

# CRIME VICTIMS WITH DEVELOPMENTAL DISABILITIES

## A Review Essay

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Rates of violence and abuse perpetrated on people with developmental disabilities (e.g., mental retardation, autism) appear significantly higher than for people without these disabilities. Few of these crimes get reported to police, and even fewer are prosecuted because officials hesitate to pursue cases that rely on the testimony of a person with a developmental disability. The author offers several conceptual models to explain their differential victimization risk, including routine activities theory, dependency-stress model, cultural stereotyping, and victim-learned compliance. This article summarizes the research evidence on crimes against children and adults with developmental disabilities. It is divided into four sections. The first section describes the nature and extent of crimes against individuals with developmental disabilities. The second reviews the literature on risk factors associated with their victimization. The third discusses the manner in which justice agencies respond to these crimes. The final section enumerates what research and policy initiatives might address the problem.

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**A**lthough violent crime in the United States has declined over the past 5 years, certain groups appear to remain at disproportionately high risk for violent victimization. In the United States, people with developmental disabilities—such as mental retardation, autism, cerebral palsy, epilepsy, and severe learning disabilities—are included in this group. The term *developmental disabilities* is defined

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by federal law (PL 98-527) as a severe chronic disability of a person that (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments, (b) is manifested before age 22, (c) is likely to continue indefinitely, and (d) results in substantial functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency (Larson, Lakin, & Anderson, 2000). *Mental retardation* is defined by the American Association on Mental Retardation (AAMR) (1992) as “significantly subaverage intellectual functioning existing concurrently with related limitations in two or more of the following applicable adaptive skills areas: communication, self-care, home living, social skills, community use, self-direction, functional academics, leisure, and work” with such limitations manifested before age 18. An IQ level below 70 is the criteria for measuring the deficit in intellectual function for retardation. It is estimated that 1.9% of the general (noninstitutionalized) U.S. population have mental retardation or developmental disabilities (Larson et al., 2000). Mental illness and mental retardation are often confused, but they are quite distinct conditions. Mental retardation and developmental disabilities pertain to subaverage intellectual functioning, whereas mental illness has nothing to do with IQ.

Although the scientific evidence is scarce, studies from the United States, Canada, Australia, and Great Britain consistently find high rates of violence and abuse affecting people with developmental disabilities. Wilson and Brewer (1992) found that the relative risk of victimization for people with retardation is highest for personal (or violent) crimes. Certain economic crimes also occur more often. For example, many individuals with mental retardation rely on state and federal benefit payments to support themselves. Frequently, these payments are forwarded through third parties. A study by the Social Security Administration found that there were problems in 20% of the cases; appointees had been accused of murder, larceny, and “slave trading,” in which beneficiaries were being sold from payee to payee (Tolchin, 1989). Not only are people with developmental disabilities at higher risk of victimization, but they also face innumerable barriers when reporting their victimization, when having their cases investi-

gated and prosecuted, and in receiving emotional support (Sobsey, 1994).

A number of social and demographic trends are converging that may worsen the situation considerably over the next several years. The incidence of developmental disabilities may be increasing due to a number of factors, such as poor prenatal nutrition, lack of access to health care, better perinatal care for fragile babies, and increases in substance abuse during pregnancy (Murphy, Boyle, Schendel, Decoufle, & Yeargin-Allsopp, 1998). For example, a recent report of the California State Council on Developmental Disabilities found that during the past decade, although the state population increased by 20%, the number of persons with developmental disabilities in California increased by 52% and the population segment with mild mental retardation doubled (Frankland, 1996).

In addition, because of deinstitutionalization and new U.S. legislation—particularly the Personal Responsibility and Work Opportunity Reconciliation Act of 1996—many people with developmental disabilities now live in unsafe community settings where they get little health care, have access to few social services, and are easy targets for criminal predators. Since 1977, the total number of people with developmental disabilities in the United States who live in large institutions has declined from 194,650 (in 1977) to 54,819 (Braddock, Hemp, Parish, & Westrich, 1998). This reduction has been accompanied by a radical increase in the number of people with disabilities who live in small community-based residences from 19,700 to 194,968 over the same period (Prouty, 1999).

Fully one third (34%) of adults with disabilities live in households with a total income of \$15,000 or less, compared with only 12% of those without disabilities (Harris, 1998). As Luckasson (1999) recently wrote,

In our society, there is a high relationship between disability and poverty; and poverty is related to criminal victimization. Poor people with disabilities living in dangerous neighborhoods, waiting at unlighted bus stops, dependent on unscrupulous friends, face many risks of victimization. (p. 11)

Of course, it is also true that those who take care of people with developmental disabilities victimize them and that people with dis-

abilities victimize one another in residential settings (Sobsey, 1994; Sobsey & Mansell, 1994). As such, it is unknown whether the overall victimization risk of people living in the community is higher than the overall victimization risk of people living in state-operated facilities. It might also be expected that the type of crime the victim suffers differs depending on his or her current living situation, but this too is unknown at this time.

