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Sexual Assault

Victimization Across the Life Span

Second Edition, Volume 3 of 3

*Special Settings
and Survivor Populations*



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Victimization Across the Life Span

Second Edition, Volume 3 of 3

Special Settings and Survivor Populations

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Publishers: Glenn E. Whaley and Marianne V. Whaley
Graphic Design Director: Glenn E. Whaley
Managing Editor: Paul K. Goode, III
Print/Production Coordinator: Jennifer M. Jones and G.W. Graphics
Cover Design: Jennifer M. Jones and G.W. Graphics
Color Prepress Specialist: Kevin Tucker
Acquisitions Editor: Glenn E. Whaley
Developmental Editor: Kristen Prysmiki
Copy Editors: Paul K. Goode, III and Ashley Maurer
Proofreader: Paul K. Goode, III

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Printed in the United States of America.

Publisher:
STM Learning, Inc.
Saint Louis, Missouri
Phone: (314) 434-2424
<http://www.stmlearning.com> orders@stmlearning.com

The Library of Congress has cataloged the printed edition as follows:

Names: Giardino, Angelo P., editor. | Faugno, Diana K., 1950- editor. |
Spencer, Mary J., 1936- editor. | Weaver, Michael L., editor. | Speck,
Patricia M., 1948- editor.

Title: Sexual assault victimization across the life span / [edited by] Angelo
P. Giardino, Diana K. Faugno, Mary J. Spencer, Michael L. Weaver, Patricia
M. Speck.

Other titles: Sexual assault victimization across the life span (Giardino)
Description: Second edition. | Saint Louis : STM Learning, Inc., [2017] |
Includes bibliographical references and index.

Identifiers: LCCN 2016031400 (print) | LCCN 2016032157 (ebook) | ISBN
9781936590018 (v. 1 : alk. paper) | ISBN 9781936590025 (v. 2 : alk. paper)
| ISBN 9781936590032 (v. 3 : alk. paper) | ISBN 9781936590476 (v. 1) |
ISBN 9781936590568 (v. 2) | ISBN 9781936590575 (v. 3)

Subjects: | MESH: Sex Offenses | Crime Victims | Forensic Medicine | Clinical
Medicine

Classification: LCC RC560.S44 (print) | LCC RC560.S44 (ebook) | NLM W 795 |
DDC 616.85/83--dc23

LC record available at <https://lccn.loc.gov/2016031400>

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FOREWORD TO THE SECOND EDITION

It is well established that sexual assault can have a significant negative and lifelong impact on the physical and emotional well-being of a person. The impact of victimization extends far beyond immediate physical or emotional trauma and may cause short- and long-term health consequences, socioeconomic instability, significant changes to civil or criminal legal outcomes, and psychotherapeutic treatment challenges.

Forensically trained professionals, whether they be advocates, nurses, scientists, lawyers, or law enforcement, use their knowledge to break down barriers for victims seeking help following sexual assault. They are more likely to conduct trauma-informed investigations; provide enhanced medical examinations; improve the quality of evidence collection and processing; provide comfort, care, advocacy, and other victim services; and participate in sexual assault response teams (SARTs). Knowledgeable professionals are more likely to recognize the neurobiology of trauma and how it impacts memory recall abilities and behavior, screen for patterns of abuse or prior assault, test for date rape drugs, offer emergency contraception and preventive medications against sexually transmitted infections, and direct survivors to supportive services. Quality forensic care fosters a believing atmosphere that supports a survivor's multifaceted path toward recovery.

Sexual Assault Victimization Across the Life Span is the most comprehensive text on its subject to date and truly covers the expansive set of circumstances and complex issues that arise with sexual assault. It is filled with useful statistics and provides a solid foundation of knowledge that is translatable to common practice situations. Key terms listed at the beginning of chapters help to inform and provide consistency in language throughout the community. The authors provide expert, multidisciplinary perspectives imperative to creating and sustaining successful SARTs and subsequently paving the way for improved, comprehensive victim experiences. I appreciate the emphasis on complex circumstances, vulnerable populations, and all-too-common scenarios involving college, military, and correctional settings. The usefulness of this text extends beyond a basic understanding of the subject and provides expansive and detailed information for even the most expert reader. I anticipate and look forward to reading and referencing this text many times in the future.

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FOREWORD TO THE SECOND EDITION

Sexual assault is a significant public health issue with long-lasting effects on individuals and communities. It is vital that health care professionals have the necessary information and tools to provide the best care to victims of sexual assault. Written by current experts in the field, *Sexual Assault Victimization Across the Life Span, Second Edition* provides a comprehensive guide to issues of sexual assault.

This revised and updated second edition covers current sexual assault issues as well as historical perspectives on services and treatment, and it includes underrepresented populations such as sexually assaulted males, the elderly, rural populations, tribal peoples, and people with physical and developmental disabilities. Even more cutting-edge and current is the inclusion of information on sexual assault in the military and among LGBTQ populations. Some of the highlights from this exemplary new collection follow.

In Volume 1 Chapter 3, “Cultural and Linguistic Aspects of Gender-Based Violence Care,” Michael Weaver helps health care providers to acquire or improve their knowledge and skills to provide culturally and linguistically appropriate care to diverse populations. Of specific focus is helping health care providers to improve communication with patients and learn to “convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.”

Because it is crucial that health care providers understand informed consent as it relates to victims and perpetrators, Volume 1 Chapter 4, “Informed Consent and Sexual Assault,” succinctly defines and explains the 4 aspects of informed consent and explains the need to understand these aspects as they apply to victim- and patient-centered care.

In order to avoid misdiagnosis, it is essential that health care providers be aware of normal and nonspecific findings in children evaluated for sexual abuse. To that end, Farah Brink, Philip Scribano, and Christine Julian clearly explain how to conduct a medical evaluation for suspected child sexual abuse and to avoid misdiagnosis in Volume 1 Chapter 8, “Differential Diagnosis of Child Sexual Abuse.”

In order to serve victims more efficiently, health care providers must work cooperatively with law enforcement, prosecutors, and victim advocates. In Volume 1 Chapter 11, “SANE/SART History and Role Development,” Linda Ledray and Patricia Powers provide a history of sexual assault nurse examiner (SANE) and sexual assault response team (SART) programs and instructions to develop and implement SANE/SART programs.

Volume 2 Chapter 4, “Dating Violence in Teens and Young Adults,” gives an excellent overview of adolescent and young adult dating violence and the necessary information that health care professionals need to effectively screen and provide services for victims of teen dating violence. This chapter also specifically explains the prevalence, consequences, and predictors of teen dating violence and the effect of teen dating violence on physical and mental health.

Volume 2 Chapter 5, “Overview of Adolescent and Adult Sexual Assault,” is perhaps the cornerstone of *Sexual Assault Across the Life Span*. By providing “historical perspective, epidemiology, and costs to society, components of an effective interdisciplinary response, the crucial development of sexual assault nurse examiner (SANE) programs, as well as theories behind preventive strategies and promising models,” this chapter offers vital information that ties together overarching subject matter from across the 3-volume set.

