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ABSTRACT

The literature is reviewed on sexual abuse, assault, and exploitation of people with disabilities; and new data from two pilot studies are introduced. The pilot studies consisted of two surveys: (1) a survey of 19 Canadian community service agencies dealing with sexual abuse, focusing on types of services provided and self-evaluation of services for disabled individuals; and (2) a survey of 62 Canadian agencies aiding disabled people, focusing on characteristics of the victim, offender, and offense; the disability's contribution to the victim's vulnerability to sexual abuse; and the nature of victim support services. The studies' results suggested that: Canadians with disabilities are at greater risk for sexual abuse; the extent of increased risk remains unclear; current services often fail to meet the needs of people with disabilities; failure becomes increasingly common as a function of the severity of the disability; and findings reported elsewhere can be generalized to Canada. The bulk of the document comprises a 200-item annotated bibliography of research studies, position papers, program descriptions, clinical reports, and media accounts, covering English-language and French-language literature in the areas of sexual abuse and assault of people with disabilities, other forms of abuse, sex education, sexuality for people with disabilities, and related materials. The survey instruments used in the two pilot studies are also included. (JDD)

FINAL REPORT

Sexual Abuse and Exploitation of People with Disabilities[1,2]

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ABSTRACT: The primary purpose of this paper is to review the literature on the sexual abuse, assault, and exploitation of people with disabilities. It also introduces new data from two pilot studies to expand on currently published information and to suggest future avenues for research. While published information about the sexual abuse of people with disabilities is still sparse, there is an increasing interest in this area. Most currently available information stresses incidence among people with specific disabilities and generally concludes that they experience increased risk for abuse. While many of these studies suffer from design flaws, there is enough information currently available to support the conclusion that people (children and adults) with disabilities are at increased risk for sexual abuse. Until now, less emphasis has been placed on the appropriateness of prevention and victims' services. Data from pilot studies indicate that many agencies serving victims of sexual abuse exclude some victims because of their disabilities and have difficulty serving other victims with disabilities. This study concludes that it is time to shift our emphasis from determination of incidence and prevalence statistics to determination of parameters for appropriate prevention and victims' services. An annotated bibliography is included as an appendix.

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Sexual Abuse and Exploitation of People with Disabilities

PURPOSE AND METHODOLOGY

Canada's national initiative against child sexual abuse is currently underway. During this developmental phase, a number of studies have been undertaken to determine more specific targets for this program. Since some preliminary information suggests that people with disabilities may be at increased risk for experiencing sexual abuse, the purpose of this study was to provide additional information on the nature and extent of risk for abuse among people with disabilities, and to determine if current prevention and treatment services meet their needs.

The primary method for gathering relevant evidence was through review of existing literature. This included a number of electronic database searches in education, law, psychology, medicine, social work, and related disciplines. Since much of the information required was not categorized by a few simple descriptors an intensive conventional library search, and consultation with service providers and other researchers was required to locate essential information.

Two pilot studies were undertaken to supplement the literature review. These were intended to: determine reliability of previously published data, determine the extent of generalization of non-Canadian data to Canada, and to provide initial data relevant to some essential issues that are not addressed in published material. One of these studies surveyed agencies serving victims of sexual abuse to determine how they served people with disabilities. The other collected some basic information about incidents of sexual abuse involving victims with disabilities. Studies were conducted in English and French.

Due to some issues that may generalize across age groups, and a tendency for some previous investigators to treat child sexual abuse and sexual assault and exploitation of adults as a single concern, this study addresses both groups of victims. Care should be taken in applying results across populations and it is essential that the distinct needs of children and adults with disabilities be recognized.

LITERATURE REVIEW

Although currently published English and French literature on sexual abuse and people with disabilities is rare, the increasing number of articles and books recently published suggests that there is growing concern and a rapidly evolving body of knowledge. As shown in Figure 1, more than 50% of 200 relevant publications identified were published in the last four years. The number of relevant publications appears to be increasing substantially each year, and this effect will likely appear even more dramatic after the remainder of publications from the 1987 publication year are indexed and accessible. There is also a clear change in the content of these publications. Earlier articles focus on philosophy, theoretical issues, sex education, and humanistic concern, but provide little data. More recent publications continue to emphasize these areas, but provide incidence and prevalence data to support these concerns. An annotated bibliography is included as Appendix A.

Studies on disabilities and risk for sexual abuse

The majority of cases of sexual abuse are likely never reported; using FBI statistics and data collected by the Seattle Rape Relief Disabilities Project, Ryerson (1981) estimates that only 20% of the cases of sexual abuse involving disabled people are ever reported to the police, community service agencies, or other authorities. Thus, it is very difficult to compile accurate statistics concerning the incidence of sexual abuse among the disabled population.

There are two reasonable approaches to compiling incidence statistics: In the first, wide-scale samples of disabled people are obtained and history of sexual abuse recorded. The incidence rate is then recorded and compared with incidence rates for the general population. This procedure is used to determine

whether there is a greater incidence of sexual abuse among the disabled sample in comparison with the general population. Incidence statistics are difficult to obtain using this direct approach; there are few data banks devoted generally to disabled people that include incidence of sexual abuse. Most often, records from specialized agencies, such as birth control counselling groups, sheltered workshops, or group homes are examined for incidence of sexual abuse.

In the second approach, wide-scale samples of victims of sexual abuse are identified. Representation of different disabilities within the sample is compiled and compared with representation within the general population. Using this procedure, it is determined whether people with certain disabilities are under- or over-represented as victims of sexual abuse. This approach leads to more stable statistics than does the former approach. It may be a better indicator of prevalence than of incidence since active case files usually reflect people victimized in a relatively fixed time interval.

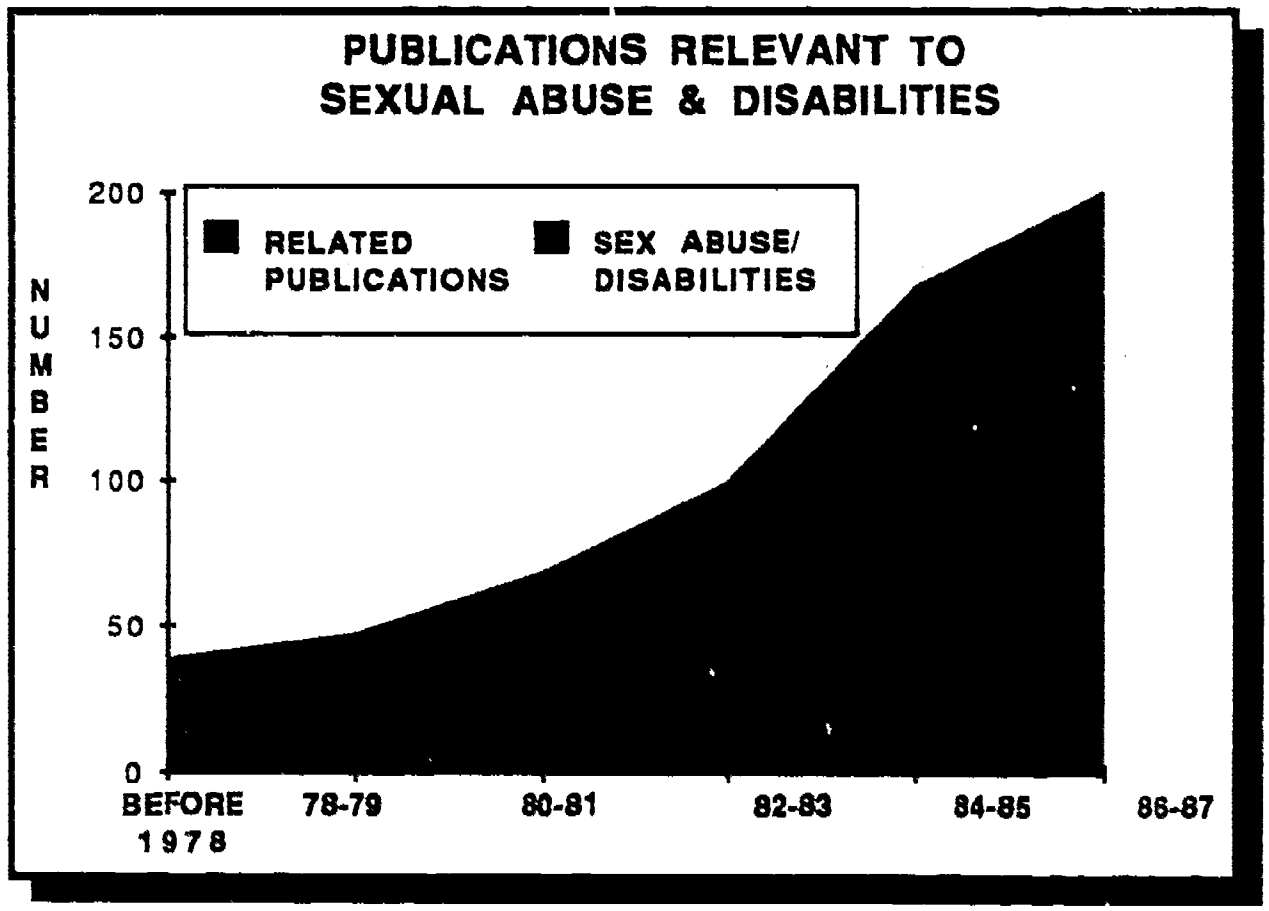

Figure 1. Less than 50 publications related to sexual abuse and disability had been published prior to 1978. Since that time there has been a rapid acceleration of publication of relevant literature.

Neither approach can determine if the disability reported is a result of the abuse rather than a prior condition that possibly put the victim at greater risk for the abuse. This is particularly important when considering that sexual abuse may be accompanied by physical abuse. Even when physical abuse is not present, regression, withdrawal, and other behavioural changes often result from sexual abuse. To minimize this ambiguity, studies that distinctly report prior disabilities are examined first. However, it should be remembered that even where disability results from abuse, any special needs of those victims must be considered in providing appropriate treatment services.

Disabilities among abuse victims. Table 1 summarizes statistics concerning prevalence of prior disabilities obtained from studies of child sexual abuse. The data were obtained through medical centre records of children who had been treated in emergency or outpatient departments over 12 to 18 month periods. Computing weighted averages, 5% of the sexually abused children had some form of intellectual impairment, 3% had a physical or sensory impairment, and 5% were psychiatrically impaired prior to the abuse. Differences in the percentages that appear in various categories are partly the result of differences in categorical definitions, but intellectually and physically impaired children are certainly over-represented in these samples. The prevalence of intellectual impairment in the general population ranges from 1 to 3% (Tarjan, Wright, Eyman, & Keeran, 1973). A comparable percentage of physical and sensory disabilities in the general population is difficult to identify since the authors' definitions were not adequately clear.

Table 2 summarizes statistics concerning child abuse. These may or may not have included sexual abuse. The Gil (1970) and Lebsack studies (cited in Soeffing, 1974) examined nationwide data banks of child abuse and the Hawkins and Duncan (1985) study considered statistics within one state; all reports were collected for a 12 month period. Weighted averages of the representation of the different types of disabilities are comparable to those obtained with cases of explicit sexual abuse; 3% of the children were intellectually impaired, 3% were physically impaired and 5% were psychiatrically impaired. Again, precise comparisons with non-abused populations are difficult to make due to inadequate specifications of criteria for inclusion in categories and differences in criteria across studies.

Table 1
Prevalence of prior disabilities in studies of victims of child sexual abuse.

Reference	n	Intellectual Impairment	Physical Impairment	Psychiatric Impairment	Other
Tilelli, Turek, & Jaffe (1980)	113	5%	2%	5%	2%
Shah, Holloway, & Valkil (1982)	174	4%	not reported	not reported	not reported
Browniing & Boatman (1977)	14	14%	14%	0	0

Table 2
Prevalence of disabilities in studies of physical abuse

Reference	n	Intellectual Impairment	Physical Impairment	Psychiatric Impairment	Other
Gil (1970)	1380	8%	14%	included in other	29%
Lebsack (1975)	14,083	2 %	2%	5%	6%
Hawkins & Duncan (1985)	126	9%	not reported	10%	not reported

In spite of methodological differences and concerns, the general consistency of these studies suggests that children with disabilities experience significant risk for sexual and physical abuse. This risk appears to be substantially greater than the risk for their non-disabled age-peers, although the difficulty in gathering accurate statistical information about either group suggests some caution in making this

comparison. There is good reason to believe that these studies underrepresent children with disabilities because these children are often rejected from services or served by specialized agencies and therefore do not appear in the case files reviewed for these studies. For example, Schilling, Kirkman, and Schinke (1986) found that although 82% of the child protection workers believed that developmental disabilities increased risk of abuse, 84% could not recall a single case that they had served, 12% had only served one, and only 4% had served two developmentally disabled clients. Even if children with disabilities only experience the same risk, they make up a very significant proportion of child sexual abuse victims and appropriate services are required. Currently, we can expect to encounter significant disabilities in about one of every seven victims of child sexual abuse. The proportion of children with disabilities in this group can be expected to increase as case reporting for children with disabilities improves (Senn, 1987).

Sexual abuse among people with disabilities. Although not comparable, specialized, direct approaches to tabulating incidence of sexual abuse support these studies demonstrating that disabled children are at risk for sexual abuse. In a study of 87 mentally retarded females between 11 to 23 years of age referred for birth control, Chamberlain, Rauh, Passer, McGrath, and Burket (1984) found that 25% had been sexually abused. In a study of 164 children with cerebral palsy receiving regular medical attention at the University of Chicago hospital, Jaudes and Diamond (1985) discovered that 14% of the children had been abused and/or neglected, including 2% reported cases of sexual abuse. Finally, in a study of 55 hearing impaired multiply handicapped children examined by otolaryngologists through the Boys Town Centre for Abused Handicapped Children, Brookhouser, Sullivan, Scanlan, and Garbarino (1986) reported that 96% of the children had been sexually abused.

Other studies. Studies that have not controlled for preexistence of the disability present an even more dramatic picture. Davies (1979) found abnormal EEG readings and active epilepsy in three to four times as many incest victims as in a matched control group. Chotiner and Lehr (1976) report a Parents Anonymous study that showed 58% of members' abused children had developmental disabilities prior to abuse problems and a Denver Department of Welfare study indicated that 70% of abused children exhibited a "mental or physical deviation" prior to the reported abuse. Schilling, Kirkham, and Schinke (1986) found that the great majority of child protection workers believed that children with developmental disabilities were at greater risk. While the perceptions of service providers do not comprise direct empirical evidence of increased incidence, they do offer social validation for the data presented above. Finally, our own (following) pilot data similarly suggest that people actively involved in providing services to sexual abuse victims believe that people with disabilities are at greater risk.

Considered as a whole, these data strongly support a relationship between disabilities and sexual abuse. The nature and extent of that relationship may be important to understanding factors that are associated with risk of abuse for all children and understanding the mechanism of this relationship may provide information useful in designing more effective treatment programs. Regardless of the precise mechanism of this relationship, the needs of these victims must be considered.

Potential Relationships Between Sexual Abuse and Disability

Why children with disabilities are more likely to be found among victims of sexual abuse is not entirely clear. A number of potential relationships have been suggested. None of these has been adequately verified through empirical research, but indirect evidence is available.

Sampling bias and case-finding factors. With small samples used in some of the reported studies, two factors may increase the apparent extent of disabilities among victims of abuse. First, potential investigators who happened to be working with groups that included higher proportions of disabilities may have been more likely to identify this area of concern, and likely to choose a sample from the same higher incidence population that they worked with. Second, studies that show no effect are less likely to be published. If other investigators undertook studies that showed no effect, those results would less likely be preserved. Thus, in spite of the apparent consistency of results indicating a higher proportion than

expected of disabilities among victims of abuse, some caution should be exercised in this conclusion.

Disability increases probability of sexual abuse. A number of factors have been suggested that link disabilities to sexual and physical abuse. In many cases it is not the actual impairment of the individual that contributes to increased risk; rather, society's expectations and treatment of people with disabilities appear to increase risk.

Zirpoli, Snell, and Loyd (1987) found that the severity of disability and the extent of maladaptive behaviour contributed significantly to risk of abuse among mentally retarded residents of state training centers. This suggests that the degree as well as the nature of the impairment may be an important factor.

Skinner (1953) presented a model of counter control in which power and authority must be restrained by individual or social counter controls to prevent abuse. People with disabilities often lack counter control. A major factor in this limitation is impaired communication. They often lack the ability or opportunity to protest effectively. Deficits in communication among developmentally disabled adolescents (Cirrin & Rowland, 1985), physically disabled children (Light, Collier & Parnes, 1985), multiply disabled children (Orelove & Sobsey, 1987), and deaf children not only reduce the amount of communication, but also heavily influence the content and circumstances of communication. All children who experience significant communication deficits show very low rates of initiation and often communicate only when responding to others. These individuals would be unlikely to report abuse, particularly if not explicitly asked.

An inability to physically defend oneself may also be a factor. Physical, sensory, and intellectual impairments all are likely to interfere with the individual's abilities to escape or resist abuse. This inability is powerfully described in a disabled victim's account of sexual assault by a "caregiver" (Anonymous,1988).

Our own pilot data (following) and published accounts also suggest that even when abuse is reported, police, courts, and social agencies are often unwilling to pursue charges when the victim is disabled (Senn, 1987). Hebert, (1986, August) described a court experience of a victim, where the judge interpreted the manifestation of the victim's cerebral palsy as disrespect for the court proceedings. The issues that surround the acceptability of testimony of a child witness are complex, but the issues that surround the acceptability of testimony of an intellectually impaired or emotionally disturbed witness are equally complex (Robertson, 1987) and the combined circumstance most often puts the victim at an insurmountable disadvantage in our court system.

It is important to recognize in considering the ways in which disability may lead to sexual abuse, that it is often not the disability that appears to increase risk; it may be society's treatment of that disability that increases risk. Children with disabilities are more likely to live outside their natural families, and there is some reason to believe that this increases risk. Rindfleisch and Rabb (1984), in comparing the risk for abuse in a very large sample of children living in institutions with children in family environments, concluded that the risk is at least doubled in institutional settings. Van Dusen's (1987) report of 250 charges of sexual abuse against 14 staff members in a Quebec group home is unfortunately not a rare occurrence. The apparent increase in risk when a child is placed outside the natural family likely results from exposure to a larger number of caregivers and settings. Children removed from their homes are often moved through a number of settings, each with a number of caregivers. Assuming the same risk from each caregiver, the greater the number a child is exposed to, the greater the risk.

While victims of sexual abuse and exploitation are often disabled, the offender is also disabled in some cases. Intellectually impaired people are more likely to be institutionalized if they are unable to protect themselves, or if they are perceived as a threat to others (Robertson, 1987). This means that institutions commonly cluster sexually aggressive and assaultive individuals with defenseless victims.

Parental demoralization, family isolation, chronic parental anxiety, and family stress are among the factors identified by Meier (1978) as increasing risk for abuse. These same factors have been identified as typical effects on families of children with severe disabilities. Thus, it would appear that parental response to the child's disability may create a family environment with increased risk for abuse.

Finally, many of our current training strategies in special education may increase the potential vulnerability of disabled students. The current focus on compliance and generalization provide reasons for concern. It is interesting to note that the cumulative index for the Journal of Applied Behavior Analysis (1987) lists over 80 articles published over the past 20 years on the importance of teaching generalization (most with disabled subjects). Only four focus on discrimination skills. This means that disabled children are typically trained to comply with the instructions of any adult and that protest or resistance are punished. Such a student becomes the perfect target for abuse.

Sexual abuse increases the risk of disability. Physical abuse has often been the direct cause of disabilities in children. For example, Buchanan and Oliver (1977) found that 3% of the 140 mentally retarded children that they studied had definitely become disabled as a result of abuse. Abuse was a possible cause for mental handicap in another 8% and neglect appeared to be a major factor for 24%. Sexual abuse as a cause of disability may appear much less likely; however, the regression, withdrawal, and emotional reaction that commonly follow sexual abuse may aggravate or mimic intellectual and behavioural problems. As a result, some of these children may be diagnosed or regarded as disabled who would not be, prior to experiencing sexual abuse.

Third factor influences risk of disability and sexual abuse. A hypothesis of mutual causation implies that some third factor increases the probability of both disability and sexual abuse. For example, Browning and Boatman (1977) point out the role of paternal alcoholism in increased risk for incest. A study was conducted reviewing 14 incest cases which constituted 3.8% of new cases over a 14-month period. Four of the children were disabled, physically or mentally. Excessively high rates of depression in mothers and alcoholism in fathers were cited as contributing to incest. The existence of disabilities among some of the children as increasing their vulnerability is seen from a psychiatric viewpoint: such children may seek physical affection from parents as an assurance that they are loved.

COMMUNITY SERVICES SURVEY

A survey was developed to determine whether community services for the treatment and prevention of sexual abuse are available and/or appropriate for disabled victims. There were four major components of the survey: type of service provided, client characteristics, self-evaluation of services provided to disabled individuals, and risk factors for sexual abuse as a function of type of disability. The survey was four pages in length and contained 11 forced-choice and open-ended questions; a copy of the survey is contained in Appendix B.

As a preliminary step in a planned, extensive service availability and needs assessment project, the survey was mailed to community service agencies dealing directly and/or indirectly with sexual abuse. These agencies included rape crisis centers, groups dealing with victims of crime, and sex education groups. Sources for these agencies were the Services to Victims and Witnesses of Crime in Canada (Norquay & Weiler, 1981), the Directory of Canadian Associations (Land & Gallagher, 1986), and initial listings in the national directory of community sexual abuse service agencies being compiled by the Developmental Disabilities Centre.

The survey sample consisted of a cross-section of national community service agencies representing all provinces and both territories. Seventy-five surveys were mailed; 10 were returned as undeliverable. The recipients were instructed to complete the survey and return it anonymously. The surveys were not coded as to location of the agency and no accounting of agency response was attempted. Because of the nature of the sampling process and survey research methods, the results of the survey must be considered to be

preliminary and only tentatively indicative of national availability of treatment and prevention programs; the proposed extensive survey will follow more conventional survey research methods and procedures.

Nineteen (29%) of the surveys were returned in reasonably complete form. Eight (11%) additional agencies responded with letters indicating that their record-keeping did not adequately categorize the information that we requested or that the retrieval of the information requested would be too difficult and so they were unable to respond. Finally, several agencies telephoned to express their inability to respond. Due to the limited number of complete responses, rank order analyses rather than raw numbers or percentages are presented. Additional responses are still being received.

Type of Service Provided. Multiple services are provided by all but one respondent agency. Counselling (individual and family) is the most common service provided, followed by advocacy and education (sex education, public education, self-defense) which are provided with approximately equal frequencies. Eighteen of the agencies estimated the number of clients they serve each year; in total, these agencies served over 55,000 clients in the past year. Of those agencies that specified the nature of their client contact, the majority of their clients receive education, followed by counselling, referrals, and/or informational services, and crisis intervention. At first, the ranks for the nature of client contact seem to contradict the ranks for the type of services provided. However, educational programs are much less labor-intensive than counselling services; hence, many more clients can be served through educational services.

Client Characteristics. Approximately one-half of the clients served by the respondent agencies in the past year were over 21 years of age (51%). Adult clients are followed in frequency by adolescents between the ages of 13 and 21 years (41%); non-adolescent children represented a small minority of the clients (5%). The clients were predominantly female (86%).

Fourteen of the agencies have served disabled individuals in the past year; these clients generally account for a significant proportion of their clients, ranging from 1-70 % with a median of 13% disabled clients. Representation of physical, intellectual, and psychiatric impairments was approximately the same across the responding agencies; this is consistent with the literature (e.g., Tilelli, Turek, & Jaffe, 1980; Shah, Holloway & Vaikil, 1982; Browning & Boatman, 1977) citing approximately equal incidence of sexual abuse among the three classes of disability. One of the agencies reported that they had been in contact with, but unable to provide services to a number of severely and profoundly retarded victims.

Self-evaluation of services provided to disabled individuals. The community service agencies generally responded that the services they provide are sometimes or often appropriate to hearing impaired, visually impaired, psychiatrically impaired, physically disabled, or mildly retarded clients. Several agencies provide services that are sometimes appropriate for moderately mentally retarded individuals. Most agencies responded that they either don't serve, or do not provide services that are appropriate for severely or profoundly mentally retarded individuals.

Those agencies that do serve disabled people are likely to make modifications to their service programs that maximize either accessibility (e.g., wheelchair accessible offices for physically disabled clients, TTD or sign language interpreters for hearing impaired clients) or communication (e.g., visual or art therapy for hearing impaired clients, audiotapes for visually impaired clients, simple language and materials for mildly and moderately mentally retarded clients). Those agencies which experience difficulty serving disabled people cited the same factors (i.e., accessibility and communication) as problems they have encountered that limit their ability to serve disabled persons.

Even though they experienced difficulties serving disabled clients, most of the respondents believed hearing impaired, visually impaired, psychiatrically impaired, physically disabled, and mildly mentally retarded individuals should be served by the same agencies that provide services to individuals without disabilities rather than by specialized agencies. The respondents were equally split on whether moderately, severely,

and profoundly mentally retarded people should be served by the same or by specialized community agencies. These beliefs in service responsibilities depending on type of disability generally mirror the agencies' abilities to serve disabled people. Respondents were more likely to believe that a particular type of disabled individual is best served by a mainstream community agency if their own agency serves that type of person without too many difficulties or modifications.

Risk factors as a function of type of disability. Although very few disabled clients were served by the community service agencies in the past year, the respondents were almost unanimous in their belief that all disabled individuals are at greater risk for sexual abuse than the general population. Two respondents believed that hearing and visually impaired individuals were at the same risk for sexual abuse compared with the general population and two respondents felt that moderately, severely, and profoundly mentally retarded individuals experienced less risk.

The beliefs about increased risk factors obtained from the survey are entirely consistent with the data on incidence (see Table 1). However, the client contact results obtained from the preliminary survey are not consistent with perceived prevalence. Compared to the incidence statistics, discussed in the previous section, and as is demonstrated by the results of the victim survey, discussed in the next section, many disabled victims are simply not receiving any community assistance.

SEXUAL ABUSE AND SERVICE PROVISION SURVEY

A survey was developed to investigate services provided to disabled victims of sexual abuse. There were four major concerns addressed by the survey: [1] characteristics of the victims, offender, and, offense; [2] whether and how the victim's disability contributed to the victim's vulnerability to sexual abuse; [3] whether the offender was charged and/or convicted of the offense and, if the offender was not charged, whether the victim's disability was a contributing factor; and [4] the nature of and satisfaction with any community services obtained to treat and/or support the victim. The survey was two pages in length and consisted of 19 open-ended and forced choice questions: see Appendix C.