Disability and victim rights advocates have begun to raise awareness of the issue of violence against people with disabilities. The National Organization for Victim Assistance addressed this issue in a conference and bulletin that discussed how victim advocates and others in the criminal justice system can work with crime victims with disabilities (Tyiska, 1998). In 1997, the Administration on Developmental Disabilities (ADD), in response to the alarming statistics and overall focus on domestic violence by the Department of Health and Human Services, funded four projects of national significance addressing violence against women with developmental disabilities.<sup>1</sup>

In 1998, Congress passed the Crime Victims with Disabilities Awareness Act of 1998, the first piece of national legislation in U.S. history to address the issue. This law requires that the National Crime Victimization Survey (NCVS) collect information on crime victims with disabilities. The NCVS is the nation's primary source of information on criminal victimization.<sup>2</sup> The Act also requested that the National Research Council of the National Academy of Sciences convene a workshop to discuss the state of knowledge in this area and highlight gaps in the research. The proceedings of this workshop are published in Petersilia, Foote, and Crowell (2001), and some of the papers referenced in this article were prepared for that workshop.

Although systematic study of crimes against people with disabilities only recently began to receive attention, there now exists a small but growing body of literature on the subject. There is relatively more information on children than adults and more information on females than males. However, it is not a scientifically rigorous literature, consisting mostly of anecdotal evidence, data from convenience samples, and nonrandom program evaluations. Moreover, there are only a few studies that focus specifically on persons with *developmental* disabilities. Studies sometimes combine physical and cognitive disabilities and mental illness with mental retardation, failing to report the results

separately for the different disability groups. This is particularly true for analyses resulting from national surveys conducted for other purposes, such as the National Crime Victimization Survey or the Survey of Inmates in Local Jails. As such, although this article specifically focuses on the victimization of persons with developmental disabilities, some of the studies reviewed do not distinguish between types of disability, and this is noted in the text.

This article summarizes the research on (a) the nature and extent of crimes against individuals with developmental disabilities, (b) the risk factors associated with their victimization, (c) the manner in which justice agencies respond to these crimes, and (d) what research and policy initiatives might address the problem.

### **EXTENT AND NATURE OF CRIMES AGAINST ADULTS WITH DISABILITIES**

Sobsey, Lucardie, and Mansell (1995) noted that societies have long victimized individuals with disabilities. In ancient times, infants with disabilities were abandoned or killed as a matter of course. During the Middle Ages, individuals with disabilities were sent to monasteries or subjected to a life of ridicule as court jesters to wealthy families. During much of the 20th century, individuals with physical, mental, or emotionally disabilities were euthanized, institutionalized, or otherwise separated from general society. When the Nazi party took control of Germany, the mass killing of people with disabilities began, and although the exact number of people with disabilities killed under the Nazi euthanasia program remains unknown, the number is estimated to be about 275,000 (Wilhelm, 1990).

Significant studies of crime victims began in the middle of the 20th century. Like much of the work that followed, early studies in victimology emphasized the importance of considering the relationship between the perpetrator and the victim. von Hentig (1948) is credited with first identifying the relationship between disability and victimization when he suggested that four categories of people were particularly vulnerable to victimization: the young, the old, females, and the mentally disabled. Sobsey and Calder (1999) observe that the relationship between disabilities and crime victimization received little

attention until the 1960s, when studies found high rates of developmental, physical, and behavioral disabilities among abused children (e.g., Birrell & Birrell, 1968; Elmer & Gregg, 1967; Gil, 1970). Studies that followed also revealed higher-than-expected rates of substantiated child abuse among children with disabilities (e.g., Buchanan & Oliver, 1977; Frisch & Rhoads, 1982). These studies demonstrated a relationship between abuse and disability, but they shed little light on why the relationship might exist or whether disability was an outcome of or a risk factor for abuse.

The book *Violence and Abuse in the Lives of People with Disabilities* (Sobsey, 1994) showed that crime and abuse was a serious problem in the lives of adults as well, both in institutional and community settings. It served as a significant wake-up call to the research community and spawned many subsequent studies. Today, however, the research literature is still methodologically weak. This is partly a result of inadequate attention and funding but also stems from a number of significant barriers to obtaining information. These barriers are discussed below.

#### BARRIERS TO OBTAINING INFORMATION

Several factors have impeded data collection and research efforts on the victimization of people with developmental disabilities. First, there is currently no systematic and recurring collection of national, state, or local information on crime victimization of people with disabilities. There exists no base rate data on victims with disabilities for the crimes for which victim data are typically gathered—including data from the NCVS, Uniform Crime Reports (UCR), National Center for Injury Prevention and Control, and the National Incidence Studies conducted on child abuse and neglect.