Sexual assault against men is just beginning to enter the public consciousness, and it continues to be underreported, under-recognized, and undertreated. In Volume 2 Chapter 7, “Adult Male Sexual Assault,” the authors provide a review of recent literature and research on the prevalence of male sexual assault, barriers to reporting, and the effects of sexual assault on the male victims. Most importantly this chapter offers recommendations for “comprehensive and compassionate care and support” of male survivors.

Sexual assault of the elderly is believed to be seriously underestimated and underreported, and it is neither well understood nor well identified by health care professionals. Volume 2 Chapter 8, “Sexual Assault Among Older Adults,” will help health care professionals provide informed care to older adult sexual assault victims.

In Volume 3 Chapter 3, “Sexual Assault and Abuse in LGBTQ Populations,” the authors provide a brief history of sexual assault and violence in LGBTQ communities as well as a literature review on sexual identities, identification of patterns of sexual assault and violence, and the impact of homophobia and heterosexism on current practices in care of LGBTQ sexual assault victims. The most helpful tool in understanding these issues is the author’s inclusion of case studies demonstrating cultural considerations for LGBTQ sexual assault victims.

Sexual Assault Victimization Across the Life Span is a comprehensive guide for up-to-date and effective response to sexual assault among the diverse populations of an ever-changing society. While written primarily for health care professionals who deal specifically with sexual assault, it will make a vital resource for anyone working with issues related to sexual assault.

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FOREWORD TO THE FIRST EDITION

Sexual assault is broadly defined as unwanted sexual contact of any kind. Among the acts included are rape, incest, molestation, fondling or grabbing, and forced viewing of or involvement in pornography. Drug-facilitated behavior was recently added in response to the recognition that pharmacologic agents can be used to make the victim more malleable. When sexual activity occurs between a significantly older person and a child, it is referred to as molestation or child sexual abuse rather than sexual assault. In children, there is often a “grooming” period during which the perpetrator gradually escalates sexual contact with the child and often does not use the force implied in the term sexual assault. But it is assault, both physical and emotional, whether the victim is a child, an adolescent, or an adult.

The reported statistics are only an estimate of the problem’s scope, with the actual reporting rate being a mere fraction of the true incidence. Surveys of adults show as many as 18% of all women in the United States have been the victim of an attempted or completed rape over the course of their lives. The incidence of male victims is lower because of reluctance of boys and men to report their victimization.

The financial costs of sexual assault are enormous. Intangible costs, such as emotional suffering and risk of death from being victimized, are beyond measurement. Short term, there are health care consequences, such as unwanted pregnancy, sexually transmitted diseases, serious emotional upheavals, inability to carry out normal daily activities, decreased productivity, and in some cases, loss of life. Long-term disabilities can be both emotional and physical. It is well documented that survivors of sexual abuse have a much higher incidence of serious and chronic mental health problems than control populations of nonabused patients. Posttraumatic stress disorder, depression, suicidal ideation, and substance abuse are all over-represented among abused groups in cast-control studies. Chronic physical symptoms, such as pain syndromes (pelvic, abdominal, chest, myalgias, headaches) and various somatization disorders, are reported in a wide variety of peer-reviewed medical specialty journals.

This book is the first to bring together the best information available concerning sexual victimization across the entire life span. Recognizing the radical differences required in approaching child, adolescent, and adult victims, the chapters are organized to present information from the medical and mental health literature specific to various age groups. Victim and perpetrator characteristics are described. Most importantly, those who provide care for these victims and who handle the disposition of the perpetrators are given specific information for all who care for the victims—the crisis hotline staff, law enforcement personnel, prehospital providers, specialized detectives, medical and mental health staff, specialized sexual assault examiners, and counselors. The information is as current, accurate, and specific as it can be in a rapidly evolving field. It will fill a need in many venues where sexual victimization is seen and care is given to victims.

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FOREWORD TO THE FIRST EDITION

Sexual abuse is not just an epidemic—it is at pandemic proportions. In the United States, perhaps 20% to 25% of adults sustain some form of sexual abuse during their childhood. These numbers are somewhat higher or lower in other countries but certainly do not vary by a factor of even 5. With such a high percentage of the world having been sexually abused, it may be legitimate to ask, is sexual abuse a “normal” behavior? Similarly, what is sexual abuse and why does it exist?

Anthropologically, concepts of appropriate sexual behaviors with young humans incorporate both biologically and culturally derived premises. Biologically, prepubertal animals are not frequent targets for sexual activity. This relative taboo is reasonably ubiquitous across species. Males and females of a given species usually wait until they achieve sexual maturity before they engage in sexual activity. This is utilitarian in that effort is not wasted on a nonreproductive member of the species. Besides olfactory, behavioral, and other cues that the individual is mature (and receptive), there are visual indicators of immaturity that seem to inhibit adults of most species. However, once having achieved sexual maturity an individual is fair game. Through most of human history, this biologic distinction of maturity has also apparently held. When the human life expectancy was a mere 30 years, however, one could not wait until the late teen years to begin reproduction.

In more recent historical times (and within certain cultures), a cultural overlay has developed that acknowledges a “delayed” maturity. Thus the age of consent is more likely to be 16 years or so, not age 10 or 11 years when some girls are having their first menstrual period. The concept especially derives from the notion that children need prolonged education and parental nurturance before they should have to compete with the adult population and its risks. The adult is supposed to ignore the development of secondary sexual characteristics (biologic maturity) and focus on chronological age with a somewhat arbitrary cutoff (eg, what is the difference between a 15 year old and a 16 year old?).

Both the biologic cutoff and the chronological cutoff are respected by most adults in society. Yet some overlook the cultural cutoff and some even ignore the biologic cutoff (ie, have sex with young children). For the latter, this is a violation of both cultural and biologic taboos.

Another biology-related taboo is having sex with close kin. The genetic implications could not have been consciously appreciated by humans through most of history, nor by some species, which also abide by this taboo. Yet nearly all human cultures respect the incest taboo a sign of a relative biologic underpinning for this behavior. Nevertheless, some adult humans also fail to respect this distinction and commit what we consider incest.

Views about appropriate and inappropriate sexual activity with younger humans have been codified into law and society as sexual abuse crimes. These are crimes about sex and reflect the perpetrator’s sexual drive. While sexual drives help to maintain the species and are overall a necessary biologic imperative, sexual abuse incorporates biologically useless activity (ie, sex with biologically immature children) and/or activity that is culturally shunned. In some instances the perpetrator may “love” the child and perhaps be the better caregiver. Yet the violation of taboos elicits a strong reaction by most members of society—reflecting a lack of concern for the child’s well-being and trampling of the society’s biologic and cultural ideations.