The survey was sent to a cross-section national sample of 170 agencies that aid disabled people, including community mental retardation groups, community cerebral palsy organizations, educational, vocational, and community living agencies, and groups dedicated to supporting and treating disabled victims of violence. The names and addresses of the agencies were obtained from directories and the national directory of community sexual abuse service agencies being compiled by the Developmental Disabilities Centre. A brief description of the project was provided to assist agencies in requesting reports. A copy of that description is included as Appendix D.

The recipients of the survey were instructed to disseminate the survey to any individual or group that was involved in or aware of any situation involving sexual abuse. The respondents were instructed not to include any information that would identify the victims, offender, reporter, or city and province of a criminal act; this was done to ensure confidentiality. Sixty-two completed reports have been received to date and additional reports are still coming in.

Characteristics of the victim, offender and offense. Victims of sexual abuse were most commonly adults (50%) and were less commonly adolescents (25%) or children (25%). In comparison with the community services survey, however, the victims' survey reveals a much greater percentage of child victims of sexual abuse than have been served by community agencies (18% victims as opposed to 8% served). Victims were predominantly female (80%).

Eighty percent of the victims were intellectually impaired; 27% of the victims had a physical impairment (generally cerebral palsy or paralysis - only one victim had a hearing impairment); and few (7%) were psychiatrically impaired. Of the total sample, 17% were multiply disabled. The victims' survey indicates many more mentally retarded victims than reported in the literature or served through the community services survey (with each source reporting intellectual impairment as representing an average of 33% of disabled victims).

Victims who were mentally retarded were most often adults (51%), followed by adolescents (23%) and children (26%); this breakdown mirrors the general age findings. Physical disabilities were somewhat more evenly distributed across age groups; 38% of the physically disabled victims were adults, 38% were adolescents, and 25% were children. Psychiatrically impaired victims were either adults (50%) or adolescents (50%). Breaking down the three variables of age, sex, and disability, the results reveal that the disabled person most at risk for sexual abuse is an intellectually impaired adult female.

Offenders were predominantly adults (85% - the remaining 15% were adolescents) and male (93%). Two-thirds of the offenders had no known disability; however, 25% were intellectually impaired, and 10% were physically disabled (generally hearing or visually impaired).

Offenders that were known to the victims (friend, acquaintance, coworker) comprised 33% of the sample; relatives (father, stepfather, uncle, stepbrother) comprised 32%; people in positions of authority (careworkers, supervisors) comprised 27%; and strangers comprised only 8% of the sample. Child victims were most often sexually abused by relatives (71%); adolescent victims were generally abused by either relatives (36%) or authority figures (43%); and adult victims were most often abused by people they knew (58%) or authority figures (31%). These results are consistent with the findings of Brookhouser, Sullivan, Scanlan, and Garbarino (1986), Shah, Holloway, and Vaikil (1982), and Tilelli, Turek, and Jaffe (1980), and demonstrate that those people in greatest contact with the victims are the most likely offenders.

Nonspecific or general statements about the type of abuse (e.g., sexual abuse, sexual exploitation, sexual assault) comprised 28% of the responses. Of the explicit responses, 51% reported fondling; 40% reported intercourse; 7% reported fellatio; 7% involved penetration with an object; 7% included physical abuse, and 11% were other types of sexual abuse (e. g., forced undressing, masturbation). There were no differences in type of offense as a function of age; across all three age groups, intercourse and fondling were the most common forms of abuse. Relatives were slightly more likely to engage in fondling and intercourse than were other known or authority figure offenders.

The offense was more likely to occur in a location associated with the victim (45% - victim's bedroom, bathroom, home), followed by a location associated with the offender (31% - offender's home or vehicle) and a public place (24% - workplace, bus stop). Younger and/or more disabled victims were more likely to be abused in a location associated with themselves; older and/or less disabled victims were more likely to be abused in a location associated with the offender. Again, these findings make sense; younger and more disabled people are more likely to remain in their own location whereas older and less disabled people are more mobile and therefore at greater risk for abuse outside of their home location. The results are also supported by the general findings reported in the literature (cf. Chamberlain, Rauh, Passer, McGrath, & Burket, 1984; Zirpoli, Snell, & Loyd, 1987).

Contribution of victim's disability to vulnerability. There were 51 responses to the questions concerning whether the victim's disability might have contributed to being at greater risk for the sexual abuse. The predominant comment, comprising 37% of the responses, had to do with the victim not having enough knowledge about appropriate sexual behaviours and/or how to defend against the assault. Although this lack of knowledge may be characteristic of mentally retarded and/or sheltered individuals, it can potentially be corrected through education. In addition, poor social skills (withdrawn, shy, unassertive) cited as responsible by 29% of the respondents, and abnormal respect for authority, cited by 14% of the

respondents, can also potentially be improved through appropriate sex education. Twenty-three percent of the respondents cited physical dependence or impairment as a factor; this was noted by all of the reporters for physically disabled victims; 9% cited poor or no language skills. In both types of situations, the victims were at least relatively helpless in either preventing or reporting the offense.

Contribution of victim's disability to legal action. Fourteen charges were laid (representing 23% of reported incidents), resulting in four convictions (representing 6% of reported incidents), one clearance of the charges (due to a lack of evidence), one unknown result; four cases are currently unresolved. There were 37 responses as to why no charges were laid. In 43% of the cases, the victim or caregivers declined to press charges. In 22% of the cases, authorities (police, lawyers, judges) declined to pursue charges, generally citing the victim as an incompetent witness. In 14% of the cases, insufficient material evidence was obtained. Many of the respondents were dissatisfied with the legal action taken or denied.

Community service contact and evaluation. Services for treatment of and/or support for the victim were sought in 82% of the cases. In rank order, the services contacted were: community social services (33% - social services, welfare, child and family services); counselling (29% - psychologist, counsellor, clergy); family or school or vocational centre (20%), specialized community (rape crisis centre, sexual assault centre), or medical (hospital, general practitioner services) (18%), and police or community living services groups (12% each).

Thirty-nine respondents evaluated the services that had been contacted and/or received. Thirty-eight percent responded that no special or modified services had been provided by the agencies but that they would have been helpful to serve the needs of the disabled victim; 10% responded that no special services had been received but the general services were adequate to meet the victim's needs. Twenty-six percent of the respondents indicated that special services were delivered and were appropriate for the disabled victim's needs; 26% replied that the special services received were still not adequate or appropriate. Older and/or less disabled victims were more likely to receive appropriate services; younger and/or more disabled victims were less likely to receive appropriate or even any services from community agencies.

CONCLUSIONS and RECOMMENDATIONS

In spite of the limitations of individual studies, the repeated finding that people with disabilities are at greater risk for sexual abuse leaves little doubt about these findings. Although most of the reviewed data came from outside of Canada, the consistency of our pilot data with the findings of the non-Canadian studies suggests that the findings reported elsewhere can be expected to generalize well to Canada. The extent of increased risk remains unclear, and although a number of factors appear as likely contributors, the mechanism for increased risk is uncertain. While recommending that research should move to more applied topics of prevention and victims' services, some further investigation of the mechanisms of increased risk may be helpful for accomplishing these ends and for increasing our understanding of risk factors for all children. Even if people with disabilities were at no greater risk than others in our society, it is imperative that appropriate prevention and treatment services be developed to meet the needs of this group of children and adults.

The literature reviewed here and our own pilot studies suggest that current services often fail to meet the needs of people with disabilities, and that failure becomes increasingly common as a function of the severity of the disability. It is time for researchers and clinicians to switch their focus from documenting the existence of this problem to develop the appropriate prevention and treatment services for people with disabilities.

In establishing appropriate services for children with disabilities, it is important to recognize general trends in service delivery for people with disabilities. Prevention and victims' services should be fully integrated with those services provided to non-disabled children and adults whenever possible. Efforts should be directed toward identification of resources and training required to enable generic community services to serve this population, not toward establishing separate services.

Special educators need to review the philosophy of curricula to increase focus on assertiveness, choice, discrimination of appropriate and inappropriate requests, and improved sex education. Legal safeguards, including standards for caregivers and improved legal rights for disabled victims of abuse, are also required.

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Appendix A

ANNOTATED BIBLIOGRAPHY:

SEXUAL ABUSE AND EXPLOITATION OF PEOPLE WITH HANDICAPS[3]

Prepared by

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The purpose of compiling this bibliography was to bring together literature from a wide range of disciplines and perspectives relevant to the sexual abuse of people with disabilities. In addition to research studies, this included position papers, program descriptions, clinical reports, and media accounts. In addition to manual search methods, references were located through electronic searches of eight major databases, and requests for information from Canadian and international organizations and individuals concerned with this topic.

This bibliography is organized in six major areas: *[1] sexual abuse and assault of people with disabilities, [2] abuse (physical, psychological, etc.) and disabilities, [3] sex education and disabilities, [4] sexuality and disabilities, [5] other relevant sexual abuse literature, and [6] other related material.* The section on *sexual abuse and assault of people with disabilities* contains references to materials most directly relevant to the study. The section on other forms of *abuse and disabilities* is included since some of the issues raised (e.g., increased risk, prevention, services for victims) may generalize to the area of sexual abuse and because some of these documents include information about sexual abuse in addition to other forms of abuse.The section on *sex education and disabilities* is included because the lack of appropriate sex education appears to be a factor increasing the vulnerability of some people with disabilities to sexual abuse. The section on *sexuality and disabilities* is included because the understanding of normal sexuality for people with disabilities is essential to the development of appropriate services for prevention of sexual abuse and for helping victims. *Other relevant sexual abuse literature* is included occasionally because it contains some information that appears to be important to the understanding of sexual abuse of people with disabilities, but is more frequently included to document the lack of consideration of special populations in the sexual abuse literature. Finally, *other related material* is included because some information that is not directly related to any of the other five categories appears important in the analysis and understanding of this phenomenon. English language literature is abstracted in English, and French language literature is abstracted in French.

Literature relevant to sexual abuse of children with disabilities has not been categorized separately from literature relevant to sexual assault of adults with disabilities because frequently the authors combine discussion of these topics and sometimes fail to clearly identify which group is being discussed. While some issues relevant to sexual abuse of children and sexual assault of adults with disabilities do generalize across the lifespan (e. g., many people with disabilities continue to require intimate contact with caregivers throughout their lives), it is important to recognize that the concerns for, and needs of children and adults with disabilities are distinct.

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[3]This bibliography was prepared as part of a project funded by Health and Welfare Canada under project number 6609-1465-CSA. Findings and opinions expressed are those of the investigators and not necessarily those of the Department.

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SEXUAL ABUSE AND ASSAULT OF PEOPLE WITH DISABILITIES

Aiello, D. (1986). Issues and concerns confronting disabled assault victims: Strategies for treatment and prevention. *Sexuality and Disability, 7* (3/4), 96-101.

Problems confronting disabled persons who have been sexually assaulted include lack of information, lack of transportation and communication difficulties.The article addresses what things should be included in counselling the disabled victim. It is noted that special accommodations need to be made in both medical and legal services to help disabled victims. Education is also needed for the disabled in areas of sexuality, empowerment, safety and self-defense.

Aiello, D., Capkin, L., & Catania, H. (1983). Strategies and techniques for serving the disabled assault victim: A pilot training program for providers and consumers. *Sexuality and Disability, 6* (3/4),135-144.

This article describes a training program on sexual assault and disability which was conducted by Moss Rehabilitation Hospital of Philadelphia. The purpose of the program was to provide information on medical, psychological, social and criminal justice concerns in the area of assault of the disabled. Four areas were addressed, including myths and attitudes concerning disabled rape victims, emergency crisis services to assault victims, the criminal justice process in relation to assault, and strategies for prevention.

Anderson, S. (Speaker). (1985) *Sexual abuse of the developmentally disabled.* (Cassette Recording L-172-14) [Available from the University of Alberta, Education Library].

This 104 minute cassette is a workshop presentation given by Shirley Anderson, a pediatrician working with the Seattle Rape Relief Crisis Centre. Much of the information presented is an account of the experience of the Seattle Centre in serving clients with a wide range of disabilities. Incidence and prevalence figures are cited, service delivery issues are discussed, and principles for accommodating special populations are presented. Figures reported suggest that problems of sexual abuse are as common or more common in this population than with the non-disabled population. Also, there is a tendency for underreporting of cases in this population that exceeds underreporting with other populations and that generic services require some specialization to meet the needs of this group.

Berkman, A. (1986). Professional responsibility: Confronting sexual abuse of people with disabilities. *Sexuality and Disability, 7*(3/4), 89-95.

Issues confronting health professionals when dealing with sexual abuse of the disabled fall into 3 areas: clinical , management, and personal. Clinical issues involve the needs and characteristics of this client population, for example, the acknowledgement of risk to this group is a necessary first step. Management issues concern how abuse is dealt with when discovered. Traditionally sex is seen as a private matter, but this view allows abuse to go undetected. Sexual abuse must be viewed first and foremost as a crime, not as a personal matter. Personal issues involve attitudes, values and beliefs of the health care professional about sexuality and exploitation. For example, a female professional may take a different view of reported abuse than a male would. Prevention should be a primary goal of any approach to sexual abuse, particularly since treatment can reach only a small percentage of victims because most are not identified. As well, research with children has shown that most abuse could have been prevented if information and education had been provided.

Brookhouser, P. E., Sullivan, P., Scanlan, J. M., & Garbarino, J. (1986). Identifying the sexually abused deaf child: The otolaryngologist's role. *Laryngoscope, 96,* 152-158.

As a primary physician for most deaf children, the otolaryngologist must be able to identify signs and symptoms of sexual abuse. Child sexual abuse is a topic of national concern as epidemiologic data indicate more than 100,000 American children become victims annually. This paper provides an overview of the incidence, demographic characteristics, risk factors, and dynamics of child sexual abuse within both the general handicapped and, specifically, the the hearing impaired populations. Strategies for identifying the sexually abused hearing impaired child are delineated including the physical appearance and behavioral manifestations of child victims, as well as the characteristics of abusive caretakers and perpetrators. Case summaries are presented which illustrate these characteristics. A national center specializing in the evaluation and treatment of abused handicapped children is described.

Browning, D. H., & Boatman, B. (1977). Incest: Children at risk. *American Journal of Psychiatry, 134*(1), 69-72.

A study was conducted reviewing 14 incest cases which constituted 3.8% of new cases over a 14 month period. Four of the children were handicapped , physically or mentally. Excessively high rates of depression in mothers and alcoholism in fathers were cited as contributing to incest. The existence of handicaps among some of the children as increasing their vulnerability is seen from a psychiatric viewpoint: such children may seek physical affection from parents as an assurance that they are loved.

Bus driver acquitted. (1987, June 23). *Chilliwack Valley Times*, pp. 1, 2.

The newspaper article states that a Chilliwack bus driver was acquitted in court on a charge of sexual assault against a thirty-five year old mentally handicapped woman. The article recounts that the driver stated that the woman approached him and kissed him while the woman states that the driver stopped the bus and sexually assaulted her. The judge stated that the difference between her story and the accused is substantial and acquitted the driver.

Cole, S. S. (1986). Facing the challenges of sexual abuse in persons with disabilities. *Sexuality and Disability, 7*(3/4), 71-87.

The presence of developmental or physical handicaps adds another dimension to sexual exploitation. The person who is dependent on relatives and care providers for personal care may be unable to distinguish appropriate affectionate behaviour and touch from exploitative touch. A first step toward prevention is the acknowledgement that sexual abuse is common. Programs which inform individuals of their rights to their own bodies must also be included. Indicators of sexual abuse are discussed, as are steps in recovery.

Corin, L. (1986). Sexual assault of the disabled: A survey of human service providers. Sexuality and Disability, 7(3/4), 110-116.

The paper describes an informal survey of human service providers in order to uncover the depth of the problem of sexual abuse of disabled adults and children. The results revealed a great deal of concern but few statistics to record the incidence of abuse. Following the survey a petition was organized for legislation to establish a commission for protection of disabled persons in Massachusetts.

Davies, R. K. (1979). Incest and vulnerable children. *Science News, 116*, 244-245.
The author found that 77% of a sample of 22 incest victims had abnormal electroencephalograph readings and 27% of the sample had overt seizure activity. These rates were 3 to 4 times those present in a control group of other hospital admissions.

Dealing with sexual abuse. (1987, April 27). *The Edmonton Sun*, p. 22.
This newspaper article discusses generally the problem of sexual abuse of handicapped children. It suggests the need for sex education of the handicapped.

Fifield, B. B. (1986). Ethical issues related to sexual abuse of disabled persons. *Sexuality and Disability*, 7(3/4), 102-109.
The author focuses on ethical issues for health professionals and in particular on how ethical standards may be applied when one is confronted with situations involving sexual abuse of disabled persons.

Foon, D. (1985). *Am I the only one?*. Vancouver: Douglas & McIntrye.
The book deals with individual stories of sexual assault. One of the stories concerns Vicki, who is deaf. It relates the fear of telling someone about the attack because Vicki thinks no one will believe her.

Grossman, R., & Sutherland, J. (Eds.). *Surviving sexual assault*. New York: Congdon & Weed.
The book deals generally on how to survive a sexual assault. It has a short section on the myths and realities of sexual assault of the handicapped person. Some suggestions for treatment of handicapped persons after assault are given.

Hawkins, W. E., & Duncan, D. F. (1985). Children's illnesses as risk factors for child abuse. *Psychological Reports, 56*, 638.
This study assessed whether children with chronic physical or mental health problems are overrepresented among victims of child abuse and neglect. Risk factors examined were: prior abuse, mental retardation, congenital physical handicaps, other physical handicaps, chronic illness, emotional disturbance, excessive crying, feeding problems and hyperactivity. When substantiated cases were compared to unsubstantiated cases, five risk factors were significantly more common among the former: chronic illness, emotional disturbance, hyperactivity, mental retardation and other physical handicaps. Emotional disturbance and mental retardation were most often indicated for substantiated abuse cases.

Hill, G. (1987, November). Sexual abuse and the mentally handicapped. *Child Sexual Abuse Newsletter*, p. 4.
The author discusses the importance of self-protection education for the mentally handicapped. Such education greatly reduces the chances of being exploited. Materials have been developed specifically for teaching sexuality concepts and self-protection to the mentally handicapped. The Seattle Rape Relief Developmental Disabilities Project is one such program. Level 1 is designed for children aged 6-11 and addresses incest and molestation.Level 2 is designed for ages 12 and up. Self-protection in social and home situations is the focus, along with assertiveness training.

Irving, K. Disabled women: The reality of assault.
The article advocates the lobbying of the provincial government in British Columbia to be more responsible for disabled women in the area of sexual assault. The article suggests that the public is unaware of the extent of the problem of sexual assault on disabled women. In 1983, the British Columbia Association for Mentally Handicapped People estimated that 90% of mentally disabled children were victims of sexual assault. Offenders are usually not caught or if caught are not brought before the court system. Victims of the attacks are not given the treatment needed, and special units should be accessible for disabled women who have been sexually assaulted.

Jailed for sexual assault. (1986, February 11). *The Upper Islander.*
The newspaper article states that a man was sentenced to four years in prison for sexually assaulting a mentally handicapped female over a period of three years during the time he was on probation for previous molesting offenses. The attacker had had two previous convictions of indecent assault on two young girls.

James, B., & Nasjleti, M. (1983). *Treating sexually abused children and their families.* Palo Alto: Consulting Psychologists Press.
Chapter three (p.25-33) presents profiles of mothers of incest victims: the passive child-woman mother; the intelligent, competent, distant mother; the rejecting, vindictive mother; and the psychotic or severely retarded mother. A severely retarded mother with no awareness of the inappropriateness of incestuous behavior may condone and actively participate in molestation of her own children. In such cases, the mother should not have custody of the child.

Jaudes, P. K., & Diamond, L.J. (1985). The handicapped child and child abuse. *Child Abuse and Neglect, 9,* 341-347.
For a group of children with handicaps, growth and development are also affected by abuse (including sexual abuse) and neglect. An understanding of the problems of the abused, handicapped child emerges from experience with 37 children with cerebral palsy who have been maltreated, coupled with a review of the literature in related areas. The authors identified the following four problems as crucial to the study of abuse and neglect to the child with handicaps: (1) abuse that causes handicaps, (2) abuse that occurs to the handicapped child, (3) compromises in care that can occur when the handicapped child becomes involved with the medical and legal systems, and (4) arrangements for foster care or other out-of-home placement for the child with handicaps. It is concluded that the very systems designed to protect and care for the child often fail, leaving the handicapped child without opportunity to reach developmental potential. In light of these observations, it is recommended that the pediatrician not only be aware of the existence of abuse and neglect in the population of handicapped children, but also serve in the dual role of coordinator of services and advocate for these children.

Krents, E., Schulman, V., & Brenner, S. (1987). Child abuse and the disabled child: Perspectives for parents. *Volta Review, 89*(5), 78-95.
The article focuses on the problem of child abuse, both physical and sexual. Providing a general background on this widespread problem, it describes disabled children's particular vulnerability to exploitation and abuse. Active roles schools and parents can assume to effectively confront and deal with this issue are described in detail. The need to intensify efforts to ensure that disabled children are provided both accurate information on sexual abuse and the necessary skills to protect themselves from victimization is stressed.

LaBarre, A. *Sexual abuse! What is it?* St. Paul: Hearing Impaired Health and Wellness.

The book is written for hearing impaired adolescents and young adults in an effort to prevent sexual abuse by giving them important information about safety issues. The book covers topics such as; (a) what sexual abuse is, (b) what some of the safety issues to be aware of are, (c) who the offenders are, and (d) what to do if it happens to someone. The book is written in a very simple and easily understood style. There are many illustrations which support the concepts presented. The book is a resource for parents to share with their hearing impaired adolescent and it also serves as a helpful educational tool for educators, counsellors, and other professionals working with hearing impaired individuals.

Longo, R. E., & Gochenor, C. (1981). Sexual assault of handicapped individuals. *Journal of Rehabilitation, 47*, 24-27.

The authors explore the relationship between handicaps and assault. They point to statements by convicted sex offenders that they have selected victims on the basis of their perception of how vulnerable the potential victim would be.

Man cleared (1987, May 11). *Kamloops News.*

A 41-year-old man was cleared of sexually assaulting a retarded teenager because he said she was willing. The judge described the occurrence as outrageous and unforgivable but he said he had to acquit the man because the accused believed there was consent, a legal defense against the charge.

Man jailed for attack on disabled woman. (1987, July 9). *Toronto Star*, p. A2.

The newspaper article reports that a man who sexually assaulted a one-armed, 73-year-old woman on her way to morning prayers received a sentence of 18 months in jail. The attacker was known to be abused in his own childhood and had schizophrenia.

Man judged not guilty of sex assault. (1987, June 26). *Comox District Free Press*, pp. 1, 3.

The newspaper article states that a part-time group home "parent" working with or supervising residents was found not guilty of sexually assaulting three mentally handicapped men. The trial was taken up by determining whether the three complainants were mentally competent and whether they were competent to take an oath. It was also noted that the judge relied on the psychologist's opinion that there is a tendency on the part of mentally handicapped people to want to please and thus if they sense that a person questioning them is seeking the answer "yes" or "no" they might give that answer in error. The psychologist also testified that mentally handicapped people may have poorer than normal memories and also might have difficulty determining the sequence of events. During the trial all three of these points became evident.

Martorana, G. R. (1985, June). Schizophreniform disorder in a mentally retarded adolescent boy following sexual victimization (Letter to the editor). *American Journal of Psychiatry, 142*(6), 784.

The letter to the editor is a comment on an earlier article in the journal about three female adolescents who developed psychoses after sexual assault, and their subsequent treatment. The writer tells of a case involving a 14 year old mentally retarded male who was sexually assaulted and developed a psychosis after the attack. The writer describes the child's subsequent treatment and recovery.

McCay, V. (1984, September). Sexual abuse (Editorial). *American Annals of the Deaf, 129*(4), 351.

The editorial discusses the issue of sexual abuse of deaf children. The opinion is expressed that the best approach to the problem is prevention. Careful hiring procedures of staff is the first step since in most cases the attacker is a member of the staff. It is imperative that once the incident has been discovered that it is brought to the attention of the administration and handled appropriately.

McCown, D. E. (1981). Father-daughter incest: A family problem. *Pediatric Nursing*, 7(4), 25-28.

The article deals generally with the problem of father-daughter incest. The article provides a composite description of the incestuous family. The child victim of incest is usually the eldest daughter living at home. There is a higher rate of incest reported in girls who are deaf, disfigured, seizure-disordered, or illegitimate. The author describes the long term effects of incest, the law regarding incest, the treatment of incest and preventive measures.

McCrone, W. P., Ziezula, F. R., & Robinson, D. (1985). Preventing child abuse. *Perspectives for Teachers of the Hearing Impaired, 3*(5), 11-13.

The article contains a bibliography of 78 resources relating to child abuse. Included are references on sexual and institutional abuse, legal aspects, personnel training, and prevention and protection programs.

MD guilty on sex charge. (1987, October 25). *The Province.*

A local pediatrician was convicted of sexually assaulting a mentally retarded girl. He was acquitted on one charge but convicted on another based on the testimony of a nurse who saw him fondle the girl while in bed.

Meier, J. H., & Sloan, M. P. (1984). The severely handicapped and child abuse. In J. Blacher (Ed.), *Severely handicapped young children and their families* (pp. 247-274). Orlando, FL: Academic Press.

The authors point out the uncertainty of the relationship between the contribution of abuse to developmental delays and the contribution of developmental delays to abuse.This chapter's primary focus is on physical abuse, not sexual abuse, but many of the issues raised appear to generalize across these two forms of abuse. They point out that the majority of children who are victims of physical abuse suffer from developmental handicaps.

Melberg, K. (1984, April). The silent epidemic. *SAMR Dialect*, p. 8.

The author discusses changes to the Criminal Code which now offer protection for all persons, including the mentally handicapped. Abuse must be brought out into the open, or laws will be useless. As well, prevention and treatment programs cannot be developed unless the problem is acknowledged. Advocates for the mentally handicapped must both ensure exploitation doesn't occur and recognize the individual's right to choose how they live (not to be overprotected).