In recent years, some states have adopted statutes that require authorities to collect data on hate- or bias-motivated crimes, and by 1998, 21 states had laws covering crimes motivated by bias against persons with disabilities (Grattet & Jenness, 2001). But hate crime laws are specifically designed to identify those crimes that are motivated by what the person *symbolizes*. In hate crimes, the individual is victimized to send a message to the larger community, not simply because their disability makes them more vulnerable to criminal pred-

ators. An examination of UCRs found that in 1997, a total of 8,049 hate and/or bias crimes were reported: Just 12 were coded as motivated by a disability. No other data were available from the UCR with regard to the victims' type of disability or age (Grattet & Jenness, 2001).

Even if formal data collection systems recorded whether the victim had a disability, the data problem would not be solved because most crimes involving victims with disabilities are not reported to the police. In 1997, among all populations, only 37% of all crimes were reported to the police (Bureau of Justice Statistics, 2000). Several factors make it likely that the rate of reporting by victims with disabilities is much lower than the average. The communication limitations of many people with developmental disabilities may interfere with their ability to report. Some of these victims are in dependent relationships with people who provide care to them, and they may fear grave personal harm if they make a report. Many people with disabilities may feel additional strong disincentives to report, such as a fear of being sent back to a more restrictive setting. Conflicts of interest, whether between a service provider and a victim or between a family perpetrator and a victim, may also interfere with proper reporting by another party.

Moreover, when crimes against persons with disabilities are reported to authorities, they are often not defined as crimes but rather as "incidents." Sobsey (1994) and Luckasson (1999) have both written about the practice of defining crimes, such as sexual assault, as "abuse and neglect" rather than as crimes subject to the criminal court system. Consequently, offenses are handled through administrative channels within a group home or institution. This practice makes the crimes against people with disabilities truly invisible (Sorensen, 1997).

These and other barriers to systematic information mean that there continues to be little information on the characteristics of victims and offenders as well as the interpersonal dynamics and contextual factors that lead to abuse, neglect, and criminal victimization.

#### **CONVENTIONAL CRIMES AGAINST ADULTS WITH DISABILITIES LIVING IN THE COMMUNITY**

The most widely cited study of the criminal victimization of adults with developmental disabilities was conducted by Wilson and Brewer

**TABLE 1: Victimization Risk by Intellectual Disability (in percentages)**

<i>Crime</i>	<i>Intellectually Disabled?</i>		<i>Relative Risk</i>
	<i>Yes</i>	<i>No</i>	
Assault	11.4	4.0	2.8
Sexual assault	3.2	0.3	10.7
Robbery	5.1	0.4	12.8
Total personal	19.7	4.7	4.2
Auto theft	0.6	0.7	0.9
Theft	7.6	6.4	1.2
Burglary	11.4	6.4	1.8
Household theft	4.4	3.7	1.2
Total property	24.0	17.2	1.4

SOURCE: Data from Wilson and Brewer (1992).

(1992). They administered a victimization questionnaire to a sample of 174 adult volunteers from three South Australia shelter workshops. The study participants' intellectual function ranged from mild to severe retardation. As shown in Table 1, Wilson and Brewer found that the relative risk of victimization was highest for personal (or violent) crimes. Persons with intellectual disabilities were 12.8 times more likely to be robbed, 10.7 times more likely to be sexually assaulted, and 2.8 times more likely to be assaulted (nonsexually). Only auto theft was lower for the group with disabilities, and that was likely due to the fact that few had cars to be stolen.

This study also found extremely low rates of reporting to the police: 40% of the crimes against people with mild mental retardation went unreported, and 71% of those against people with severe mental retardation went unreported (Wilson & Brewer, 1992). They also found that although people with disabilities and without disabilities were equally likely to report crimes in Australia, people with intellectual disabilities were more likely to report the crime indirectly, through family members or caregivers.

Other studies confirm the particularly high rates of sexual assault against females with developmental disabilities (Carmody, 1990; Hard, 1986; Sobsey, Mansell, & Wells, 1991). Most of these victimization studies use data from Canada, England, and Australia. In the United States, the major source of data on crime victimization is the NCVS. The NCVS is a survey of a nationally representative sample of



**TABLE 2: Victimization Risks for Persons With Disabilities Relative to the U.S. General Population for Persons Who Use a Proxy (in percentages)**

<i>Crime</i>	<i>Number of Victims</i>	<i>Relative Risk</i>
Any	37	0.13
Assault	4	0.14
Sexual assault	4	1.95
Robbery	11	0.21
Auto theft	0	NA
Theft	18	0.10
Burglary	2	0.76
Other theft	2	0.17
All other crimes	10	0.13

SOURCE: Petersilia, Foote, and Crowell (2001).

NOTE: NA = Not applicable.

households and individuals within those households. Persons in the NCVS are asked (by telephone or in person) to report on the crimes they experienced and whether or not they reported them to law enforcement authorities. The NCVS allows respondents to be interviewed by proxy (usually another member of the household) if the respondent is a minor child, away for the entire interview period, or physically or mentally incapacitated. "Incapacitation" can range from hearing impairment to severe mental retardation.