What can be done about this? One option would be to ignore the abuse. Yet this historically has not been done if the act becomes known, and it fails to meet the developmental needs of children. Another option would be to mount an aggressive prevention campaign aimed at perpetrators before they commit sexual abuse (pri-

mary and secondary prevention). This has not been done to any significant extent as yet. The third option is what most of this book is about—identifying sexual abuse when it has occurred and providing the types of interventions that might minimize its impact. We can treat the child and treat and/or incarcerate the offender. Considerable progress has occurred in the last three decades that enables us to better understand, identify and intervene with child sexual abuse. The results of this progress are reflected in the state-of-the-art descriptions within this volume. These approaches make a real difference in children's lives and help us to respect the boundaries we place on sexual activity with our young.

One unanswered question remains: When will we as a society care enough about our children to make the substantial efforts required to implement the very best in primary, secondary, and tertiary prevention for our children? Until this becomes a cultural imperative of its own, we will continue to need books such as these, and the misery of lost childhoods will contribute to a sordid reality. Let us hope that some future generation can appreciate the brilliance of the work portrayed herein, but is also able to view child sexual abuse as an extinct historical oddity.

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PREFACE TO THE SECOND EDITION

It is incumbent upon those responsible for survivors' well-being to continually interrogate and reevaluate best practices in investigation, prosecution, medical care, and prevention of sexual violence. To that end, we offer the revised and updated second edition of *Sexual Assault Victimization Across the Life Span*. This latest edition is reconceived as a 3-volume set, lending focus to 3 overarching subjects: the role of the multidisciplinary team, response to specific age groups, and the unique concerns of special survivor populations.

Volume 1: Investigation, Diagnosis, and the Multidisciplinary Team details principles of investigation in sexual assault and the responsibilities of multidisciplinary team members across fields, including medicine, medical forensic examination, emergency medical services, law enforcement, prosecution, and victim advocacy. It is of vital importance that readers in every branch of the multidisciplinary team recall the essential value of interdisciplinary cooperation in the interest of resilient recovery for those in our care.

Volume 2: Evaluation of Children and Adults and *Volume 3: Special Settings and Survivor Populations* outline response strategies tailored to the needs of specific survivor groups. The second volume addresses sexual assault and abuse in survivors across the life span, including chapters on teen dating violence, campus sexual assault, sexual abuse of the elderly, STIs in children, and sexually assaulted adolescent males. The third volume examines the role of environment and survivor identity in cases of sexual assault. Readers will enjoy the benefit of chapters geared toward sexual assault survivors in the military, correctional settings, LGBTQ communities, and others.

We are pleased to offer the new and expanded second edition of *Sexual Assault Victimization Across the Life Span* to our readers and colleagues. We sincerely hope and believe that its contents and the collective expertise of its contributors will prove valuable in research, response, and care for survivors of sexual violence.

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PREFACE TO THE FIRST EDITION

What is sexual assault? It is a crime of violence, where the assailant uses sexual contact as a weapon, seeking to gain power and control. Often youths and adolescents are disproportionately targeted, although sexual assault can occur at any age. Sexual assault is also an act of opportunity. Particularly vulnerable populations include children, especially young females, and individuals who are less able to care for themselves, such as the homeless or physically or mentally handicapped persons. Their vulnerability and ease of manipulation makes them prey.

Who commits these acts? While there is no classic profile of an offender, child sex abusers tend to be males who are known to the child's caregivers, and 80% of the women who are assaulted know their attackers, as well—they are their ex-husbands, their stepfathers, their boyfriends, and other friends or relatives. Men may also experience victimization.

To protect victims from these offenders will require a change in the attitude of society toward its most vulnerable members. Society must value these individuals before anything will be done. Education plays a key role in accomplishing this change in attitude. This book was prepared with the goal of disseminating the information required to bring about change, to better protect and care for victims of sexual assault. Written for health care professionals and other mandated reporters, *Sexual Assault Victimization Across the Life Span* offers a complete approach to the topic. The problem is defined, all aspects are explored, and treatment and interventions are outlined. Victim characteristics are explored, especially those seen in children. But most importantly, useful information is offered to those who provide care for these victims and those who handle the disposition of the perpetrators. We see the problem through the eyes of many professionals: physicians, paramedics, law enforcement personnel, the judicial system, social workers, and people who work with children. This covers everyone from the crisis hotline staff, to police and law enforcement personnel, to prehospital providers, to specially trained detectives, to skilled medical staff, to trained sexual assault examiners, to rape crisis counselors. Finally, the text offers information on programs that are in place or are under consideration to aid in the prevention of sexual assault.

Knowledge gives us the power to intervene, and this book offers current, accurate, and specific data concerning the problem of sexual assault. With the information at hand, we can become empowered and participate in effective interventions to prevent sexual assault as well as care for its victims.

Angelo P. Giardino, MD, PhD

REVIEWS

The second edition of Sexual Assault Victimization: Across the Life Span is a comprehensive, evidence-based collection of resource material for the sexual assault nurse examiner (SANE) written by experts in the field of forensic medicine and nursing. Chapters address the holistic health needs of the sexual assault patient. Chapters of particular interest for the SANE include those addressing the medical forensic exam and evidence collection. Several chapters address the sensitive needs of special populations such as children, the elderly, victims of gender-based violence, and male patients. The chapters are well written, with attention to detail and current research. There are a plethora of case studies and photographs to illustrate the key points in chapters. Each chapter ends with discussion questions, challenging readers to thoughtfully consider adoption into their practice. These books are a must-have for SANEs and SANE programs.

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Sexual Assault Victimization Across the Life Span, Second Edition is an expansive, thorough 3-volume resource for medical professionals and multidisciplinary partners working on behalf of sexual assault victims. Unique to this collection is the focus on evidence-based investigation, diagnosis, evaluation, and the needs of special populations. One author highlights the complex need for understanding the cultural background and semantic/linguistic nuances essential to a compassionate approach to sexual assault victims. Others emphasize the critical importance of a thoughtful, trauma-informed approach to the victim, underscored by a core principle—“Start by believing.”—which may be the key to safe disclosure, participation in a medical forensic evaluation, and cooperation with investigation and prosecution, all of which enhances the likelihood of justice for victims. Each chapter includes current foundational information, clearly delineated lists of symptoms or suggestions, and discussion questions. This should be a go-to reference for sexual assault response team partners in health care, criminal justice, and victim advocacy.

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Sexual Assault Victimization Across the Lifespan, Second Edition is a comprehensive text that will be a valuable resource for all health care providers involved in the evaluation and management of sexual assault victims. The full, 3-volume set consists of 39 chapters, each dealing with a different aspect of sexual assault, including assault of boys and male adolescents, persons with disabilities, and assault among LGBTQ populations. Chapters are comprehensive and detailed. Of particular value are the sections referred to as “Tips from the Bench,” that include comments beyond the medical assessment that may have relevance to child protective services, law enforcement, and mental health providers. In addition, each chapter starts off with a section designated “Purpose of the Chapter” which sets the agenda for the chapter, followed by the chapter’s learning objectives. This book will serve as an invaluable guide to those who care for sexual assault victims.