Melberg, K. (1984, June). The silent epidemic. *SAMR Dialect*, p. 11-12.
In the second part of her series, the author addresses the issue of mentally handicapped assault victims whose court cases have resulted in acquittal or dismissal due to the court's position that the victims are not reliable witnesses. Advocates of the mentally handicapped believe that responsibility lies with advocates and members of the justice system to ensure the rights of the mentally handicapped are upheld. In particular, interpreters could be used in court to overcome communication problems.To achieve the goal of successful prosecution of these crimes, lawyers need to familiarize themselves with the mentally handicapped population and professionals working with the mentally handicapped need to acquaint themselves with the workings of the legal system.

Melberg, K. (1984 August). The silent epidemic. *SAMR Dialect*, p. 10.
The author discusses the options available when a mentally handicapped person is sexually assaulted. An alternative to a criminal charge is a complaint of sexual harassment under the Human Rights Code. In such a case, the burden of proof is not as severe, since no jail term is involved. In court cases, spending time with the mentally handicapped victim can help assure the victim. However, the prosecutor's case is only as strong as the witness. Since the evidence given by the mentally handicapped usually isn't given much weight, education of police, lawyers and judges must occur before changes in attitude will take place.

Melberg, K. (1985, December). The silent epidemic. *SAMR Dialect*, p. 6
Greater awareness among police, social workers, prosecutors and judges is needed to deal with abuse of the handicapped. Although these professionals have a mandate to work with the abused child, many are not comfortable with children and this type of crime, whether the child is handicapped of not. It is very difficult to have evidence given by children under 10 admitted in court; because of believability. Preparing children for the courtroom experience ahead of time has been helpful in obtaining strong evidence from children. The use of interpreters for the handicapped must at the least, be tried.

Mogilla, R. (1986). Sexual abuse and disability. *SIECUS Report*, 9-10.
The author tells the true story of a disabled girl who was sexually assaulted by her stepfather. The story is only one of numerous cases. A review of the statistics available on sexual assault of the disabled is given. A general overview of the problem is briefly discussed.

More abuse found in disabled. (1987, March 31). *Winnipeg Free Press.*
The newspaper gives a report done in Ontario on the abuse of disabled women as compared to non-disabled women. The article discusses the findings of the survey on 62 disabled and non-disabled women. The author of the report was in Winnipeg for a weekend conference with members of a group call Disabled Women's Network.

Rinear, E. E. (1985). Sexual assault and the handicapped victim. In A. W. Burgess (Ed.), *Rape and sexual assault* (pp. 139-145). New York: Garland Publishing.

The chapter discusses the problem of sexual assault of handicapped persons. A handicapped person is more vulnerable to sexual assault and may also face a number of additional problems. Emotionally handicapped individuals may find that others fail to believe that they were actually assaulted or victimized. Individuals with physical and perceptual handicaps may also be targeted as victims of sexual offenders because of their restricted abilities. Handicapped persons are also limited in the type and amount of resistance that they are able to mount against their assailants. Handicapped individuals who are dependent on others may be exploited by offenders who manipulate the victim's dependence. The article discusses the coping behaviours used by rape victims . These can be viewed as comprising three distinct phases: 1) the threat of attack; 2) the attack itself; and 3) the period immediately thereafter. The article also discusses possible methods of prevention of victimization of handicapped people. Possible preventative methods are self-defense classes for handicapped persons, crisis centers and support group availability, education of the public and prosecutors, and educational programs implemented in institutions.

Ryerson, E. (1981). Sexual abuse of disabled persons and prevention alternatives. In Bullard, D.G., & Knight, S.E. (Eds.). *Sexuality and physical disability: Personal perspectives* (pp.235-242). St. Louis: C.V. Mosby.

This chapter was instrumental in raising the public awareness of the nature and extent of the problem of sexual abuse for people with disabilities. It also describes the Seattle Rape Relief Crisis Centre's work with people with disabilities. This program was one of the first to attempt to recognize and meet the unique challenges of this group and has become a model for programs internationally.

S., M.J., & K., S. D. (1984, September). Abuse of children with disabilities - time to stop pretending (Editorial). *Exceptional Parent, 14*(6), 16-18.

The editorial states the reasons that children with disabilities are more likely to be abused than other children. The reasons are that caring for children with disabilities usually increases stress, requires more time, energy and interest, and that these children are more dependent than non-disabled children.

Schaefer, G. (1987, July 5). Molester "sorry". *The Province.*

The newspaper article is a report of a sentencing hearing of a 53-year old former Surrey school trustee who had pleaded guilty to 10 counts of molesting eight foster children. The man now states that he is sorry for his actions. Some of his victims were mentally retarded children placed in his care by the B.C. government.

Schor, D. P. (1987). Sex and sexual abuse of developmentally disabled adolescents. *Seminars in Adolescent Medicine*, *3*(1), 1-7.

The author discusses aspects of sexuality and sexual abuse of adolescents who are developmentally disabled. The developmentally disabled adolescent has difficulties in achieving maturation and independence, partly due to being dependent on others for physical care. As well, caregivers and school personnel may be overprotective and inhibit the child's learning of self-care and social skills. The author uses Finkelhor's (1984) Four Preconditions of Sexual Abuse model to explain the victimization of handicapped adolescents. The model suggests the presence within the potential offender of a motivation to sexually abuse a child, the overcoming of internal and external inhibitions against acting on this motivation, and the overcoming of the child's resistance. In applying the model, the author points to motivational factors of the perpetrator involving attraction to child-like behaviour of certain retarded adolescents and satisfaction in engaging in an adult relationship without accompanying adult emotional interaction. It may be easier for the perpetrator to overcome internal (societal) inhibitions to abuse in a society that devalues mentally handicapped people. Since the mentally handicapped are often stereotyped as having abnormal sex drives, prohibitions may be further weakened. Overcoming external (situational) inhibitions may be easier because mentally handicapped adolescents have fewer situational safeguards to protect them from sexual exploitation. These adolescents lead more isolated lives and are often cared for by surrogates who can restrict access to outsiders. Typically the child is unaware of how to obtain help if a problem arises. Characteristics of the mentally handicapped can contribute to the perpetrator's overcoming of the child's resistance. They are often more easily led and have a greater need to please others. Often they are lacking attention and affection. They may have no sex education. In addition, they may face being disbelieved or may lack communication skills to report abuse. The author discusses prevention, noting that programs to prevent sexual abuse of developmentally disabled adolescents are rare. However, information on this group is readily available for caregivers. There has also been an increased awareness of stresses placed on families with disabled children and many physicians recognize that some children are at greater risk for abuse due to their individual behaviour. Activities or programs to assist in attaining independence and social competency can reduce vulnerability. Sex education, including abuse prevention can serve to protect many developmentally disabled adolescents.

Seemanova, E. (1971). A study of the children of incestuous matings. *Human Heredity, 21*, 108-128.

Mental retardation was found in 14% of mothers of children born as a result of incestuous relationships, about 460 times the number expected by chance. The author does not control for any increased expectation of mentally handicapped woman being more likely to conceive children as a result of incest, or of differences in case finding in handicapped and nonhandicapped populations.

Senn, C. Y. (1987). *Issues and questions involved in the sexual abuse of persons with intellectual impairments.* Downsview, Ontario: G. Allan Roeher Institute.

This 211 page report prepared for the Family Violence Prevention Division of Health and Welfare Canada provides a thorough treatment of its topic. The author summarizes a number of studies which appear to show increased risk of sexual abuse for people with intellectual impairments, though indicating caution in interpretation because estimates by researchers of this and the non-disabled population vary widely . Senn points out difficulties in obtaining data from institutional settings, but presents indirect evidence of sexual abuse problems in institutions, and explores developmental disabilities as a risk factor. She concludes that people with intellectual impairment experience at least equal risk for sexual abuse. Finkelhor's model of risk factors is used as a conceptual basis for explaining increased risk among children with intellectual impairments. Symptoms of child sexual abuse are discussed in relation to children with intellectual impairment. The author summarizes information on sexual offenders with disabilities, pointing out that many of these offenders had been victims of sexual abuse as children. Legal issues related to consent, ability to testify in court, and charter implications are explored. Detailed recommendations for prevention and treatment are included. The report includes a long list of references, including many unpublished and hard to find documents.

Starr, R., Dietrich, K. N., Fischhoff, J., Ceresnie, S., & Zweier, D. (1984). The contribution of handicapping conditions to child abuse. *Topics in Early Childhood Special Education, 4*(1), 55-69.

The literature on the contribution of low birthweight, perinatal problems, congenital disorders, and mental retardation to child abuse is reviewed. While existing transactional and ecological theories suggest such child factors should contribute to abuse, a careful analysis of studies indicates handicapping conditions are not major causal factors. Results of prospective, longitudinal research suggest that minor deviations in child behavior rather than major handicaps are related to the occurrence of abuse. Efforts to help families adjust to having a handicapped child, while helpful in alleviating the stresses in such families, will not have a major impact on the incidence of abuse.

Stuart, C. (1986). Helping physically disabled victims of sexual assault. *Medical Aspects of Human Sexuality, 20*(11), 101-102.

The article explains the approach a physician should take when dealing with a physically disabled victim. The physician must be aware of the two myths about sexual assault of disabled victims: 1) Disabled people are immune to sexual assault and 2) only woman are raped. There are four stages of recovery; (1) shock, (2) anger, (3) understanding and acceptance, and (4) integration into life experience. For physically disabled victims, there may be more difficulty in negotiating these stages than for an able-bodied victim. The physician's role is to provide for the physical and emotional needs of the victim and to gather medical evidence for possible prosecution of the perpetrator. It is important to remember that the disabled have an additional need: to be allowed to make decisions for themselves. The decision to be made involves the crime itself and how the victim will deal with it.

Stuart, C. K., & Stuart, V. W. (1981). Sexual assault: Disabled perspective. *Sexuality and Disability, 4*(4), 246-253.

The article discusses sexual assault against disabled persons with regard to common myths about sexual assault, defense against assault, rape, recovery from assault, and suggestions for assisting disabled sexual assault victims.

Szymanski, L. S., & Jansen, P. E. (1980). Assessment of sexuality and sexual vulnerability of retarded persons. In L. S. Szymanski & P. E. Tanguay (Eds.), *Emotional disorders of mentally retarded persons* (pp. 111-128). Baltimore: University Park Press.

The authors note that most often sexual abuse is perpetrated not by the delinquent individuals, but by society and its laws. There are references given to the studies and laws which deny the right of sexual expression to retarded persons. The authors discuss; (a) sexuality of retarded persons as a genetic threat to society, (b) sexuality of institutionalized retarded persons, (c) unconstitutionality of laws restricting sexuality of retarded persons, (d) prevention and management of sexual abuse of retarded persons, (e) treatment of sexual abuse, and (6) prevention of sexual abuse.

Van Dusen, L. (November 2, 1987). ' We just want the truth,' *Maclean's, 100* (44), 56, 58.

In 1986, Montréal police laid 250 charges against 14 people after investigating sexual abuse in a group home. Charges were all dropped one year later after determination that the witnesses, between 8 and 12 years old, would not provide reliable testimony. Quebec officials indicated that in spite of the high number of charges, the case has not produced wide-scale public interest because it is outside the mainstream of regular schools and daycares.

Washington State Department of Social and Health Services. (1983). *Sexual exploitation: What parents of handicapped persons should know.* Olympia: Author. (EDRS No. 258 408).

This brochure defines five major areas of sexual exploitation under Washington State law. Changes in child behaviour that may indicate victimization are discussed, as well as immediate and long-term action that parents can take. Also described are services offered by the Seattle Rape Relief Developmental Disabilities Project.

Vocational & Rehabilitation Research Institute. (1986). *Sexual assault manual: Information and procedures following a sexual assault.* Calgary: Author.

This manual provides practical procedures and information for parents, teachers, and other caregivers regarding what to do after a sexual assault has occurred that involves a victim with disabilities. It includes useful guidelines for interacting with medical and law enforcement services. It explores special issues regarding the recognition of physical and emotional trauma in victims with disabilities and suggests supportive measures. Many forms are provided for reporting the assault and documenting post-assault services. Some content is specific to Alberta or to Calgary, but much can be easily generalized to other locations.

Watson, J.D. (1984). Talking about the best kept secret: Sexual abuse and children with disabilities. *Exceptional Parent, 14*(6), 18-23.

Children with disabilities are more vulnerable to sexual abuse, as they are likely to be more dependent, physically and psychologically, on adults. Poor social judgement and lack of experience about appropriate sexual behaviour can leave a child unable to recognize deviant behaviour. Although disabled children may be physically or psychologically unable to report sexual abuse, they may display symptoms that parents and teachers should recognize. Responses to abuse and preventive measures are also discussed.

Zirpoli, T.J. (1986). Child abuse and children with handicaps. *Remedial and Special Education*, 7(2), 39-48.

The article reviews factors contributing to parental physical abuse of children with handicaps. Abuse was found to be a response to an interaction of variables within the parent, the child and the environment. These variables were found to be associated with many characteristics of families who had children with handicaps. Characteristics of abused children were found to be similar to characteristics of many children with handicaps. As well, children with handicaps were found to be at considerable risk for abuse and in fact, were disproportionately represented in child abuse samples. Intervention and the role of educators is also discussed.

ABUSE (PHYSICAL, PSYCHOLOGICAL, ETC.) AND DISABILITIES

Ad Hoc Committee on Adults in Need of Protection. (1987, November 5). *A review of proposed legislation: Adult Protection Act.* A paper presented to special legislative committee on bill 77, Adult Protection Act, Charlottetown, Prince Edward Island.

The paper is a presentation by the Ad Hoc Committee on Adults in Need of Protection on the proposed legislation, Adult Protection Act, to the special legislative committee holding hearings on the act. The paper states that there are a large number of dependent adults (including the elderly and the physically and mentally disabled) who are abused and neglected. The definition of abuse includes both physical, mental and financial. The committee recommends the following: (a) The justice system must accommodate the act by sentencing which reflects the seriousness of the crime and by reduced delays to time of trial, (b) Reporting of abuse should be mandatory, (c) Accountability and the possibility of being charged need to be made clear in the legislation, (d) The definition of "in need of protection" owing to physical or mental infirmity should be reworded to mean physical or mental disability (or mentally handicapped), (e) The act looks at short term intervention which could lead to further abuse should the adult return to his former situation, (f) The act could penalize individuals financially if they have to bear the costs of medical attention and legal action arranged for them by the Minister/Court, (g) The Act takes all responsibility away from health professionals and institutions for treatment by removing all liability, (h) Intervention has to be in the best interests of the individual, allowing the individual to make his/her own choices, (i) A major campaign must be directed to raise public consciousness, resulting in increased awareness and affecting change in the attitudes of care-givers who abuse or neglect, (j) A method of reporting adult abuse or neglect must be designed to deal with increased public involvement, (k) Education and support of care-givers is essential, and (l) the Department of Health and Social Services must give attention to necessary staffing levels to accommodate this act.

Adler, R. (1986). Physical maltreatment of children. *Australian and New Zealand Journal of Psychiatry, 20*, 404-412.

The author discusses abuse in regard to parent factors, infant factors and parent-child interaction. In relation to infant factors, two studies are cited which deal with handicaps and abuse. The author states that the evidence is difficult to interpret since it is not clear whether the abuse is caused by, or due to the handicap. As well, the author finds little to suggest that infants with difficult temperments are more likely to be abused, but believes further study is warranted. In the area of prevention, the author maintains that before prevention programs can be implemented, it is necessary to predict vulnerable families. Prediction instruments have been used, but there are many problems with them. These include uncertain sensitivity or specificity, the risk of labelling and creating self-fulfilling prophecies, and the risk of overpredicting in disorders of low incidence.

Andre, C. E. (1985). Child maltreatment and handicapped children: An examination of family characteristics and service provision. *Dissertation Abstracts International, 46*(3), 792-A..

Studies on child maltreatment have revealed that a disproportionate number of maltreated children are handicapped. Research has suggested not only that handicapped children may be at greater risk for maltreatment than nonhandicapped children, but also, that children may develop handicaps as a consequence of maltreatment. The purpose of this study was threefold: 1) to estimate the prevalence of handicapped children in the population of children served by public social service agencies; 2) to identify differences between handicapped and nonhandicapped groups with respect to family characteristics which differentiate maltreated children from non-maltreated children in each group; 3) to examine the nature of services provided to handicapped and nonhandicapped maltreated children. A sample comprised of 308 handicapped maltreated children, 301 handicapped non-maltreated children, 295 nonhandicapped maltreated children, and 319 nonhandicapped non-maltreated children was drawn from a nationally representative stratified random sample of children receiving public social services in 1977 surveyed by WESTAT, inc. under contract to the U. S. Children's Bureau. Data were analyzed using bivariate correlation analysis, two-way analysis of variance, and discriminant analysis of variance, and discriminant analysis. Findings revealed a higher prevalence of handicapped children among maltreated children (23%) than among all children served by public social service agencies (16%). Handicapped maltreated children were distinguished by a higher incidence of substance abuse and emotional problems among their care-givers and by their greater likelihood of not being under parental custody. These children were also the children most likely to be in out-of-home placements. With the exception of the provision of protective services, there was little discrimination in the service response to maltreated children, handicapped or otherwise, and non-maltreated children. A lack of child-oriented services to handicapped and nonhandicapped maltreated children, such as counselling or mental health services, was notable. Findings suggest that handicapped and nonhandicapped maltreated children may be subject to professional neglect. The relative lack of child-oriented services to these children must be addressed by service planners. Also, the large proportion of handicapped maltreated children in long-term placement indicates a need for services designed to facilitate a child's return to the natural family or for arrangements for permanent placement through adoption.

Bellett, G. (1985, June 10). Friends of the handicapped seek ways to prevent abuse. *Vancouver Sun*, p. A14.

The newspaper article reports that the group, British Columbians for Mentally Handicapped People has urged Attorney-General Brian Smith to give authorities the right to apprehend mentally handicapped adults suspected of being physically or sexually abused. The group is asking for legislation to protect hundreds of mentally handicapped people living in private homes or in centres operated for profit.

Bill 77: *Adult Protection Act.* (1987). Prince Edward Island.

The purpose of this bill is to recognize responsibility for the provision of assistance and protective services to dependent adults who are incapable of providing necessary care for themselves or who are the victims of abuse or neglect by those responsible for their care. Abuse includes offensive mistreatment, whether physical, sexual, mental, emotional, material or any combination thereof, that causes or is reasonably likely to cause the victim severe physical or psychological harm or significant material loss to his/her estate. Neglect means a lack of or failure to provide necessary care, aid, guidance or attention which causes or is reasonably likely to cause the victim severe physical or psychological harm or significant material loss to his/her estate. A dependent adult includes mentally, and physically handicapped adults including the elderly. The Act is to be applied with respect to the following principles: (a) Persons with disabilities deserve quality of treatment, care and attention, (b) Disabled persons have a need for self-determination and to have their person, estate and civil rights protected, (c) An adult is entitled to live in the manner he/she wishes provided that is his/her conscious choice and, (d) Any intervention should be designed for specific needs of the adult, limited in scope, and subject to review and revision. Section 4 of the bill provides for reporting of cases of persons in need of assistance or protection. Reporting is not mandatory. Persons in need of assistance includes an adult who is a victim of abuse by someone having recognized supervisory responsibility for the person's well-being. Once a report is made, the Minister may direct his officials to conduct an investigation and if that reveals cause for concern, a full assessment of the social, economic, and medical circumstances may be undertaken. If the person is determined to be in need of protection or assistance, the Minister under section 8 may prepare a case plan to remedy the problem. It is intended that the case plan be developed on a cooperative basis taking into account the wishes of the person and the observations of the person having supervisory responsibility. The assistance given (section 10) may include provision of, arrangement of payment for, or referral to counselling, speech and hearing therapy, occupational therapy and physiotherapy, legal counsel and financial management, application for trustee or guardianship functions, residential accommodation and personal nursing care, and any other health, social or other type of service that may be determined necessary for the person's welfare. Section 12 authorizes the court to make a protective intervention order which may include directions concerning the conduct of a person found to be a source of harm or danger to the person in need of protection. Sections 15 to 19 provide for guardianship of the person or estate of the person requiring assistance or protection. It is incumbent on the Minister to show that protective intervention is in the best interests of the person and that the least intrusive option is being sought. An order for protective intervention must be reviewed within six months from the date it is made. Sections 23 and 24 relate to emergency intervention, without a court order, to protect the person or estate. The Minister is obliged to explain in simple terms to the person affected and the person providing care what assistance or other intervention is proposed to be given. The bill also relieves the health-care professional or institution or its staff of liability in rendering treatment to a person who is in need of assistance or protection.

Buchanan, A. & Oliver, J. E. (1977). Abuse and neglect as a cause of mental retardation: A study of 140 children admitted to subnormality hospitals in Wiltshire. *British Journal of Psychiatry, 131*, 458-467.

This survey of 140 children under 16 in two subnormality hospitals showed that 3 per cent of the children had definitely been rendered mentally handicapped as a consequence of violent abuse, and that a possible maximum total of 11 percent might have been thus rendered mentally handicapped. In 24 per cent of the children, neglect was considered to be a contributory factor in reducing intellectual potential. Impairment of intellect from abuse and neglect, especially in those with "vulnerable" brains due to pre-existing abnormality, may be much more common than is generally realized .

Camblin, L. D., Jr. (1982). A survey of state efforts in gathering information on child abuse and neglect in handicapped populations. *Child Abuse and Neglect, 6*(4), 465-472.

This article reports on a survey of the 50 states and the District of Columbia in regard to reporting of abuse and neglect of handicapped children. Of 51 respondents, 7 did not have a standardized reporting form. Forty-four states do use either a national or state form. It was found that of this group, 18 (40.9 %) forms do not mention pre-existing handicaps. Much variation in reporting style was found among the 26 states which do gather information on handicapping conditions. Respondents were also asked about accuracy of information submitted by local resources on abuse of handicapped children. Forty-three percent of state representatives reported that locally collected information was inaccurate. Forty-one percent stated their information was accurate, but not one agency claimed it was precise. The remaining 15.6 % either did not respond or did not know if the information was accurate. The author states that in order for the true relationship of handicaps to abuse to be understood, state representatives must ensure this information is collected in a uniform manner.

Caplan, P. (1986). Is there a relationship between child abuse and learning disability? *Canadian Journal of Behavioural Science, 18*(4), 367-38.

It has been suggested that there is a relationship between child abuse and learning disability. Perhaps child abuse causes learning disability; perhaps learning disability places a child at particular risk for being abuse; perhaps both are true. No adequate investigation of the possible relationships of child abuse to learning disability can be carried out in the absence of adequate, consensual definitions of "child abuse" and "learning disability", and such definitions have been lacking in the work done thus far. Furthermore, the extant research has been plagued by methodological problems, which further impede a clear view of a possible cause-effect relationship. This paper is a review of the pertinent studies that have been done, with an analysis of their shortcomings. It is concluded that at this time, despite the fact that case reports link child abuse with learning disability in some individual cases, there is no evidence either that abused children are more likely than nonabused children to have a learning disability or that learning disabled children are more likely than children without learning disabilities to be abused.

Child abuse and cerebral palsy. (1983, May 21 - Editorial). *The Lancet*, p. 1143.

The editorial reviews the findings of a recent study which discusses a disturbing two-way relationship between child abuse and cerebral palsy. The study by Diamond and Jaudes revealed that some cerebral palsy is caused by abuse, but that those with cerebral palsy are also at risk for abuse. The editorial states that based on this finding more studies should be done to examine conditions which lead to abuse of cerebral palsy victims.

Coon, K. B., Beck, F. W., & Coon, R. C. (1980). Implications for evaluating abused children. *Child Abuse and Neglect, 4*,153-156.

The article reports results of a study of identified child abuse victims. School records were obtained with regard to behavioral problems, suspensions and referral to special education classes. Results showed that all students had normal grades. Suspensions were in line with the rest of the school population. Eleven of 55 students were referred for special education evaluation. Two of these were found to have no learning problems. Of the other 9 students, 2 were designated as emotionally disturbed, 2 as educable mentally retarded, 3 as learning disabled and 2 as slow learners. The authors conclude that a "strong possibility " has been raised that earlier in-house outcome studies of abused children overestimated the percentage of developmental disabilities.

Diamond, L. J., & Jaudes, P. K. (1983). Child abuse in a cerebral-palsied population. ***Developmental Medicine and Child Neurology, 25,*** **169-174.**

Of cerebral-palsied children seen in one care center over a 12-month period, 17 had been subject to child abuse. Eight of these children's cerebral palsy was a result of abuse. The findings suggest that there is a high incidence of child abuse among children with cerebral palsy. There is a "double indication " for abuse, both as a cause and a result of cerebral palsy.

Disabled women more likely to be battered, survey suggests. (1987, April 1). ***Toronto Star,*** **p. F9.**

The newspaper reports on the finding that disabled women are more likely than non-disabled to be victims of battering and sexual assault, especially when they are young. The report based on a survey of 62 women by the Ontario Ministry of Community and Social Services discovered almost half of those disabled had been sexually assaulted as children, compared to 34 percent for non-disabled. Sixty-seven percent of disabled women reported being battered as children while only 34 per cent of non-disabled women reported abuse during childhood. Thirty-three percent of the disabled women reported they have been battered during their adult years, mostly by husbands, while only 22 per cent of non-disabled women reported similar abuse. For sexual abuse, the survey found more non-disabled women - 31 per cent - reported being sexually assaulted as adults, compared with 23 percent of the disabled women.

Disabled Women's Network Toronto. (1987). ***Violent acts against disabled women*** **(Research rep.). Toronto, Ontario: Author.**

The report determined the incidence of violent assault against disabled women. The study was conducted with 30 disabled participants and 32 non-disabled participants. Each of the participants was given a questionnaire to complete. The questionnaire was divided into eight sections: background information, child physical abuse, child sexual abuse, adult physical abuse, adult sexual abuse, medical assault, and a section for comments. Under the section on background, the report collated results on the types of disability, living situation, financial status, and marital status of the disabled women. Under the other sections, the report collated results of the frequency, duration and identification of the assailant. The report found that over two thirds of the disabled women reported that they had been battered as children. Almost half of the disabled women had been sexually abused as children. One third had been battered as adults. Almost one quarter had been sexually assaulted during adulthood. Almost two-thirds had been medically assaulted. Not only is the incidence of violence against disabled women extremely high, but disabled women the figures indicate, are more likely to be assaulted or abused than non-disabled women. The only exception to this is in the area of adult sexual assault where about 10 percent more non-disabled women are assaulted.

