RAPE TREATMENT RECOMMENDATIONS FOR DISABLED PEOPLE

by

NORA J. BALADERIAN, M.A., M.F.C.C.
Sexuality and Disability Consultant

BARBARA FAYE WAXMAN
Consultant: Disability and Health Policy

July 1985

© 1985 Baladerian/Waxman
ALL RIGHTS RESERVED

NCJRS
SEP 13 1988
ACQUISITIONS
RAPE TREATMENT RECOMMENDATIONS FOR DISABLED PEOPLE

by

NORA J. BALADERIAN, M.A., M.F.C.C.
Sexuality and Disability Consultant

BARBARA FAYE WAXMAN
Consultant: Disability and Health Policy

July 1985

© 1985 Baladerian/Waxman

DEFINITION OF DISABILITY

Introduction

Disabled people comprise a minority group with many of the same social and political problems as other minority groups. The problems disabled individuals have regarding assault are based partly on their functional limitations, which in many cases impose some degree of dependence on others (as women have on men, children on adults), and mostly on the social devaluation experienced by all those having disabilities, and like members of other minority groups.

Typology

For the purposes of this protocol, a disabled person means "any person who has a physical or mental impairment which substantially limits one or more major life activities". 1. "Major life activities" include caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. (NOTE: Guidelines for service delivery will be described according to the following categories: mobility impairment, mental illness, developmental disability, hearing impairment/deaf, visual impairment/blind, and communication impairment.)

Terminology

The language of disability indicates that persons with disabilities are usually perceived exclusively in terms of their disabilities, that they are confined to a "handicapped role" in which they are seen primarily as recipients of medical treatment, and that this role also includes ascribed traits of
helplessness, dependency, abnormality of appearance and functioning, total incapacity of every aspect of personhood, and ultimately subhumanness.

The most common terms used to identify persons with disabilities are "the exceptional", "having special needs", "patients", "cases", "handicapped", "the disabled", "the deaf", "the victim of", "invalid", "crippled", "deformed", "wheelchair bound", "the blind", "the mentally retarded". All these terms are considered pejorative, and contribute to stigmatization by reinforcing the tendency to perceive persons with disabilities only in terms of their disability. These labels focus on what is usually the most visible or apparent characteristic of the person, and obscure all other characteristics such as the person's personality, identity, and needs. Disabled persons seem to be expected to surrender control of their lives to professionals to receive treatment. They are chronically viewed as helpless and dependent, in need of cure but incurable; primarily objects of professional supervision and treatment.

The discussion of terminology is important for three reasons. First, these terms reflect a prejudice that disabled people are subhuman and therefore easier to objectify, which is what assailants do. Second, the disabled person may have internalized the prejudices. These lead to feelings such as valuelessness and feeling little control or power over their own lives. Finally, service delivery often reflects these prejudices. The disability is not the primary concern in sexual assault services, and must not be considered as such. It is a secondary, and perhaps related concern to the immediate crisis. It is fundamental that the caregivers' language such as: disabled person, individual with mental retardation, etc., reflect this understanding. Avoiding words such as "specially
challenged", "crippled", "differently abled", and "handicapped" will demonstrate acceptance of disabled people.

Although the sexual abuse professional may have no training in disability, their skills and resources can be augmented with training or consultation (including the attached readings listed), or collaboration with other types of disability support services.

DISABLED PERSON'S PERCEPTION OF SERVICE PROVIDERS

It can be assumed that some people with disabilities fear insensitive treatment by the professionals (which is a frequent and recurring experience throughout the disability aspect of many of their lives), and so, do not report sexual assault. Thus an important consideration in providing services is co-management of the treatment process. Treatment success depends largely on the degree to which the disabled survivor has made his/her own plans, and is enhanced when s/he takes an active part in decision-making. This idea of "co-management" involves not only cooperation, but active participation on the part of both the survivor and caregiver. Co-management improves the client's self esteem, builds her/his motivation to use services, and especially in the area of sexual assault where the fund of knowledge is not always sufficient to meet the situation, it integrates the client's knowledge of their own needs, as well as their views of how to proceed. This model for providing sexual assault services to disabled people is an especially useful way to help them to regain power in their lives subsequent to an assault. Because disabled people are confronted by an organizational pattern which perpetuates a "medical model" treatment, they hold a low-level status in the treatment hierarchy. Under this model decisions are made for the client by the "professional", and self
determination is not considered an important factor. The co-management model is useful because a major goal of care for people who have been sexually assaulted is to support the client in regaining personal power, because a feeling of a loss of power over her life, future or world characterizes the crisis that follows sexual assault. If the sexual assault victim with a disability has not felt power and control over his/her own treatment in the past, this new partnership can help her/him establish that.