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Chapter 1, “Overview of Sexual Assault, Abuse, and Exploitation” is the perfect synopsis of the history of sexual assault and abuse across the life span. Regardless of their background, multidisciplinary team members can glean critical knowledge from the text, which explains the history of sexual assault and child protection laws in the United States and across the world.

The chapter “Sexually Transmitted Infections in Sexually Abused Children” concisely covers the epidemiology of the major STIs in children, testing methods, implications of the results, and treatment options. Diagnosing sexual abuse is intrinsically challenging but this chapter provides an exceptional overview for clinicians, while citing outstanding references.

“Screening for and Treatment of Sexual Abuse Histories in Boys and Male Adolescents” provides tools to appropriately care for these children. The authors discuss evidence-based research regarding trends in child sexual abuse and highlight slight but important differences between young male and female victims.

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The new Sexual Assault Victimization Across the Life Span, Second Edition is a must-have resource for those who care for or respond to victims of sexual assault and abuse. There are several essential texts that I recommend programs consider keeping close at hand for reference, and this book is one of them. SANE programs and multidisciplinary collaborative team members should consider this for their professional bookshelves and libraries. It provides crucial information on the range of issues that may have potential impact on sexual assault victims of all ages. Included in this new edition are critical issues sexual assault examiners and the entire response team can tackle together as they work to provide competent, ethical, patient-focused care. These issues can impact the long-term health and well-being of their patients and ultimately the safety of their communities.

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Sexual Assault Victimization Across the Life Span is an intricate and comprehensive compendium of information on all aspects of sexual assault. The breadth and depth of information is exceptional—from detailing the responsibilities of prosecutors and sexual abuse examiners, to a discussion of workplace sexual assault, and issues of dealing with sexual abuse in children with disabilities. This 3-volume compilation should be a mandatory resource in any organization engaged in any facet of sexual assault response or for anyone who wants a resource that deals with any or all of the multiple aspects of sexual abuse. The logical, functional structure of the volumes dividing the subject into investigation, evaluation of children and adults, and lastly, a volume on special settings and survivor populations greatly enhances the ease of using this material.

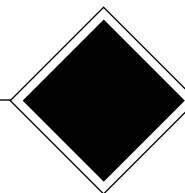
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Forensic nurses must command knowledge of many variables, including a wide array of patient traits, types of physical and emotional trauma, and appropriate treatment options. Sexual Assault Victimization Across the Life Span provides a rare combination of intricate procedural detail while maintaining an easy-to-follow tone that is instantly valuable to seasoned practitioners as well as professionals just gaining familiarity with the complexities inherent to sexual assault exams. Topics ranging from exam procedures to tips on preparing for testimony in court are readily accessible through the quick reference format. The text goes beyond theoretical ideas and definitions, providing step-by-step instructions for techniques to identify causality factors and detailed procedures for delivering appropriate treatment. This is a "one-stop shop" for current best practices that any professional associated with the sexual assault response community can instantly put into practical use.

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The new second edition of Sexual Assault Victimization Across the Life Span is an important contribution to the field of sexual assault and violence. It is probably the leading textbook in the field, and it is a must-have for all medical professionals who care for victims of sexual violence. The beauty of the book is that it truly covers victims across the life span and provides guidance and tools to address the needs of all survivors. The text is logically organized into 3 volumes: Investigation, Diagnosis, and the Multidisciplinary Team, Evaluation of Children and Adults, and Special Settings and Survivor Populations. Each chapter contains key points highlighting important concepts and principles for the benefit of the reader.

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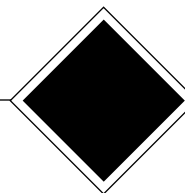


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Sexual Assault

Victimization Across the Life Span

Second Edition, Volume 3 of 3

*Special Settings
and Survivor Populations*



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SEXUAL ASSAULT AND ABUSE OF CHILDREN WITH DISABILITIES: AN EVOLVING FUTURE

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PURPOSE OF CHAPTER

Children with disabilities, as a subpopulation of the generic child population, experience significantly more abuse and neglect yet far less representation in the research literature and treatment efforts. This chapter describes some of the most salient issues involving child abuse and neglect among children with disabilities, with a specific focus on sexual abuse and children with intellectual disabilities. The issues covered include (1) reasons for heightened vulnerability to abuse and prejudice facing children with disabilities and its relationship to unequal access to justice and treatment; (2) abuse disclosure and barriers to reporting; (3) differing manifestations of trauma, especially in children with intellectual disabilities and mental health concerns; (4) forensic issues; and (5) treatment issues, including providing therapy, risk reduction education, and planning. The authors have been practicing in this area for many years and present not only some of the issues they have encountered, but also the great promise that lies in this complex and emotionally rewarding field. This chapter concludes by citing ongoing efforts required to ensure equal justice, improve safety for children with disabilities, and create a better environment for victim recovery and reduction of future risk. More work remains to be done in treatment, risk reduction, research, and dissemination of training programs for responders to better serve children with disabilities and their families and those who support them.

OBJECTIVES

By the end of this chapter, the reader will be able to: understand the reasons for heightened vulnerability to abuse and prejudice and relationship to unequal access to justice and treatment; abuse disclosure and barriers to reporting; differing manifestations of trauma; forensic issues; and treatment issues including providing therapy, risk reduction education, and planning.

KEY POINTS

1. Children with disabilities benefit from therapy after abuse occurs.
2. The basic tenets are the same for children with and without disabilities.
3. Learning how to effectively provide therapy to children with disabilities requires substantial practice and supervision.
4. Working with children with disabilities is challenging, rewarding, and an ongoing learning experience.

KEY TERMS

- *Behavioral overshadowing*: Occurs when the clinician assumes the psychopathology is shaped and maintained by the person's environment regardless of the person's intellectual capacity.
- *Diagnostic overshadowing*: Occurs when clinicians are less likely to diagnose psychopathology or provide a diagnosis of lesser severity when people are identified as having an intellectual disability.¹
- *Vertical prosecution*: Policies and procedures that follow the child through the entire scope of protective services, from first response through court appearances.
- *Deaf*: Individuals who use American Sign Language (ASL) as their primary language use the written term Deaf with an uppercase "D" to indicate their rich culture in addition to their primary language.
- *deaf*: The term deaf with a lower case "d" designates those persons who have a hearing disability who are not part of the Deaf culture, and do not use ASL as their primary language, nor do they share behavioral and attitudinal differences.