Fine, M. J. (1986). Intervening with abusing parents of handicapped children. *Techniques, 2*(4), 353-363.

The author examines abuse of handicapped children in terms of systems theory. A case history of one family is presented. In the view of systems theory, parents bring to the family experiences from their families of origin. Stability, coping skills, supportiveness and religious beliefs brought to the family will vary. The introduction of a handicapped child may seem to be the cause of the family's stress, but other family stresses, transitions, and unresolved issues between the parents need to be looked at. Maintaining the family unit should be a goal of intervention. Education about the child's condition, development and common frustrations and problems is of prime importance. Since alienation of the family is a significant contributing factors to abuse, the parents should be informed of community resources, networks and respite care available. Ongoing support of professionals is another important consideration. The author outlines a multidimensional intervention approach that operates on an: (a) education-information level, (b) skill acquisition level, (c) the belief-insight level, and (d) behavioral change level.

Friedrich, W. N., & Boriskin, J. A. (1976). The role of the child in abuse: A review of the literature. *American Journal of Orthopsychiatry, 46*(4), 580-590.

This paper reviews the literature and discusses the role of the child in abuse, with special attention to identification of particular types of children who may be most at risk. Those children who are at risk include premature children, and mentally and physically handicapped children. The authors review the literature on the incidence of mental retardation among battered and neglected children. The literature is also reviewed on abused children with physical handicaps.

Friedrich, W. N., & Boriskin, J. A. (1978). Primary prevention of child abuse: Focus on the special child. *Hospital and Community Psychiatry, 29*(4), 248-256.

The authors review the literature on child abuse and present evidence demonstrating that children who are born prematurely, or who are sickly, or mentally or physically handicapped are at high risk for child abuse. The authors do not define child abuse and neglect in the article, and it is unclear whether the definiton includes sexual abuse. The authors describe ways to identify such children and suggest a number of primary prevention techniques that can reduce parental stress and help prevent child abuse. The techniques include day-care programs for handicapped children, mothers' social clubs, and lay health visitors to give support and impart proper maternal attitudes.

Frisch, L. E. & Rhoads, F. A. (1982). Child abuse and neglect in children referred for learning evaluation. *Journal of Learning Disability, 15*(10), 538-541.

During the 1977-78 school year, 430 children form the island of Oahu, Hawaii, were referred to a central school problem clinic for evaluation of learning problems. The proportion of these children (6.7%) who had been independently reported to the state child abuse agency was compared, after age adjustment, to the rate of such reporting for all children on the island and was found to be 3.5 times higher. The types of abuse and/or neglect reported were similar for the children with learning problems and for other island children. These findings strengthen the argument for a link between child maltreatment and developmental disabilities.

Frodi, A. M. (1981). Contribution of infant characteristics to child abuse. American *Journal of Mental Deficiency, 85*(4), 341-349.

This review suggested that atypical infants/children (with mental, physical, or behavioural abnormalities) are at risk for child abuse. An explanatory model of abuse was outlined and several studies were described whose findings provided support for the model. Some infants or infant attributes are especially likely to be perceived as aversive and as such may serve as aggression-facilitating stimuli. Other factors that contribute to the probability of abuse are dispositions of the parent, such as hyperreactivity to noxious stimulation. Such dispositions may be constitutional or may have developed during negative transactions with the child. Characteristics of the child and of the caretaker as well as their social ecology all affect the likelihood of abuse.

Garbarino, J., Brookhouser, P. E., & Authier, K. J. (Eds.). (1987). *Special children-special risks: The maltreatment of children with disabilities.* New York: Aldine De Gruyter.

This comprehensive book contains chapters relating to: (1) factors that contribute to maltreatment of handicapped children; (2) the way in which supporting and strengthening families contributes to preventing maltreatment; (3) the handicapped child's relationship with nondisabled siblings and peers and their potential effects on children's well-being and development; (4) the role of educators in prevention and identification of maltreatment; (5) the incidence of abuse in residential settings and implications for its prevention; (6) the role of the federal government in regard to legislation affecting handicapped children who are abused; (7) therapeutic issues, including a discussion of the long-term effects of abuse, intervention, the client, the therapist and therapeutic methods; (8) medical issues, including indicators of physical and sexual abuse; (9) special legal problems in protecting handicapped children; (10) children within the criminal justice system; and (11) a discussion of model community approaches for bringing together the concern, knowledge, resources and efforts of the systems that may separately address the problemsof child abuse and handicapping conditions. The issue of sexual abuse is discussed only briefly, in terms of detection, effects, reporting and prevention.

Glaser, D., & Bentovime, A. (1979). Abuse and risk to handicapped and chronically ill children. *Child Abuse and Neglect, 3,* 565-575.

Weekly meetings have been held since 1973 in the Hospital for Sick Children (London) to discuss children thought to be at risk for, or actually abused through nonaccidental injury, neglect, rejection or non-medical failure to thrive. During the years 1973-1977, a total of 189 children were discussed at regular meetings. Fifteen children were excluded from this group because of insufficient information being documented or because on review there was felt to be little evidence of abuse or the presence of risk factors. In this group of children feared to be at risk for, or actually abused, there were two clear subdivisions; those children who were handicapped prior to abuse and those children who were previously non-handicapped. Patterns of abuse and age distribution between these two groups have been found to differ considerably. Within the handicapped group, it appeared that beyond a moderate degree of illness or handicap, increasing severity does not contribute materially to the degree of abuse. The degree of social/emotional stress is the important varying factor.

Grothaus, R. S. (1985). Abuse of women with disabilities. In S. Browne, D. Connors, & N. Stern (Eds.), *With the Power of Each Breath* (pp.124-128). Pittsburgh: Cleis Press.

The author discusses the problem of abuse of disabled women. It is a personal problem as well as a political problem. Disabled women are discriminated against not only based on their disability but also on their gender. The author makes ten recommendations as a starting point for discussion and action to find solutions: (1) increased attention by policy makers; (2) increased enforcement of disability non-discrimination laws; (3) increased funding for programs; (4) education by disabled persons of workers in all violence oriented programs; (5) development of resource lists in programs that provide specialized assistance; (6) better education of staff in medical facilities; (7) provision of adequate equipment in medical facilities; (8) recognition by the disability civil rights movement that women with disabilities face double discrimination; (9) recognition by the feminist movement that disabled women are being excluded by inaccessible meeting places and by ignorance; and (10) agitation by disabled women to demand that their concerns be considered and that their needs be met.

Green, A. H., Gaines, R. W., & Sandgrund, A. (1974). Child abuse: Pathological syndrome of family interaction. *American Journal of Psychiatry, 131*(8), 882-886.

A study of mothers of 60 abused children was conducted to determine the characteristics of abusing parents and of the abused child and environmental stress factors. Characteristics of a child that contribute to abuse were found to be of 2 types: 1) Extreme physical or psychological deviance such as psychoses, mental retardation or brain damage; and 2) normal traits which are misperceived by or have special significance for the abusive parent, such as a child who resembles a hated ex-husband. In combination with the low self-esteem of abusive parents, "defective" children are seen as further proof of the parent's inadequacy. The poor impulse control of these parents allows aggression against the child to occur.

Hebert, P. (1986, August). Our justice system is lacking (Letter to the editor). *Spokesman, p.* 4.

The director of Edmonton's Disabled Victims of Violence writes that often the criminal justice system and courts are not aware of the disabled person's response to a specific situation. In some circumstances, a disabled person will react to stress by laughter which in a courtroom can be construed against the victims. The criminal justice system and the courts have to have an understanding of the person with the disability if a fair trial is to be given.

Hensy, O., Ilett, S. J., & Rosenbloom, L. (1983, August 13). Child abuse and cerebral palsy (Letter to the editor). *The Lancet*, p. 400.

The letter to the editor is in response to an editorial which stated the results of a recent study by Diamond and Jaudes on child abuse and cerebral palsy. In the study by Diamond and Jaudes, it suggested that in as many as 20% of children with cerebral palsy, child abuse was a cause of, or a response to, the handicapping condition. The authors of the letter to the editor indicate that their experience suggests that although child abuse is a cause of handicap, it is not as common a cause as stated by Diamond and Jaudes.

Hughes, H. M., & DiBrezzo, R. (1987). Physical and emotional abuse and motor development: A preliminary investigation. *Perceptual and Motor Skills, 64*, 469-470.

A study was conducted of children temporarily residing in a women's shelter who had reportedly been abused, and a comparison group of non-abused children in the same shelter. The mothers of the children were interviewed as to learning difficulties experienced by their children. Twelve percent of non-abused and 22% of physically abused children were reported to have language delays. Eleven percent of non-abused and 23% of physically abused children were reported to have learning difficulties. The authors conclude that further research using standardized measures of motor development and skills would be valuable.

Kaplan, S. J., & Pelcovitz, D. (1982). Child abuse & neglect and sexual abuse. *Psychiatric Clinics of North America, 5*(2), 321-332.

The authors discuss child abuse and sexual abuse in terms of the theory that abuse occurs as a result of interaction between a psychologically vulnerable parent, a child who is in some way "special" and environmental factors. The authors state that while some researchers have theorized that "specialness" of the child may contribute to abuse, it is difficult to determine whether physical or mental handicap is the cause or effect of abuse. Environmental factors contributing to abuse include stress and social isolation. In terms of treatment, the authors note that most often the perpetrator is the focus of treatment although the abused child is at risk for serious emotional and developmental disorders.

Kline, D. F. (1977). *Child abuse and neglect: A primer for school personnel.* Reston, VA: The Council for Exceptional Children.

The purpose of the book is to provide teachers, administrators, school board members, and parent-teacher organizations with basic information regarding child abuse and neglect. Handicapped children are only referred to briefly as inviting abuse more frequently than nonhandicapped children. However, the author states that there is no way to identify which one among several children in a family will be abused. The book discusses generally the legal and professional responsibilities of teachers, identification of the problem, reporting procedures and report forms, and prevention methods.

MacDonald, A. (1987, November 5). Adult Protection Act pleases committee. *Journal Power.*

The newspaper article discusses the presentation of the Ad Hoc Committee on Adults in Need of Protection, a sub-committee of the P.E.I. Inter-Agency Committee on the proposed Adult Protection Act to a special legislative committee holding hearings on the act. The proposed act is designed to recognize responsibility for the provision of assistance and protection services to dependent adults who cannot care for themselves or who are abused or neglected by caregivers. The committee's presentation discusses the recognition of the problem of abuse and neglect of dependent adults (includes the elderly, mentally and physically frail). The committee sees the act as a tool for public education, reinforcement of responsibility and granting legal power to intervene in extreme cases of neglect or abuse. Strategies must be developed to aid in identification, crisis intervention, education and advocacy for dependent adults and their caregivers. The committee identified some problems with the legislation: (a) the act does not make reporting mandatory, (b) the act could penalize individuals financially if they have to bear the cost of medical attention and legal action, and (c) the act takes all responsibility away from health professionals and institutions for treatment by removing liability.

Marion, R. L. (1981). *Educators, parents, and exceptional children.* Rockville, Maryland: Aspen.

This book describes roles that teachers can adopt to fulfill meaningful functions while seeking to involve parents of exceptional children and youth in special education. The definition of an exceptional child includes a mentally or physically handicapped child as well as a learning disabled child. Chapter 8 deals specifically with teachers becoming involved with families of abused exceptional children. There are three major contributing factors to child abuse: a parent, a child and a situation. The characteristics of abuse-prone parents and abuse-prone situations are discussed. Special or exceptional children have been identified as at higher risk for abuse. The special educator's responsibility is to identify and report the abused child and to work with the parents of the abused child. The educator should develop specific skills for the parent involvement program. These necessary skills are discussed.

McCaffrey, M. (1979). Abused and neglected children are exceptional children. *Teaching Exceptional Children, 11*(2), 47-50.

The article discusses the role of a teacher when child abuse or neglect is suspected. The teacher has the responsibility according to law to report suspected cases of child abuse (including sexual abuse) and neglect. The teacher also has a professional responsibility. A teacher should find out the resources that are available to her both in and out of school. The school staff should be given inservice training on the problem of child abuse and neglect. The teachers can organize policy development or program development even without inservice training. The staff should provide followup assessment and evaluation, and support services once a case has been reported. The teacher should recognize children in potential high risk situations. These are children who are premature, disruptive, or handicapped .

McFadden, E. J., Zlefert, M., & Stovall, B. (1984). *Preventing abuse in foster care.* Washington: National Center on Child Abuse and Neglect.

This manual provides training instructors with teaching approaches to be used with a 10-unit curriculum for foster care staff. Considered in the curriculum are the dynamics of child abuse in foster families, the need for prevention activities on a systems level, the worker's task in handling abuse in foster care placements, and the worker's role of helping foster parents with behaviour management. The introduction suggests teaching approaches likely to be effective with child welfare staff and discusses the class's physical setting, classroom procedures, and curriculum theme. The first session presents data on child abuse in foster care and the second identifies the high risk child and stress within the foster family. Two sessions on prevention focus on family structure and risk-assessment techniques, overload foster families, matching, and monitoring, with attention to indicators pointing to a child at risk. The session on the worker's educational role interprets the difference between discipline and punishment and indicates discipline expectations for foster parents. Other units explore ways to work with the foster family in assessing and managing the child's behaviour, staff placement of adolescents, indicators of adolescent abuse, and methods of interviewing adolescents. The final 2 sessions focus on child abuse in the home.

McPherson, C. (1984, February 6). Metro defense courses teach disabled to survive. *Toronto Star,* B3.

The newspaper article indicates that many self-protection and education courses are specifically tailored to teach disabled people how to fend for themselves . Within Metro Toronto, a number of courses are offered. The article details the programs offer by different agencies representing handicapped persons.

Meddin, B. J. (1985). The assessment of risk in child abuse and neglect case investigations. *Child Abuse and Neglect, 9,* 57-62.

In the process of investigating reports of abuse and neglect, child protective service workers are called upon to make numerous case decisions. Critical to much of this decision making is the assessment by the worker of the potential risk of harm that exists to the child regarding further abuse or neglect. This paper, based on two separate research studies, identifies the criteria child protective service workers use to assess this potential risk of harm to the child. The research identified eight criteria workers use to assess the risk involved. They are: (1) the age and (2) the functioning of the child - physical and mental abilities; (3) the cooperation, and (4) functioning of the prime caretaker; (5) the intent of the perpetrator , and (6) the current access that the perpetrator has to the child; (7) the severity of the current incident; and (8) the existence of previous incidents.

Meier, J. H. (1978). *A multifactorial model of child abuse dynamics.* (Monograph) No. 3:4/83). Beaumont, CA: Research Division, CHILDHELP USA/INTERNATIONAL.

A model of child abuse is discussed that includes parental, child, and ecological factors. Some factors that are discussed that may have special significance for disabled populations are: [a] abuse of the parent as a child, [b] parental demoralization, [c] chronic parental anxiety, [d] parental alcohol and/or drug dependency, [e] family stress, [f] mental or physical illness of the child, [g] child behavior problems, [h] lack of communication behaviour by the child, [i] disturbance of relationship between parents, [j] social isolation, and [k] lack of relevant family education.

Melling, L. (1984). Wife abuse in the deaf community. *Response to Violence in the Family and Sexual Assault, 7*(1),1-2,12.

The article focuses on wife abuse in the deaf community. Violence against deaf women is inflicted by deaf men as well as hearing men. For the hearing- impaired woman, all the problems facing battered women are exacerbated by communicating with those who do not speak her language and the critical lack of information and services available to her. The deaf woman has special problems in that there is an information gap between herself and others. There is also the community factor. The deaf community is extremely close, strong and insular. The wife has a greater dependence on this community and is afraid of threatening this support system. Professionals are beginning to develop responses to the problem. Their approach is operating on three levels; 1) to educate those working with domestic abuse victims to the special needs of deaf women, 2) to educate hearing-impaired people about the problem of domestic violence, and 3) to train those working with the deaf to identify and assist battered women.

Money, J. (1982). Child abuse: Growth, IQ deficit, and learning disability. *Journal of Learning Disability, 15*(10), 579-582.

Behaviour that has been criminalized makes criminals not only of those who practice it but also of professionals who fail to report their knowledge of it. Professionals have invented the "bastard science" of victimology in which, by focusing on the victims and handing the offenders over to the law, they miss the scientific opportunity to discover the cause and prevention of the offense. Evidence of child abuse and neglect as a primary cause of permanent IQ impairment and learning disability, though long known, has been largely disregarded in favor of hereditary and quasineurological theories of etiology. There is a syndrome, namely abuse dwarfism (also known as psychosocial dwarfism), in which growth in stature and pubertal physique, growth in intelligence, and growth and maturation of behavior all are retarded and even permanently impaired in response to child abuse and neglect. Early rescue into a nonabusive environment permits catch-up growth, whereas delayed rescue hinders it, with consequent persistent IQ impairment and learning disability.

Morgan, S. R. (1987). *Abuse and neglect of handicapped children.* Boston: College Hill Press.

Children with disabilites are victims of abuse at least as often as other children. Some children acquire handicapping conditions as a result of abuse. Premature infants are abused and neglected significantly more than others. Infants with birth defects are more likely to be victims of gross life threatening neglect. Alcohol is noted as a factor in child sexual abuse and other forms of abuse.

Nesbit, S. C., & Karaglanis, L. D. (1982). Child abuse: Exceptionality as a risk factor. *The Alberta Journal of Educational Research, 28*(1), 69-76.

Child abuse and neglect is defined as including physical or mental injury, sexual abuse, negligent treatment or maltreatment . It is clear that abuse can cause a handicapping condition, but it is not clear whether handicap antedates abuse or results from it. To unravel the matrix and assign a weighting to a specific handicap as a causal factor presents extreme difficulties. The article reviews the literature on a handicapping condition as a causal factor for abuse. The article also reviews literature on how the community, school and teacher can help prevent child abuse associated with exceptionality.

Per-Lee, M. S. (1981). *Victim witness project for the handicapped: Victim justice for disabled persons: A resource manual.* Washington: Gallaudet College.

The author discusses a number of factors related to service accessibility for victims with disabilities. The author states that service accessiblity for persons with disabilities is limited. Factors related to accessiblity include degree of architectural and programatic suitability, willingness to individualize to clients needs, and the clients awareness of service accessibility.

Rose, E., & Hardman, M. L. (1981). The abused mentally retarded child. *Education and Training of the Mentally Retarded Child, 16*(2),114-118.

The authors review research in the area of child abuse and mental handicaps. The literature reveals a higher incidence of mental handicaps in children who have been abused; the handicaps being a result of abuse or neglect. The authors point out that a problem with interpreting the research is that definitions of mental retardation and child abuse are not standardized across studies. A discussion of ways of breaking the abused child-abusing parent cycle and treatment is included.

Sandgrund, A., Gaines, R. W., & Green, A. H. (1974). Child abuse and mental retardation: A problem of cause and effect. *American Journal of Mental Deficiency, 79*(3), 327-330.

A study of abused children using control groups was undertaken in order to determine the psychological effects of abuse on the victim. Sixty abused and 60 non-abused children were interviewed and tested by a psychiatrist and a psychologist. The results indicated that 25% of the abused sample, 20% of the neglected sample and 3% of the non-abused sample were intellectually retarded. The authors conclude that the cause-effect relationship between retardation and abuse cannot be determined from their study.

Schilling, R. F., Kirkham, M. A., & Schinke, S. P. (1986). Do child protection services neglect developmentally disabled children? *Education and training of the Mentally Retarded, 21,* 21-26

The authors consider the relationship between child protection services and children with developmental disabilities. In spite of data suggesting that children with developmental disabilities are more likely to be abused, they are underrepresented in the caseloads of child protection workers. They point out that child protection agencies may consider children with handicaps to be outside their mandate and assume they are served by other agencies. In their survey of Child Protection Service workers, the authors found that although 82% believed that developmental disability increased risk of abuse, 84% had never served a developmentally disabled client (12% had only served one and 4% had only served two).

Schilling, R. F. , & Schinke, S. P. (1984). Maltreatment and mental retardation. In J. M. Berg & J. M. de Jong (Eds.), *Social, psychological, and educational aspects* (pp.11-22). Baltimore: University Park Press.

The authors state that mentally retarded children are at greater risk of abuse and neglect, since ordinary care standards are inadequate for this group. Retarded children may have unique requirements for feeding, clothing, prosthetics and attention to safety. There is also a higher risk of emotional neglect by parents who are unable to accept their child's limitations. Some retarded children have behavioural characteristics such as tantrums, aggressiveness and noncompliance that impact negatively on the parents. In general, the physical, emotional and financial burden of raising a handicapped child causes family stress and increases the risk of abuse. In regard to intervention, parents can be taught coping skills and how to enhance their social supports. The authors conducted pilot studies of group training for families. The results showed more self-control, calmness, positive self-talk and self-praise among the participants. In their discussion of retarded persons in the community, the authors state that as retarded people gain greater freedom they will be at greater risk for exploitation, since their relative dependency puts them in a vulnerable position. The mentally handicapped may have difficulty grasping community standards of sexuality, e.g., conversation, touching and public masturbation, and therefore may find themselves in exploitive situations. Prevention of sexual abuse includes training in appropriate sexual behaviour, meaning both rights and responsibilities.

Scholz, J. P., & Meier, J. H. (1983). Competency of abused children in a residential treatment program. In J. E. Leavitt (Ed.) *Child abuse and neglect: Research and Innovation* (NATO Advanced Sciences Series). The Hague: Nijhoff.

This study and review found that more than half of the child abuse victims tested suffered significant developmental delays.

Sloan, I. J. (1983). *Child abuse: Governing law and legislation.* New York: Oceana Publications.

The books deals generally with child abuse laws and legislation in the United States. Chapter 2 surveys key elements of the statutes dealing with the reporting of suspected or known cases of child abuse and neglect. The key elements of the statutes are: (a) the purpose of the state reporting law, (b) reportable circumstances, (c) the definition of abuse and neglect, (d) age limits of children, (e) the required state of mind of the reporter, and (f) who must and may report. Also discussed are immunity for reporting and other acts, abrogation of privileges, special exemptions, and the criminal and civil sanctions imposed for failure to report. In terms of the sexual abuse of handicapped children, the purpose of any reporting statute is three-fold: (1) to identify the child in peril as quickly as possible whether handicapped or not; (2) to designate an agency to receive and investigate reports of suspected child abuse; and (3) to offer, where appropriate, services and treatment. The definition of child abuse and neglect is often different

[Sloan, I. J. Continued] from state to state. Most definitions include sexual abuse, and there are some states, such as Florida, which broaden it to include sexual exploitation. The age limit federally for child abuse is any child under 18 or the age specified by the state. Several states include in their age limit definition mentally retarded persons, regardless of age. Ohio sets the age at 18 years or any crippled or otherwise physically or mentally handicapped child under 21. Washington's law applies to adult developmentally disabled persons, and Nebraska extends protection to incompetent or disabled persons. Most states require physicians and teachers to report. Only nineteen jurisdictions mandate "any person" or "any other person" to report, but thirty-two require careworkers to report. Where the agency responsible for the investigation of the abuse is related administratively to the institution in which the alleged abuse took place, a number of states incorporate clauses into their legislation insuring independence in the investigation. Forty-eight states specifically include "sexual abuse" in their reporting law definitions. The trend [Sloan, I. J. (1983). Child abuse: Governing law and legislation. New York: Oceana. continued] is to make sexual abuse by a parent or caretaker a form of child abuse which must be reported if suspected. However, some states' reporting law definitions of sexual abuse include abuse caused by any person. Chapter 5 deals with the legal issue of sexual abuse of children. All states have established statutory standards, criteria, and procedures for bringing a civil child protective proceeding in juvenile or family court based on an allegation of abuse by a parent or caretaker. Like other types of child abuse, sexual abuse may be the grounds for the proceeding even if sexual abuse is not explicitly mentioned in the state's statutory definition. The threshold question in all child abuse cases relates to the competency of the child victim/witness. Most jurisdictions no longer set an age below which a child is incompetent to testify. Instead, the court has discretion to allow a child to testify if he or she is capable of accurately observing and communicating past events and understands the necessity of telling the truth. Although the article does not comment on this fact, the handicapped are particularly affected by this law. Further, evidentiary problems for children in general (and especially for mentally handicapped, although not stated in the article)are the rule in some states. Mostevidence of sexual abuse is only circumstantial, requiring corroboration, and the child's testimony may change or be forgotten by the time of trial.

Sluyter, G. V. & Cleland, C. C. (1979). Resident abuse: A continuing dilemma. *American Corrective Therapy Journal, 33*(4), 99-102.

The authors propose a system for dealing with physical abuse in residential settings. A standardized process for investigating reports of abuse must be developed. A decision paradigm for administrators to use in determining what action should be taken is presented. The decision paradigm takes into account whether there are demonstrable injuries or not; whether the client can or cannot testify on his or her own behalf, whether witnesses (if any) are reliable and whether the suspect admits or denies guilt. The recommended action for the given circumstances is included. As a step towards prevention, clients could be physically examined on admission. Thus any scars or lesions brought to light could be evaluated in terms of the client's initial examination. Another preventive measure is informing new employees of the unacceptability of abuse and the consequences to be expected if it occurs. Keeping routine records of accidental injuries before an abuse situation arises may provide clues as to the perpetrator by checking frequency of injuries across dormitories and shifts, when a complaint arises.

Soeffing, M. (1975). Abused children are exceptional children. *Exceptional Children, 42,* 126-133.

Research in the area of abused children and handicaps is reviewed in this article. Several studies found that many abused children do have intellectual or physical handicaps. Research on handicaps as a result of abuse has reported a high incidence of mental, emotional and physical handicaps. Implications for educators are discussed in terms of signs of abuse and school policy on reporting. A summary of federal programs in the U.S. is also given.

Solomons, G. (1979). Child abuse and developmental disabilities. *Developmental Medicine and Child Neurology, 21*(1), 101-108.

The author reviews literature in the area of child abuse and developmental disabilities. Handicaps are found to be both contributing to and resulting from abuse. As a member of the medical profession, the author stresses the importance of recognizing abuse in patients and of offering assistance to families when abuse is discovered.

Sterling-Honig, A. (1980). Parent involvement and the development of children with special needs. *Early Child Development and Care, 6*(3), 179-199.