SEXUAL EXPLOITATION AS A DISABILITY ISSUE

Persons who have a disability are especially vulnerable to sexual attack (as well as other types of attack) for the following reasons.

They are perceived as being helpless, and therefore "easy prey" for the criminal looking for an easy crime...little ability of the victim to fight back, either at the time of the crime or afterwards. In sexual attack, the issue is not sexual so much as it is an issue of power, and exercising of one's power over another. Who better than someone with a disability whom one might be easily able to physically overpower...or someone with mental illness or mental retardation whose psychological power is reduced.

Persons with developmental disabilities, as well as persons with other types of disability, are often brought up to be "nice", which means to be obedient to virtually all adults. Assertion, and development of personal power are not usual components of the education and upbringing. Therefore, personal resources to avoid or fend off an attack have not been acquired.

The experience of "sexual battery" is a common one among persons with disabilities. Although this is not handled as seriously or vigorously by persons in responsible positions in
facilities that serve persons with disabilities, this type of sexual attack is serious and demands attention. Sexual battery is the sexual touching of another, against that persons' wishes. Many persons are subjected to sexual battery, but receive no assistance either in reporting and receiving treatment and redress for their victimization, or in receiving training in how to respond to this type of attack. Efforts should be made in all educational and training programs to include this important aspect of sexual abuse.

Additionally, there is a lack of training in using community resources, such as a YMCA to acquire self-defense skills. Furthermore, many of these agencies do not offer classes to persons with disabilities. Scattered efforts exist, but these do not respond to the need of the community.

WHO PERPETRATES

Persons who sexually assault persons with disabilities are the same category of person who assaults persons without disabilities. However, we do know that in 90% of the cases, the attacker is well-known by the survivor. Perpetrators are: parents, step-parents, siblings (full, step or other), babysitters, attendant care providers, residential service providers, school personnel (teachers, teacher aides, administrative school staff, janitors, school bus drivers), work personnel (sheltered workshop executive directors, administrators, line staff) competitive employment work staff (boss, supervisor, business owner), professionals (psychologists, physical therapists, medical doctors), medical care staff (hospital nurses, attendants). Persons in a position of trust with the survivor.

They fit the same "profile" as other persons who sexually assault. They should be treated the same as any other
perpetrator of sexual assault.

Many times, the perpetrator does not rape the victim, but sexually exploits or batters the survivor. This is common in the school and sheltered workshop setting. Here, the survivor feels that she is in a psychological bind, as this is the person in charge of her work (paycheck), and she does not feel that she is able to complain, or she will lose her job, or her payrate will be reduced. It is important to instruct and support workshop workers in the prevention and reporting of sexual harassment and exploitation. It is also important to take steps with the perpetrator to eliminate this behavior and/or his continued employment, for example, reporting him to the police, so that at record can be begun against him, and a record filed, in the event s/he seeks employment with other care-taking responsibilities.

MOBILITY IMPAIRMENT

DEFINITION

These disabilities impair or limit mobility and/or movement. Individuals may use electric or manual wheelchairs, crutches, canes, braces, walkers, gurneys, or nothing at all.

Disabilities include amputation, cerebral palsy, multiple sclerosis, muscular distrophy, rheumatoid arthritis, spinal cord injury, short stature. Rather than give a description of each here, the service provider should provide service according to the information about the survivor's individual needs, which can be obtained during the medical/social interview.