MALTREATMENT STUDIES OF CHILDREN WITH DISABILITIES

There are few methodologically strong research studies that examine the prevalence of maltreatment in children with disabilities. Although studies vary in their methodology and the samples used, research findings are fairly consistent and support the hypothesis that disability increases risk for maltreatment.^{2,3} This chapter provides a review of the salient issues facing children with disabilities and those who care for and provide services to them. Recognition of their vulnerability to maltreatment has also revealed additional inequities that are faced by children with disabilities that include institutional barriers to reporting abuse incidents, unequal access when seeking justice, professionals' bias toward recognizing mental health concerns and maltreatment-related psychological suffering, and accessing psychological treatment. Additional struggles include having both educational and support persons adequately trained to recognize and report abuse to reduce the risk for future abuse.

HEIGHTENED RISK FOR MALTREATMENT

The *National Incidence Study of Child Abuse and Neglect (NIS-2)* reviewed the files of 36 child protection services (CPS) agencies across the country.⁴ Researchers reported that children with disabilities were abused at a rate 1.7 times higher than the rate of children without disabilities. Sullivan and Knutson⁵ suggested that these figures were likely an underestimate due to methodological issues they identified with the study. Since this chapter was written, NIS-4 was published. Readers are encouraged to read this updated document.

Sullivan and Knutson⁶ conducted a subsequent study of 50 278 young and school-aged children and adolescents and young adults aged through 21 years in Omaha, Nebraska that is considered one of the most comprehensive studies of its kind. This study merged child abuse data from 4 different sources in 3 research studies, including law enforcement, CPS, parochial schools, and hospital emergency rooms (ERs). The overall rate of maltreatment for children without disabilities was 11%. Children with disabilities had an overall rate of 31% for maltreatment. Data indicated that children with disabilities were 3.4 times more likely to be neglected and physically, sexually, and emotionally abused compared with nondisabled children. Neglect was the single most prevalent form of maltreatment and most maltreated children experienced more than one form of maltreatment.⁶

In comparison with children without disabilities, children with intellectual disabilities were 3.7 times as likely to have been neglected, 3.8 times as likely to be emotionally abused, 3.8 times as likely to be physically abused, 4 times as likely to be sexually abused, and 3.8 times as likely to experience at least 1 category of abuse. Overall, children with developmental disabilities had 4 times the risk for all varieties of maltreatment. Children who are Deaf and hard-of-hearing had twice the risk for neglect and emotional abuse and nearly 4 times the risk for physical abuse than their nondisabled counterparts. Children with speech and language difficulties had 5 times the risk for neglect and physical abuse and 3 times the risk for sexual abuse. Children with learning or orthopedic disabilities had twice the risk for all varieties of maltreatment. The highest risk for maltreatment was seen in children with behavioral disorders, who had a risk that was 7 times higher for neglect, physical abuse, and emotional abuse and 5.5 times higher for sexual abuse than children without disabilities.⁶ Despite the variations in patterns noted across research studies, overall the research in this domain indicates that children with disabilities are at greater risk for all types of maltreatment in comparison to their nondisabled peers.⁷ Results from a British Columbia survey of high school students showed that students who had a limiting health condition or disability were more than twice as likely as peers to report physical abuse and sexual abuse and 3 times as likely to have experienced both physical and sexual abuse.⁸ Earlier studies on abuse and disability revealed that psychological treatment services for victims were often inaccessible or inappropriately adapted to their needs,⁹ resulting in many victims with disabilities not receiving appropriate treatment for trauma.

In October of 2011, the US Bureau of Justice published its *National Crime Victimization Survey*, including a special report, “Crime Against Persons with Disabilities, 2008-2010.”¹⁰ The survey is a randomized household telephone survey of persons aged 12 years and older; institutions are excluded from the survey. It is important to note that this survey does not include information that distinguishes the child and adult populations. The findings are significant, however, as they reflect higher rates of abuse of individuals with disabilities. For example, the age-adjusted rate of violent crime against individuals with disabilities (28 per 1000) was nearly twice the rate for the nondisabled population (15 per 1000). Serious crime, including sexual assault among other crimes was 16 per 1000 persons with disabilities compared to 5 per 1000 of those without disabilities. The report found that in 2010, individuals with disabilities aged 12 through 15 years had an unadjusted rate of violent victimization of 61 per 1000, over twice that rate for the nondisabled population of 23 per 1000. These findings support the research findings of other studies reporting much higher rates of victimization of individuals with disabilities.

Reasons for Heightened Vulnerability to Maltreatment

There are a number of factors that contribute to the heightened vulnerability to abuse and neglect that is observed in children with disabilities. There are individual characteristics as well as social circumstances and contexts that contribute to heightened vulnerability. Contributing factors may not only reflect specific aspects of the person’s disabilities but also the contexts in which they live as well as how society treats them. Some children, for example, may have limited social skills, limited access to relationships and friendships, limited opportunities for social engagement, limited knowledge about body and sexuality and affective vocabulary, and limited experience with using assertiveness skills or reinforcing personal boundaries. Also, when a child is fairly socially isolated, they may be lonely and have poor social discrimination skills and limited understanding of dangerous situations and risk, such as social and personal ambiguity. Many children with a disability may struggle with feelings of poor self-esteem; limited sense of personal agency or self-efficacy; as well as prolonged dependency on others, both for physical and psychological needs. When a child is more dependent on others for intimate care and services in isolated settings, such as transportation, risks may be substantial because of the contexts in

which and the individuals with whom they spend their time. Similarly, socialization practices that promote and reward compliance and obedience; a lack of experience with relationships, negotiating about one's needs, and saying no; and choice-making can contribute to greater vulnerability.¹¹

Historically, many children with disabilities have had less experience with making choices. Sometimes, children are not taught to make choices, but rather taught to defer to the opinions of others who, they are taught, know best. This often produces learned compliance, which makes children more vulnerable. Vulnerability-enhancing situations, when paired with a desire to please others and to avoid punishment, become important forces in heightening vulnerability, especially when interacting with people in positions of authority, such as adults, teachers, staff, and other caregivers.

Sometimes, children with disabilities are isolated from the community and paid staff is their only source of social support. As a result, children may have very limited access to social support or advocacy to protect them from abuse, support them if they are ever victimized, or both. Beyond these individual and social factors, however, is the larger social context in which children with disabilities live and are identified in relation to others who do not have a disability.²

Prejudice exists at all levels of society and is most commonly demonstrated in over-generalized, learned attitudes toward people who are seen as not conforming to what is perceived to be normal within that society. Children with disabilities, both intellectual and physical, live within society as members of an often marginalized and devalued group of people who are seen by others as less than or as otherwise failing to meet the ideal in terms of achievement, accomplishment, behaviors, skills, relationships, and level of independence. This bias against children with disabilities creates a lower level of personal and social status and it has significant implications for how their personal needs and rights are addressed across many settings, including those that are essential in helping them deal with the consequences of maltreatment.