This paper examines the ways in which parents may be helped and supported in the task of providing stimulating environments for handicapped young children and in the development of their skills as therapists and educators. Parents have a special relationship with the child and are well placed to help him. They require support, however, in coming to terms with the handicap. A handicapped child has been found to be at risk for child abuse and neglect by parents or caregivers. Therefore primary prevention means that parents have to be the focus of therapeutic efforts to help families serve their function of nurturing the young. When neglect or abuse has occured, treatment must include the family or recurrence may be inevitable. Further, an effort should be made to prevent child abuse by educating parents before the abuse occurs. Help for the handicapped child must therefore be considered in light of help for the family.

Zadnik, D. (1973). Social and medical aspects of the battered child with vision impairment. *New Outlook for the Blind, 67*(6), 241-250.

The article does not discuss sexual abuse specifically but deals with abuse generally. The author relates a personal experience of an abused child who was blind. Many children may be visually handicapped or blind due to child abuse, or their handicapped may make them susceptible to abuse. Often the problem is unrecognized by agencies who work with these blind children. The article suggests that certain eye disorders are indicators of child abuse. Further, the general characteristics of the parents may also be a factor in indicating abuse. It is important for agency and school personnel to offer immediate, consistent, and continuing emotional support to the family. Some experiences in an agency for the blind illustrate the possible tragedy of inadequate awareness of child abuse as well as some practical suggestions for serving the suspected battered child and his family.

SEX EDUCATION & DISABILITIES

Amary, I. B. (1980). *Social awareness, hygiene, and sex education for the mentally retarded-developmentally disabled.* Illinois: Charles C. Thomas.

The book deals with the topic of sex instruction for people who are mentally handicapped. The author emphasizes the need for comprehensive and appropriate education programs for the developmentally disabled. The sex education curriculum should include the gradual teaching of basic anatomy and body functions of both sexes. The author includes in his discussion the principles of good grooming, health, and hygiene. Further, the topic of social awareness and sexual behavior is discussed. He deals with the role of the family in sex education of the mentally handicapped.

American Foundation for the Blind. (1975). *Sex education for the visually handicapped in schools and agencies: Selected papers.* New York: Author.

The book includes articles on program development and implementation, and the need for such programs and ideas for curriculum development. The opening paper is especially eloquent in discussing the need for normal sexual development for the visually impaired.

Anderson, J. (1987, November). Educating deaf children about sexual abuse and their safety. *Child Sexual Abuse Newsletter,* p. 5.

The principal of a Vancouver school for deaf children outlines the learning needs of deaf children in regard to sexual abuse.Three main needs are identified: 1) Deaf children need a standardized vocabulary to talk about sexual abuse and prevention; 2) A variety of media should be employed to make up for a lack of social experience. Teaching children to distinguish between good and bad feelings and to judge appropriate and inappropriate behavior are of utmost importance; and 3) Deaf children need more time to integrate the concepts.

Behrns, C., & Fisher, G. (1983). *Self protection for the handicapped.* Kent, WA; Grand View School. (EDRS No. 263 705).

This curriculum is a modification of the Curriculum for Developing an Awareness of Sexual Exploitation and Teaching Self-Protection Techniques developed by the Developmental Disabilities Project of Seattle Rape Relief. The Self Protection curriculum contains one level instead of the two that the original curriculum has; the intent being that younger (8-13) or more handicapped students would be taught the first five units only, during the first few times the curriculum is taught. Vocabulary has been simplified and some lessons omitted while others have been added. Where possible, third person characteristics have been changed to first person in the narrative stories, making them easier to identify with. References to rape and sexual exploitation have largely been omitted for two reasons. Firstly, the self-protection curriculum deals with exploitation in general, rather than specifically with sexual exploitation. Secondly, since many students have little knowledge of sexual intercourse, the concept of rape would have no meaning. Where the original curriculum refers to a victim as being raped, the self-protection curriculum refers to the victim as being "hurt." The curriculum has been evaluated and selected as a model program for use in the state of Washington.

Chipouras, S., Cornelius, D., Daniels, S. M., & Makas, E. (1979). *Who cares? A handbook on sex education and counseling services for disabled people.* Baltimore: University Park Press.

The handbook presents a careful compilation of available information on the need for and the provision of sex education/counselling services. It includes recommendations, based on research, for greater availability and increased applicability of these services to the particular needs of individuals who happen to be disabled. The handbook is organized into sections, providing foundation information first, more specific information for particular populations next and finally supplemental material and resource listings. Section I: *Sexuality & Disability* is the foundation of the handbook and should be read first. It provides the current state of the art and research results. Sections II through V assume that the reader is familiar with the information presented in Section I. They provide more specialized information which applies to disabled consumers, counsellors and other service providers, trainers, and policymakers. Included in these sections are discussions of specific issues which are relevant to the above populations. Appendices A through H provide a resource listing, survey report, bibliographies and other supplemental material. These sections are intended to be used as reference guides to additional information in the area of sexuality and disability.

Conway, A. (1977). Normalization: A beginning without an end. *Special Children, 3*(3), 39-45, 50.

The author briefly outlines the history of institutionalization of the mentally retarded in the United States. The attitude of the general public towards the mentally handicapped is reflected in studies confirming institutionalization as the means to deal with the mentally handicapped. With the modern trend towards normalization of the handicapped, the public has not adequately decided about sex education of the handicapped. It was at one time thought best that the handicapped were sterilized but the courts and some of the public were unwilling to enforce such a measure. The issue of sexuality and the handicapped has to be defined for the future because modern programs for devalued or deinstitutionalized persons should set goals to insure success and not leave them open ended, thereby inviting failure.

Craft, A., & Craft, M. (1983) . *Sex Education and Counselling for Mentally Handicapped.* England: Costello

The authors review the research and literature on sex education and counselling of mentally handicapped people. Suggestions are made as to the direction that must be taken in terms of counselling, birth control techniques, and the special role in training professional and paraprofessional staff who work with those who are mentally handicapped. Such vital issues as marriage, reproduction, institutional policies, sterilization, and consent from the developmentally handicapped are covered. There are practical suggestions for implementing seminars and workshops designed for training staff.

Deutsch, H., & Bustow, S. (1982). *Developmental disabilities: A training guide.* Boston: CBI Publishing.

Chapter ten deals with the general sequence of sexual development of the developmentally disabled. It discusses the types of social and sexual education necessary to prepare a retarded person for the least restrictive expression of his or her sexuality. It discusses specifically the areas of masturbation and homosexual behavior in the disabled. Suggestions for sex-educators as to teaching methods in the area are given.

Developmental Disabilities Project, Seattle Rape Relief. (1979). *A curriculum for developing an awareness of sexual exploitation and teaching self-protection techniques.* Seattle: Seattle Rape Relief.

The curriculum is designed for teachers and other workers to teach an awareness of sexual exploitation and self-protection techniques. The curriculum is intended for use with students who are moderate to borderline mentally retarded; suggested alterations are included for use with visually impaired, learning impaired, orthopedically handicapped, learning disabled, and behaviorally disordered (emotionally disturbed) students. The Level I curriculum is designed for use with elementary level children ages six to eleven. This portion of the curriculum doesn't address the issue of rape or forced sexual assault. The lessons at this level emphasize precautions necessary with strangers and recognition of inappropriate touching by authority figures and relatives. The Level II curriculum is designed for adolescents age twelve to nineteen, and mentally retarded adults. Students functioning at this level learn self-protective behaviours in a variety of situations. They are introduced to male-female rape, and male-male rape. Students learn to recognize potentially exploitive situations and exploitive touching. Exercises teach assertive verbal and behavioural responses to potentially exploitive home, social, and travel situations. Each unit contains an introduction, a listing of unit goals and objectives, outlines of activities and materials for meeting objectives and pretests and posttests. Transcriptions for slides and audiotapes used with the units are provided, as are vignettes describing potentially exploitive situations and appropriate and inappropriate responses to them.

Developmental Disabilities Project, Seattle Rape Relief. (1983). Teacher training manual sexual abuse of persons with disabilities: Techniques for planning and implementing a self protection program. Seattle: Seattle Rape Relief.

This manual provides a systematic approach to developing a special education program concerning sexual exploitation within a school system. The manual includes guidelines for training of special education administrators, teachers, counsellors, nurses, other professionals and parents concerning awareness about sexual exploitation of handicapped individuals. The manual is divided into 6 units. Unit 1 provides basic information concerning sexual abuse, including laws, statistics, and dynamics. Unit 2 provides information concerning how to inform school administrators and elicit their support to develop a program on sexual exploitation. Unit 3 provides suggested formats for educating parents as well as gaining their support for introducing a program into the schools. A "parent attitude survey" is included which can be used to measure the parents receptivity to sexuality and sex exploitation education. Units 4 and 5 concerning teacher training include detailed training formats. Unit 6 provides bibliographies of curricula which are appropriate to teach handicapped children about sexuality and sexual exploitation. Several curricula are suggested. Some curricula are tailored to the needs of students with specific handicapping conditions.

Dickman, I. R. (Ed.). (1975). *Sex education and family life for visually handicapped children and youth: A resource guide.* New York: Sex Information and Education Council of the United States & American Foundation for the Blind, Inc.

The book is divided into three sections with each addressing a crucial aspect of teaching sexuality. Part I covers basic philosophical issues about sex education for the visually impaired. Part II is a developmental sequence of suggested learning activities and concepts. Part III is an especially helpful resource and information guide with sections on printed, audio-visual, braille, and large type materials. Addresses of various agencies, services, and manufacturers are also included.

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

The authors argue that just as society must provide mentally retarded persons with appropriate feedback as to whether social behavior is acceptable or not, the mentally retarded need direction in sexual behavior. Mentally retarded people need to learn to distinguish between public and private behaviors. Since this group frequently is required to engage in familiar activities (such as hugging) with relative strangers, they also require information on who is a stranger and who is a friend.

Dupras, A., Levy, J. J., et. al. (1984). *Sexualité et difficulté d'adaptation.* Longueuil, PQ: Editions IRIS, Institut de recherces et d'informations sexologiques inc.

Ce livre contient en première partie des comptes rendus de sondages d'opinions sur la sexualité des personnes en dificulté d'adaptation. Plusieurs auteurs ont contribué à la rédaction de ce volume et présentent chacun un aspect de la sexualité chez les gens handicapés. Il est notamment question de la stérilisation des personnes déficientes mentales et de leur vécu sexuel. Des expériences pratiques d'éducation sexuelle auprès d'handicapés physiques sont relatées.

Dupras, A., Lévy, J. J., & Tremblay, R. (1978). *Education sexuelle des personnes en difficulté d'adaptation.* Montréal: Conseil du Québec de l'enfance exceptionnelle.

Cette monographie est constituée de plusieurs écrits provenant de diverses personnes s'intéressant à la sexualité des gens handicapés. La première partie du livre est composée d'essais théoriques où l'on aborde entre autres le développement de la sexualité chez les déficients mentaux ainsi que le contrôle des naissances. La seconde partie consiste en des recherches empiriques tandis que la troisième est consacrée aux expériences pratiques et ce, au niveau de l'éducation sexuelle notamment avec des handicapés tant physiques que mentaux. Des témoignages de personnes conernées sont exposés et des recommandations sont élaborées.

Feutl, R. (1987, April 27). Sex education is for everyone. *The Edmonton Sun*, p.22.

The article is the last of a two part series on the problems with sexuality faced by mentally handicapped persons. The article deals with teaching the handicapped about sex and their right not to be abused.

Fischer, H. L., Krajicek, M. J., & Borthick, W. A. (1973). *Sex education for the developmentally disabled: A guide for parents, teachers, and professionals.* Baltimore: University Park Press.

The book gives a very brief introduction to sex education for the developmentally disabled. A structured interview with line drawings of various sexual concepts, functions, and structures is included. The chapters on parent involvement and teacher-professional workshops include some helpful questionnaires and organizational tips. A bibliography is also included.

Fletcher, D., & Ogle, P. (1981). A realistic approach to sex education for the developmentally disabled: The human growth and development curriculum. *Journal For Special Educators, 17*(4), 316-325.

Little agreement exists concerning what actually constitutes an adequate, appropriate sex education program for developmentally disabled persons. Most of the sex education programs talked around sex rather than about sex. The newly developed programs focus on the teaching of the biological facts of human sexuality. The program is taught separately from the rest of the regular educational curriculum. The following curriculum outline is presented to show how the biological facts of human sexuality can be appropriately integrated into the regular curriculum through a human growth and development approach which then logically becomes an integral part of the total life adjustment curriculum for the developmentally disabled. The six levels of the curriculum outline are presented in developmental sequence. The categories of social identity, physiological identity and health and hygiene are presented at each of the six levels. Chronological and mental ages are purposefully omitted from the outline because the developmentally disabled person enters the sequence at whatever level they are currently functioning, regardless of age.

Foxx, R., McMorrow, M. J., Storey, K., & Rogers, B. (1984). Teaching social/sexual skills to mentally retarded adults. *American Journal of Mental Deficiency, 89*(1), 9-15.

A social/sexual skills training program for institutionalized mentally retarded adults was evaluated. The target behaviours involved a verbal action or reaction within six skill areas and were taught using a commercially available table game, Sorry, and a specially designed card deck. The program featured response-specific feedback, self-monitoring, individualized reinforcers, and individualized performance criterion levels. A multiple baseline across two groups (n=3 per group) revealed that there were increases in all skill areas. Generalization occurred in individual and group tests conducted by a retarded peer. The program appears to be an effective method of training social sexual skills because it produces effects that generalize.

Gordon, S. (1979). *Sex education and the library: A basic bibliography for the general public with special resources for the librarian.* Syracuse, N.Y.: ERIC Clearinghouse on Information Resources.

This bibliography is preceded by a presentation of arguments in favour of the dissemination of sex education information. The issues which should, at minimum, be included in a quality sex education program are listed. The author discusses the role of parents, the role of librarians and public opinion on sex education. Approximately 260 titles are suggested; they are grouped by categories such as age and special interest, for example, religion and sexuality, or history of sexual attitudes. Eleven books are listed under the heading "Sexuality and People with Handicaps".

Haavik, S.F., & Menninger, K. A., II. (1981). *Sexuality, law, and the developmentally disabled person.* Baltimore: Paul H. Brookes.

This book provides a good history and overview of sexual behaviour, marriage, parenthood and sterilization of people with developmental disabilities. It discusses law and ethical issues relevant to each of these topics. It also includes practical information on sex education programs. It raises the difficult issue of balance between protection from sexual exploitation and allowing freedom of sexual expression.

Hamre-Nietupski, S., & Ford, A. (1981). Sex education and related skills: A series of programs implemented with severely handicapped students. *Sexuality and Disability, 4*(3), 179-193.

The article describes a program in which severely handicapped students (mental /physical handicaps) were given training in sex education and related skills. Reproduction, birth control and self-care were covered as part of the training. Students who received the training are now using the skills and the data show that skills have generalized to situations in which direct training was not given.

Hamre-Nietupski, S., & Williams, W. (1977). Implementation of selected sex education and social skills to severely handicapped students. *Education and Training of the Mentally Retarded,12*(4), 364-372.

A sex education/social skills program for severely mentally handicapped people is described in this article. The sex education component consisted of teaching the student to distinguish gender and body parts, as well as self-care skills.The social skills component involved teaching appropriate social behaviors and interactions and social manners. Results of the program showed that the great majority of students mastered the skills taught.

Hill. (1987, November 1). *Sexual abuse and mentally handicapped. Child Sexual Abuse Newsletter,* p. 4.

The article states that 88% of mentally handicapped people are exploited. However, only 12% are exploited if they have received self-protection education. Based on these figures, the suggestion is made that education is the key. The Seattle Rape Relief Developmental Disabilities Project's package for sex education for mentally handicapped should be used.

Hopper, C. E., & Allen, W. A. (1980). *Sex education for physically handicapped youth.* Springfield, IL: Charles C. Thomas.

This book provides basic sex education material addressed to adolescents with physical handicaps. It combines factual information about sexual mechanics with motivational content on developing a positive self-concept and mutually supportive relationships with others. It does not deal directly with issues of sexual abuse and exploitation.

Janicki, M. P., Jacobsen, J. W., Zigman, W. B., & Gordon, N. H. (1984). Characteristics of employees of community residences for retarded persons. *Education and Training of the Mentally Retarded, 14,* 35-44.

This study reports data from 2800 community residence workers serving clients with mental retardation. Staff development related to human sexuality was considered the greatest need for staff training by 19.5% of these workers. This training need ranked fifth higher than first aid, or communication programming.

Kempton, W. (1975). *Sex education for persons with disabilities that hinder learning: A teacher's guide.* Massachusetts: Duxbury Press.

This guide is to be used by teachers of persons with learning handicaps, mainly in schools, institutions, and sheltered workshops. Much of the material used has been taken from previous authorities; the remainder has been accumulated from the experiences and expertise of pioneer sex education teachers. The author discusses the need for teachers to teach sex education to the handicapped and tells the teacher how this should be done.

Kempton, W. (1978). Sex education for the mentally handicapped. *Sexuality and Disability, 1*, 137-146.

The article presents the results of an evaluation of 31 courses presented to 430 mentally handicapped persons using the slide series, "Sexuality and the Mentally Handicapped". The results reported serve a more heuristic than a conclusive purpose. The overall conclusion is that the results support the argument for sex education and no dramatic negative behaviour was cited. The sex education program did not motivate or stimulate inappropriate behaviour.

Kempton, W. (1977). The sexual adolescent who is mentally retarded. *Journal of Pediatric Psychology, 2*(3), 104-107.

Adolescents who are mentally retarded are described; the current trend of accepting them as social-sexual persons in comparison to past practices of suppressing their freedom because they are sexual is discussed. The importance of sex education is emphasized; it should be included in a broader program of preparation for skills in social living because of the recent innovations in mainstreaming the mentally retarded individual into the community. Issues on birth control are discussed and methods of teaching sex education outlined.

Knappett, K., & Wagner, N. (1976). Sex education and the blind. *Education of the Visually Handicapped, 8*(1), 1-5.

A review of the literature indicated that sex education in the schools is of particular importance to the blind because other avenues of receiving sexual information are generally not available. However, due to a combination of attitudes about the blind and about sex education, it has only been in the last three or four years that sex education has been seriously considered. It was concluded that positive changes in the attitude of society towards sex education of the blind is largely dependent upon changes in the view that society takes of sexuality in general.

McNab, W. L. (1978). The sexual needs of the handicapped. *Journal of School Health, 48*(5), 301-306.

One of the basic needs of life to the handicapped, as well as to all individuals, is the understanding of one's own sexuality. Sex education can help handicapped individuals in finding sexual satisfaction and may foster self-responsibility, maturity and positive actions towards other rehabilitation goals. Traditionally, the teachings of sexuality to handicapped persons have run into objections resulting from society's negative attitude toward the handicapped and parental apprehension regarding the decision-making skills of their children in relation to acceptable and unacceptable sexual behaviours. However, the Education for All Handicapped Children Act of 1975 has provided a way for parents and health professionals to put pressure on local, state and federal programs to allocate funds for the development of a sound sex education program. As professionals in health education it is our challenge and responsibility to see that the sexual needs of the handicapped are not forgotten.

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

This book provides an overview of sexuality in the lives of people with mental retardation. It groups people with mental retardation according to severity and the concurrent presence of physical handicaps. Sexual needs in all groups appears to be similar and not typically different from anyone else. Problems in social integration and communication skills, however, often complicate sexuality for people with more than mild mental retardation. Sexual abuse is discussed in regard to the mentally retarded offender, but not in regard to victimization of the mentally handicapped person.

Morris, A. (1982). *A curriculum guide: Social and self-protection skills for the severely handicapped.* Washington: Molly Roeseler Anderson.

This is an appropriate guide for non-verbal students to be taught about self-protection skills to prevent abuse of the handicapped. The guide can be used independently of other written material or audio-visuals.

National Center on Educational Media and Materials for the Handicapped. (1978). Mildly handicapped: Sex education, secondary level. Columbus: Author.

This bibliography contains 66 abstracts of sex education materials (films, books, filmstrips) that are considered suitable for mildly handicapped junior or senior high school students. Each abstract contains evaluation information (if available), type of media, full descriptions and states the group for whom the material would be suitable.

Noble, B. (1987, November 1). Sexual concepts and visually impaired. *Child Sexual Abuse Newsletter,* p. 9.

Children who are visually impaired have to be taught sex education differently than sighted children. Their sexual experience is limited by their sight. It is necessary to modify existing programs of sex education so that verbal dialogue makes up for the visual images presented in the program.

O'Day, B. (1983). *Preventing sexual abuse of persons with disabilities.* St. Paul: Minnesota Department of Corrections, Program for Victims of Sexual Assault.

Sexual abuse prevention curricula are given for hearing impaired, physically disabled, blind or mentally retarded students. Each curriculum contains lessons which basically cover the following: vocabulary, types of touching, myths and facts about sexual abuse, acquaintance rape, what to do if you are victimized, reactions and feelings of victims, personal safety and assertiveness. Some variations are made, depending on the group being addressed. Accompanying each lesson, information is provided in terms of objectives, materials to be used and presentation instructions. The manual also contains a parents' guide, a teachers ' guide, exercises and 20 posters illustrating aspects of the lessons.

Re B (1987) 2 All ER 206 (HL).

This case report is about a local authority who had care of a mentally handicapped and epileptic 17-year-old girl who had a mental age of five or six. She had no understanding of the connection between sexual intercourse and pregnancy and birth, and would not be able to cope with birth nor care for a child of her own. She was not capable of consenting to marriage. She was, however, exhibiting the normal sexual drive and inclinations for someone of her chronological age. There was expert evidence that it was vital that she should not be permitted to become pregnant and that certain contraceptive drugs would react with drugs administered to control her instability and epilepsy. There was further evidence that it would be difficult, if not impossible to place her on a course of oral contraceptive pills. The local authority, which had no wish to institutionalize her, applied to the court for her to be made a ward of the court and for leave to ge given for her to undergo a sterilization operation. The application was supported by the minor's mother. The judge granted the application, and an appeal to the Court of Appeal was dismissed . The final appeal to the House of Lords was also dismissed. The court held that the paramount consideration for the exercise of the wardship jurisdiction was the welfare and best interests of the ward in question and accordingly, where it was for the welfare and in the best interests of the ward that he or she be sterilized, the court had jurisdiction to authorize the operation. Given the facts, sterilization was for the welfare and in the best interests of the minor and therefore the appeal would be dismissed. There is express disagreement in the case with

[Re B (1987) 2 All ER 206 (HL). continued.] the view taken by the Supreme Court of Canada, in the case of Re Eve, on the limits of the *parens patriae* jurisdiction. The court states that the issue is not whether the sterilization is therapeutic or non-therapeutic, but whether it is in the best interests of the person whom the court is asked to protect. Lord Templeman expresses the opinion that the decision should be made by a Superior Court rather than left to a parent or guardian.

Re Eve (1986) 2 S. C. R. 388 (SCC).

This law report concerns the court case involving a mentally retarded adult, Eve, and her mother's request for permission to consent to the sterilization of Eve. The mother feared that Eve might innocently become pregnant and consequently force Mrs E. who was widowed and approaching sixty, to assume responsibility for the child. The application sought: (a) a declaration that Eve was mentally incompetent pursuant to the Mental Health Act, (b) the appointment of Mrs E. as committee of Eve, (c) authorization for Eve's undergoing a tubal ligation. The application for authorization for sterilization was denied and an appeal to the Supreme Court of Prince Edward Island was launched. The appeal was allowed. An appeal was made to the Supreme Court of Canada to reverse the decision. The court found that permission for Eve's mother to consent to the sterilization could not be given. The court based its finding on the following rationale; first, the court found that there was no relevent provincial legislation that gives a court jurisdiction to appoint a committee vested with the power to consent to or authorize surgical procedures for contraceptive purposes on an adult who is mentally incompetent. Second, the court's *parens patriae* jurisdiction is only available if the purpose of the sterilization is therapeutic. To reach its conclusion on jurisdiction the court engaged in an extensive examination of the orgins, scope and limits of *parens patriae* jurisdiction. This finding of the court means two things; first, it excludes non-therapeutic sterilization from the *parens patriae* jurisdiction; and second, a non-therapeutic sterilization can never safely be determined to be in the bests interest of a mentally incompetent person. The court also found that the onus of proof lies upon the person seeking the authority for sterilization and the burden, although a civil one, must be commensurate with the seriousness of the measure proposed. The court did not address the issue as to whether the Canadian Charter of Rights and Freedoms protects an individual against a non-therapeutic sterilization without that individual's consent. The court stated that the legislatures may legislate for non-therapeutic sterilization but the legislation must be able to withstand the scrutiny of the courts under the Charter.

Rowe, W. S. , & Savage, S. (1987). *Sexuality and the developmentally handicapped: A guidebook for health care professionals.* Queenston, ONT: The Edwin Mellen Press.

This volume provides a good review of the literature, useful information, and interesting recommendations and suggestions for health care (and other) professionals. Chapter topics include: human sexuality, knowledge (background information), attitudes, skills for professionals, policy and law (U.S. and Canadian), masturbation, homosexuality, assaultive and offensive sexual behavior, and sexual variations. There is much helpful resource and reference information. Much more emphasis is placed on the role of people with disabilities as offenders rather than victims of sexual assault, but the general information is very useful.

Ryerson, E. (1984). Sexual abuse and self-protection education for developmentally disabled youth: A priority need. *SIECUS Report, 13(1), 1-3.*

The author states that the reporting rate of sexual abuse among the developmentally disabled is lower than that of the general population. The explanation given is that 99% of the abusers are relatives or care workers, and therefore the victim is either unaware that she or he is being exploited or is very confused about the sexual activity and the intent of the offender. The offender often leads the victim to believe that theirs is a "special" relationship or convinces the victim to keep the activity a secret. The Developmental Disabilities Project's curriculum for preventing sexual exploitation is available to schools, but due to economic issues and the sensitivity of the subject matter, it is not being used by many schools. The author stresses that self-protection education is of critical importance and therefore should be a priority, overriding economic concerns and embarrassment.

Ryerson, E., & Sundem, J. M. (1981). Development of a curriculum on sexual exploitation and self-protection for handicapped students. *Education Unlimited, 3*(4), 26-31.

Given the overwhelming statistics, the psychological as well as the physical consequences for the victims, the national trend toward greater independence for handicapped individuals, the lack of programs designed to assist handicapped persons to prevent sexual exploitation, and the need for such material expressed by special educators, The Curriculum for Developing an Awareness of Sexual Exploitation and Teaching Self-Protection Techniques was developed by the Seattle Rape Relief Developmental Disabilities Project. The article explains the curriculum. It was tested by thirteen teachers who taught this pilot curriculum and completed as part of the pilot test a "Field Test Questionnaire on each lesson they completed. The suggestions from these questionnaires were: (a) that students needed some basic background prior to being taught the program, and (b) the teachers needed support from parents, school district administration and additional personnel in order for the program to work. Information was also collected regarding critical incidents which may have occurred since the beginning of the curriculum in February, 1980.