McCleary and Wiebe (1999) analyzed the 1997 NCVS to determine how many persons with physical or intellectual handicaps completed the survey using a proxy interview and, given those responses, whether those persons reported higher incidents of victimization than persons without disabilities. They found that approximately 4% of all NCVS personal victimization interviews were conducted by proxy. Of these, 30% were justified by physical or mental incapacity. In these interviews, a total of 37 victimization incidents were reported by proxies (see Table 2).

McCleary and Wiebe (1999) computed the relative risk (RR) attributed to disability—that is, differences in the victimization risks of persons with disabilities and those without disabilities in their victimization experiences. (Note that they were unable to analyze mental and physical disabilities separately because the original survey instrument grouped them into a single category.) The McCleary and Wiebe RR for the NCVS samples are shown in Table 2. They found that mentally

or physically incapacitated people faced significantly *lower* risks of victimization than the general population. If specific crimes are examined, however, mentally or physically incapacitated persons had a significantly higher risk of sexual assault—they were nearly twice as likely to report (by proxy) a sexual assault. The higher risk of sexual assault is consistent with the findings of Wilson and Brewer and others and with the prevailing theory of victimization.

However, as the authors note, the lower risks of assault and robbery may be an artifact of the proxy interview method or differences in the sample. When surveying about victimization experiences, the validity of responses will depend on whether the subject comprehends what is a criminal event. In some cases, this comprehension can be ensured simply by describing to the respondent the differences between a theft and a burglary. However, some individuals, such as the young or developmentally disabled, may not even recognize that the event was inappropriate or illegal. Unwillingness to disclose may be especially problematic when assessing the victimization of persons with disabilities because the majority of these incidents may be committed by known offenders. Sobsey (1994) examined offender-victim relationships with data from the University of Alberta's Disability Project, and out of 215 cases of abuse among adults with a developmental disability, 52% were victimized by someone who was associated through contact with disability services. Other research has also found that a large proportion of victimizations are committed by service providers, family members, and peers with disabilities (Turk & Brown, 1992; Westcott, 1992). Certainly, the accuracy of data is jeopardized when assessing the victimization of a person whose proxy interview is conducted with the person who is the perpetrator.

#### **VICTIMIZATION OF ADULTS WITH DISABILITIES IN INSTITUTIONS AND JAILS**

Sobsey (1994) suggested that persons with disabilities in institutions may face greater risks than people in the community because victimization by caregivers and peers with disabilities is common. Sobsey is specifically referring to victimization that occurs in state-run developmental centers, and he provides anecdotal evidence that violence and abuse in such settings is widespread (Sobsey, 1994).

Others agree with him (Crossmaker, 1991), and in fact, it was the reports of abuse and violence in such institutions that led to the closure of many of them and spurred the deinstitutionalization movement. One weakness of the NCVS data discussed above is that it is a household survey and excludes persons in institutions. There are no national studies of the victimization and abuse of persons with disabilities residing in institutions, although such a research effort is certainly warranted.

A recent analysis was completed, however, examining the victimization rates of persons with and without disabilities who reside in jails. Wiebe and Petersilia (2000) used data from the 1996 Survey of Inmates in Local Jails to assess the risk of victimization faced by male inmates with a disability. The survey asked inmates to self-report the physical and sexual assault victimizations they had experienced since their admission to jail. Inmates were also asked to self-report the presence of several types of disabilities (e.g., hearing loss, speech impediments, learning disability, physical disability, and physical or mental disability that limits work). The analyses then examined the victimization risk associated with inmates who had at least one type of disability, controlling for a number of factors previously found to be related to the risk of victimization or violence in jail (e.g., age, race, criminal history, past physical and sexual abuse, drinking and drug history, and institutional factors such as cell crowding, unit type, or work assignment). Again, however, this survey failed to allow a separate analysis for persons with physical versus cognitive disabilities. The analysis showed that jail inmates with a disability were 1.4 times more likely than nondisabled inmates to be harmed in jail. With regard to sexual assault, inmates with disabilities were 3 times as likely as others to be sexually assaulted while in jail. Both of these results were statistically significant ( $p < .05$ ).

#### **FAMILY AND CAREGIVER VIOLENCE AGAINST PEOPLE WITH DISABILITIES**

In 1994, the Violence Against Women Act (VAWA) added several federal domestic violence crimes to the criminal code and provided for a civil rights remedy for victims of sexual assault and domestic violence. However, the VAWA does not provide recognition of domes-

tic violence against women with disabilities, and, in the words of one researcher, "the experiences of violence against women with disabilities have been neither voiced nor heard" (Chenoweth, 1997, p. 33).

