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Patterns of Sexual Abuse and Assault

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Patterns of sexual abuse and sexual assault are analyzed from 162 reports involving victims with disabilities. Results suggest that abuse and assault are frequently repeated and chronic, often result in significant harm to the victim, and are rarely reported to child welfare or law enforcement authorities. Many offenses are committed by paid service providers and occur in disability service settings, but other offenses occur in the same situations as sexual abuse and assault of victims without disabilities. Victims are predominantly female and offenders are predominantly male. Charges and convictions are rare. Victims with disabilities often experience difficulty obtaining treatment services that are accessible and appropriate to their needs. Discussion considers a multifactorial, ecological model of abuse and recommends some possible prevention strategies.

KEY WORDS: Child sexual abuse; sexual assault; disabilities.

INTRODUCTION

The nature, extent, and patterns of sexual abuse and assault of persons with disabilities demonstrate a need for more prevention and treatment programs. In this article, the underlying meaning of these patterns and factors contributing to the continuation of abuse and assault are discussed. Before examining these patterns a brief review of relevant background information is necessary to establish context.

Children with disabilities are known to experience increased risk of being abused.(1,2) Ammerman, Van Haslett, Mersen, McGonigle, and Lubetsky(3) found that 39% of multihandicapped children admitted to an American psychi-

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atric institution had known histories of abuse. Gil(4) found 8% of 1,380 abused children had mental disabilities, 14% had physical disabilities, and 29% had other disabilities. Benedict, White, Wulff, and Hall(5) found that 10.6% ($^{53}/_{500}$) of multihandicapped children assessed by the Kennedy Institute in Baltimore between 1973 and 1984 had substantiated reports of child maltreatment. Although this funding is not the central focus of this research and the authors imply that this rate is not particularly high the State of Maryland Child Protective Services reports a rate of 10.18 per 1000 for 1987 for all reports and that only 24.6% are substantiated. When these numbers are converted to rates per 500 for a ten year period they indicate a rate in the general population of 11.96 per 500 or 2.39%. Thus, the number of cases reported appears to be 4.43 times the expected value.

The reasons for the relationship between abuse and disability are not entirely clear. Certainly, abuse is one cause of disability, and with improved diagnostic techniques, abuse is being recognized as the cause in more cases than previously thought.(6) However, abuse appears to be more frequent among people with disabilities even when it is ruled out as a cause of the disability. This relationship has sometimes been explained by hypothesizing that disability creates dependency that causes stress(7) for families and that families become abusive in response to stress. This relationship, however, has not been supported by research which fails to confirm that dependency level is a predictor of abuse.(5,8,9)

Sexual abuse of children with disabilities and sexual assault of adults with disabilities also appear to occur at a higher rate than in people without identified disability.(10) Doucette(11) found that women with a variety of disabilities were about one and a half times as likely to have been sexually abused as children as non-disabled women. Jacobson and Richardson(12) found high rates of sexual assault among women admitted to psychiatric care and discovered that 81 of 100 women admitted had a history of major physical or sexual assault prior to admission. Sullivan, Vernon, and Scanlan(13) cite several studies suggesting that 54% of deaf boys and 50% of deaf girls are sexually abused as children. Considering the presented norms for sexual abuse in the general population of 10% of boys and 25% for girls, these figures suggest the rate of sexual abuse is doubled for girls and five times as high for boys who are deaf. In a study of 55 hearing impaired children (36 males and 19 females) examined at the Boys Town Center for Abused Handicapped Children, Brookhouser, Sullivan, Scanlan, and Garbarino(14) found that 53 (96%) of the children had been sexually abused, Davies(15) found abnormal EEG readings and active epilepsy in three to four times as many incest victims as in a matched control group. Many additional studies linking physical and sexual abuse to disability have been reported.(16)

Although increased risk is well documented, little research has been done

that describes sexual abuse and assault as they affect people with disabilities. To gain a clearer picture of the nature of these phenomena, reports from victims and their advocates were collected and analyzed. This paper presents the results of this research and discusses the implications of those results.