Schuster, C. S. (1986). Sex education of the visually impaired child: The role of parents. *Journal of Visual Impairment and Blindness, 80*(4), 675-680.

Children who are visually impaired cannot use observation to learn acceptable social skills. The author describes strategies parents can use to cultivate positive sexual attitudes in their visually impaired children. The author maintains that parents can educate their children by allowing them to touch themselves and other family members as well as bathing and toileting together, keeping in mind that such behavior satisfies the child's needs, not the adult's. Appropriate learning experiences are outlined for each stage of the child's life.

Shaman, E. (1985). *Choices: A sexual assault prevention workbook for persons who are deaf and hard of hearing.* Seattle: Seattle Rape Relief.

The primary goal of the workbook is to reduce the risk of sexual assault for persons with disabilities by providing information about sexual assault and prevention strategies. The workbook discusses what sexual assault is, the facts on sexual assault, the law on sexual assault, the offenders, sexual assault prevention skills, safety recommendations, and resources available. Exercises are provided with the workbook for the student to complete with questions and theoretical situations which a deaf or hard of hearing student might encounter.

Shaman, E. (1985). *Choices: A sexual assault prevention workbook for persons with physical disabilities.* Seattle: Seattle Rape Relief.

The primary goal of the workbook is to reduce the risk of sexual assault for persons with disabilities by providing information about sexual assault and prevention strategies. The workbook discusses what sexual assault is, the facts on sexual assault, the law on sexual assault, the offenders, sexual assault prevention skills, safety recommendations, and resources available. Exercises are provided with the workbook for the student to complete with questions and theoretical situations which a physically disabled student might encounter.

Shaman, E. (1985). *Choices: A sexual assault prevention workbook for persons with visual impairments.* Seattle: Seattle Rape Relief.

The primary goal of the workbook is to reduce the risk of sexual assault for persons with disabilities by providing information about sexual assault and prevention strategies. The workbook has large print which makes for easy reading for those with visual impairments. The workbook discusses what sexual assault is, the facts on sexual assault, the law on sexual assault, the offenders, sexual assault prevention skills, safety recommendations, and resources available. Exercises are provided with the workbook for the student to complete with questions and theoretical situations which a visually impaired student might encounter.

Smigielski, P., & Steinmann, M. (1981). Teaching sex education to multiply handicapped adolescents. *Journal of School Health, 51(4),* 238-241.

The paper presents principles for health educators in providing sex education to individuals with cognitive and visual handicaps. The principles are applied to the case study of David, a 19 year old man who is moderately mentally retarded and blind. The experience in providing sex education for David reinforced that sex education for multiply handicapped children must involve a coordinated effort between school administrators, teachers, school nurses and parents. In developing a sex education program for an adolescent who is mentally retarded and blind, the program must emphasize concrete teaching, visual compensators, resource persons, repetition of content and opportunities for social learning. Nurses and special educators can serve as consultants to health educators in planning a sex education program. They may reduce parental discomfort by stressing sexuality as an indicator of normalcy. They also may serve as resources to parents by providing listings of sex education materials as well as offering guidance and support in dealing with the emerging sexuality of their child. The combined efforts of these persons can help to protect the rights of every child to have access to adequate sex education despite the limitations of a handicap.

Stuart, C. K., & Stuart, V. W. (1983). *Sexuality and sexual assault: Disabled perspectives.* Minnesota: Learning Resources.

The authors share their concept of a model workshop whose general goals are to improve sexual awareness of persons with disabilities and to introduce such persons to issues relating to sexual assault, its prevention, and emergency care and recovery. It is structured for ten three-hour sessions.

Tegtmeier, W. (1977). Sex education with retarded adults. *Special Children, 3*(3), 19, 21-36.
The article is a transcript of one meeting of a sex education group of retarded women at the AHRC Training Center and Workshop in New York City. This particular session is not meant to be a model of sex education or of counselling with the retarded, but is meant to illustrate the kind of discussion that can occur when an atmosphere of openness is fostered. It also illustrates some of the ways our clients react to sexual material. A real attempt is made in these groups and throughout the shop, to relate directly and acceptingly to trainees' sexual feelings. The program tries to help them overcome the fear, guilt, confusion, and frustration that sexuality is laden with for many of the retarded.

Varnet, T. (1984). Sex education and the disabled-teaching adult responsibilities. *The Exceptional Parent*, 43-46.
The parent of a developmentally disabled young girl explains the necessity of parents insuring adequate sex education for their child. The paper is a parent's personal account of the problems encountered when attempting to get sex education as part of her child's regular curriculum.

Vockell, E., & Vockell, K. (1977). Social perception: implications for sex education of the mentally retarded. *Special Children, 3*(2), 5-8.
Sex education programs have focused on two main concerns; (1) imparting information about sexual matters to students, and (2) developing healthy attitudes toward sexuality. Such programs have bypassed the possibility that sexual behaviour might be closely related to students' levels of social perception, and that assessment of functional levels in this area might be an important key to success in sex education programs. Whenever possible such perception training should be provided as a normal part of a child's education rather than as a part of a "crash " sex education program. The student could engage in intensive practice for specific social situations such as dating,etc.

West Conta Costa Rape Crisis Center. (1986). *Disabled children's prevention program*. San Pablo, California: Author.
The center has a program for children with various disabilities for sex assault prevention. The program will have the following components: (a) A disability awareness training program for CAPP staff members who will be working with children with disabilities in the schools, (b) Training for special education teachers in an abuse-prevention curriculum they can use with their students in the classroom, (c) Parent and teacher workshops with a disability focus, and (d) Assault prevention workshops for children in special classes.

Walter, E. (1982). Continuity of sexuality education in programs serving people with mental handicaps. *Sexuality and Disability, 5*(1), 9-13.
In order for sex education programs for the mentally handicapped to be successful, three factors are of major importance. First, the sex education program must be seen as a priority, rather than a one-time event. Second, a local source of training, consultation and teaching materials is necessary for agencies to draw upon. Third, the needs of the clients, agencies, parents and the public must be recognized at the program's outset.

Wong, C.B. (1978). Parent involvement in a public school program. *The Exceptional Parent, 8*(5), 15-19.

The author describes a sex education program for mentally handicapped students at her daughter's school. The three goals of the program were; (1) to develop in the students an awareness of themselves as sexual beings; (2) to help students understand that sexual feelings exist and are not shameful; and (3) to teach students about attitudes and expectations of society. The underlying aims of the program were to prevent unacceptable social behavior and to reduce the likelihood of exploitation.

SEXUALITY & DISABILITIES

Atwell, A. A., & Jamison, C. B. (1977). *The mentally retarded: Answers to questions about sex.* Los Angeles: Western Psychological Services.

This book attempts to answer a wide range of questions about sexuality in people labeled as mentally retarded. It would provide a useful introduction for parents, teachers, or the general public with interest in this area. It would be a useful reference for those involved in planning sex education for people with developmental disabilities, but it is not really suited for use as a sex education program in itself.

Ayrault, E. W. (1981). *Sex, love, and the physically handicapped.* New York: Continuum Publishing.

This book is an attempt to sexually liberate the physically handicapped by broadening the attitude and acceptance of them by the nonhandicapped. Sexuality shapes one's personality, develops one's emotions, and determines how well one socializes. It is dependent upon a person's attitudes toward himself and his relationships with other people. The book discusses the importance of sexuality, and the development of sexuality though the early years and into adulthood. It also discusses sexuality and rehabilitation.

Barrett, M. (1984). Resources on sexuality and physical disability. *Rehabilitation Digest,* 15-18.

Much of the growing literature in the field of sexuality for persons with a physical disability now deals with the sexual implications of specific disabilities or conditions. The article lists some of the literature that is available on the topic. The author supplies a brief annotation about each reference.

Bullard, D. G., & Knight, S. E. (Eds.). (1981). *Sexuality and physical disability: Personal perspectives.* St. Louis: C.V. Mosby.

This book combines information on a wide range of related topics. Its 36 chapters include information on personal experiences and professional issues. Sex education, sex therapy and counselling, sexuality and attendant care and many other topics are included. Ellen Ryerson's chapter on sexual abuse of people with disabilities was instrumental in raising public awareness of the nature and extent of the problems. There is a useful list of agencies and bibliography which is now a bit dated.

Burgdorf, R. L., Jr. (1983). Procreation, marriage, and raising children. In R. L. Burgdorf, Jr., & P. P. Spicer, *The legal rights of handicapped persons: Cases, materials, and text* (pp.371-426). Baltimore: Paul H. Brookes.

The chapter is a supplement to the earlier edition in 1980 (see Shuger) of the U. S. law on legal rights of handicapped people regarding procreation, marriage, and raising children. There have not been any important new directions in regards to the rights of handicapped persons to enter marriage. However, significant judicial development has occurred in regard to sterilization and parental rights. Several courts have found a *parens patriae* authority to order sterilization operations performed when proper procedures have been followed to insure that sterilization is in the best interest of a legally competent handicapped person. Several judicial opinions have recognized and protected the rights of mentally and physically handicapped individuals to retain the custody of their children.

Chamberlain, A., Rauh, J., Passer, A., McGrath, M., & Burket, R. (1984). Issues in fertility control for mentally retarded female adolescents: Sexual activity, sexual abuse, and contraception. *Pediatrics, 73*(4), 445-450.

This article reports on a study of 87 mentally retarded females ranging in age from 11 to 23 years, with regard to sexual activity, assault, and contraception. Forty-six percent of subjects were mildly retarded, 27% were moderately retarded and 27% were severely retarded. The results indicated that 34% of subjects had had sexual intercourse (51% mildly, 30% moderately, 9% severely retarded). Twenty-five percent of the subjects had a known history of sexual assault- one-third of mildly retarded, one-quarter of moderately retarded and 9% of severely retarded. Ten percent of sexually abused females were incest victims. Forty-eight percent of the sample had used birth control. Choice of a method of birth control is a special problem for the mentally handicapped, since the health care provider has little normative data with which to compare the patient and because patient communication and comprehension difficulties may put up barriers to utilization.

Davis, L. F. Touch, sexuality and power in residential settings. *British Journal of Social Work, 5*(4), 397-411.

This paper examines areas of concern surrounding touch, sexuality, and associated power in residential establishments. The place of touch and the expression of sexuality are considered in relation to residents and staff. The paper specifically examines five residential groups - the physically handicapped, the mentally retarded, the elderly, and the adolescents together with members of the staff. The author expresses the belief that the rights of these groups should be no less than those of their peers who are not similarly situated. The current practice is to not allow these groups control over their own sexuality. The author does not make a demand for unfettered freedom, but makes a plea for an examination of the rights which care workers or the general public assume they acquire over others merely because residentially confined groups are forced to live in buildings and situations for which the care worker or general public have responsibility.

Downes, M. (1982). Counseling women with developmental disabilities. *Women and Therapy, 1*(3), 101-109.

The focus of this paper is on women with developmental disabilities and their counselling needs. The purpose of this paper is to offer clinicians insight and increased awareness of the counselling needs of women with developmental disabilities. The paper gave the responses of three women who are developmentally disabled to a questionnaire. Given the various living situations, intellectual abilities, and emotional stability of the three women, the writer concludes from the survey that what these women know and do not know regarding sex reflects the attitudes of the general population, i.e. regarding attitudes about birth control, masturbation, dating, marriage. It seems to confirm further that which most of the public already know- sex is difficult for people to talk about. The message to the helping professional is that the person with a developmental disability is a person first, with the same basic needs for love and acceptance that others have. Their capacity for finding resources to help meet these needs is limited and women in this population are at particular risk. Given the appropriate educational and therapeutic environment a woman with developmental disabilities can live out her sexuality in a physically and emotionally healthy way within herself and with those around her.

Edmonson, B., McCombs, K., & Wish, J. (1979). What retarded adults believe about sex. *American Journal of Mental Deficiency, 84*(1),11-18.

The Socio-Sexual Knowledge and Attitudes Test was administered to two groups of mentally handicapped males and females-institutionalized and those in the community. The results indicated that knowledge scores were related to the respondents' gender and place of residence which reflected differences in experiences, instruction and interest. Institutionalized women had the highest scores on dating, marriage, intercourse, menstruation and birth control, but had the lowest scores on intimacy , homosexuality and community risks and hazards. Institutionalized men had the lowest scores on seven categories and the highest on none. Community women scored higher than the other groups on intimacy, community risks and venereal disease and lowest on intercourse and masturbation. Community men scored highest on anatomy, masturbation, homosexuality and alcohol and drugs and scored the lowest on marriage, menstruation and birth control. The authors state that in view of the sexual stimuli from tv, magazines, peers and neighbours, to try and preserve the naivete of the handicapped is unrealistic. The data from the study indicate that the handicapped can acquire facts and attitudes that make up responsible behavior, but that most respondents were poorly prepared for such knowledge.

Finkel, P., Fishwick, M., Nessel, K. L., & Solz, D. (1981). Sexuality and attendant care: A panel discussion. In Bullard, D. G., & Knight, S. E. (Eds.). *Sexuality and physical disability: Personal perspectives* (pp. 111-123). St. Louis: C.V. Mosby.

This chapter provides personal perspectives on the intimacy of relationships between personal care attendants and the people who they provide care for. The ambiguity of roles created by supposed physical detachment and close personal contact often creates problems. Some people who require personal care attendants establish overt sexual relationships with their caregivers which may be rewarding for both parties, but the level of dependence of one partner on the other for care creates potential power inequalities which may threaten the relationship.

Giami, A., Humbert-Viveret, C., & Laval, D. (1983). *L'ange et la bête; représentation de la sexualité des handicapés mentaux par les parents et les éducateurs.* Paris: Les publications du CTNERHI (Centre technique national d'études et de recherches sur les handicapes et les inadaptations).

La problématique de cet ouvrage est de recueillir les opinions des parents d'enfants handicapés mentaux ainsi que celles des éducateurs. La question principale est de savoir comment ces deux groupes voient la sexualité des handicapés mentaux. Selon les résultats obtenus, les parents en général désexualisent les handicapés. De leur côté, les éducateurs ont une opinion quelque peu différente mais affirment que les jeunes adultes handicapés mentaux sont incapables d'avoir des rapports sexuels complets. Seule la masturbation est perçue comme révélateur des possibilités sexuelles des handicapés mentaux; la masturbation individuelle et/ou collective reste donc une des figures dominantes de la sexualité des handicapés mentaux.

Greengross, W. *Entitled to love: The sexual and emotional needs of the handicapped.* London: Malaby Press.

The aim of the book is to establish that the handicapped have a right to love and to be loved. At present, the public, parents and educators are not permitting the handicapped the right to express love through their sexuality. The book discusses marriage, the role of the parent and staff careworkers, and sex education of the handicapped. As well, special problems of the mentally handicapped are discussed with respect to sex.

Institute of Law Research and Reform. (1986). *Sterilization: Minors and mentally incompetent adults.* Edmonton, Alberta: Author.

The Institute of Law Research and Reform have presented a discussion paper on the subject of sterilization of minors and the mentally incompetent. The purpose of the study was to ascertain the present law of sterilization, to ascertain how often, on whose decision and for what reasons sterilizations are being performed on minors and mentally incompetent adults in Alberta, and to decide whether the present law adequately protects the interest of the minor or mentally incompetent adults being sterilized and the physician performing the operation and, if it does not, to recommend change. The existing law is unclear about who may make what sterilization decision for what purposes in what circumstances for minors and mentally incompetent adults. The report details past sterilization laws and present sterilization laws. The repeal of the Sexual Sterilization Act in 1972 left Alberta without a statute on sterilization. In the absence of specific legislation, the authority for sterilization from guardians or parents has been argued to come from three possible sources of law: (1) the law places a duty on parents and guardian to make provision for persons in their charge; (2) the law permits a parent or guardian to substitute his consent for the consent of a minor or mentally incompetent adult to beneficial treatment; and (3) the law confers supervisory and protective jurisdiction on the courts. It is uncertain whether any of these sources is broad enough to cover contraceptive procedures and hygienic hysterectomies. There are also charter considerations which may effect the issue of sterilization of the mentally handicapped. The paper discusses the various pertinent sections. The position of the law in England, and the United States and the findings of the Law Reform Commission of Canada Study and Recommendations are also discussed. From the examination of these sources, the Institute makes some tentative recommendations. The recommendations are divided into two parts; the first part identifies the persons and sterilization purposes that should be made subject to appropriate substantive and procedural safeguards; and the second part suggests what those safeguards should be. The Institute does not recommend any change in the law of consent by a mentally competent adult to his own sterilization (that is, a mentally competent adult can give valid consent to medical treatment, contraceptive procedures or a hygienic hysterectomy). The Institute does not recommend a contraceptive procedure or hygienic hysterectomy for a mentally incompetent minor who is reasonably likely to become competent with maturation, or on a mentally incompetent person who may become competent. For a permanently mentally incompetent person (minor or adult), sterilization for the above purpose should be available based on the equality of rights argument, but the sterilization decision should be subject to the imposition of stringent procedural safeguards to ensure that sterilizations are performed in appropriate circumstances and that the power to authorize the performance of sterilization on permanently mentally incompetent persons is not abused. The safeguards that should be implemented were divided into a majority and a minority viewpoint. The report discusses each.

Lafrance, G. (1975). De la sexualité des handicapés et des autres minorités. *Feux verts*, no. 3.

Cet article lève le voile sur les interdits et préjugés qui pèsent encore sur la sexualité des handicapés et autres minorités. Ecrit par un handicapé, cet article déplore les attitudes négatives de la société, laquelle considère les handicapés comme des êtres asexués. Pour arriver à vivre leur sexualité, ils doivent dépasser les mythes stéréotypés de la beauté physique et être prêts à aimer et à se sentir aimés. L'auteur aborde également le problème de la répression dans les institutions.

Nigro, G. (1976). Some observations on personal relationships and sexual relationships among lifelong disabled Americans. *Rehabilitation Literature, 37*(11), 328-330, 334.

The author discusses his experience of working with physically and mentally handicapped people in the area of sex education. It is often the case that these persons have little understanding in the area since they have been very dependent on others most of their lives and have reduced contact with other children in peer-oriented situations. The author states that there is a four-fold task for professionals working in this area; (a) improve the attitude of the public, the professionals who work with the disabled, their families, and the disabled themselves; (b) provide knowledge about human sexuality; (c) promote opportunities for sexual experiences for any handicapped person who chooses to indulge in sex; and (d) improve the ability to establish meaningful personal relationships which may then become sexual.

Passer, A., Rauh, J., Chamberlain, A., McGrath, M., & Burket, R. (1984). Issues in fertility control for mentally retarded female adolescents: Parental attitudes toward sterilization. *Pediatrics, 73*(4), 451-454.

This article reports on a study of parental attitudes on sterilization of mentally retarded daughters. Sixty-nine parents were interviewed.Forty-six percent had considered sterilization. Thirteen of 32 parents who had considered sterilization decided against it. Eighteen parents were still seeking sterilization and the remaining parent had obtained the procedure for her daughter.Fifty-two percent of parents of mildly retarded thought their daughters should give informed consent. Nineteen percent and 10% of parents of moderately and severely retarded subjects, respectively, thought their daughters could give consent. When asked about attitudes to sterilization legislation, 67 parents responded. Eighty-five percent favored a statute enabling sterilization of mentally retarded persons. Twelve percent did not favor such a statute and 3% of respondents answered that they did not know.

Pitceathly, A. S., & Chapman, J. W. (1985). Sexuality, marriage and parenthood of mentally retarded people. *International Journal for the Advancement of Counselling, 8*(3), 173-181.

The authors discuss the sexuality of the mentally handicapped, pointing out that these individuals require knowledge of physical and emotional aspects of development. As well, with increasing normalization and integration into the community, there is greater risk that the mentally handicapped will be abused and exploited. The authors present suggestions for counsellors who are involved in providing sex education and marriage counselling to the mentally handicapped.

Robinault, I. P. (1978). Sex, society, and the disabled: A developmental inquiry into roles, reactions, and responsibilities. New York: Harper.

A rapidly interacting and poorly understood variety of cultural forces have concurrently produced a sexual revolution which expresses itself haphazardly in literature, in entertainment media, and in some overt behaviour of youth and adults. It is the premise of this book that a developmental perspective, discussed in easily understood terms, may prove to be a connecting thread though this confusion. Therefore, the sexuality of individuals with chronic disability (congenital or acquired) is presented in the sequence of the life-cycle from infancy through older ages. The challenges at each stage are pointed out from the perspective of how individuals and their advocates in the helping professions balance innate and acquired capabilities with realistic interpersonal experiences, with confusing social cues, and in spite of the limitations of present-day knowledge and technologies. Samples are chosen from real life experience and research reports to illustrate, at each stage, what the disabled share with their able-bodied contemporaries, where adjustments have to be considered, and what realistic options exist. The book's purpose is to stimulate productive inquiry among professions that concern themselves with the sexuality of the disabled, and to relate existing professional resources to the needs of people with disabilities. A comprehensive bibliography on the sexuality of the disabled is also included.

Rowe, W., Savage, S., & Dennis-Delaney, J. (1987). The effects of training in human sexuality for individuals working with developmentally disabled persons.

A study was conducted to explore: (a) whether a course in human sexuality and the developmentally disabled results in more accepting attitudes towards the sexuality of developmentally disabled persons and (b) whether the course participants would have greater skills in dealing with sexual issues in counselling. The participants attended a two and half day workshop which focused on three aspects of clinical training in human sexuality-knowledge, attitude and skill. Results showed that the training positively influenced participants' attitudes towards sexuality and the developmentally disabled, but that skill development did not significantly improve after training. It is suggested that skill development may require ongoing consultation and training.

Sha'ked, A. (1978) *Human Sexuality in Physical and Mental Disabilities: An Annotated Bibliography*. Bloomington: Indiana University Press.

This 303 page book is a comprehensive bibliography containing references to books and articles related to sexuality . Categories included are the physically disabled, blindness, deafness, mental retardation and learning disability, cerebral palsy, spinal-cord injury and 18 other medical or psychiatric conditions.

Shuger, N. B. (1980). Procreation, marriage, and raising children. In R. L. Burgdorf, Jr. (Ed.), *The legal rights of handicapped persons: Cases, materials, and text* (pp.857-992). Baltimore: Paul H. Brookes.

The chapter discusses the law of procreation, marriage, and raising children for disabled persons in the U. S. The author traces the historical sources of deprivation of the right to procreate for the disabled. In the 1920's a eugenics movement spurred the belief that the prevalence of mental and physical disabilities was the root of all social problems and that mental retardation was hereditary in all cases. The result was a number of statutes which required sterilization of all criminals, idiots, imbeciles, or rapists. The statutes were tested in court on the ground of being unconstitutional. Some cases were successful on this basis and others were not. (The author has reproduced these cases.) Gradually, the unconstitutionality of the legislation and the realization that not all mental retardation is hereditary lead to a movement away from sterilization. The modern legal approach has been to accept legislation that permits sterilization when it is in the best interest of the mentally retarded person, when in the best interest of the public, and when it is likely that the mentally retarded person would procreate a mentally retarded child. It is an approach which permits sterilization in rare cases. In the absence of a statute, there isn't any authority for a guardian to have a mentally retarded person sterilized. The author also sets out cases dealing with marriage of the handicapped. There have been and still are a large number of statutes restricting the handicapped person's right to marry. Some of the statutes have been struck down, but others have not depending upon whether the statute satisfies procedural due process, substantive due process, and equal protection. The issue of capacity to marry and presumption of validity is also discussed. The right of a parent to raise children, although constitutionally ingrained, has not been applied to mentally retarded parents and his/her child in all cases. The author gives cases where a child can be taken from his mentally retarded parent on the basis that there is the superior right of the state to take custody when the parent is mentally or morally unfit or incapable of caring for the child, or the welfare of the child requires it. Cases are cited which test the constitutional validity of such an action.

Sohn, H. A. (1983, October). *Child abuse prevention and the mentally handicapped.* Paper presented at a conference on "The Mentally Handicapped Parent", Chatham, Ont.

The author addresses the question of whether children of retarded parents are at greater risk for abuse. Literature reviews by other authors are cited; the overall conclusion being that the mentally handicapped make unacceptable parents. The research reviewed is considered to be methodologically weak, however. The author concludes that more research is necessary, since there is sufficient reason to be concerned about the relationship between child abuse and mental handicaps.

Taylor, H. (Interview with Lisa McGann, registered nurse at G. F. Strong Rehabilitation Centre in Vancouver).

The article is an interview with a registered nurse who works at a rehabilitation centre with physically disabled women. The interviewer asks questions concerning the problems faced by disabled women regarding their sexuality as viewed by themselves and the general public.

Ufford Dickerson, M. (1982). New challenges for parents of the mentally retarded in the 1980s. *The Exceptional Child, 29*(1), 5-12.

The person who has mental retardation is the primary client for professionals, and his or her family system is an important but secondary concern. Since the adult person who has mental retardation must be viewed as the primary client, all discussion and plans that concern him must be formulated with him/her, and not on his behalf. Although considerable attention has been given to securing lifetime financial support and educational opportunities for the mentally retarded, there has been less attention given to meeting the general health needs of the mentally retarded. In the 1980s, parents of the mentally retarded will have to meet the following challenges with respect to the general health of the mentally retarded: (a) Dare to raise adults, not children; (b) Resist limiting individuals because of labels that result from evaluation; (c) Discuss the child 's retardation openly with him/her; (d) Celebrate the child's emerging sexuality; (e) Discuss the child's sexuality in relation to mental retardation; (f) Use respite services to promote growth and development; (g) Accept recommendations for treatment; (h) Anticipate the child's separation from home; (i) Resist the temptation to provide unnecessary guardianship; (j) Confirm the child's right to maturity. Each of these challenges is then discussed in the article.

Waynberg, J. (1981). *Handicap et sexualité.* Paris: Masson.

Dans cette monographie, il est question d'abord de la sexualité des personnes ayant un ou des handicaps physiques. Ensuite, quelques sous-chapitres traitent de la sexualité des malades mentaux; on dénonce le fait qu'elle soit réprimée notamment dans les institutions. Un sondage d'opinion sur la sexualité des handicapés mentaux a été effectué, celui-ci rélévant qu'on ne doit permettre aux handicapés mentaux de se reproduire. Il est à noter en dernier lieu qu'une étude critique de publications traitant de la sexualité des handicapés mentaux fait l'objet d'un des chapitres de ce livre.

