Sexual Abuse Treatment for Persons With Developmental Disabilities

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Recent research by the Sexual Abuse and Disability Project at the University of Alberta included a survey of 119 sexual abuse victims with developmental disabilities. Their responses indicated that sexual abuse treatment services for people with developmental disabilities are typically inaccessible, unavailable, and inappropriate. Inadequate treatment services appear to be due to the paucity of qualified professionals in the area of sexual abuse and developmental disabilities coupled with the slow development of appropriate sexual abuse treatment approaches. The application of adapted therapy approaches for people with developmental disabilities and examples of adapted sexual abuse treatment for children and women abused as children are presented. Sexual abuse treatment issues for the developmentally disabled are discussed for practitioners’ consideration.

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

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

Previous research by the Sexual Abuse and Disability Project studied the incidence of sexual abuse in people with disabilities (Sobsey & Varnhagen, 1988) and sexual abuse prevention strategies (Sobsey & Mansell, 1989). More recent research involved a survey of sexually abused people with disabilities.

Sexual Abuse and Disability Project Survey

Method

The survey’s 21 questions were aimed to evaluate a variety of aspects of sexual abuse and asked about attributes of offenders and victims; offender’s relationship to the victim; the number and nature of abuse episodes; charges, reports, and convictions; the impact on abuse victims; and victim treatment services. The questionnaires used in the study received approval by the Research and Ethics Committee of the Educational Psychology Department of the University of Alberta and complied with the APA’s ethical standards. Researchers sent the questionnaire to advocacy groups, service agencies, and sexual assault centers. The questionnaires were completed by client advocates and victims with disabilities in both Canada and the United States. There were 170 questionnaires returned to the Sexual Abuse and Disability Project by mail and telephone between 1987 and 1990. At the time of this writing, this research sample is the largest of its kind available.

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

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

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

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

**Results**

The mean age of the 119 victims with developmental disabilities was 20.2 years (range = 1.5 – 51 years, SD = 10.4). Victims were primarily female (80.2%); close to 20% (19.8%) of victims were male. The mean age of offenders was 33.4 years (range = 14 – 80 years, SD = 13.8). Primarily, offenders were male (60.8%), but there were some female offenders (9.2%). The mean date of offenses was 1986 (range = 1978 – 1990, SD = 2.26).

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

The locations in which abuse took place and the offenders' relationship to the victim were also determined by the survey. People with developmental disabilities experienced abuse in several different environments. Private homes (57.3%), vehicles (20.3%), group homes (8.5%), institutions (7.7%), public places (7.7%), other settings associated with rehabilitation services (4.3%), other (2.6%), and hospitals (1.7%) were environments where abuse took place. Offenders included paid caregivers providing services related to their victims' disabilities (26.3%), natural family members (17%), neighbors or acquaintances (3.5%), and service providers for services unrelated to their victims' disabilities (10.5%). Other offenders included strangers (6.0%), disabled peers (8.3%), transportation providers (6.0%), family members (4.5%), dates (3.0%), and step-relatives (0.5%). From the survey's results, it appears that many sexually abused people with developmental disabilities are abused by workers in the service delivery system.

The 119 victims with developmental disabilities included 38 victims with severe and profound disabilities, 28 with mild and moderate disabilities, and 39 with an unspecified degree of intellectual impairment. A comparison of the survey results of the 38 victims with severe and profound developmental disabilities and 42 victims with mild and moderate developmental disabilities was conducted. The other 39 victims were excluded from this analysis because respondents did not specify the degree of intellectual impairment.

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

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

Of the respondents, 9.8% of those with mild and moderate disabilities and 17.7% of those with severe and profound disabilities reported that they experienced withdrawal. Of the respondents with mild and moderate disabilities and those with severe and profound disabilities, 19.6% and 31.1% respectively reported that they developed aggressive and/or other behavioral problems, such as inappropriate sexual behavior. Reports of experiencing no emotional or social problems came from 3.9% of the respondents with mild and moderate disabilities and 0 respondents with more severe disabilities. Reports of being moved out of their home came from 2.0% of respondents with mild and moderate disabilities and 11.1% of respondents with severe and profound disabilities. Reports of losing program placement came from 7.8% of respondents with mild and moderate disabilities and 4.4% of respondents with severe and profound disabilities. Of the respondents with mild and moderate disabilities and severe and profound disabilities, 56.8% and 35.5% respectively reported unspecified emotional distress as abuse sequelae.