METHOD AND SAMPLE

The reports analyzed in this chapter were collected over a two year period at the University of Alberta, Sexual Abuse and Disability Project. Requests were sent to a sample of sexual assault treatment centers and disability advocacy groups asking people with disabilities who had been victimized and their advocates to fill out reports describing the offenses. It is important to note that this method does not allow for a truly random sample. This limitation was imposed by the covert nature of the phenomenon under investigation and the ethical requirement of maintaining the privacy of informants. Police reports were rejected as a source of data for two reasons. First, many crimes against people with disabilities are never reported (36% of this sample). Second, there is no uniform reporting of victims' disabilities on North American police reports which makes it impossible to identify the population to be sampled.

One hundred and sixty-six reports were filed, and four were rejected because of incomplete information, duplication of previous reports, or failing to meet the criteria for sexual assault (i.e., third party reports of apparently consenting sexual activity between adults were excluded). All of the reports originated from North America: 88% originated from Canada with the remainder coming from the United States. The offenses described in these reports took place between 1960 and 1990 (mean year of occurrence = 1986.1, standard deviation = 3.7 years). Most of the offenses took place between 1986 and 1990, but some older cases were included because disclosure was delayed and the victim was currently receiving treatment.

RESULTS

The Victims

A wide range of disabilities was displayed in this sample as indicated in Table 1. Three additional reports did not specify the nature of the victim's disability adequately for placement in any of these categories. The total number of disabilities exceeded the number of victims because many victims had multiple disabilities. Of those identified as having intellectual impairment, 21 (28.4%) were identified as having a mild disability, 19 (25.7%) were identified

Table 1. Disabilities of victims in sample

	Intellectual Impairment	Mobility Impairment	Hearing Impairment	Psychological Impairment	Visual Impairment	Neurological Impairment	Autism	Learning Disability
Number	114	33	21	17	7	6	3	2
Percent	70.3	20.4	13.0	10.5	4.3	3.7	1.9	1.2

as having a moderate disability, 27 (36.5%) were identified as having a severe, and 7 (27.0%) were identified as having a profound disability. The remaining 20 victims with intellectual impairment had no specific level specified. While the numbers in various disability categories is important to describe the sample, relative frequencies should not be interpreted to reflect relative risk or incidence since the sample was not random.

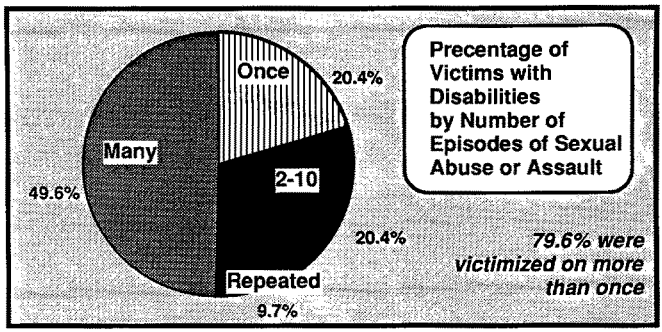
Ages of victims ranged from 18 months to 57-years-old with a mean age of 19.2 years. Most victims in this sample were adults. Those 21-years-old and above constituted 42.5% and those 18 through 20 constituted another 9.4%. Younger victims included 15.6% that were 13 through 17-years-old, 23.8% that were 7 through 12-years-old, and 8.8% that were younger than 6 years old. It is important to note that a more restrictive criterion was used for inclusion of adults and adolescents. There had to be clear evidence of coercion or harm in these reports, while this was not required for inclusion of reports involving children 12 and under.

Like most sex crimes, these offenses were largely committed by men against women. Most victims were women (81.7%) and most offenders were men (90.8%), although male victims (18.3%) and female offenders (9.2%) were reported in smaller but significant numbers. As in the general population, the predominance of female victims was weaker among younger victims; 95.6% of victims over 21 were women, compared with 64.3% of child victims, age 5 and under, who were girls.