Wolf, L., & Zarfas, D. E. (1982). Parents' attitudes toward sterilization of their mentally retarded children. *American Journal of Mental Deficiency, 87*(2), 122-129.

A survey of parents of mentally retarded children revealed that 71% agreed with involuntary sterilization and 67% agreed with voluntary sterilization. Forty-four percent felt that consent should be legally regulated, 49% did not, and 6% did not know. Sixty-four percent of parents did not feel a need for a legally authorized third person or committee to be involved in sterilization decisions. Twenty-five percent did desire external input and 11% did not know. The authors conclude that a number of issues must be addressed when discussing sterilization. Questions tc be answered include the following: (a) Can parenting ability be predicted by tests? (b) Are children of mentally retarded parents at a disadvantage? (c) How successful are marriages of the mentally retarded? (d) What stresses are involved for mentally retarded persons who marry and parent and is support available? and (e) How do mentally retarded people adjust to sterilization?

OTHER RELEVANT SEXUAL ABUSE LITERATURE

Badgley, R. F. (Chairman) (1984) Sexual offenses against children (vols. 1 & 2). Ottawa: Canadian Government Printing Centre (Catalogue No. J 2-50 / 1984 E).

The committee developed fifty-two recommendations on incidence and prevalence, including: [a] the establishment of an office of Commissioner to implement social and legal reform, [b] a national program of public education relevant to the prevention of sexual offenses against children, [c] reforms of the Canadian Criminal code relevant to sexual offenses, [d] reforms of the principles of evidence, [e] measures to strengthen the provision of services, [f] the development of relevant information systems, [g] the establishment of a national research agenda, [h] implementation of specific initiatives against juvenile prostitution, and [i] specific measures against child pornography. Statistics presented suggest one in two females and one in three males had been victims of sexual offenses, with four of five victims experiencing the offense before age 21, and the majority of cases going unreported. Over half of the incidents occurred in the victims' homes. While the special implications of other potentially handicapping conditions are not addressed (they are beyond the mandate and scope of the report), much of the content has relevance for this population. The synthesis of information from a wide variety of sources and the references make this report valuable reference information for researchers and clinicians, and indispensable for those involved in public policy.

Brodyagg, L., Gates, M., Singer, S., Tucker, M., & White, R. (1975). *Rape and its victims: A report for citizens, health facilities, and criminal justice agencies.* Washington: National Institute of Criminal Justice.

This 360 page report provides police, medical facilities, prosecutors, and citizens' action groups with guidelines for victims services and law enforcement. General guidelines provide a good starting place and this report was no doubt influential in shaping current services. No special consideration of victims with handicaps is apparent in the report.

Child Abuse and Neglect Database

This entire database was searched for information related to sexual abuse and incest and disabilities. Only seven articles on these topics were located in the database as of November, 1987, indicating the dearth of available materials to date.

Conseil du statut de la femme. (1986). *Rapport et propositions sur la prévention des abus sexuels à l'égard des enfants.* Québec: Gouvernement du Québec.

Les objectifs généraux de cet ouvrage sont d'analyser les abus sexuels commis à l'intérieur des familles et les ressources en terme de prévention. De plus, un inventaire des recommandations formulées par divers organismes publics ainsi que les besoins identifiés par des intervenants concernés sont exposés. Au niveau de la prévention, notons l'éducation sexuelle, en particulier à l'école et ce, par une sensibilisation auprès des élèves et du personnel scolaire.

De Champlain, J., & Messier, C. (1984). *La protection sociale des victimes d'abus sexuels ... où en sommes-nous au Québec?* Québec: Gouvernement du Québec, Comité de protection de la jeunesse

La première partie de cet ouvrage vise à définir l'abus sexuel et ses différents types. D'après une étude échelonnée sur 3 ans, le nombre de cas d'abus sexuels a plus que doublé (379 en 1978 / 806 en 1981). Présentation du profil des victimes et des agresseurs. Dans 40% des cas, les enfants ayant subi une agression sexuelle qui ont été signalés sont déjà connus d'un Centre de services sociaux et près d'un quart sont en famille d'accueil. Dans plus de 50% des cas, l'agression sexuelle est de nature incestueuse impliquant dans presque la totalité des cas le père et sa fille. Les auteurs s'interrogent sur l'accessibilité des services et révèlent que plusieurs cas d'enfants ne sont pas traités adéquatement ou pas assez rapidement ou encore, totalement ignorés. Présentation de modèles d'intervention et de traitement. Il est à noter qu'une version abrégée de cet ouvrage est disponible et contient 69 pages.

de Young, M. (1982). *The sexual victimization of children.* Jefferson, NC: McFarland & Company.

This book covers a range of topics relevant to child sexual abuse. The author cites other studies along with her own data relevant to the prevalence of handicapping conditions among children who have been sexually abused. The author cites several studies that suggest that daughters with neurological handicaps and a variety of other disabilities are more likely to be victims of incest. The author also notes in her study of pedophilic offenders that mental retardation was a rare finding.

Drouet, M., & Rouyer, M. (1986). *L'enfant violenté; des mauvais traitements à l'inceste.* Paris: Le Centurion.

Ce livre contient seulement deux chapitres; le premier aborde les divers types de mauvais traitements que peuvent subir les enfants et l'autre, l'inceste. Dans ce dernier cas, il est question de l'origine de l'inceste puis le profil d'une famille incestueuse est tracé. Il est spécifié dans la définition que l'inceste consiste en toute relation à caractère sexuel entre un enfant et un adulte ayant un rôle parental à son égard. Les conséquences de l'acte incestueux sont exposées de même que les diverses formes de traitement.

Elliott, M. (1985) *Preventing child sexual assault: A practical guide to talking with children.* London: Bedford Square Press.

This book is designed for parents and teachers. It provides suggestions on how to prepare children to prevent sexual abuse. It stresses the importance of physical abilities to resist or run away, and communication skills to report events to appropriate authorities figures. The implications for children unable to carry out these functions are not discussed. This book also fails to address sexual abuse and assault, by parents or teachers, which appears to occur much more frequently than offenses by strangers.

Ellis, M. (1986). *Surviving procedures after a sexual assault.* Vancouver, B.C.: Press Gang

The book is a practical guide for women victims of sexual assault and the procedure that they may follow after an assault has occurred. The book does not deal specifically with handicapped persons. However, it would be of value to anyone who is not knowledgeable about the court system, including people with disabilities, their caregivers, and advocates. It explains the choices and the process of the police and court system after a sexual assault.

Finkelhor, D. (1984). *Child Sexual Abuse.* New York: The Free Press.

The author proposes the Four Preconditions Model of Sexual Abuse consisting of : (1) A potential offender who had some motivation to abuse a child sexually ; (2) The potential offender had to overcome internal inhibitions against acting on the motivation; (3) The potential offender had to overcome external impediments to committing sexual abuse; (4) The potential offender or some other factor had to undermine or overcome a child's possible resistance to the sexual abuse. With regard to precondition 3, factors predisposing to overcoming external inhibitors include; a mother who is not close to the child; social isolation of family ; or unusual opportunities to be alone with the child. Factors predisposing to overcoming a child's resistance (precondition 4) include a child who is emotionally deprived; a child who lacks knowledge about sexual abuse; a situation of unusual trust between child and offender and coercion. All of the above predisposing factors are applicable to children with handicaps, although the author does not specifically make this connection. He does, however, point out in his suggestions for further research that physical or emotional handicaps may compromise the child's ability to avoid abuse.

Finkelhor, D. (1986). The prevention of child sexual abuse: An overview of needs and problems. In B. Schlesinger (Ed.), *Sexual abuse of children in the 1980's: Ten essays and an annotated bibliography* (pp. 16-29). Toronto: University of *Toronto Press.*

In the 1980s, dozens of child sexual abuse educational prevention programs have appeared. This article discusses the need for such programs based on two factors: (1) the percentage of all children likely to suffer abuse, and (2) the likelihood that those who are abused will not receive treatment. The prevention programs have been directed at a very broad spectrum of children based on the realization that boys are victimized as well as girls, children are victimized at an early age and handicapped children are also victimized. Some prevention education has been aimed at parents. The author discusses some of the problems that have arisen with parents as educators. The article also discusses the common concepts that are in the prevention programs.

Gigeroff, A. K. (1968). *Sexual deviation in the criminal law, pedophilic offenses.* Toronto: University of Toronto Press.

Forty-five percent of child sexual abusers studied were heavy drinkers. Economic stress is associated with an increased incidence of child sexual abuse.

Gil, E. (1982). Institutional abuse of children in out-of-home care. In R. Hansen (Ed.), *Institutional abuse of children and youth* (pp. 7-13). New York: Haworth Press.

Seventy- seven percent of abuse reports were physical abuse, and twenty-three percent were sexual abuse. Actual incidence and prevalence is unclear. Under reporting is a major problem.

Gothard, T. W., Runyan, D. K., & Hadler, J. L. (1985). The diagnosis and evaluation of child maltreatment. *Journal of Emergency Medicine, 3*(3), 181-194.

Child maltreatment continues to be one of the most common and difficult problems seen in the emergency room. An early estimate indicated that up to 10% of children under age 6 seen in emergency departments have some form of nonaccidental injury. Recent data suggest that approximately 1 % of the child population are victims of maltreatment each year. Many of these cases involve only subtle signs and have great potential to pass undetected. The article points out that past reports have suggested that prematurity, mental retardation, physical handicaps and being a twin all place the child at increased risk for maltreatment. The definition of maltreatment in the article is wide enough to include sexual abuse. The article provides a review of the various forms of maltreatment, with emphasis on the key points involved with the patient's history, physical examination, and management. The protocol for evaluating maltreatment from the North Carolina Memorial Hospital is presented. This framework will aid the physician in the crucial first step of identifying maltreatment, which, along with diligent follow-up and the assistance of the available social services, offers the best hope for further prevention.

Gravel, S. (1985). *Le traitement judiciare des délits d'agression sexuelle dans le district de Montréal.* Montréal: Université de Montréal.

Cette recherche démontre un traitement judiciaire différentiel des délits d'agression sexuelle comparativement aux autres délits de violence contre la personne et ce, en raison du caractère particulier des agressions sexuelles auxquelles sont associées nombre de mythes et de stéréotypes. Les personnes accusées d'agression sexuelle envers des enfants ou des adolescents plaident plus souvent la culpabilité que lorsque la victime est adulte. Toutefois, les sentences sont moins sévères dans le premier cas que dans le second car la violence physique est moins fréquemment utilisée lorsque la victime est un enfant.

Kelley, S. J. (1986). Learned helplessness in the sexually abused child. *Issues in Comprehensive Pediatric Nursing, 9*(3), 193-207.

The author discusses child sexual abuse in terms of the theory of learned helplessness. The child is in an unequal power position with the adult and thus feels incapable of refusing. The abuse is repetitive and controlled by the adult and the child learns that her attempts at avoidance do not affect the outcome. Realizing that resistance has been ineffective in the past, the child may discontinue resistance.The child then tends to attribute the cause of abuse to herself rather than to the adult, who is seen as infallible. The child also believes that nothing she can do will stop the abuse from occurring in the future. The balance of the article concerns interventions for nurses who are caring for abused children.

Lane, M. E. (1982). *The legal response to sexual abuse of children: A review of current procedural and legal practices in the child welfare and criminal justice systems.* Toronto: Metropolitan Chairman's Special Committee on Child Abuse.

The background paper examines the legal context of child sexual abuse. More particularly, the focus is on the child welfare and criminal justice systems which together have primary responsibility for mobilizing the legal response to the problem. The review was commissioned by the Special Committee in an attempt to understand the experience of children involved in either child welfare or criminal justice proceedings as a result of sexual abuse. As such the results provide valuable direction in re-shaping those legal policies and procedures which inadvertently place child victims in further jeopardy. The first section reviews the legal context of child sexual abuse and examines law and procedures in both child welfare and criminal jurisdictions. Next, the response of the child welfare system is reviewed, including a review of relevant literature, current practices and the opportunities presented by the forthcoming omnibus legislation on children's services. The last section examines child sexual abuse in the context of the criminal justice system, including a review of practices related to investigation, laying charges, treatment of the victim and accused, convictions and sentencing.

McPherson, C. (1984, February 6). Vulnerable victims of assault. *Toronto Star*, B1, B2,

The newspaper article gives an overview of the problem of sexual assault on persons with handicaps. While there are virtually no statistics on the rate of assault and crime against handicapped people, most experts say that crime is no more frequent than crime against able-bodied people. But the disabled are clearly more vulnerable. Further, attacks on the disabled can have more severe consequences than on an abled-bodied person. The handicapped can't communicate to authorities as readily as able-bodied persons can, especially if the victim is deaf or blind. Further, there is a fear by the victim that if the crime is reported that there may be repercussions - losing a job, or some other benefit. The disabled also have a poor self-image of themselves. Generally, if a disabled person is sexually assaulted, the chance for a conviction is low. In court, a mentally retarded victim has his credibility attacked as do other victims. At the moment, there is a review of the court process and its availability to the handicapped being done by a member of the Ontario judiciary.

Messier, C. (1984). Les abus sexuels d'enfants. *Relations*, juillet-août 1984, p. 190-194.

Cet article dénote une progression constante des cas d'abus sexuels envers des enfants. La proportion est de 4 filles pour un garçon. L'auteur dresse le profil des personnes abusives et révèle que dans 92% des cas, l'abuseur est connu de la victime. L'âge moyen des victimes est de 12.1 ans. Parmi celles-ci, 7% ont une déficience intellectuelle et 6% ont un handicap physique. Quelques solutions de traitement sont exposées telles la solution judiciaire et la solution de l'intervention sociale qui consiste en un traitement psycho-social. Cet article met également l'accent sur la prévention par le biais d'une éducation sexuelle appropriée.

Mrazek, P. B. (1981). The nature of incest: A review of contributing factors. In P. B. Mrazek & C. H. Kempe (eds.), *Sexually abused children and their families* (pp. 97-107). Oxford: Pergamon Press.

The author reviews known and suspected factors in incest. Several factors may have particular relevance to developmentally disabled populations. Social isolation identified as a factor has been identified as a problem for many families with handicapped children. Stress is another factor that exists as a constant reality for many families with handicapped children. Alcoholism has also been noted as a significant factor for incest. Alcoholism within the family has also been identified as a major cause of handicapping conditions for children. Mental subnormality has also been identified as a factor in both the adult and the child.

Mrazek, P. B., & Mrazek, D. A. (1981). Effects of child sexual abuse. In P. B. Mrazek & C. H. Kempe (Eds.), *Sexually abused children and their families* (pp. 225-245). Oxford: Pergamon Press

The authors point to three studies that suggest that impaired educational performance and intellectual retardation may result from sexual abuse of the child.

Myre, J. G. (1986). *Les enfants mal aimés: On en retrouve dans votre quartier et chez vous ... Réagissons.* Québec: Comité de protection de la jeunesse.

Ce rapport révèle que les abus sexuels sont une réalité chez une fille sur deux et un garçon sur trois. De ces enfants, trois sur cinq ont été menacés ou forcés physiquement par leurs agresseurs, qui sont dans la plupart des cas des personnes connues des victimes avec qui elles entretenaient des rapports de confiance. L'auteur insiste sur les traumatismes conséquents à ces actes de même qu'à l'intervention requise. Un inventaire des ressources du Québec est exposé.

Nanaimo Rape/Assault Centre. (1984). *Realities of child sexual abuse.* Nanaimo, B.C.: Author.

his book provides a good summary of basic information and issues related to child sexual abuse. Text is generally well written and free of technical jargon. Helpful lists of references and resources are included. Special issues related to disabilities are not discussed.

Paiement, J., & Pilon, J. (1985). *Les agressions sexuelles faites aux enfants: Parlons-en pour mieux les prévenir.* Montréal: Parents anonymes du Québec inc.

Quelques exemples d'abus sexuels sont donnés sous forme de lexique tels le viol, l'inceste, la pédophilie etc. Il est question des effets de l'abus sexuel sur l'enfant et des facteurs susceptibles d'influencer le degré de traumatisme subi. Ces facteurs sont: relation entre l'enfant et l'agresseur, nature et fréquence de l'agression, personnalité et âge de l'enfant, réactions de l'entourage. Une distinction est faite entre les effets à long terme et à court terme. Profil de l'agresseur. Attitudes à adopter et règles à suivre pour aider un enfant abusé sexuellement et attitudes et réactions à éviter.

Pettis, K. W., & Hughes, R. D. (1985). Sexual victimization of children: implications for educators. *Behavioral Disorders, 10*(3), 175-182.

The authors provide information to educators who may come into contact with sexual abuse. Several articles are cited in which the authors found higher risk of abuse in mentally or physically handicapped or emotionally disturbed populations.

Rindfleisch, N., & Rabb, J. (1984). How much of a problem is resident mistreatment in child welfare institutions? *Child Abuse and Neglect, 8*, 33-40.

The purpose of this article is to provide information developed since 1980 by the Institutional Children Protection Project regarding the size and significance of the problem of mistreatment in child welfare residential institutions. In the 1,700 facilities surveyed, there are about 69,000 children and youths. Maltreatment in the survey meant abuse and neglect. The definition of abuse and neglect used in the survey was the respondent's own subjective view. As a result the authors believe the data represent incidents of a generally more serious nature but the survey does not give a breakdown of the specific type of abuse. Rates of utilization vary among Health and Human Services (H.H.S.) regions from 8 per 10,000 to 19 per 10,000 children and youth in the population. The average rate is 12 per 10,000. The survey also included visits to sites to confirm the results. Observations of site visitors suggest that only one out of five complainable situations may be reported to child protection agencies. A list of complainable occurrences that come to the attention of site visitors is included to document the problem. The list includes incidents of sexual abuse. The authors believe residential complaint rates may be twice as large as intrafamilial complaint rates.

Schlesinger, B. (Ed.). (1986). *Sexual abuse of children in the 1980s: An annotated bibliography.* Toronto: University of Toronto Press.

The book contains ten essays on different aspects of child sexual abuse. It also contains an annotated bibliography on the problem. The annotated bibliography is divided into different subject areas. One of the areas containing an article is on mentally retarded and sexual abuse.

Sgroi, S. (1986). *L'agression sexuelle et l'enfant: Approche et thérapies.* Québec: Editions du Trécarré.

A travers ces 427 pages, il est question de l'exploitation envers les enfants et ce, tant au niveau du diagnostic que du traitment. Un profil de la situation est dressé et il en ressort que l'inceste est un phénomène courant dans les cas d'exploitation sexuelle. Parmi les traitements à envisager, notons la thérapie de groupe pour les victimes. Un traitement est également conseillé aux mères de même qu'à la famille au complet. Une évaluation des programmes actuels est faite et des suggestions sont apportées tant au niveau de la prévention que du traitement. Dans ce volume, in n'est aucunement question de victimes d'agression sexuelle ayant un handicap quelconque.

Sgroi, S. (1987). Les agressions sexuelles contre les enfants: Le point de vue d'une spécialiste américaine. *Justice*, sept. '87, pp. 10-11.

Cet article est un compte rendu d'une conférence donnée par une américaine lors de son passage à Montréal. Elle aborde l'abus sexuel dans toutes ses dimensions et préconise une approche intégrée (médicale, sociale, judiciaire) pour le combattre. Pour elle, la façon idéale de stopper les agressions sexuelles, c'est d'imposer la thérapie à l'agresseur pour un minimum de cinq ans, celle-ci devant être faite en group. De plus, l'agresseur devrait défrayer les coûts de sa thérapie comme cela se fait aux Etats-Unis.

Sgroi, S. M. (Ed.). (1982). *Handbook of clinical intervention in child sexual abuse.* Lexington, MA: Lexington Books.

This book provides many chapters on the treatment of victims of child sexual abuse. There is virtually no discussion, however, of special needs of victims with disabilities. The methods discussed generally depend heavily on the verbal skills of the victim which has serious implications for victims with little receptive or productive language.

Sgroi, S. M. (1982). Introduction: The state of the art in child-sexual-abuse intervention. In S. M. Sgroi (Ed.). *Handbook of clinical intervention in child sexual abuse.* (pp. 1-8). Lexington, MA: Lexington Books.

The author in discussing child sexual abuse refers to information that suggests that child sexual abuse is characterized by power inequalities and that the abusive act is motivated by power, aggression, and the perceived power disadvantage of the victim. This suggests a conceptual framework for understanding why disabled individuals are at greater risk. They are perceived as defenseless (and in many cases are more vulnerable) by their abusers and thus become more attractive victims.

Shah, C. P., Holloway, C. P., & Vaikil, D. V. (1982). Sexual abuse of children. *Annals of Emergency Medicine, 11*(1), 18-23.

The article reviews the characterisics of 843 cases of sexual abuse seen at the emergency department of the Hospital for Sick Children (HSC) in Toronto in 1962, 1967, and from 1977 to 1978. The children ranged in age from 23 days to 18 years, with a mean age of 9.8 years. Most (89.4%) were girls. The 174 cases seen from 1977 to 1978 were analyzed in detail. Among these, intercourse was the form of abuse in 70 (40%); molestation, in 41 (24%); and exhibitionism, in 36 (20%). Almost half (49%) of the offenses occurred in the child's or assailant's home. Of the 174 cases, there were seven children who were diagnosed prev iously as mentally retarded. The age range was from 12 to 17 years, with a mean age of 14.3 years. All but one were girls. The assailant was unknown in three cases, an acquaintance in three other cases, and a relative in one case.

Shore, D. A. (1982). Sexual abuse and sexual education in child caring institutions. In J. R. Conte, & D. A. Shore (Eds.), *Social work and child sexual abuse* (pp. 171-184). New York: The Haworth Press.

The author of this chapter suggests that sexual neglect and sexual abuse are problems in institutional care of children and youth, but points out that this topic has not been the subject of any research. Sexual neglect is discussed as the failure to provide appropriate role models, adequate sex education, or opportunities for appropriate sexual expression. Sexual neglect in addition to being directly harmful is viewed as contributing to the risk of sexual abuse.

Steele, B. F., & Alexander, H. (1981). Long-term effects of sexual abuse in childhood. In P. B. Mrazek & C. H. Kempe (Eds.), *Sexually abused children and their families* (pp.223-234). Oxford: Pergamon Press.

In reviewing the prognosis for victims of child sexual abuse, the authors point out that children with intellectual deficits or emotional disorders have a worse prognosis for long-term adjustment than non-handicapped victims.

Zeller, C. (1987). *Des enfants maltraités au Québec?* Les publications du Québec, Comité de protection de la jeunesse.

L'auteur dresse un portrait des enfants maltraités au Québec. Parmi ceux-ci, 28% souffrent d'un ou de plusieurs handicaps, principalement de problèmes de langage ou de déficience mentale La moitié sont des mésadaptés sociaux. Dans le cas des abus sexuels, une victime sur cinq souffre d'un handicap et 11% de plusieurs. 57% sont des mésadaptés sociaux . Un chapitre entier est consacré à l'inceste et un autre à la sexualité des jeunes. En dernier lieu, l'auteur met l'accent sur la protection des victimes d'abus sexuels ainsi que sur le traitement de l'inceste en particulier.

OTHER RELATED MATERIAL

Baker, L. B., Seltzer, G. B., & Seltzer, M. M. (1977). *As close as possible: Community residences for retarded adults.* Boston: Little, Brown and Company.

The authors conducted a survey of community residences for mentally handicapped adults across the United States. Of interest here is the data obtained on the autonomy of the residents in regard to entertaining nonresidents of the opposite sex within the house. The results showed 5.6% of residences did not allow residents to entertain members of the opposite sex; 27.5% allowed such visits, but only in certain rooms; 7.8% allowed such visits, but only at certain times; 29.4% allowed the visits, with both time and place restrictions; 16.6% had no policy; and 13.1% left the decision up to the resident. In total, 70.3% of the residences had some type of restriction in regard to socializing with the opposite sex.These results point to the lack of autonomy given to many developmentally disabled persons in the area of social-sexual relationships. The opportunities for developing appropriate relationships with the opposite sex are largely restricted. When combined with an absence of sex education, many residents may be more vulnerable to sexual exploitation.

Blumberg, M. L., (1979). Character disorders in traumatized and handicapped children. *American Journal of Psychotherapy, 33*(2), 201-213.

Character disorders represent neurotic behaviour disturbances that may have their origin during the early formative years of childhood. Precipitating factors are family crises of death, divorce, violence, and particularly child abuse and neglect. Sexual abuse of the child may create latent, long-range disturbances that will affect future adult adjustment. Stresses of a poor socioeconomic environment, the gang, and school difficulties are further aggravation. Violence in the popular television medium has a profound influence on the viewer, especially in the presence of an existing character disorder or a disturbed personality. Physical handicaps and mental retardation are problems with which children and their families must cope adequately lest they predispose to the development of character disorders. The effects of emotional dysfunction in childhood are often apparent in later life as aberrant adult behaviour patterns. Preventive and therapeutic measures should be initiated early and a multidisciplinary approach with long follow-up should be adopted.

Bristol, M. M., & Schopler, E. (1984). A developmental perspective on stress and coping in families of autistic children. In J. Blacher (Ed.), *Severely handicapped young children and their families* (pp. 91-142). Orlando, FL: Academic Press.

This chapter provides a good discussion of the stress that families of autistic children experience. It details the nature and extent of stress that the families of many children with disabilities experience.

Cirrin, F. M., & Rowland, C. M. (1985). Communicative assessment of nonverbal youths with severe/profound mental retardation. *Mental Retardation, 23*,52-62.

The authors use natural observation to study communication functions of severely handicapped, nonverbal signers in an institution. Their low rates of initiation and dependence on others for interaction may provide clues to why many victims of abuse with disabilities fail to report abuse until directly questioned.

Cullen, J. I., & Boersma, F. J. (1982). The influence of coping strategies on the manifestation of learned helplessness. *Contemporary Educational Psychology, 7,* 346-356.