Disability-Negative Culture

Individuals with disabilities often identify the negative attitudes about people with disabilities as one of the most powerful disabilities facing them. In most societies, there are tiered values held within all cultures, wherein certain individuals are, by virtue of their personal characteristics, held in higher esteem and, thus, seen as more valuable or more important than others. The influence of these values is felt profoundly by children with disabilities, and these values about their relative value are communicated to them throughout their life by many different influential sources (eg, parents, teachers, medical professionals, or peers). The significance of these devaluing attitudes impacts people with disabilities at many levels and adds another layer of complexity to the struggles facing a group who is vulnerable to maltreatment and abuse as well as mental health problems. Many people with disabilities may internalize these negative attitudes over time and have difficulty valuing themselves as people and will suffer from poor self-esteem among other emotional and mental health difficulties. This devaluing perspective influences how children with disabilities are served when mental health services are required and often negatively influences and contributes to inadequate access to psychological treatment and unequal justice for child abuse victims.

HEIGHTENED VULNERABILITY TO MENTAL HEALTH DISORDERS

Both children and adults with developmental disabilities have a heightened risk for developing mental health disorders.¹² Prevalence of psychiatric disorder is greater in children with intellectual disabilities compared to children who have typical cognitive functioning¹³; it is also higher in both children and adults with severe intellectual disabilities.¹⁴ Mental health problems in childhood and adolescence, especially those with cooccurring high levels of internalizing and externalizing symptoms, are important risk factors for both sexual maltreatment and victimization by peers (eg, bullying).¹⁵

The mental health problems of people with intellectual disabilities have historically been neglected by mental health professionals due to biases about developmental and intellectual disability (ID). *Diagnostic overshadowing* occurs when clinicians are less likely to diagnose psychopathology or provide a diagnosis of lesser severity when people are identified as having an intellectual disability.¹ *Behavioral overshadowing* occurs when clinicians tend to identify psychopathology as a learned behavior while failing to recognize it as an indication of mental illness. In *diagnostic overshadowing*, the clinician assumes the intellectual disability is the root of the problem. In *behavioral overshadowing* the clinician assumes the psychopathology is shaped and maintained by the person's environment regardless of the person's intellectual capacity.

Professional biases have been evident for years as various authors debated whether people with developmental disabilities could experience physical pain or even be depressed or anxious. The biases implied that people with intellectual disabilities did not suffer in the same manner as people with typical cognitive ability. The historical emphasis on achieving insight during therapy prevented many professionals from seeing a range of other possible therapies (eg, cognitive-behavioral, play, hypnotherapy, energy psychology, eye movement desensitization and processing [EMDR]) as having potential benefits for this long-neglected population.¹¹ Despite this state of negligence, an increasing number of mental health professionals are serving children and adults with developmental disabilities and there is growing interest in professional organizations that are involved in producing publications, conferences, professional training, resource sharing, and research. These include but are not limited to the following: The National Association for the Dually Diagnosed (NADD) (<http://www.thenadd.org>), the International Association for the Scientific Study of Intellectual Disabilities (IASSID) (<http://www.iassid.org>), the Association of University Centers on Disability (AUCD) and the University Centers for Excellence in Developmental Disabilities Education (UCEDD) (<http://www.aucd.org>), Royal Society for Mentally Handicapped Children and Adults (Mencap) (<http://www.mencap.org.uk>), and the American Association for Intellectual and Developmental Disability (AAIDD) (<http://www.aidd.org>).

As research in trauma and maltreatment has progressed, significant strides have been made in understanding the long-term impact of trauma on affect, arousal, and neurological organization as well as development and functioning.¹⁶ Research has also addressed how developmental level impacts symptom presentation in mental health disorders.¹⁷ Charlot¹⁷ indicates that a person's developmental level impacts the presentation of clinical surface features. Symptoms may take on different meanings depending on a person's stage of development. People at similar stages of cognitive development to a young child will display the same variation in phenomenology.

In 2007, NADD produced *Diagnostic Manual—Intellectual Disability: A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability (DM-ID)*.¹⁸ This manual serves as a guide for clinicians making diagnoses of patients with an intellectual disability. The *DM-ID* seeks to enhance reliability and more accurate psychiatric diagnosis of people with intellectual disabilities, using evidence-based methods and the expert consensus model. The *DM-ID* provides advice and considerations for assessing and diagnosing people with ID. The more severe the impairments in communication and comprehension, the more additional sources of information are necessary where individual symptoms cannot be verified by self-report. The *DM-ID* clarifies where criteria need to be adapted or not and how to differentiate common behaviours in ID from psychiatric disorders. People must be evaluated within the context of their intellectual impairment. The severity of the ID greatly affects the mental health interview, and the higher functioning the person is, the fewer alterations are needed.

UNDERSTANDING TRAUMA SYMPTOMS IN INTELLECTUAL DISABILITY

The *DM-ID* chapter devoted to posttraumatic stress disorder (PTSD)¹⁹ cites trauma research and reviews the implications that the developmental level at which trauma

occurs has a significant impact on the capacity of the victim to adapt.²⁰ Increasingly more is being understood about the neurological and developmental implications of trauma¹⁶; however, we are far from understanding the full implications and manifestations of trauma, not only in the general population, but in children with ID as well. Trauma is seen, increasingly, as having significant impact on the development and maturation of self-regulatory processes resulting in chronic affect dysregulation, destructive behavior directed toward self and others, as well as learning disabilities, dissociative problems, somatization, and distortions of self and others. People with ID may be more vulnerable than the general population to the disruptive effects of trauma, showing high levels of self-injury, impulsivity, acting out, difficulty describing emotional states, understanding causality, and distorted self-concept. Higher reactivity, reduced coping ability, being more easily overwhelmed and less able to assign meaning to experiences are also noted.¹⁹

THE EFFECTS OF TRAUMA ON COGNITIVE FUNCTIONING

Trauma has been shown to decrease cognitive functioning and even to correlate with higher incidents of intellectual disabilities. It may in fact be that trauma also lowers IQ, and children with early histories of abuse may actually be functioning at a lower cognitive level due, in part, to the neurobiological effects of the abuse they endured. Although the existing research is scarce, the following section provides a brief overview of case studies and controlled research studies, including studies of both children and adults with physical and intellectual disabilities.

The Bucharest Early Intervention Project²¹ looked at 136 children who were institutionalized in Romania as orphans. The children were between 6 and 31 months of age. Sixty-eight were randomly assigned to foster care settings, in which at least one parent was home all day and not working, and 68 were left in the orphanage. There were significant differences in the IQs of the children. Those left in the institution had an average IQ score of 73, while those placed in foster care had an average IQ of 85. A control group of children raised in their biological home in Romania had average IQ scores of 110. The most significant differences in IQ scores between children in the orphanages and children in the institution were found in those children who had entered foster care before 24 months. This finding implies that the effects of neglect actually lower IQ.