PHYSICAL FACILITY CONSIDERATIONS:

The physical accessibility of the facility is vital in serving this individual in crisis. Inaccessible interview or lab rooms, will mean a decrease in required privacy, thus risking re-traumatization.
INTERVIEW

During the initial interview questions regarding his/her disability must be asked so evidence can be collected and a medical intervention provided appropriately.

1. What is the etiology of the disability?

2. How much of a role can the client take in preparing self for exam: un/dressing, transferring (from wheelchair to exam table)?

3. Has she ever had a pelvic exam? - Many physically disabled people cannot comfortably assume the traditional (lithotomy) pelvic exam position because of:

   Joint stiffness and inflammation
   paralysis
   lack of muscle control/weakness
   hip or back pain
   spasticity
   lack of balance
   muscular contractions

   As a result an alternative exam position must be used. A disabled person is the best source for what position will work. Knowledge gained from the survivor, together with technical material such as the book "Table Manners"(2), can guarantee a cooperative and sensitive exam.

4. What medications are currently used?

5. How should bowel and bladder apparatus be managed during exam?

6. Certain body areas may lack sensation and injuries sustained during the attack may not be felt by the survivor (especially persons with spinal cord injury or multiple sclerosis). Where are those areas?

7. Does s/he have hypersensitivity or autonomic dysreflexia?

Role of Significant Others

Physically disabled people often have personal care attendants, parents or partners assisting them in activities of daily living. First, ask the survivor if s/he wants that person
involved in the procedure. If the client consents, continue to relate primarily with the client, not the significant other. The client must remain the partner in the co-management model unless s/he is a minor, or is temporarily unable to consent to emergency services.

**DURING THE PHYSICAL EXAM**

As discussed earlier, the survivor has probably had negative encounters with medical professionals who objectified his/her body; the assailant just did the same. This is an opportunity to hand over control to the disabled person and personalize the encounter. Touch the client during the transfer and exam only at a time comfortable with him/her, and in a way directed by the individual. Protecting the persons privacy and body integrity is vital.

**DISABILITY SERVICE SYSTEMS**

Creating linkages with disability specialists and agencies will increase the Sexual Abuse caregiver's confidence in serving the physically disabled survivor, through the sharing of resources and training. Such agencies are Independent Living Centers, Rehabilitation Psychology Departments of Rehabilitation hospitals, multiple sclerosis Society, Muscular Dystrophy Association, Arthritis Society, etc.

**MENTALLY ILL**

Persons with mental illness (schizophrenia, paranoia, psychosis) are living in the community without daily supervision or assistance in increasingly greater numbers these days, as the push towards community living has been continuing. Unfortunately, the money that was to have followed them as they moved out of structured living settings into independent living situations did not. Therefore, many are not connected to mental
health programs or workers, such as psychologists or counselors.

Persons with mental illness have difficulty understanding "reality". They may be tentative and unsure about their actions (fear is a large component of their mental operations). They may appear "different" in their physical appearance (dress, posture, gait). They are not prepared to avoid, or fend off an attacker. It is likely that if an attack is attempted, it will be completed, due to the usual vulnerability and readiness to "obey". Passivity is a common component of mental illness. But so is adamant refusal, to comply with a command. These reactions depend, of course, on the individual, and on the type of mental illness. However, neither reaction lends itself to a reality based response to an attack. The stubborn refusal, while it may prevent an attack (this might be quite effective with a non-violent sexual approach), may provoke a violent rapist.

INTERVIEW

In interviewing the survivor, you should seek the consultation of a mental health specialist. First, make sure the survivor is comfortable, in a small but not crowded interviewing room. Do not have more than two people in the room, unless additional persons are requested by the survivor.

Be prepared for the survivor to come in and out of the interview, mentally. She may wonder from the topic of discussion frequently. Allow her to do so, then gently guide the interview back to the incident that occurred. Allow her to describe what happened at her own pace.

MEDICAL EXAM

The survivor has probably had many doctor visits. However, this is of particular emotional duress. As you would with other survivor, explain the procedures that will occur. Do so slowly, graphically, but without excitement. Frequently ask if she is
following your line of thought. Ask for any questions. Give as much information as you can. Do not depend on her to ask questions that will fill in the gap. Repeat as necessary. This type of interview will be time-consuming, but is required by this type of survivor. Be patient.