The multiple oppressions of being female, disabled, and battered leave this community extremely vulnerable to intimate partners and to caregivers. In fact, all of the barriers an able-bodied victim of domestic violence might face are simply compounded by the victim's own disability as well as the paucity of services available to help her lead a violence-free life. Burstow (1992) wrote,

If women's "helplessness" and vulnerability generally are seen as an opportunity as well as an excuse for male violence, disabled women's vulnerability is seen as a blanket invitation. Disabled women are attacked again and again by partners, caretakers, and strangers. (p. 93)

Although reliable statistics are few, some researchers who have delved into this area call the problem an epidemic, with most conceding it is a vast unknown.

Societal attitudes about women with disabilities may be the cause of this exclusion because many people assume that women in this population do not have significant others. Grothaus (1985) stated, "Women with severe disabilities are not expected to have relationships. We are perceived as asexual, as not desiring love or sex or a committed involvement" (p. 125). However, women with disabilities are involved in intimate relationships and are very concerned about the issue of violence within these settings. A recent survey of women with disabilities found that abuse and violence was one of the top five concerns of 92% of the participants and that 85% rated it as "very important." The report stated,

The results of the Delphi survey indicate that women with disabilities themselves recognize abuse and violence, especially caretaker abuse, as a high-priority issue that gets little attention from most service providers and policy makers. Women with disabilities share with nondisabled women the fact that their intimate partners may physically, emotionally, or verbally abuse them. However, they can also be subject to the types of abuse that are not issues for nondisabled women, such as denial of medications, withholding of attendant services, or

preventing use of assistive devices. (Berkeley Planning Associates, 1997, p. 7)

Erwin (1999) noted that, once in an abusive relationship, women with disabilities are motivated to stay by the same host of factors that keep women without disabilities in these relationships—fear of further violence, belief the batterer will change, love of the abuser, religious beliefs, and many other concerns. But, for women with disabilities, there are additional factors that can limit their ability to leave, such as physically not being able to exit the house, not knowing if the local shelter is physically accessible (i.e., has a wheelchair ramp, workers who know sign language), fear of losing caregiver service if they report the abuse, fear they will be institutionalized if they leave their partner, and lack of resources. The latter is particularly important because many women with disabilities either do not work or are not employed full-time. The unemployment rate of women who are disabled is reported to be 74%, and those who do work earn only 64% of the wages of able-bodied women.

The issue of caregiver violence is a unique one faced by persons with disabilities. Many rely on a paid or unpaid personal assistant to help them with a host of daily activities ranging from grocery shopping to bathing. There is no general survey of abuse and violence by caretakers. The one study by the National Institute of Health (NIH) did identify abuse by attendants and health care providers and found that women with disabilities are significantly more likely to be abused by this population (Young, Nosek, Howland, & Rintala, 1997). (Boys and men with disabilities also probably have higher rates of abuse, but there is no empirical data on this.)

Curry and Powers (1999) sought to measure the abuse of women with disabilities by their personal assistance services providers in an Oregon sample. They divided survey participants into women with physical disability (PD) and those with developmental disability (DD). They found that women with DD were significantly more likely to report that they had ever experienced several types of abuse, whereas those with PD were significantly more likely to report that they had experienced abuse within the past year. Asked about strategies that might help to stop or prevent abuse by personal assistants,

women with PD and DD included the same six strategies: (a) choose your own personal assistant, (b) have a backup personal assistant available, (c) set limits with your personal assistant, (d) clarify the personal assistant job description, (e) arrange for emergency transportation, and (f) have clear communication with your personal assistant. Women with PD and DD ranked the same three strategies as least helpful: (a) call the police, (b) use humor during stress, and (c) wait until you can act.

#### **BATTERING DURING PREGNANCY**

Erwin (1999) noted that battering during pregnancy causes an unknown number of disabilities in the women's children. Sobsey (1994) said various studies show that between 4% and 23% of women are battered during pregnancy and that those who are battered during pregnancy are twice as likely to have complications to their pregnancy than those who experienced trauma as the result of falls or auto accidents. This is obviously a cause for some alarm, as the rates of abuse of children with disabilities are also higher than for children without disabilities. Because spousal abuse within families correlates to increased risk of child abuse with these same families, the offspring whose mother was abused during pregnancy would also experience greater risk for abuse as infants, children, and young adults.

This abuse and disability cycle presented by Sobsey (1994) posits that some people become entrapped within the cycle, either being born with a disability or becoming disabled as a result of abuse, thus increasing their chances of further abuse. In families in which the mother is battered, even if there is no violence perpetrated on her during a pregnancy nor on the children after birth, the effects of witnessing the violence can have an impact on the child's development and learning, producing what might be termed a *secondary disability*.

#### **ABUSE AND NEGLECT OF CHILDREN WITH DISABILITIES**

There has been relatively more research exploring the relationship between disability, child abuse, and neglect, although the data is still

woefully inadequate. An extensive review of this literature was recently prepared by Sullivan (1999), and this section draws heavily from her article.