The Offenses

Vaginal or anal penetration was described in 53.1% of the reports. Fondling or masturbation were described in 41.4%. Oral-genital contact was reported in 24.7% (7.4% to the victim's genitalia; 17.3% to the offender's). A number of offenses (4.9%) were categorized as forced participation, involving coerced sexual interaction between two or more victims but not necessarily the offender. Some reports disclosed abuse in terms that were not specific enough to categorize (4.3%), and the remaining offenses (23.5%) included a diverse variety of other abusive behavior. Many victims experienced more than one category (mean = 1.52) of sexual abuse.

Fig. 1. Percentage of victims with disabilities experiencing single, or multiple episodes of sexual abuse or sexual assault.

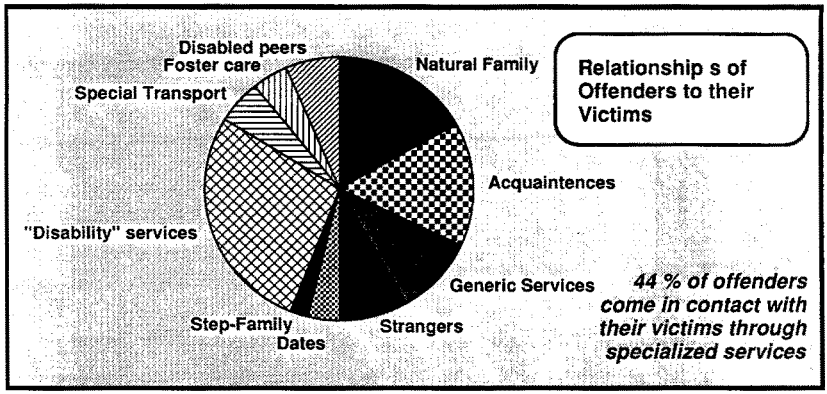


As illustrated in Figure 1, most victims experienced abuse on more than one occasion. Single offenses were reported in about one fifth (20.4%) of the cases. Another fifth (20.4%) of reports described two to ten incidents (mean = 3.85). The largest group (49.6%) disclosed abuse on "many" (greater than 10) occasions, and although they did not specify enough information for further categorization, the remaining 9.7% described abuse as repeated.

Less than half (46.7%) of the reports of sexual offenses against people with disabilities revealed physical harm, which ranged from minor bruising to death. Minor injuries typically not requiring treatment were reported in 20.7% of cases, and more severe injuries requiring treatment were reported in 18.5%. Although a small number of pregnancies (2.2%) and sexually transmitted diseases (5.2%) were also reported, these percentages are likely to be low estimates because report forms did not specifically request this information, and many respondents may not have included these occurrences in their definition of physical harm.

Emotional, behavioral, and social consequences appeared to be universal (reported in 9.8% of victims). Although two (1.2% of the sample) reports indicated no emotional harm was apparent, these were third party reports of victims with severe communication deficits, suggesting the possibility that these cases may reflect the inability to communicate these effects rather than their lack of existence. Uncategorized emotional distress was expressed to varying degrees by 63.0%. of the victims. In addition, withdrawal was reported among 26.5% of victims. Another 24.7% exhibited aggression, non-compliance, inappropriate sexual behavior, and other "behavior disorders." These behavior problems often resulted in secondary harmful consequences such as punishment or intrusive treatment of the victim. Another form of secondary harmful consequence occurred when victims were removed from their homes (6.8%) or programs

Fig. 2. Relationship of perpetrators of sexual offenses to their victims with disabilities.



(6.2%) as a method of controlling the abuse. Victims with intellectual disabilities were less likely to be reported to exhibit withdrawal as a consequence of abuse, but lost placements (e.g., residential, vocational) were much more common in this group (Sobsey, in press). The lower rate of reporting of withdrawal among victims with intellectual disabilities may reflect a difference in response, but may also reflect caregivers' inability to recognize withdrawal in this group since many of these were third party reports. Withdrawal may also be masked by communication impairment.