She may become hysterical during the medical exam, and refuse to cooperate. See if she wants to wait awhile and try again. You may have to "give up" conducting the medical exam, for the better mental health of the survivor.

LEGAL ISSUES

The mental health of the survivor is not an issue as a competent witness. She must of course be able to distinguish the truth from a lie. If she can adequately describe the assault, the chances are good that if she reports the rape, the DA will file. She will, however, need an advocate to assist her through the legal process. She will need preparation for the trial, if the case goes to trial, and should be made as comfortable in the courtroom as possible. Conduct a "familiarization" process for her, including visiting the courtroom, explaining who all of the "players" are and what their jobs will be. Role play how a standard case is handled. Make sure that the same person remains her advocate throughout the process.

COMMUNITY SERVICES

Refer the client to County Mental Health services, for rape trauma syndrome treatment. She may require specialized services. Make sure she gets someone who is skilled and experienced in working with persons with mental illness of her type. Also, you may refer her to the local Mental Health Alliance group, for referrals to groups that help survivors with mental illness. In addition, you could contact your local Community Mental Health Center (federally and locally funded programs), which are located
in most large communities.

DEVELOPMENTAL DISABILITIES

DEFINITIONS

Persons with developmental disabilities are defined as those persons who have mental retardation, cerebral palsy, autism, epilepsy or other neurological impairments that demand services similar to that required for an individual with mental retardation. Functional limitations include impairments in learning, self-care, receptive and expressive language, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

THE INTERVIEW

First, if the individual is a wheelchair user, the building, interview room and restroom must be physically accessible. Do not use a room or building that requires that you carry the individual into it. Find an accessible location if yours is not.

Second, do not have more than two persons interviewing the survivor. Preferably one person. If the survivor wants to be accompanied by a friend, let this person be the with survivor as requested by the survivor. However, if the survivor wishes to be alone at any point, do not let the friend "insist" on being present. Be an advocate for the survivor.

Third, pay attention to the level of understanding the survivor has. Do not use words that may be difficult to understand (such as "rape", "survivor", "victim", and words for parts of the body... learn from the survivor the words she uses for these acts and body parts).

Fourth, let the survivor tell what happened in her own words, and at her own rate. She may deviate from the story, and start talking about other things. Gently guide her back into the story of the rape.
Fifth, give information. Do not expect her to ask questions that will fill in the gaps (for example, your name: Tell her your name, and what she is to call you.) Cover all points you need to cover at least twice. Have the client say back to you in her own words what you have told her, to assure that she understood. In discussing the rape, use visual aids, such as drawings, pictures, anatomically correct dolls, physical models...anything you can to enhance the communication between you and the survivor.

If the survivor has a physical disability, please refer in this Protocol to the section on physical disability, for additional information on conducting the interview, and for the medical exam.

Do not infantalize the survivor, but do use language that she can easily understand. Treat her as you would another person of the same age, but adjust your language level and teaching level.

Prepare the survivor for the medical exam, by explaining and demonstration all of the procedures. She may never have had a gynecological exam before. For many persons, these are extremely traumatic. Explain that the exam is very important, but that if she is unable to complete the exam not to feel badly. You will not force her to complete the exam. Explain the consequences of not completing the exam.

If the client is over 18 years of age, she may have a legal guardian. A legal guardian is a person who in a court of law has been awarded a legal conservatorship of the client. In order to know what areas of life this covers, you must ask the conservator in what areas the conservatorship was awarded. If the conservatorship includes medical treatment, then the conservator must sign any medical authorization papers as well as the client.
If there has been no court-awarded conservatorship, the client is legally able to sign forms for herself, and these cannot be signed by another. Being the parent of an individual over 18 years of age does not qualify one as the legal guardian, although that parent is certainly still the parent, as for anyone.

**MEDICAL EXAMINATION**

For the person with a developmental disability that includes a physical disability, please also refer to this section under "physical disability". In addition to these considerations, also use these guidelines:

Prior to the exam, discuss all procedures that will be done with the client, using the actual materials (speculum, slide, etc.) so she can have a full understanding of what will be done.