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

The appropriateness of the sexual abuse treatment for the respondent’s individual needs was evaluated. A few respondents with mild and moderate disabilities (5.7%) received the same services as nondisabled clients and required no special treatment modifications. None of the more severely disabled people received appropriate treatment through these services. A little over a quarter of clients with moderate and mild disabilities (28.5%) received services that adequately met their needs. Yet fewer clients (7.4%) with more severe disabilities received specialized or individualized services. There were attempts to meet the special needs of clients with disabilities, but these were considered inadequate for 22.8% of the respondents with mild and moderate disabilities and for 14.3% of respondents with severe and profound disabilities. Many respondents with mild and moderate disabilities (42.8%) and most of the respondents with severe and profound disabilities (77.8%) required accommodations to their special needs that were not available to them. More than half the people with developmental disabilities (51.1%) were in this category, but this included significantly more of the people with severe disabilities (p < .01). None of the survey respondents suggested that there were unnecessary accommodations made for them.

Discussion

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

Attitudes Toward Disability

Pervasive attitudes surrounding disability are often negative and consist of myths that portray people with disabilities as helpless, damaged, inhuman, asexual, and insensitive to pain (Sobsey & Mansell, 1990). Myths and devaluing attitudes toward disability can encourage desensitization to the plight of the disabled. Unfortunately, when professionals develop these attitudes, their disabled clients may suffer negative consequences (Cushna et al., 1980; Crossmaker, 1991). Myths about the “asexuality” and “insensitivity to pain” of the developmentally disabled may have been particularly influential in the acknowledgment of sexual abuse being delayed and in the continuing inadequacy of sexual abuse treatment services. Misconceptions surrounding the “asexuality” of people with developmental disabilities have been particularly influential and damaging. The insensitivity of many people with developmental disabilities and the resulting denial of their sexuality clearly overlooks the inherent sexuality of all people. Nevertheless, this myth has justified denying both sexuality education and sexual expression to the developmentally disabled (Abramson, Parker, & Weisberg, 1988; Kempton & Kahn, 1991). Denying the developmentally disabled access to sexuality education increases their vulnerability to possible pregnancy, venereal diseases, and abuse by persons exploiting their inadequate knowledge about sexuality (Shaman, 1986). Sexuality education that includes teaching self-protective behavior and assertiveness may be an important sexual abuse prevention strategy (Sobsey & Mansell, 1990). Notions about asexuality have prevented many caregivers from acknowledging potential sexual abuse risk and have delayed the implementation of abuse prevention strategies, such as educating staff to be able to detect sexual abuse. Caregivers overlooking the possibility of sexual abuse ensured that abuse continued undetected and prevented people from being protected and receiving help.

The inaccurate belief about the “insensitivity to pain” stems from the reasoning that because developmentally disabled people do not understand what has happened to them, they do not suffer pain (Crossmaker, 1986; Sobsey & Mansell, 1990). There is no evidence to support the notion that the developmentally disabled experience different emotional abuse sequelae than do individuals without disabilities (Cruz, Price-Williams, & Anderson, 1988; Sullivan, Scanlan, Knutson, Brookhouser, & Schulte, in press; Varley, 1994). Beliefs about pain insensitivity may have been influential in contributing to the inaccessibility of treatment services. Professionals erroneously believing that the developmentally disabled are asexual and insensitive to pain may have hindered acknowledgement, detection, and prevention of sexual abuse and contributed to the inaccessibility of treatment services.

Treatment Accessibility

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

Treatment Availability

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

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

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

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

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

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

Another group of researchers adapted group therapy techniques including role-playing and group discussions in sexual abuse treatment for developmentally disabled women who experienced intrafamilial child sexual abuse (Cruz et al., 1988). They used a cotherapy approach, with one therapist with expertise in sexual abuse and another with expertise in developmental disability, in an adapted group approach to sexual abuse treatment. Cruz et al. (1988) have presented a promising example of adapted sexual abuse treatment for the developmentally disabled. Emphasizing professional liaison through the therapist team with adapted sexual abuse treatment may help ensure availability and appropriateness of sexual abuse treatment. For practitioners providing sexual abuse treatment to the developmentally disabled, there are several personal and professional issues to consider.

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

People with developmental disabilities often have poor coping skills, weak problem-solving skills, and poor communication skills, accompanied by low self-esteem, feelings of inadequacy, and isolation (Spackman et al., 1990). Cruz et al. (1988) noted that developmentally disabled women who were sexually abused as children have significant issues related to guilt, immaturity needs, lack of self-esteem, and feelings of isolation, and difficulty handling and expressing anger. Clients may have concerns and confusion about their sexuality and feelings about being "damaged goods"; their dependency on others may exacerbate fears of retaliation and abandonment. Practitioners need to recognize that the impact of these combined issues for the developmentally disabled person in sexual abuse treatment may be more complicated than for sexually abused people without developmental disabilities.

Conclusion

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

References


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