The Perpetrators

Perpetrators were predominantly males (90.8%), but some female perpetrators were also reported (9.2%). The average age of offenders was 32.8-years-old, including a range from 10 to 87 years old.

In 56.0% of the cases, abusers had a relationship to the client similar to those commonly found among non-disabled victims of abuse. Natural family members comprised 16.8%, acquaintances (e.g., neighbors, friends of family) comprised 15.2%, paid generic service providers (e.g., babysitters) comprised 9.8%, strangers comprised 8.2%, dates comprised 3.8%, and step-family members comprised 2.2%. This pattern is illustrated in Figure 2.

In another 44.0% of the cases, the abusers had a relationship with the victim that appeared to be specifically related to the victim's disability. Disability service providers (e.g., personal care attendants, psychiatrists, residential care staff) comprised 27.7% of the abusers, specialized transportation providers comprised 5.4%, and specialized foster parents comprised 4.3%. Another 6.5% was comprised of other disabled individuals, typically clustered with the victim

in a specialized program. The extent of risk associated with specialized services suggests an ecological explanation for the increased risk experienced by victims with disabilities. Ecological models consider the interaction of potential offenders and victims within the context of specific environments and broader cultural influences.(17)

Based on the percentage of offenders that are associated with specialized services, it would be reasonable to expect risk to increase by an additional 78% due to exposure to the "disabilities service system" alone. The extent of this elevation of risk would be adequate to explain most of the findings of increased incidence among individuals with disabilities.

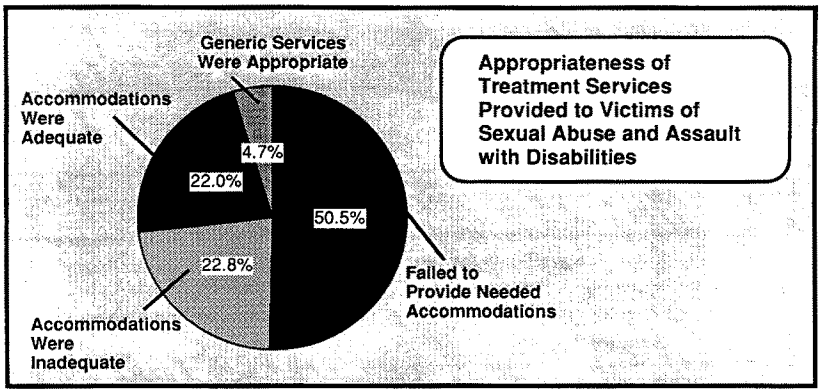
The role of the service system is also suggested by the environments in which abuse took place. Sexual abuse and assault of individuals with disabilities most frequently took place in private homes (51.9%), but it also occurred in public places (8.9%) and other generic community environments (2.5%), but abuse was also likely to occur in group homes (6.3%), institutions (12.7%), hospitals (3.2%), vehicles used for specialized transportation (10.1%), and other environments associated with the victim's disability (4.4%). In total, 36.7% of abuse took place in environments that the victim encountered as a result of being disabled.

Although the offender was known in 95.6% of cases, only 22.2% of the offenders described in these reports were charged with the offense, and only 8.0% (36.1% of those charged) of them were convicted. In some cases failure to charge the offender resulted from refusal by the police (19,8% of cases that did not result in charges), or prosecutors (5.5% of cases that did not result in charges). In others courts dropped charges at a preliminary hearing (2.2%) Nevertheless, the most frequent reason for failure to lay charges was that the victims and their advocates did not report these crimes to law enforcement agencies (65.9% of case that did not result in charges). Many of the victims and their advocates indicated that they did not report abuse because they felt it was useless or because they feared retribution from the offender or interruption of services as a consequence of reporting. The experiences of those among this sample and elsewhere(18) who reported to abuse to authorities and elsewhere suggest that such fears are often justified.