Before the exam, ask the client who she would like to be in the room with her, and who she would like to have wait outside. It is recommended that as few persons as possible be in the room with her. Follow her request.

During the exam, have the physician "talk her through": the exam, that is, prior to doing any procedure, tell the survivor what is about to happen, how it will feel, how long it will last, what it is for, and what she can do to relax. Give her specific instructions (for example, which pieces of clothing to remove and what to do with them) and keep her focussed on relaxation techniques. If at anytime during the procedure she wants to quit, let her.

**LEGAL ISSUES**

If this is a case of forced rape, the major issue will be the client's ability to give testimony, if she decides to report. This will require training and preparation, and she should have an advocate assigned to her. The mental retardation of the survivor is not an issue as a competent witness. She must of
course be able to distinguish the truth from a lie. If she can adequately describe the assault, the chances are that if she reports the rape, the DA will file. She will, however, need an advocate to assist her through the legal process. She will need preparation for the trial, if the case goes to trial, and should be made as comfortable in the courtroom as possible. Conduct a "familiarization" process for her, including visiting the courtroom, explaining who all of the "players" are and what their jobs will be. Role play how a standard case is handled. Make sure that the same person remains her advocate throughout the process.

If this is a case of statutory rape (based on client's supposed inability to provide informed consent), your first step is to have a qualified mental health practitioner who is also a Certified sex educator or counselor and has experience working with developmentally disabled individuals conduct an assessment of her ability to understand the nature and consequences of the act of coitus. Do not refer to a psychologist of other mental qualifications. The Regional Centers or ASSECT (American Association of Sex Educators, Counselors and Therapists) can provide names of competent examiners in your area.

If your client is the offender and has a developmental disability, the case will probably be referred to Probation, and a diversion program set up in which the client will be seen in therapy and a structure day and residential program.

COMMUNITY SERVICES

The primary service agency for persons with developmental disabilities is the Regional Center. Regional Centers geographically cover the State. They provide information and referral services. They can also pay for certain services, such as evaluations and limited counseling. They can also provide
legal advice and advocacy through the services of their Client Right's Advocate, which each Regional Center has. A list of Regional Centers can be obtained by calling the State Department of Developmental Services in Sacramento.

Additional service providers include agencies that are specific to the disability of the individual, for example, the Epilepsy Society, the Down's Syndrome Parents Group in Los Angeles. Often these associations have knowledge of experts in this area you can contact. Other sources of information would be the local Special Education school district, and the Association of Retarded Citizens in your area.

**VISUALLY IMPAIRED/BLIND**

**DEFINITION**

If vision is 20/200, the person is considered legally blind. A person with no perception of visual stimuli is totally blind. There is a range in-between, with most persons having some vision. It is important to clarify the degree of sight the individual has from the start. S/he may be easily disoriented at this time of crisis, and may need your assistance more than they usually need from others.

Most blind persons are independently mobile with the assistance of a cane or a guide-dog. The client always has and must continue to have complete control over these assistance devices.

**INTERVIEW**

If more than one person is involved in interviewing the blind survivor, be sure to say your name to help keep her/him oriented, because voices do sound remarkably similar. Before you begin, orient the client to the physical layout of their surroundings. Although each person has their preferred ways, the following are accepted methods of assisting a blind person (3):
1) Offer your upper arm/elbow to the blind client
2) Walk slightly ahead of the blind client
3) When walking through a narrow passage, swing your arm towards your back.
4) When arriving at a chair where the client is to sit, place her/his hand on top of the back of the chair. From there s/he can feel the rest of the chair. If the hand is placed on one arm, it is difficult to tell if it is the left or right chair arm.
5) Verbally orient the client to the room, telling her where the door is, what other furniture is in the room and where it is located, and who else is in the room at the time, and when they leave or others enter.

During the social/medical interview requiring the signing of consent forms, information on cassette tape is helpful. If you do not have this available, reading the form with an advocate present is an appropriate alternative. In ascertaining what occurred during the assault, using three-dimensional models can be helpful.

