatment for parolees
- ☐ Other (Please specify below)

_____

_____

45. Research

- ☐ Study offenders' victim selection patterns
- ☐ Study appropriate self-defense strategies
- ☐ Study victim attributes
- ☐ Study offender attributes
- ☐ Study service delivery system attributes
- ☐ Study victims' treatment programs
- ☐ Study cultural attitudes
- ☐ Study justice system
- ☐ Other (Please specify below)

_____

_____