Treatment Services

The most frequent service sought for the victims of these offenses was counselling (41.8%). Various services or support from current caregivers (14.1%) and medical services (14.1%) were also frequently required or provided. Legal (7.3%) and protective services (7.9%) were sought in a smaller but still considerable number of cases, while abuse prevention education was

Fig. 3. Appropriateness of treatment services provided to sexual assault and abuse victims with disabilities.



sought in only a small number cases (3.4%). Although the victims and/or their caregivers attempted to access more than one category of service in a number of cases, no attempt was made to secure any treatment or support in 11.3% of all cases.

Medical services and assistance from current caregivers was less frequently sought for individuals with intellectual disabilities than for victims with other disabilities.(17) Also, legal intervention, abuse prevention education, and protective services were more frequently sought for victims with intellectual disabilities.

Many victims (45.8%) experienced difficulty finding required treatment services, and, as shown in Figure 3, even when services were successfully located, they often failed to meet the victim's needs. Most of the services (50.4%) failed to provide any accommodation to the special needs of the individual with a disability. Another 22.8% were viewed as inadequately attempting to meet the special needs of these victims. Nevertheless, 22.0% were viewed as adequately accommodating the special needs of the victims and the generic services provided to other victims were considered appropriate in 4.7% of cases. In no case were services rated as going too far, making unnecessary modifications that were not really required. These findings were similar for victims with other categories of disability.

DISCUSSION

Based on the results described in this study and other previously summarized research, there appears to be little doubt that people with a wide variety of

disabilities are frequently the victims of sexual abuse as children and/or sexual assault as adults, that these offenses are often severe and repeated, and that they typically result in social, emotional, and behavioral harm and often to physical harm to the victims, while perpetrators typically go unreported or unpunished. Even after abuse is disclosed, treatment services are often inaccessible or inappropriate to the needs of victims with disabilities.

Although sexual offenses against people with disabilities appear to be different in some respects, they are not unique. In most respects they appear similar to other sex crimes (e.g., predominantly male offenders and female victims, similarity of relationships of offenders to victims in many cases, evidence of underlying abuse of power), and differences that do exist appear to exist as extremes on a continuum rather than fundamental differences (e.g., increase in incidence). Nevertheless, issues arise from these results that require further discussion and point toward both enhanced understanding of abuse and practical implications for prevention and treatment.

An Ecological Model

Ecological models of abuse consider interacting factors at three different levels.(17,19,20) First, the *microsystem* includes the dynamics of offender-victim interaction. Second, the *macrosystem* is the influential social context in which these interactions take place (e.g., family, institution). Third, the *exosystem* is a broader but also influential set of cultural and social beliefs that interacts with the other two levels (e.g., values placed on power, human rights, or individuals, beliefs in justice, or punishment). These three systems continually interact and the interactions are sometimes viewed as a fourth system, the *mesosystem*. This model appears to be an appropriate framework for understanding sexual abuse and assault of people with disabilities. The interactions between the offender and victim are characterized by an inequity of power, but this inequity can only be understood by considering the environment in which they interact and the cultural milieu in which they exist.

Power and Sexuality

Women and children without disabilities are more often victims of sexual offenses than men are. Fused with the offenders' sexual preferences, the perception that women and children are defenseless or unable to persecute effectively may result in lowering the inhibitions of potential offenders and making these "defenseless victims" more attractive.(21) The cultural exosystem of perceived passivity of women and children may be exaggerated or increased by the

social reaction to disability. Disabled people, especially women and children are also perceived to be weak and passive, and many have been trained in rehabilitation and education programs to be compliant. There is a special relationship between sexuality and aggression for offenders who abuse disabled women and children. The dynamics between the offender and victim are shaped by cultural and societal expectations. Because of the double reduction in external inhibition and the increased possibility of successful offenses, offenders may see disabled women and children as the most vulnerable victims and "easy targets" for sexual offenses. At the macrosystem level children and women with disabilities are more likely to be isolated with potential offenders in homes or institutional settings. More women then men are admitted to psychiatric facilities and children with disabilities are more likely than non-disabled children to be in residential placements other than their natural families.