Professionals, including child protection workers and educators, believe that children with disabilities are at high risk for abuse and that some disabilities are caused or exacerbated by abuse (Sobsey, 1994; Sobsey & Varnhagen, 1989). However, there is a surprising lack of methodologically sound research in the field of child abuse and disability. Existing literature addressing the problem of abuse and the disabled can be categorized under three major headings: (a) the perception of high incidence rates of victimization among children with disabilities, (b) the proportion of children with disabilities within a sample of abuse victims, and (c) the proportion of abuse victims within a sample of children with disabilities.

#### PERCEPTION OF HIGH INCIDENCE RATES

Children with disabilities are presumed to increase stress between parents and other caregivers and thereby to be at risk for abuse. Some authors argue that children with mental retardation are at greater risk because ordinary standards of care are inadequate for them (Schilling & Schinke, 1984) and because they are less protected by the incest taboo than are children of normal intelligence (Neutra, Levy, & Parker, 1977).

Many people with disabilities exhibit behavioral characteristics, such as tantrums, aggressiveness, and noncompliance, that negatively affect their parents and caregivers, increasing the risk of abuse. Finally, various disabilities—including mental retardation, cerebral palsy, developmental delays, speech and language disabilities, and multiple-personality disorders—have been attributed to abuse and neglect (for a complete review, see Sullivan, 1999).

Specific caretaking roles required for some disabilities may play a role in increasing the risk of abuse. One study found, for example, that the majority of day-care abuse occurs around toileting (Finkelhor & Baron, 1986), suggesting that disabilities resulting in a need for toileting assistance may be associated with increased risk of abuse. Residential placement may also provide opportunity for abuse by caretakers. For example, a study of deaf youth found that sexual abuse

tended to occur in bathrooms and bedrooms at residential educational facilities or in specialized transportation (Sullivan & Scanlan, 1987).

#### EPIDEMIOLOGICAL STUDIES

Several epidemiological studies address the prevalence of maltreatment among children with disabilities and a control group of children without disabilities. They were completed at the Center for Abused Children with Disabilities at the Boys Town National Research Hospital in Omaha, Nebraska.

A hospital-based study of maltreatment among children with disabilities merged more than 39,000 hospital records from 10 years (1982 to 1992) with the social service central registry, the foster care review board, and police records to identify cases of both intrafamilial and extrafamilial maltreatment (Sullivan & Knutson, 1998a). The merger resulted in more than 6,000 matches and a maltreatment prevalence rate of 15%. Among the children identified as maltreated, 64% had a disability compared with 32% of the nonabused children.

The medical-based research was replicated with a school-based data pool, which permitted prevalence estimates of abuse among children with disabilities to be based on standard definitions of maltreatment and homogeneous education-based definitions of disabilities. The school-based study merged almost 50,000 records from Omaha public and parochial schoolchildren matriculated during the 1994-1995 school year with the Nebraska central registry, the foster care review board, and Omaha police records of child maltreatment (Sullivan & Knutson, 1998b). Among the public schools, 22% of the maltreated children had a disability. In contrast, 31% of the children with an identified disability had records of maltreatment in either social services or police agencies. The relative risk for maltreatment among children with disabilities was found to be 3 times that of other children. Overall, there was a strong association between disabilities and neglect, so children with disabilities were 4 times more likely to be victims of neglect than other children. Children with behavior disorders and mental disabilities were significantly more likely to be neglected than children with other disabilities (Sullivan, 1999).



#### **CHILDHOOD DISABILITIES AS A CONSEQUENCE OF VICTIMIZATION**

Disabilities can also result from the experience of violence or some form of child maltreatment. Although data are limited on the prevalence of acquired disabilities, given the problem of determining the temporal association between the onset of the disability and the occurrence of the violent act, it is known that 33% of all spinal cord injuries are the result of intentional violence (Waters, Cressy, & Adkins, 1996), but it is not known whether there were other preexisting disabilities among those who suffered spinal cord injury.

Traumatic brain injury is the most devastating type of pediatric trauma. Each year an estimated 50,000 children and adolescents sustain permanent disability as the result of brain injury (Stylianou, 1998). Unfortunately, follow-up data on the nature and extent of the child's disability status typically do not cover events beyond the resolution of the acute trauma.

#### **INSTITUTIONAL ABUSE OF CHILDREN**

Approximately 2% of the 4.5 million children and youth with disabilities in the United States live in institutions, including schools for the blind, deaf, and physically disabled; institutions for the mentally retarded; and facilities for the mentally ill. Some research has found residential placement to be a risk factor for experiencing sexual or physical abuse (Sullivan, Vernon, & Scanlan, 1987), but there remain very little empirical data on childhood victimization in institutional settings.

#### **CONVENTIONAL VIOLENT CRIMES**

Given the lack of crime victimization data collected on persons with disabilities in general, it is not surprising that minimal research has been conducted on children and youth with disabilities as victims of conventional violent crimes. Among the few studies of these types of crimes, one found that high school students with learning disabilities were more likely to be victims of crime (theft and sexual assault)

than peers who do not have disabilities, and the other found that students with behavior disorders were more likely to be victims of violent crimes (aggravated assault, robbery, and rape) than peers who have learning disabilities or mental retardation (Sullivan, 1999). Because these studies included only a small sample and had other limitations, however, it is safe to say that there is essentially no data on the criminal victimization of children with disabilities.

