Sexual Abuse: Incidence, Risk Factors, Screening, and Treatment

People with disabilities are at an increased risk for all types of abuse, and people with developmental disabilities are even more so. In terms of sexual violence, it is estimated that 50%-90% of people with intellectual and developmental disabilities (ID/DD) will experience sexual assault, sexual abuse, or sexual exploitation in their lifetime (Cox-Lindenbaum & Watson, 2002). Perpetrators may be service providers, family members, acquaintances, strangers, or other individuals with disabilities.

Inaccurate stereotypes about the sexuality of people with intellectual and developmental disabilities persist. The topics of both sexuality and sexual abuse of people with intellectual and/or developmental disabilities often remains taboo. Stereotypes about the asexuality or hypersexuality of people with ID/DD contribute to the erroneous but common beliefs that 1) sexual abuse of people with intellectual and developmental disabilities is rare, or that 2) any form of sexual contact is welcomed by people with ID/DD.

Several risk factors increase the vulnerability of individuals with ID/DD to sexual abuse. People requiring more extensive support typically need caregiver assistance with intimate activities, including menstrual hygiene, toileting, bathing, and dressing. This need for intimate care necessarily results in situations in which the service provider/caregiver is alone with the individual. High turnover rates for direct service workers may result in individuals being exposed to numerous staff members with multiple opportunities for abuse to occur. Group living situations also increase risk of sexual victimization, not only by staff but by other residents of the facility (McCartney & Campbell, 1998). Additionally, individuals who have received very limited sex and sexual abuse education, or who have significant intellectual disabilities may not have the knowledge and skills to identify or escape abusive situations.

When sexual abuse has occurred, people with ID/DD may face communication barriers when they attempt to report abuse. Indeed, perpetrators may attempt to restrict the individual's ability to report by denying or removing access to needed assistive devices, such as wheelchairs or communication devices. Because the intensity and depth of sex education provided to people with ID/DD is typically poor, the individual may lack the knowledge or vocabulary to understand that abuse has taken place or to describe the abuse. Because many people with ID/DD are effectively excluded from their communities by segregated work and living arrangements, they may not have access to the community resources (such as Rape Crisis Centers) that are typically available to people who have been sexually abused or sexually assaulted. Unfortunately, some of these community resources are not accessible to people with disabilities, and may even discriminate against victims with disabilities, particularly intellectual disabilities (Civjan, 2000).

Finally, service providers, agencies, and law enforcement professionals often view people with ID/DD as non-credible witnesses (Keilty & Connelly, 2001). These stereotypes and assumptions may be factors in victim selection by perpetrators. As a result of all of these factors, both reporting rates and prosecution rates for sexual abuse of people with ID/DD are very low, despite the epidemic rate of incidence (Cox-Lindenbaum & Watson, 2002).

It is critical that primary care providers be alert to the possibility that patients with ID/DD may be experiencing or may have experienced sexual abuse. When a patient with ID/DD relates that he or she has experienced sexual abuse, the primary care provider should immediately take the appropriate steps to ensure that the patient is protected and that the abuse is reported (see the resource document on Legal and Ethical Issues). If the individual is nonverbal, there is an array of red flags which may indicate abuse: the emergence of self-injurious or aggressive behavior, unexplained mood changes, sleep or appetite changes, unexplained cuts or bruising, excessive or inappropriate sexual behavior, avoidance of specific settings or people, withdrawal, substance abuse, injuries to the genital area, and/or sexually transmitted diseases (Davis, 2005).

Individuals with ID/DD may experience psychological symptoms subsequent to abuse or other traumatic experiences which may be ameliorated by therapy and/or pharmaceutical interventions (Mitchell & Clegg, 2005). Primary care providers should be prepared to make appropriate referrals when indicated.

Note: The above document contains general legal information; it is not legal advice and it does not create an attorney/client relationship. As laws and circumstances differ, the prudent health care practitioner should discuss these issues with his or her attorney before proceeding.

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