For more than a decade there has been an increasing awareness of the role of power inequities in sexual assault and sexual abuse,(22) yet the effectiveness of antilibidinal drugs(23) in suppressing sexual offenses that power and aggression alone are inadequate to explain these offenses in the absence of coexisting sexual motivation. However, the consistent pattern of abuse of vulnerable people by those that wield power described in our results and throughout the literature suggests that sexual drives alone provide an equally inadequate explanation. The association of aggressive power with sexuality seems to provide the only plausible answer. Such an abnormal association of aggression and power may occur as a result of dysfunction in limbic areas of the brain. It may also occur as a result of learned experiences as illustrated by the many victims of child abuse who become adult abusers.(24) Likely these organic and experiential factors interact in offenders.

The failure of internal and external inhibiting mechanisms in the presence of strongly associated sexuality and aggression results in sexual offenses. The increased vulnerability of children and adults with disabilities appears to occur because internal and external inhibition are reduced. Some disabilities have direct effects on reduction of external inhibition, but these effects appear to be relatively minor. For example, people with impaired motor skills will likely be less able to physically defend themselves. Indirect effects of disability seem to have much greater influence in increasing vulnerability. Indirect effects, refer to factors which are not specifically a result of disability, but rather result from society's response to disability. Results suggest that exposure to specialized services is a major source of risk. For example, society's isolation of individuals in institutions as a response to disability appears to decrease external inhibitions of potential offenders since abuse may be easily concealed in these settings. Passivity does not typically occur as a result of disability, but may occur as result of the use of psychotropic drugs to reduce noncompliant behavior. It is frightening and ironic that the victims' reports that we analyzed in-

cluded several cases of victims who developed non-compliant or inappropriate behavior as a response to their abuse, and were placed on intrusive behavior management programs or tranquilizers to suppress their behavior before the true cause was determined.

Internal inhibition may also be reduced through cultural devaluation of people with disabilities. Wolfensberger(25) details a number of cultural stereotypes of people with intellectual impairment that portray them as dangerous, helpless, diseased, or worthless. The power of these images of the life of a person with a disability as being without value becomes apparent in cases where infants with disabilities are systematically starved to death with the approval of physicians and the courts because their life is considered by others to be not worth living.(26) The same kind of devaluation allows offenders to believe that there is little reason to feel guilt or inhibition because their victims' lives are already valueless.

Goffman(27) suggests that stigmatized people often are taught to share devalued images of themselves and subsequently allow themselves to be victimized as a result of their perceived inferiority. This internalized devaluation may be the most insidious and destructive form and help to explain some of the perceived passivity and reluctance to report among victims with disabilities. Justice and Justice(28) suggest that disability is a risk factor for abuse in cultures that devalue people with disabilities, but not in cultures that place a higher value on them. Our findings appear consistent with their view, but direct, empirical research is required to test this hypothesis.

The Abusive Caregiver

The high incidence of abuse by service providers reported in our results is disheartening, but it should not be interpreted to mean that most caregivers are abusive. It is important to remember that a single abusive caregiver can abuse a large number of victims. The average child molester is believed to have about 70 victims before being apprehended and this number may be much higher in isolated group living environments.(29) Furthermore, children and adults with disabilities may be exposed to many more individuals. For example, Lakin, Bruininks, Hill, and Hauber(30) found an average annual staff turnover rate of 32.8% in public residential facilities and 54.2% in private residential facilities. Furthermore, around-the-clock staffing requires at least five staff for each one on duty at given time, and staff is often rotated from unit to unit. Thus, most children growing up in institutional settings come in contact with hundreds of caregivers in contrast to a much smaller number encountered in natural families. Several cases in our reports also suggest self-selection of offenders into the system. Many agencies continue to hire with little or no attempt to screen out

people with histories of abuse or assault and some agencies seek physically powerful and assertive staff because they believe that these individuals will exert better control over service consumers. In these cases, people with previous convictions and fugitives on charges of sexual offenses were hired as caregivers and committed further offenses. In some of this sample of reports, caregivers reporting abuse were harassed or threatened by their coworkers and employers, sometimes forcing them to resign, while no action was taken against the reported abuser.