### WHY VICTIMIZATION IS DISPROPORTIONATE

People with disabilities may be particularly vulnerable to crimes involving interpersonal violence, such as physical or sexual assault, because as a population—regardless of age or gender—they are often the least able to recognize danger, the least able to protect themselves, and the least able to obtain assistance within the criminal justice system. People with disabilities may also misinterpret social cues and believe everyone is their friend. A desire for acceptance often leads people with cognitive disabilities to acquiesce to behavior they do not like or do not want for fear of losing social contact.

They are also frequently dependent on others to provide care for them, and this care can be quite intimate. When a person is dependent on another for food, clothing, shelter, and all social interaction, that dependency sometimes prevents him or her from resisting abuse. Most people with disabilities have little access to resources (e.g., transportation to the police station), and most do not receive sex education (it is surprising that special education students often do not receive the required sex education courses that students without disabilities receive). And the victim with cognitive disabilities may lack the vocabulary to report the abuse. Even if it is reported, the victim is often not believed or is thought to be fantasizing or to have merely misinterpreted what occurred. This leaves the person with a disability continually vulnerable to victimization, because perpetrators come to learn they may victimize them without fear of consequences.

All of these are plausible explanations, but none have been empirically tested. However, many of those writing about the issue use the routine activities theory or lifestyle model to explain their differences in victimization probabilities.

#### **ROUTINE ACTIVITIES OR LIFESTYLE MODEL OF VICTIMIZATION**

Routine activities theory was originally developed by criminologists to explain differences in victimization risks for different population groups—for example, males, non-Whites, or those with low incomes (Felson, 1987). It was later used to explain differences in victimization risks for those with disabilities (Petersilia, 2000; Sobsey, 1994). In simple terms, routine activities theory holds that victimization risk is a function of lifestyle and/or patterns of routine activities. People who are demographically similar—based on variables such as age, sex, race, income, and social setting—face similar victimization risks because of differences in lifestyles or routine activities that enhance a person's exposure to risky places and potential offenders. In other words, the activities that we engage in, where we live, and how we move around the community create the opportunity for crimes against us. Offenders select targets that offer the greatest net rewards.

When one group is selected as a target for crime more frequently than another, it usually meets three conditions: (a) group members are exposed more frequently to motivated offenders (proximity), (b) group members are more attractive as targets in that they afford a better yield to the offender (easy sex), and (c) group members are more accessible or less defended against victimization (lack of guardianship or access to justice). Persons with developmental disabilities clearly meet all three of these conditions. For example, institutional care may function both to increase the exposure of people with disabilities to potential offenders and may isolate them from sources of protection, such as the police. An offender may choose an individual with a disability as a victim out of a belief that apprehension is less likely and that punishment will be less severe if apprehension occurs.

Many aspects of the service delivery system may also place persons with disabilities at risk. For example, one study found that 44% of all offenders against people with disabilities made initial contact with their victims through the web of special services provided to people with disabilities (Sobsey, 1991). Other delivery system procedures integrate those who are unable to protect themselves with those who are dangerous to others. For example, the reclassification of drug addicts as people with disabilities allowed addicts to live in subsidized

housing along with people with disabilities. Although not all drug addicts are offenders and not all people with disabilities are vulnerable, the combination has been viewed as creating a high-risk environment (Petersilia, 2000).

The higher victimization of persons with disabilities, particularly children, has also been explained by the dependency-stress model. Used extensively between the 1960s and the 1990s, this model is fashioned on several premises: children with disabilities are more dependent on their caregivers, increased dependency increases the demands on caregivers, increased demands result in increased stress for caregivers, and caregivers abuse their charges because they cannot cope with the increased stress. Although this model appears to be logical, little research supports it, and some research seems to contradict it altogether (for a review, see Sullivan, 1999). Furthermore, the model can be construed as excusing offenders or even transforming them into victims while blaming the real victims for causing stress.

Sobsey and Calder (1999) recently developed a more complex multifactorial model of the risk of violence directed at people with disabilities. Their model synthesizes existing models and draws from their own extensive experience and research. Although the model is grounded in empirical research and case study material, it has not been empirically tested and the authors write that "most elements of the conceptual model are largely informed conjecture" (p. 2). Still, the model integrates a wide range of concepts, models, and theories into a rational organizational structure for understanding this complex phenomenon.

#### **SOBSEY AND CALDER'S MULTIFACTORIAL MODEL OF VIOLENCE**

The multifactorial model incorporates characteristics of the potential victim, the potential offender, and interactions between the potential victim and potential offender and the relationship that determines those interactions. The model incorporates social control agents, the environment in which interactions occur, and the culture of the society that influences every interaction within it.