In a similar finding, Brenner and Saigh²² found that the MRI scans of adults who had survived physical and or sexual abuse as children and who suffered from PTSD had hippocampi that were 12% smaller than those of control subjects who did not experience childhood abuse. The hippocampus is the working memory—the part of the brain that enables us to store and later apply information. Evidently, this part is damaged by repeated exposure to trauma. Stein et al²³ found that women who had endured ongoing sexual abuse in childhood had significantly less volume in their left hippocampus as opposed to women who had not been sexually abused in childhood. Again, this creates difficulties in memory and learning as opposed to those with no hippocampal damage.

Some researchers suggest the effects of abuse for people with intellectual disabilities are similar and share the same range of heterogeneity found in the nondisabled population.²⁴ Considerable anecdotal evidence supports the hypothesis that the effects of sexual abuse are similar to those documented in the general literature on the effects of sexual abuse. Sequeira & Hollins²⁵ reviewed this literature extensively and concluded that following sexual abuse, people with intellectual disabilities may experience a range of psychopathology similar to that noted in the general population. However, methodological limits indicate that the results to-date had been inconclusive regarding causality and more systematic research was needed. Their subsequent study²⁶ has made a significant contribution to understanding trauma effects in this group. A case-controlled comparison, including standardized

criteria for determining sexual abuse, standardized measures of symptomology, and psychopathology and group assignment compared adults with ID against a control group with no suspected or reported sexual abuse. Individuals with ID demonstrated more severe behavior problems than the comparison group. The largest differences were found for aggressive and agitated behavior, including aggression toward others, self-injury, temper outbursts, and sudden mood changes. The abused group also had more symptoms of social withdrawal.

Over the last several years, more attention has been dedicated to providing treatment to children and adults with developmental disabilities who have been sexually abused.²⁷⁻³⁴ The number of professionals who are doing this work is growing and is supported increasingly through professional training and exposure to and experience with this group as well as advancing knowledge of the neurological and developmental implications of trauma.³⁵ Although much more remains to be learned about the traumatic manifestations of maltreatment on children with disabilities, clear progress is being made in this domain.

BARRIERS TO ABUSE RECOGNITION, REPORTING, AND EQUAL JUSTICE

In the Bucharest study,²¹ children who remained in the orphanage had significantly more behavioral difficulties. Thirty-two percent were reported to have severe behavioral problems, whereas only 25% of those placed in foster care had behavioral difficulties, and only 6.8% of children raised in their biological homes had behavioral issues. Even more significant, 55% of the institutionalized children were diagnosed with an Axis 1 disorder, while 25% of the foster care-placed children and only 13% of the biologically raised children were diagnosed with Axis 1 disorders. Children will express their trauma through behavior. Language itself is more difficult to develop when the working memory is impaired, as findings suggest may be the case with traumatized children. For traumatized children, behavior becomes the primary language of fear, despair, frustration, and loss. Subsequently, those children are labeled as having “behavioral problems,” and thus, the vicious cycle begins.

In other domains, it is clear that bias continues to exert influence in abuse recognition and reporting; however, the picture is more complex than being solely a product of bias. The extent of discrimination encountered by people with intellectual disability was highlighted by reports from Mencap, a leading advocacy organization in the United Kingdom (UK) for people with intellectual disability. Mencap's³⁶ 2007 report, *Barriers to Justice: A Mencap Study Into How the Criminal Justice System Treats People With Learning Disabilities* suggested that people with intellectual disabilities were twice as likely to be victims of crime but were not receiving equal and just treatment from the legal process. *Barriers to Justice* demonstrated that barriers exist for people with intellectual disabilities within the legal system and that a significant complication in this process was law enforcement professionals' lack of knowledge and understanding of the implications for a person's communication and comprehension issues. Some respondents in the study felt that law enforcement officials' response was offhand or dismissive and that this was due to their disabilities.³⁶ Perhaps the most notable indicator of the widespread nature of prejudice against children with disabilities is the frequent lack of outrage that is noted when stories of people with disabilities being abused reach the public in the news or when children with disabilities are abused within their schools in the name of interventions or behavioural control. Educational program discipline policies often allow for interventions with children with disabilities that would not be considered acceptable for children without disabilities, such as lengthy time outs or physical restraints.

Failure to implement individual education plans (IEPs) that could have protected a child is another significant issue. One case example from one of the chapter's authors'

practice included a child who had been sexually assaulted by a male school employee. In the child's IEP, it was explicitly stated that only female bus drivers be assigned to her bus due to her PTSD and phobic responses that began with the assault. One day, there was a change in staffing and a male driver was assigned in violation of the IEP. The child did not want to board the bus under these circumstances and was perceived by staff as behaving in a combative and stubborn, noncompliant manner. The child was forced to take the ride with the male driver. The emotional welfare of this abused child was not properly communicated to staff as needed and the significance of the potential harm for this child was disregarded. In another circumstance, a male child was assigned a paraeducator to accompany or shadow him throughout the day. In violation of the written IEP, the paraeducator decided not to accompany him to the bathroom, where he was sexually assaulted by 2 neurotypical boys. Failure to follow the IEP and provide the necessary level of supervision and support effectively set the child up to be sexually assaulted. In these cases, the failure of the school to adhere to the IEP was brought to the attention of the school. In the former case, the school maintained that no harm came to the child because the male driver did not harm her but did recognize the violation of the terms of the IEP. The psychological distress the child experienced was not recognized by the school. In the latter case, the child's mother reported the abuse to the police, and while no legal consequences to the paraeducator occurred, a successful civil lawsuit was brought against the district. In the latter case, there were no criminal charges filed against the perpetrators.

There are a number of barriers to recognizing abuse in children with disabilities. Some barriers are cognitive in nature and rooted in stereotypes that include the belief that people who have intellectual disabilities are childlike and, therefore, asexual and cannot be sexually abused. Other preconceived ideas suggest that if a person does not understand what has happened or its significance that they do not suffer similarly to others who do not have a disability. As noted earlier, there is a long history in mental health and medical services of struggling with ideas about people with developmental disabilities experiencing pain and emotional suffering, or benefitting from therapy interventions. Both chapter authors have encountered variations of these difficulties in direct disclosures that come from a child with a disability that are treated as either attention seeking or making up stories and disregarded outright. Misattribution of signs to nonabusive causes is not especially uncommon in the chapter authors' clinical experience. In these circumstances, people failed to acknowledge or otherwise denied the reality of what was directly before them because to acknowledge this reality was too unpalatable or incomprehensible. In the experience of the authors, although abuse professionals, special education teachers, therapists, administrators, and others believe that child abuse exists, they often have trouble believing that anyone would do that to a child with a disability. In such cases, they become blind to clear evidence, including children's complaints.