**MEDICAL EXAM**

Orient the client to the exam room so she will know where the furniture is located, where to place her clothes, and how you would like her to lie on the exam table. Talk with him/her throughout the exam. Explain what you are about to do before you touch any body area.

**LEGAL ISSUES**

The visually impaired survivor can provide a fund of valuable information helpful in identifying an assailant. They may be able to identify a voice, a particular walk, clothing, etc. It is vital that law enforcement and legal personnel accept these types of identification as well as visual ones.
Braille Institute and Foundation for the Junior Blind are the primary resource agencies.

NON-DISABLED INDIVIDUAL WHO BECOME DISABLED AS A RESULT OF THE ATTACK.

There are clients who, whether or not they had a disability before being sexually assaulted, may acquire a new disability as a result of the attack.

The work of adjustment to the assault and injury begins subsequent to a stabilization of any life threatening situation. The disability acquired may include amputations, head trauma, spinal cord injuries, blindness, burns. The combination of the sexual assault and injury as a product of "mayhem" creates a crisis, where services assisting adjustment must be carefully orchestrated between the Sexual Assault specialist and Disability - Psychology-Rehabilitation Specialists.

The first emotion displayed by this client will probably be denial, which occurs at this time to allow the client to adjust in their own time to the trauma and the reality to loss. This denial must be respected and protected by those providing services. In bringing the reality of permanent disability home to the survivor in the denial phase of adjustment, it is best that the Sexual Assault Specialist help him/her understand and talk about the incident, while at the same time consulting with the Disability Specialist about the right timing to introduce the disability to the survivor. Though the client will know the medical status from the physician/s, it will probably be the client who brings up the psychology of the injuries. If there is a Patient Advocate, s/he should work together with the Sexual Assault Specialist. The survivor will be faced with adjustment to the disability and new lifestyle, and will begin the healing
process regarding the sexual assault.

(Note: This section and the section following on communication disability are taken from source #3 in Footnotes)

Deafness/Hearing Impairment

If the hearing-impaired person is waiting in a private room and has been left alone for a period of time, when you enter the room do not approach from behind and touch the person. You can either enter the room and flash the lights (hearing-impaired people are accustomed to this method since many have "flashing doorbells" and "flashing alarm" clocks), or walk around in front of the client so s/he is not startled by your sudden appearance. Remember, s/he will not hear your footsteps.

Do not assume that an affirmative nodding of the head indicates the hearing-impaired person has understood what has been said or is necessarily agreeing with what was said. The nod of the head may mean the person knows you are talking, sees what you pointed to, or may be feeling uncomfortable because s/he does not understand what is going on. This is a characteristic that some hearing-impaired people (and many others) use when they are not sure what to do, but may be reluctant and/or fearful to admit it. It is important to get feedback so the counselor can check out the accuracy of the message received. Do not be misguided by the nod, if you sense it is not intended to mean "yes."

If staff personnel will take the time to learn even a few basic signs, they will find they can develop almost instant rapport with the hearing-impaired client who seeks service. This will enable the hearing-impaired person to feel more relaxed and comfortable about coming to the agency. The dividends will be worth the effort.

C. Method of Communication

Hearing-impaired persons have a variety of ways to communicate with hearing persons. It is best to ask the hearing-impaired person how s/he wishes to communicate and then follow the method the client indicated. If it appears that the suggested method is not effective, the staff person should let the hearing-impaired person know s/he does not feel the communication is clear and then, together, seek an alternate method.

The three methods generally used by hearing impaired persons are speechreading/lipreading, writing, sign language/use of interpreters.

1. Speechreading/Lipreading

Some hearing-impaired persons, especially those with some residual hearing, can communicate quite effectively by lipreading. However, many factors influence how well you will be understood. Some general rules to observe are:
. Speak in a normal voice.
. Articulate words clearly.
. Do not exaggerate mouth movements.
. Do not move your head up and down or turn to the side; any movement can prevent the hearing-impaired person from being able to follow lip movement.
. Have good lighting in the room, but do not position yourself in front of a window or bright lamp where the person is looking into glare from the lighting.
. Be careful of "busy backgrounds" such as bright, colorful, busy prints or stripes in wall coverings or personal clothing close to the face.
. Be aware that moustaches and beards can interfere with the communication process.
. Keep your sentences short and simple; rather than one complex sentence, use two short ones.
. Rephrase rather than repeat comments when you are not understood.
. Write down any problem word(s) that are not being understood.