Thirty learning disabled and thirty normally achieving fourth grade boys experienced failure on a problem solving task, following which they received either tutor assistance or self-instructional training to induce success in coping with failure, or a no-training condition. Training effects were assessed on a subsequent problem solving task and a measure of continuing motivation. Tutor-assistance training was more effective than self-instructional training for decreasing the number of problems on which learning-disabled boys gave up prior to solution. Compared with their untrained controls, learning-disabled subjects with tutor assistance training gave up less often and solved more problems. Continuing motivation increased with learning-disabled boys who received tutor-assistance training and normally achieving boys without training. Untrained normal achievers attributed failure to adoption of specific task strategies, while untrained learning-disabled boys attributed failure to task difficulty. It was suggested that characteristics of learned helplessness were apparent in the impaired performance of the learning-disabled boys. Normal achievers appeared to have developed active and independent strategies for coping with failure. Relevant implications suggest that training may reduce learned helplessness in disabled populations and may be useful in reducing vulnerability to abuse.

***Journal of Applied Behavior Analysis.* (1987). Cumulative Index, *Journal of Applied Behavior Analysis, 20,* (4, part 2), 429-493.**

The index lists over 80 articles on the importance of teaching generalization (most with disabled subjects) published over the past 20 years, but only four that focus on discrimination skills. This means that handicapped children are typically trained to comply with the instructions of any adult and that protest or resistance are punished. Such a student becomes the perfect target for abuse.

Lakin, K. C., & Bruininks, R. H. (1985). Social integration of developmentally disabled persons. In K. C. Lakin & R. H. Bruininks (Eds.), *Strategies for achieving community integration of developmentally disabled citizens* (pp. 3-25). Baltimore: Paul H. Brookes.

This chapter contains statistics regarding the movement away from institutionalization of the developmentally disabled. Between 1966 and 1981, public school systems in the U.S. expanded special education services from 2.1 million to 3.9 million handicapped children. The total population of large state institutions for developmentally disabled persons decreased from 194,650 to 119,335 between 1967 and 1982. During the same period, the number of developmentally disabled persons in private and state facilities decreased from 130.4 to 106.3 per 100,000 of U. S. population. Finally, between 1969 and 1982 the number of developmentally disabled persons in smaller, privately operated placements grew from 24,355 to 115,032. As more and more developmentally disabled people live in the community at large, a greater number of incidents of sexual abuse may come to the attention of community agencies, rather than being handled within institutions.

Light, J., Collier, B., & Parnes, P. (1985). Communicative interaction between young nonspeaking physically disabled children and their primary caregivers. *Augmentative and Alternative Communication, 1,* 74-83.

The authors study communication functions in physically handicapped children. Overall low rates of communication, especially of initiation suggest that many victims of abuse with disabilities would be unlikely to report the incident unless directly asked.

Mayer, A. (1985). ***Sexual abuse: Causes, consequences and treatment of incestuous and pedophilic acts.*** **Florida: Learning Publications.**
The book deals with with incestuous and pedophilic acts and the causes, consequences and treatment of these acts. It specifically deals with sexual abuse of handicapped children in the section on children who are at risk (p. 35).The author states that children who are handicapped are at risk because there is less likelihood that they will disclose the fact that abuse is occurring.

McAfee, J. K., & Gural, M. (1988). Individuals with mental retardation and the criminal justice system: The view from States' attorneys general. ***Mental Retardation, 26,*** **5-12.**
This article deals primarily with people with mental retardation who are accused of criminal offenses. However, some of the problems cited with defendants also are of concern to victims. Police, prosecutors, and judges typically lack information about people with disabilities.

Orelove, F. P., & Sobsey, D. (1987). ***Educating children with multiple disabilities.*** **Baltimore, MD: Paul H. Brookes.**
This book provides information relevant to the education of children with multiple handicaps. The chapter on communication addresses the extreme limits of many individuals who are unable to report or testify regarding abuse, and often lack the ability to communicate rejection or protest against abuse. Often their primitive attempts to communicate their protest or rejection of abuse are viewed as inappropriate behaviour on their part and punished by their caregivers. Punishment of rejection and protest behaviour subsequently leads to more withdrawn and compliant behaviour.

Schilit, J. (1979). The retarded offender and criminal justice personnel. ***Exceptional Children, 46,*** **16-22.**
This article discusses people who are mentally handicapped who are accused of a crime. One of the findings, however, is also important for victims with disabilities. Schilit found that 90% of police officers, judges, and lawyers involved in criminal cases had no training or expertise in mental retardation.

Shevin, M., & Klein, N. K. (1984). The importance of choice-making skills for students with severe disabilities. ***Journal of the Association for Persons with Severe Handicaps, 9,*** **159-166.**
The authors point out the limited decision making skills and high degree of cue dependency of severely handicapped individuals. The authors indicate that this may result more from inappropriate training than from the disability, and urge decision making training. Such training may be essential to the development of meaningful prevention programs.

Silverman, R. A. (1974). Victim typologies: Overview, critique, and reformulation. In I. Drapkin & E. Viano (Eds.), *Victimology* (pp. 55-65). Lexington, Mass: Lexington Books.

The author critically reviews major victim typologies. He examines victim classifications undertaken by Von Hentig, Mendelsohn, Abdel-Fattah, Sellin and Wolfgang. Von Hentig's classification is based on social, psychological and biological factors of which one of the classifications is the mentally defective and another is the mentally deranged. Mendelsohn's classification is characterized by the amount of guilt a victim contributes to the event. One classification is the "completely innocent" victim and an example is of all children. Abdel Fattah's classification is based on the participation of the victim in the crime. One classification is latent or predisposed victims who because of peculiar predispositions or traits of character are more liable than others to be victims of certain types of offenses. Sellin's and Wolfgang's classification is based on relatedness of the victim to the crime. For example, primary or secondary victim are two classifications. The author makes a recommendation as to the best typology.

Skinner, B. F. (1953). *Science and human behavior.* New York: Macmillan.

Skinner explores the notion of counter control, and presents a model in which power and authority must be restrained by individual or social counter controls to prevent abuse. This model is consistent with the notion that people with disabilities are victimized because they lack counter control, and that "absolute power corrupts absolutely."

Souther, M. D. (1984). Developmentally disabled, abused and neglected children. In Dept. of Health and Human Services, *Perspectives on child maltreatment in the mid 80's* (pp.33-35). Washington, DC: Human Development Services.

Abused and neglected children are frequently at risk for developmental disabilities. Studies show that children who have been abused and neglected can become handicapped because of their maltreatment.

Stoneman, Z., & Brady G. H. (1984). Research with families of severely handicapped children: Theoretical and methodological considerations. In J. Blacher (Ed.), *Severely handicapped young children and their families: Research in review.* (pp. 179-214) Orlando, FL: Academic Press.

Methods for studying families are reviewed. The authors suggest that a severely handicapped child places great stress on the mental and physical resources of family members . The authors also stress the fact that little is really known about the family dynamics of families of children with severe handicaps. They point out that spousal relationships may be altered by the demands of the severely handicapped child.

Streissguth, A. P., Barr, H. M., & Martin, D. C. (1983). Maternal alcohol use and neonatal habituation assessed with the Brazelton Scale. *Child Development*, 54, 1109-1118.

This article describes some of the research that helped document the nature and extent of mental retardation that is associated with maternal alcohol use during pregnancy. The evidence suggests that maternal alcohol use is a major causal factor in mental retardation.

Turner, T. S. (1988, February). Human rights concerns in health care institutions. *The Spokesman*, 17-18.
This article discusses the effect of institutionalization on the social, emotional, and legal status of those who enter them. The author points out that institutionalization is characterized by choicelessness, powerlessness and vulnerability. People typically adapt by becoming increasingly passive, dependent and compliant. Although the author does not directly address abuse issues, such an individual is likely to be at risk for abuse and exploitation

White, R., Benedict, M., Wulff, L., & Kelley, M. (1987). Physical disabilities as risk factors for child maltreatment: A selected review. *American Journal of Orthopsychiatry, 57*(1), 93-101.
The child maltreatment literature, which implies that children with physical disabilities may be at increased risk for abuse or neglect, is evaluated with reference to theoretical, definitional, and methodological concerns. Research issues are discussed and suggestions made for further delineating and defining the nature of any linkages that may exist.

Wilcox, B., & Bellamy, G. T. (1982). *Design of high school programs for severely handicapped students*. Baltimore: Paul H. Brookes.
As an example of a leading guide to high school curricula for the severely handicapped, it can be seen that the major areas of education include vocational preparation, independent living and leisure/recreation. However, sex education is not addressed in this book at all.

Von Hentig, H. (1967). *The criminal and his victims*. U.S.: Archon Books.
The book examines the characteristics of criminals and the characteristics of the victim. It notes that certain studies suggest a relationship between physical disability and crime. The studies cannot be conclusive since the size of the population of disabled is unknown, and other social factors effect this figure - 1) the second world war produced a number of disabled and 2) past criminal activity was punished by disfigurement of a person. The author also notes that the superstition that mental deficiency is a direct cause of crime has been done away with but that studies show that those with lower intelligence populate the prison. This fact may arise because a crime committed by those of higher intellect goes undetected. The author recognizes four general classes of victims - the young, the female, the old, and the mentally defective. These classes are more likely to be a victim of an attack because of their weakness or vulnerability. The author has classified victims by "general classes" and by "psychological" types. The author bases his criteria on social, psychological and biological factors which offer indications for classification. The author also has seven more specific classes: 1) the immigrants, minorities, and dull normals; 2) the depressed; 3) the acquisitive; 4) the wanton; 5) the lonesome and heart broken; 6) the tormentor; and 7) the blocked, exempted and fighting victim.

Zigler, E., & Balla, D. (1981). Issues in personality and motivation in mentally retarded persons. In M. J. Begab, H. C. Haywood, & H. L. Garber (Eds.), *Psychosocial influences in retarded performance* (pp 197-218). Baltimore, MD: University Park Press.

The authors cite their research findings in regard to personality characteristics of mentally handicapped individuals living in institutions. Several characteristics have been found to be typical in the mentally handicapped. Social deprivation tends to increase the handicapped child's motivation to interact with adults for social reinforcement. Overdependency on peers, teachers and other nonfamily socializing agents increases as the mentally handicapped child grows older. These children also tend to make choices that increase their chances of receiving reinforcement when given problem-solving tasks, which indicates an expectancy of failure. Imitativeness and outerdirectedness, meaning a great reliance on external cues to guide behaviour, are also common character traits. The potential effects of the characteristics noted regarding sexual abuse are that mentally handicapped people may be easily coerced into exploitive situations because of the attention and affection the victim perceives he or she is getting. As well, the reliance on cues from external sources and dependence on others decreases the chances of the victim resisting the abuser. In situations where the child does object to the abuse, the expectation of failure may inhibit him or her from trying to stop the abuse or ask for help.

Zirpoli, T. J., Snell, M. E., & Loyd, B. H. (1987). Characteristics of persons with mental retardation who have been abused by caregivers. *The Journal of Special Education, 21*(2), 31-41.

The relationship between specific characteristics of individuals with mental retardation, as rated by their teachers, and their abuse by residential caregivers was investigated. Teacher ratings of 91 abuse victims from five state training centers in Virginia for individuals with mental retardation were compared to 91 randomly selected control subjects from the same facilities. Discriminant analysis results indicated a significant relationship ($p < .001$) between abuse status and a linear combination of subject characteristics. In addition, the Pearson chi square test of independence was used to test the relationship between individual characteristics and behaviours of subjects and abuse status. Results indicated a significant relationship ($p < .05$) between abuse status and teacher ratings of level of functioning and frequency of maladaptive behaviours. Implications for caregivers and educators are discussed.

APPENDIX B

Service Delivery Survey

1. What are the overall purposes of your agency?

2. What services do you provide ? [Please circle all appropriate services.]

Counselling **Family Counselling**
Advocacy **Sex Education**
Legal Services **Medical Treatment**
Criminal Investigation
Other:_____
_____

3. Approximately how many people do you serve each year? _____

4. Approximately how many of your clients fall into the following categories? [Please note that some clients may be listed in more than one category]

AGE: ____ under 6 ____ 6-12 ____13-16 ____17-21 ____ over 21

SEX: ____ female ____male

DISABILITY:

____none
____hearing impaired
____visually impaired
____psychiatrically impaired
____ physically handicapped
____mildly mentally retarded
____ moderately mentally retarded
____severely mentally retarded
____profoundly mentally retarded

5. Approximately how many potential clients cannot be served due to the nature and extent of their disability?

____ hearing impaired
____ visually impaired
____ psychiatrically impaired
____ physically handicapped
____ mildly mentally retarded
____ moderately mentally retarded
____ severely mentally retarded
____ profoundly mentally retarded

6. Are the services you provide to other clients appropriate to clients with the following disabilities? [Please circle appropriate responses]

hearing impaired	YES	NO	SOMETIMES	NOT SERVED
visually impaired	YES	NO	SOMETIMES	NOT SERVED
psychiatrically impaired	YES	NO	SOMETIMES	NOT SERVED
physically handicapped	YES	NO	SOMETIMES	NOT SERVED
mildly mentally retarded	YES	NO	SOMETIMES	NOT SERVED
moderately mentally retarded	YES	NO	SOMETIMES	NOT SERVED
severely mentally retarded	YES	NO	SOMETIMES	NOT SERVED
profoundly mentally retarded	YES	NO	SOMETIMES	NOT SERVED

7. What (if any) modifications do you make in your services to each of the following clients?

hearing impaired clients

visually impaired clients

psychiatrically impaired clients

physically handicapped clients

mildly mentally retarded clients

moderately mentally retarded clients

severely mentally retarded clients

profoundly mentally retarded clients

8. What (if any) problems have you experienced in trying to serve people in any of the following categories?

hearing impaired clients

visually impaired clients

psychiatrically impaired clients

physically handicapped clients

mildly mentally retarded clients

moderately mentally retarded clients

severely mentally retarded clients

profoundly mentally retarded clients

9. What resources would be most useful to remedy any problems cited above?

10. Based on your experience, for each category of disability, indicate how you feel the risk of sexual abuse/ sexual assault compares with that for the general population.

hearing impaired	reduced risk	same risk	increased risk
visually impaired	reduced risk	same risk	increased risk
psychiatrically impaired	reduced risk	same risk	increased risk
physically handicapped	reduced risk	same risk	increased risk
mildly mentally retarded	reduced risk	same risk	increased risk
moderately mentally retarded	reduced risk	same risk	increased risk
severely mentally retarded	reduced risk	same risk	increased risk
profoundly mentally retarded	reduced risk	same risk	increased risk

11. Do you feel sexual assault victims' services should be provided to people with each of the following

disabilities by the same agencies that provide those services to people without disabilities or by special agencies?

CLIENTS	*SERVICE OPTIONS*
hearing impaired	a. by the same agencies b. by special agencies
visually impaired	a. by the same agencies b. by special agencies
psychiatrically impaired	a. by the same agencies b. by special agencies
physically handicapped	a. by the same agencies b. by special agencies
mildly mentally retarded	a. by the same agencies b. by special agencies
moderately mentally retarded	a. by the same agencies b. by special agencies
severely mentally retarded	a. by the same agencies b. by special agencies
profoundly mentally retarded	a. by the same agencies b. by special agencies

Please return this form to: **Developmental Disabilities Centre** Sexual Abuse & Exploitation Study / 6-123 Education North / University of Alberta / Edmonton, AB T6G 2G5 [403] 432-3755 by December 15, 1987.

Appendix C

SEXUAL ABUSE & DISABILITY STUDY REPORT FORM

Please fill out the following report as completely as possible. **To ensure confidentiality, do not identify victim, offender, or reporter of criminal acts.** Attach additional sheets if you wish. Report information related to only one victim on each form. Copy or request additional forms if you wish to make more than one report. RETURN BY DECEMBER 31, 1987 to **Developmental Disabilities Centre: Sexual Abuse & Exploitation Study / 6-123 Education North / University of Alberta / Edmonton, AB T6G 2G5 .** ***BE SURE TO COMPLETE BOTH SIDES OF REPORT!***

1. DATE OR APPROXIMATE DATE OF SINGLE OFFENSE: Date __ __ Month __ __ Year __ __

2. APPROXIMATE TIME OF DAY: [list] __ __ **Hour** [circle] **AM** [or] **PM**

3. IF REPEATED OFFENSE, ON HOW MANY OCCASIONS DID THIS OCCUR? ____

4. WHERE DID THIS OCCUR? (for example, victims bedroom in home, public park, group home basement)

5. PLEASE DESCRIBE OFFENSE BRIEFLY BUT CLEARLY._____

_____

_____

6. HOW DID YOU GAIN KNOWLEDGE OF THE OFFENSE? _____

_____

7. WAS THE OFFENDER CHARGED WITH THE OFFENSE? [circle] **YES** [or] **NO**

7A1. IF YES, WHAT WAS THE CHARGE? _____

7B. IF NO, WHY NOT? _____

_____

9. WAS THE OFFENDER CONVICTED OF THE OFFENSE? [circle] **YES** [or] **NO**

10. WHAT WERE THE AGE AND SEX OF THE VICTIM? ____**YEARS**
[circle] **MALE** [or]**FEMALE**

10A. . WHAT WERE THE AGE AND SEX OF THE OFFENDER? ____**YEARS**
[circle] **MALE** [or]**FEMALE**

11. WHAT WAS THE RELATIONSHIP OF THE OFFENDER TO THE VICTIM? [for example, step-brother, stranger, teacher, parent, personal care attendant]

_____

12. WHAT WERE THE NATURE AND EXTENT OF THE VICTIM'S DISABILITY [or DISABILITIES]?

12A. IF THE OFFENDER WAS ALSO DISABLED WHAT WAS THE NATURE AND EXTENT OF DISABILIY?

---

13. IN WHAT WAY, [IF ANY, DID THE VICTIM'S DISABILITIES CONTRIBUTE TO VULNERABILITY?

---

14. WHAT WAS THE NATURE AND EXTENT OF PHYSICAL INJURY TO THE VICTIM [if any]?

---

15. WHAT WAS THE NATURE AND EXTENT OF SOCIAL, EMOTIONAL, AND / OR BEHAVIORAL INJURY TO THE VICTIM [if any]?

---

16. WHAT TYPES OF SERVICES WERE SOUGHT TO TREAT OR SUPPORT THE VICTIM?

---

17. IF TREATMENT OR SUPPORT SERVICES WERE SOUGHT, WAS THERE DIFFICULTY IN OBTAINING SERVICES FOR THE VICTIM BECAUSE OF THE VICTIM'S DISABILITIES? [circle] YES [or] NO

18. IF SERVICES WERE OBTAINED, WERE DID THESE SERVICES FULLY MEET ANY SPECIAL NEEDS OF THE VICTIM THAT RESULTED FROM THE VICTIM'S DISABILITIES? [Circle One]

A. THE VICTIM RECEIVED THE SAME SERVICE AS OTHERS, NO SPECIAL SERVICES REQUIRED

B. SERVICES FOR THE VICTIM MET THE SPECIAL NEEDS OF THE VICTIM'S DISABILITIES

C. SERVICES WERE ALTERED TO MEET THE SPECIAL NEEDS OF THIS VICTIM, BUT THE ALTERATIONS WERE NOT ADEQUATE

D. NO SPECIAL SERVICES WERE PROVIDED, BUT THEY WOULD HAVE BEEN HELPFUL

E. SPECIAL SERVICES WERE PROVIDED BECAUSE OF THE VICTIM'S DISABILITIES, BUT WERE NOT REALLY NECESSARY

19. OTHER COMMENTS:

ETUDE SUR LES ABUS SEXUELS ET LES HANDICAPES

FORMULAIRE DE RAPPORT

Remplissez le rapport suivant le plus complètement possible. Pour assurer la confidentialité, ne mentionnez pas le nom de la victime, de l'abuseur ou de l'informateur des actes criminels. Joignez des feuilles additionnelles si vous le désirez. Reportez l'information à une seule victime sur chaque formule. Copiez ou demandez des formulaires additionnels si vous désirez produire plus d'un rapport. RETOURNEZ AVANT LE 31 DECEMBRE 1987 A :
UNIVERSITE DE MONTREAL, a/s Jacques Langevin, C.P.6128 , succursale A, Montréal, Québec, H3C 3J7

ASSUREZ-VOUS D'AVOIR COMPLETE LES DEUX FEUILLES DE CE RAPPORT.

1. DATE OU JOUR APPROXIMATIF DE L'OFFENSE: Date __ __ Mois __ __ Année __ __

2. TEMPS APPROXIMATIF DE LA JOURNEE: Heure __ __ AM ou PM (encerclez)

3. S'IL NE S'AGIT PAS D'UNE PREMIERE OFFENSE, COMBIEN DE FOIS CELA EST-IL ARRIVE ? _____

4. OU CELA EST-IL ARRIVE ? (par exemple: chambre à coucher de la victime, stationnement public, sous-sol d'édifice à logement, etc...)
_____

5. DECRIVEZ BRIEVEMENT ET CLAIREMENT L'OFFENSE. _____
_____ _____
_____

6. COMMENT AVEZ-VOUS ETE INFORME DE L'OFFENSE ? _____
_____

7. L'ABUSEUR A-T-IL ETE ACCUSE DE L'OFFENSE ? oui ou non (ercerclez)

7A. SI OUI, QUELLE A ETE L'ACCUSATION? _____

7B. SI NON, POURQUOI? _____
_____

8. L'ABUSEUR A-T-IL ETE DECLARE COUPABLE DE L'OFFENSE? oui ou non (encerclez)

9. QUELS ETAIENT L'AGE ET LE SEXE DE LA VICTIME? ___ ans
masculin ou féminin (encerclez)

10. QUELS ETAIENT L'AGE ET LE SEXE DE L'ABUSEUR? ___ ans
masculin ou féminin (encerclez)

11. QUELLE ETAIT LA RELATION ENTRE L'ABUSEUR ET LA VICTIME? (par exemple, beau-frère, étranger, professeur, parent, préposé aux soins personnels...)

_____

12. QUELLE ETAIT LA NATURE ET L'AMPLEUR DE L'HANDICAP (ou des handicaps) DE LA VICTIME? _____

12A. SI L'ABUSEUR ETAIT LUI AUSSI HANDICAPE, QUELLE ETAIT LA NATURE ET L'AMPLEUR DE SON HANDICAP? _____

13. DE QUELLE MANIERE, S'IL Y A LIEU, LES HANDICAPS DE LA VICTIME ONT-ILS CONTRIBUES A SA VULNERABILITE? _____

14. QUELLE A ETE LA NATURE ET L'AMPLEUR DES BLESSURES PHYSIQUES DE LA VICTIME (s'il y a lieu) ? _____

15. QUELLE A ETE LA NATURE ET L'AMPLEUR DE LA BLESSURE SOCIALE, EMOTIONNELLE OU MORALE DE LA VICTIME (s'il y a lieu) ? _____

_____

16. QUELS GENRES DE SERVICES ONT TENTE DE TRAITER OU DE SUPPORTER LA VICTIME?

_____

17. SI UN TRAITEMENT OU UN SERVICE D'ASSISTANCE A ETE TENTE, A-T-IL ETE DIFFICILE D'OBTENIR DES SERVICES POUR LA VICTIME A CAUSE DE SES HANDICAPS?

oui ou non (encerclez)

18. SI DES SERVICES ONT ETE OBTENUS, CEUX-CI ONT-ILS PLEINEMENT RENCONTRES TOUS LES BESOINS SPECIFIQUES RESULTANTS DU OU DES HANDICAPS DE LA VICTIME?

(Encerclez un choix)

A. LA VICTIME A RECU LE MEME SERVICE QUE LES AUTRES, AUCUN SERVICE SPECIAL NE FUT REQUIS

B. LES SERVICES APPORTES A LA VICTIME ONT TENU COMPTE DES BESOINS SPECIFIQUES A SON (OU SES) HANDICAP(S)

C. LES SEVICES ONT ETE MODIFIES POUR RENCONTRER LES BESOINS SPECIFIQUES A CETTE VICTIME MAIS LES MODIFICATIONS N'ETAIENT PAS ADEQUATES

D. AUCUN SERVICE SPECIAL N'A ETE FOURNI MAIS IL AURAIT ETE UTILE DE LE FAIRE

E. DES SERVICES SPECIAUX ONT ETE UTILISES A CAUSE DU (OU DES) HANDICAP(S) DE LA VICTIME MAIS N'ETAIENT PAS VRAIMENT NECESSAIRES

19. AUTRES COMMENTAIRES:

Appendix D

NATIONAL STUDY OF DISABILITIES AND SEXUAL ABUSE

Dick Sobsey
University of Alberta

The University of Alberta Developmental Disabilities Centre is currently conducting an intensive four month study of ***Sexual Abuse and Exploitation of Children and Young Adults with Disabilities*** as part of a series of studies sponsored by Health and Welfare Canada to help determine national priorities for the National initiative against child sexual abuse. The primary focus of the study is Developmental Disabilities, but the study has been expanded to identify issues and concerns for people with all types of disabilities. The investigators, Dick Sobsey and Connie Varnhagan, would be grateful for assistance from all interested in the topic. Little published information is available indicating the nature or extent of the problem and it is important that any existing problems are adequately documented to ensure that Health and Welfare Canada considers the needs of this group in planning future priorities.

Preliminary information suggests that the risk of sexual abuse and exploitation is increased for people with disabilities and that a higher proportion of victims of sexual abuse and exploitation are disabled than would be expected from the proportion in the general population. It also appears that many of the services provided to other victims of abuse are inaccessible to or inappropriate for people with some types of disabilities. Therefore, this group appears to be more likely victimized and less likely to receive appropriate treatment and support services.

If you have information regarding this problem or suggestions for the investigators you can contact the investigators. Information presented before December 31st, 1987 can be included in making a report to Health and Welfare Canada, but all information will be retained by the investigators. The authors would be especially grateful to people willing to provide brief reports of specific incidents. Case report forms will be provided on request,but reports may be presented in any format. No identifying information regarding the victim should be included in the report. Informants need not identify themselves.

For those providing treatment, support or prevention services to disabled victims of sexual abuse or involved in research relevant to this study, please contact the investigators. They will send you a form for listing in our national resource directory that will help build a network of people concerned with this topic. They would also appreciate any information (or better yet copies of) on reports, briefs, documents, newpaper clippings, bibliographies, or similar documents related to this topic particularly very recent or unpublished documents that might be difficult to obtain through the standard library search.

Your help will be appreciated, but more importantly, it will help to fully document and important problem. This documentation is an essential step toward protecting people with handicaps from sexual abuse and exploitation and developing more appropriate services for those who have been victimized.

Please contact the investigators with any relevant information: **Dick Sobsey / Developmental Disabilities Centre / Sexual Abuse & Exploitation Study / 6-123 Education North / University of Alberta / Edmonton, AB T6G 2G5 [403] 432-3755.** Thank you for your help.