The Right to a Safe Environment

Traditionally, these offenses have been viewed as isolated occurrences beyond the control of the agencies that are responsible for the services provided. As more is known regarding the patterns of these offenses, questions of agency responsibility must be addressed. For example, if an agency fails to screen employees for history of abuse, can the agencies be held responsible for future abuse committed by that person while in their employ? If an agency clusters known offenders with vulnerable individuals without providing adequate safeguards against assaults, does the agency bear responsibility for the abuse that results? Such questions are being considered by courts across North America and increasingly agencies are being held responsible. No agency or institution can be expected to provide an absolutely riskfree environment, however, every agency must be expected to provide at least the same level of safety available within the community, and failure to provide reasonable safeguards represents negligence on the part of these agencies and a violation of the rights of the individuals that these agencies serve. Considering the increased risks that are currently experienced by people with disabilities, prevention strategies must be identified and implemented.

Prevention Strategies

Based on the results and discussion so far a number of prevention strategies may be of value. Most sexual child abuse prevention programs focus on the child's ability to resist abuse. This strategy has wisely been criticized as simplistic and inadequate,(31) but some intervention may be valuable at this level when combined with other prevention methods. People with disabilities should be taught to discriminate appropriate occasions for compliance and for assertiveness, not taught generalized compliance with everyone for all things.

Of course, as with non-disabled victims, saying "NO!" is not always adequate. Prevention programs should clearly teach this limitation to prevent further damage and self-blame that might otherwise occur if an individual is victimized. Appropriate sex education is also essential. The belief that keeping sex a secret from people with disabilities somehow protects them is as unrealistic as it is distasteful.

Treatment programs for offenders are also important, since many offenders will repeat their offenses without effective treatment. Treatment for victims is also an important prevention strategy since a significant proportion of victims will become future offenders in the absence of successful treatment.(32) Programs should also focus on preventing all members of society from becoming offenders, emphasizing social adjustment and attitudes consistent with support rather than exploitation of others. Careful screening of people working as caregivers to vulnerable individuals would also significantly reduce sexual abuse of people with disabilities.

Support for functional, natural families of people with disabilities may result in decreased reliance on paid service providers and thus reduce the risk. Continued movement away from isolated service delivery toward community integration also appears to be a positive step. Although risks exist in the community, they appear to be significantly lower than the risks associated with institutionalized care.(33) Counter control systems, for example, independent advocates and complainant protection legislation can also be expected to reduce risk.

Since exposure to the service delivery system for disabled people appears to increase the risk of abuse, the use of this system must be considered for prevention. If victims who cannot (or do not) speak for themselves were provided with the assistance, risk of abuse might be reduced. It is essential that any such advocates are independent of service providers to avoid conflict of interest.

Nevertheless, disabled victims who do not report or seek assistance should probably not be viewed as inherently different from non-disabled victims who make similar decisions. Until and unless personal safety, respectful treatment, and continuity of service can be guaranteed, it is impossible to dispute the decision of any victim to remain silent. Although impossible to determine, it is possible that the victims with intellectual disabilities who had their abuse disclosed by advocates might not have been willing to disclose or seek treatment if they had the choice, or the ability to make that decision for themselves. Future research to determine the effectiveness of having an advocate working with a victim would be useful.