Even the most proficient lipreaders may understand only about 25% of what is said, so be mindful of this in your communication interactions. There are many words that look alike, so the opportunity for misunderstanding is great. Check out what the person has understood you to say so that you can be certain the information received is correct.

2. Writing

To resort to writing is a laborious and time-consuming task, both for the hearing-impaired person and agency personnel. It is not often that this method proves to be satisfactory for lengthy or in-depth communication. Many hearing-impaired persons have a significant language deficiency, caused by the loss of hearing. Many will not always be able to express their concerns or phrase their questions in an understandable form for the person unfamiliar with working with the hearing-impaired. This difficulty or inability to communicate clearly by writing should never be thought to reflect the deaf person's basic intellectual capacity. Stop and think how you acquired language. Much of what we learn comes through our hearing and when a person is deprived of that capability, learning a language becomes an enormous and laborious task.

For many deaf persons, written English is simply a secondary language to "American Sign Language" in which they are far more fluent.
If you need to use writing for communication, use simple words and short sentences. If you are working with a client who has a hearing loss and no interpreter is available, it may help to write out essential questions, instructions and useful references ahead of time; then, use this list during your meetings.

Try to avoid the use of "agency jargon" unless it is clearly explained. Pictures and drawings will help to make the communication clear. Caution is again advised in assuming that the communication has been fully understood; seek feedback from the hearing-impaired person so that you can check that the message or information has been clearly understood.

3. Sign Language and Use of Interpreters

For many hearing-impaired persons, communication in sign language is the preferred method. With a qualified interpreter (if the agency staff person does not know sign language), communication can flow smoothly and rather quickly. The hearing-impaired person will feel much more comfortable expressing feelings and discussing questions if an interpreter is used to facilitate communication.

Agency personnel should make it clear to all parties involved that all information discussed is confidential and will be respected as such by all persons. Certified interpreters are governed by a Code of Ethics from the national organization headquartered in Washington, D.C.

When using an interpreter, remember to have eye contact with and speak directly to the hearing-impaired person, NOT to the interpreter. The hearing-impaired person will need to focus on the interpreter, but will also attempt to keep the staff person in eye contact. Here is an example of the proper way to address the communication.

(Staff person looking directly at the hearing-impaired person):
"Did you come for a pregnancy test today?"

(Interpreter verbalizing what the hearing impaired person is signing):
"Yes, I have an appointment at 2:00 p.m."

It is incorrect for the agency person to say to the interpreter:
"Ask her if she has an appointment for a pregnancy test today."

It is incorrect for the interpreter to respond:
"Yes, she has an appointment at 2:00 p.m."

The interpreter will always respond in the first person, not the third person. Likewise, you should phrase questions in the first person to the hearing-impaired person.

The interpreter must interpret all communication that takes place within the setting; this does not allow for any person to say to the interpreter, "This is just between you and me, don't interpret this." The interpreter is required by the Code of Ethics to interpret all communication, both what the agency staff person says and whatever signing the hearing-impaired person does within the setting.
Position and lighting are important factors to consider. Again, the hearing-impaired person should not be looking into a window or lamp glare, or at a busy background. This places an undue strain on the communication process. The interpreter should be seated so that the hearing-impaired person can see both the agency person and the interpreter simultaneously.

Here are two examples of acceptable positioning:

4. Where Can You Locate an Interpreter?

When a hearing-impaired person makes an appointment, ask if s/he wants an interpreter. If so, ask if s/he has made arrangements to have an interpreter. If not, the agency can contact the state organization of the Registry of Interpreters for the Deaf, the State or perhaps a community service center serving the hearing-impaired population. Local hearing and speech centers may be another resource to obtain names of qualified interpreters. If these resources are not available to the agency, contact can be made with the national Registry of Interpreters for the Deaf (RID) in Washington, D.C. The national office maintains a directory listing all certified interpreters in the nation.