Other barriers to recognition and reporting, parallel those that are encountered with children who do not have disabilities. In institutional settings (eg, school, church, recreational settings) there can be a fairly well-deserved but unfortunate reputation for exhibiting a desire to support and to maintain the conspiracy of silence that is so central to the dynamic of silencing victims. Lately, news reports have noted the growing number of examples of religious and educational institutions worldwide that have protected predators at the expense of vulnerable children.³⁷ Barriers for reporting within institutions for employees may include retribution for reporting, job loss, shunning from coworkers, and the disincentives for not reporting may be substantial. Staff may receive very clear directives to have the institution avoid at all costs controversy, negative abuse-related publicity that effects the institution's reputation, situations that imperil their funding, or produce criminal charges or litigation. This barrier can also exist for professionals who are legally mandated to report suspected abuse. Some mandated reporters may fail to report abuse of children

with disabilities for many reasons, including that they do not believe that that child really experiences any negative consequences from the abuse. Other disincentives may exist for mandated reporters, especially teachers, who fear that filing a report of suspected abuse will lead to negative consequences for them personally, including loss of tenure, social censure, and even retribution by those committing the abuse.

While some children are targeted for abuse because of the negative attitudes toward individuals with a disability (eg, bullying, sexual abuse) some children may not receive adequate treatment and attention equal to that of the typically developing child by first responders, law enforcement, CPS, and others who are obligated to thoroughly investigate every case of child abuse. The reasons for the barriers are not limited to biases and stereotypes but may also be complicated by inadequate training and experience working with children with disabilities, apprehension about their lack of knowledge, and, for some, personal discomfort with diversity. Some professionals feel undertrained and unable to carry out their duties effectively for children with disabilities or fear the unknown due to their lack of experience with individuals with disabilities. Still others may be overworked or burning out and may resent the extra effort needed to do this type of work well. Unfortunately, the children with disabilities who require enthusiastic and supportive case management from responders may not be receiving it due to these combined factors.

Although underreporting is thought to be fairly common in the typical child population, it is unknown what estimates would describe this situation in children with disabilities given the myriad barriers that exist with recognizing and reporting abuse. Factors contributing to this situation may include the fact that many children are unaware of abuse as a concept, may not be aware that what is occurring is worthy of complaint, have no one to whom to complain who will report the abuse, and those to whom they can report may be reluctant to report for reasons similar to those found for typically developing children.

Although in some cases there is direct verbal disclosure of abuse from a child with a disability, in clinical experience of the authors, this is less often the case than other individuals in the child's life discovering physical symptoms, such as bruises, cuts, bleeding, sexually transmitted infections (STIs), and pregnancy. Others may notice through their observations small changes in the child's behavior, such as increased interest in sexual matters such as pregnancy, sexual comments, or both or behaviors such as masturbation, regression or loss of skills, increased outbursts, increased anxiety, emotional reactivity, difficulty soothing, and social withdrawal that alerts others to the occurrence of abuse. In the experience of the authors, many variations of this type of discovery have been seen. In one case, a young woman with autism was increasingly upset when it was time to end her weekend visits with her parents and return to the state hospital where she lived. Her behavior on Sunday afternoons was so out of control that the parents discussed the matter with hospital staff, who recommended that she discontinue weekly visits with her parents and only see them monthly. Her parents resisted this suggestion and noted progressively worse outbursts weekly. During one weekend visit, the father emerged from the bathroom while completing the zipping up of his pants. Upon seeing this, his daughter instantly lay on the floor in front of him and raised her legs up as if to receive him sexually. It was at this time the parents realized that she was being sexually abused at the hospital and predictably shown increasing resistance and distress when returning. It may have explained the staff's counseling them to reduce the parents' time with their daughter, thereby further increasing her isolation and reducing the likelihood of discovering the abuse occurring in the institution. As a nonverbal child, she did not have any means of describing what she was experiencing and the parents had been unable to figure out the cause of her upsets. In another case, a young high school girl was described as showing a change in her mood from being fairly happy-go-lucky to

becoming more serious. Although she was not found to be depressed or showing any other psychological disturbance, in retrospect the parents did notice a shift to a more serious manner. In retrospect, they also recalled that she had begun to ask questions about pregnancy, including whether they thought she could ever get pregnant and how old do you have to be to get pregnant. At the time, the parents believed she was becoming more sexually aware but did not know that she was being stalked and had seen another girl raped by the same boy who later raped her at school. She did not reveal her fears to her parents and, in fact, did not reveal the rape for several days. As these cases and others reveal, the collective signs can be subtle and often parents and families are neither taught nor prepared to see signs of abuse. Frequently, only when physical signs appear can the worst fears be confirmed and action taken.

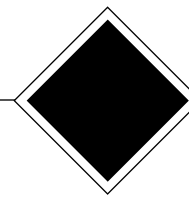
INVESTIGATION AND TRAINING

The work that follows reporting suspicions of abuse demands thorough investigation at least equal to that conducted in cases of typically developing children. However, equal effort is not necessarily the norm. Factors that interfere include both the child's disability and the skills of the responders. It is the responsibility of the responders (eg, CPS, law enforcement, ER professionals, investigators, detectives, forensic interviewers) to learn how to effectively communicate, interview, and investigate regardless of the child's disability. There is a dearth of training in this area; therefore, equal justice is not present in the majority of cases. This contributes to the lower number of substantiated cases, far below that which would be expected based on what is known of incidence and prevalence studies.

In the past 8 to 10 years, training programs have been produced to help fill this gap, including written curricula and training DVDs. More often than not, these are developed and used for a short period of time under a grant. When the grant ends, however, the work does not continue as the relevant agencies (eg, CPS, law enforcement, child advocacy centers [CACs]) do not incorporate the work into their protocols and programs. In some circumstances, there may be one person on staff who takes special interest in implementing protocols and programs into the facility or agency where they work; however, when that person leaves their position, the importance given to the work may be diminished until someone else takes up the cause or recognizes its gravity and the significance of maintaining continuity of service.

Training, education, and support have been identified as excellent ways to remove these barriers to equal justice for child abuse victims with disabilities. These negative attitudes, while pervasive in the culture, can also be changed over time. These attitudes are products of the culture in which people have grown up. Yet, it is incumbent upon those in the child-serving professions to do a personal examination and improve attitudes. Such attitudes can be found among school personnel at all levels, parents, neighbors, after school programs, and other places throughout the culture. It is essential for those in the child-serving professions to support the shift both in themselves and toward intrinsically valuing one another. While calling for a values change in the culture may seem a tall order, it is fundamental to making the critical changes to delivering services to and ensuring equal justice for children with disabilities who become victims of abuse. Increasing professionals' exposure and experience and training with children with disabilities is often essential to laying the groundwork for not only attitudinal changes, but also for increasing the number of professionals who are actively involved in this work and parents who are advocating for changes.

Unfortunately, there is often little or no training for education providers, law enforcement professionals, CPS workers, victim advocates, and other essential personnel, to help overcome cultural or disability biases. Although sensitivity training programs have been instituted to help recognize and overcome a variety of prejudices, very few address issues of disability and physical difference. Interaction with people whose appearance varies greatly from the norm (eg, those with rare genetic conditions)



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