Our underlying cultural beliefs that often devalue people with disabilities and support the use of power and aggression against others may prove among

the most difficult factors to modify. Nevertheless, changing these beliefs may prove to be significant in reducing abuse of people with disabilities.

Accessible and Appropriate Treatment

A recent study of transition houses for abused women indicates that few are accessible to disabled women and their children.(34) The results of this study suggest that more frequent disclosure would have little practical value to victims unless significant changes make services more available and appropriate to the needs of victims with disabilities.

Accessible and appropriate treatment for adult and children with disabilities who are victims of sexual abuse and assault must also be considered within the ecological model. Again at three levels, there is the microsystem of the interaction between the treatment provider and the victim, there is the family, institutional and social context for the treatment at the macrosystem level, and finally the attitudes towards victims, right to treatment and the cultural exosystem.

Accessibility at the treatment level involves both physical accessibility and suitability for the victims. Physical accessibility in the form of ramped entrances, elevators, wide doorways, accessible bathrooms, and all other accommodations for mobility impaired persons must also include appropriate lighting and equipment for people with sensory impairments. Structural accessibility will not be adequate, however, if the service is not appropriate or accessible. Sign language interpreters, personal care attendants and advocates may all be a necessary part of the treatment team. This not only adds a significant cost to the treatment but also affects the interaction between service provider and the disabled victim. Issues of confidentiality and trust must be considered along with personal dynamics between a specialized service provider working with the disabled person and the treatment professional working with the victim. Individualization is essential in determining how these services are provided. For example, some individuals will prefer to have a familiar translator with whom they have established a trust relationship involved in their treatment. Others may prefer not to use their regular translators because of the confidential nature of their treatment..

At the macrosystem level there is often considerable difficulty in gaining access to services from within an institution, group home, or family home if the disabled victim does not have an external, independent advocate. Without adequate support systems for transportation, accommodation and communication, the victim alone cannot seek out assistance and likely could not find appropriate services.

Appropriateness of treatment cannot be determined by any one form of

accommodation to specific disabilities. It is related to flexibility and individuality. Some people with disabilities who have been victimized may be well served with little or no special accommodation; others may require highly specialized treatment. Whether treatment involves counselling, prevention education or protection, all people with disabilities will require individualized service. Individualization becomes the greatest challenge for most treatment programs. Most treatment programs are meant to provide generic and are not equipped to individualize for clients with disabilities. This is partially due to the lack of awareness about abuse against people with disabilities and the lack of reporting or seeking of treatment, but the devaluation of people with disabilities resulting in a belief that they are less worthy of treatment especially in light of the high demand for service from non-disabled victims.

Such attitudes are part of the exosystem of our cultural values and there is no simple approach available to change them. However, to provide appropriate treatment to people with disabilities some important steps may be useful. First, disabled people and disabled victims always must be consulted and involved in the development and delivery of any services they receive. It is vital that services be accessible to all, appropriate, flexible, and integrated with services for consumers without disabilities. Although there may be some times when some separate treatment services prove useful (e.g., group therapy for women using sign language).

The second step in treatment of disabled victims is information. Many disabled people who have been victimized, are being abused, or may be abused are not aware of reporting procedures or treatment availability. Thus, it is essential that as accessible and appropriate services become available, potential consumers of these services are made aware of their existence. Independent living centers and advocacy agencies may work along with service providers and other public agencies to educate people with disabilities about these services. Although there is no simple answer to creating accessible and appropriate services for all victims of abuse, the principle of individualization required for meeting the needs of victims with disabilities would probably have beneficial effects on services for all victims.

CONCLUSION

In this article, we have presented data on some of the patterns of sexual abuse of people with disabilities. We have discussed these results in relation to an ecological model of abuse and made some recommendations regarding basic prevention and treatment strategies. In spite of the many negative aspects of the problem addressed by this article, the recognition of this problem is a necessary step toward future improvement of the situation. The emerging literature on

sexual abuse of people with disabilities(16) suggests that this first step has already been taken.

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