Family members are not recommended as interpreters for other family members.

The matter of payment for the interpreter needs to be clarified during the initial contact, i.e., who is paying for the service and the amount of payment.

5. Communicating with Nonverbal Clients

Some clients with speech impairments may use various devices to assist their communication. For clients with cerebral palsy (CP), for example, this may be particularly important. The following suggestions may be helpful:

- Speak to the nonverbal client as you would any other. Do not assume mental retardation or deafness.
If clients use an alphabet or talking board, say the work or letter aloud as they point. That way they will know you are following their meaning.

If the client is trying to articulate a word, but you are stuck and cannot figure it out, ask her/him to think of another word or to spell it out. Sometimes, two relaxed people can listen more effectively than one who is trying very hard. With the client's permission, invite a colleague in to help.

A good interpreter for a person whose speech is affected by CP may be another person with CP whose speech is unaffected, but who has lived with other people with CP.
MYTH: DD/CMI People Are Not Emotionally Damaged By Assault. They probably do not consider the incident as sexual abuse or may not know what has happened to them, so it makes no difference.

FACT: This is an obvious denial of a basic human right for self-determination over our bodies. This attitude of denial can only be detrimental, hindering the assaulted person from working out her feelings as her guilt and silence are reinforced.

MYTH: Disabled People Are Not Raped Because They Are Sexually Unattractive. This myth involves two misconceptions: 1) persons with disabilities are unattractive and 2) rape is a sexual act.

FACT: Intellectual and emotional impairments do not limit a person's ability to conform to our society's standards of beauty. Secondly, rape is an act of violence in which sex is used as a weapon. It is an act of power and control. Assaulters are not seeking someone who is sexually attractive, but someone who is an easy target.

MYTH: Disabled People Are Promiscuous: They Ask For It.

FACT: This again implies that rape is a sexual act. Shifting the blame from the rapist to the survivor provides an escape from dealing with the problem.

MYTH: Sexual Abuse of Persons Treated DD/CMI Can Be Prevented By Keeping Them Away From The Community, Secured In a Protective Environment.

FACT: Most assailters are within the victim's "protective environment." A prevention project in Seattle found that 99% of sexual assaults against children were by relatives, friends, acquaintances or caretakers. A study by the National Institute of Mental Health (1983) showed that 81% of assaults against mental patients are committed by hospital staff.

MYTH: Most Rapists Are Mentally Ill or Mentally Retarded.

FACT: Research shows that men who rape have normal psychological profiles, differing from other men only in that they have a greater tendency to express violence.

MYTH: People Labeled DD/CMI Are Not Capable of Learning Skills to Prevent Sexual Assault.

FACT: DD/CMI people may need to begin learning skills at a basic level, but each person possesses a potential for growth. We have documented several incidences in which both children and people seen as disabled have successfully deterred assaults, after receiving just a few basic skills.

MYTH: Mentally Ill and Mentally Retarded People Lie About Sexual Assault.

FACT: Approximately 90% of all sexual assaults go unreported. This figure may be higher for persons with disabilities due to their lack of information about how to report, the fear of being blamed for the assault, the fear of retaliation by the assailter, and the fear of not being believed.
FOOTNOTES:
1. Section 504 of the 1973 Rehabilitation Act
2. *Table Manners, A Guide to the Pelvic Examination for Disabled Women and Health Care Providers, Ferrera, Susan and Hughes, Katrine. Sex Education for Disabled People, 477 Fifteenth Street, Oakland, CA 94612.

RESOURCES
Regional Centers for Developmentally Disabled People
Call Area Board X for the one nearest you (213) 736-3402
They can supply you with names and addresses of specialized interest groups such as the Epilepsy Society, etc.

*Nora J. Baladerian, M.A., M.F.C.C. (213) 391-2420
*Barbara Faye Waxman, B.A., (213) 392-1627

*Can give you names of specialized resource persons and up-to-date agency resource information upon request.

*Closing House—202-690-7850

Advisor of Disabled
202-690-7888