### Victim-Related Factors

Sobsey and Calder (1999) note that in attempting to understand why individuals with disabilities are victimized, some prefer not to examine the role of the victim, believing that such an examination shifts blame from the offender. However, they argue, denying that victim attributes and behavior influence risk suggests that individuals are powerless to reduce their risk, and evidence shows that factors such as age, gender, lifestyle, socioeconomic status, and disability affect the risk of victimization. Thus, exploring and understanding the reasons for differential risk may help to reduce risk for vulnerable members of society.

*Direct effects of disability.* A disability can directly affect the capacity of individuals to protect themselves, to avoid or escape from victimization, and to seek help. Some disabilities also increase dependency on caregivers. These effects of disability in increasing risk are minimal for very young children (because all young children are extremely limited in these abilities), but they become increasingly important in older children and adults. In addition, some disabilities impair judgment. People with developmental or psychiatric disabilities often have difficulty identifying when to be compliant and when to assert themselves. As a result, they may be victimized both when they comply too easily and when their refusal to comply provokes retaliation.

*Socially mediated effects of disability.* People with disabilities are often taught unquestioning compliance but rarely taught assertiveness and choice making. In addition, Sobsey and Calder maintain that they are (a) rarely taught their human and civil rights, (b) frequently taught to respond in the same way to a large number of caregivers rather than distinguishing family members and others from strangers, (c) often denied appropriate sex education, (d) often taught passive communication strategies but few social control functions, and (e) often taught through physical prompting that does not allow for the development of an age-appropriate sense of personal space, which may be perceived

as vulnerability by sexual offenders. These teachings or omissions in education put individuals with disabilities at risks that are not inherent to the individual or the disability.

*Victim precipitation.* Victims sometimes exhibit behaviors that elicit violence on the part of the perpetrator. This does not mean, however, that the violence is justified by the behavior or that the violence was intended to be criminal. For instance, an individual with a developmental disability was beaten by police when he was mistaken for a robber who was resisting arrest because he did not communicate with the arresting officers (Bryant, 1998).

Persons with developmental disabilities may have difficulty recognizing situations in which danger exists and therefore may be less likely to take precautions. These victim-precipitation factors are likely to interact with offender disinhibitions, particularly when the atypical behavior associated with some disabilities requires caregiver intervention.

*Attractive victims.* Although perceived vulnerability is a factor in the selection of an individual with a developmental disability as a victim, vulnerability by itself is rarely, if ever, sufficient to motivate a crime. The potential victim must have something the offender wants or have the ability to produce an event the offender finds desirable. Motivating factors include the following:

1. Control over the victim: Many crimes against people with disabilities are related to coercion or punishment in an effort to gain control over the victim's behavior.
2. Sex: Sexual offenses against people with disabilities appear to be common. In some cases, offenders have a special sexual attraction to people with specific disabilities. Others may have a need to direct sexual aggression toward individuals they consider to be vulnerable.
3. Money: In some cases, people with disabilities may stand between offenders and a large amount of money. Caregivers of individuals with disabilities have been known to kill their charges to gain control of money left by parents for the ongoing care of their offspring; medical negligence or other court awards; insurance settlements; life insurance policies; social security benefits; and the like (see, e.g., Norton, 1994). More commonly, caregiver-offenders simply keep their vic-

tims alive in a state of fear and neglect while they continue to collect rent.

4. Few alternatives to exploitation: Victims of violence who have disabilities sometimes allow themselves to remain in risky situations or to be victimized because life offers them few alternatives. For example, an abusive caretaker may be retained because no one else can be found.

### **Offender-Related Factors**

In many instances, offenders target people with developmental disabilities because of their perception of them as vulnerable, their personality profile, or their lack of training in the care of individuals with disabilities. In addition, some offenders are themselves afflicted with a developmental disability. Specific offender-related factors in the victimization of people with developmental disabilities are discussed in the following sections.

*Perceived vulnerability.* The perception that disability increases vulnerability may add to the risk of victimization. Perceived vulnerability refers to the potential offender's estimation of a potential victim's vulnerability. It may be based in part on actual vulnerability or on a misperception of vulnerability. In either case, an attractive victim is one who appears vulnerable to the offender. Media portrayals of people with disabilities may add to this perception of vulnerability. Some movies portray persons with a vision, hearing, or other disability as helpless victims of predators.

*Profiles of offenders.* Some authors suggest that at least some offenders against people with developmental disabilities fit specific profiles. Sobsey (1994) outlines two basic profiles for caregiver offenders: predatory caregivers and corrupted caregivers. These profiles apply mainly to paid and volunteer caregivers. As noted previously, Sobsey and Doe (1991) analyzed 162 reports of sexual abuse involving victims with disabilities and found that 44% of all offenders against people with disabilities made initial contact with their victims through the web of special services provided to people with disabilities.

Predatory caregivers seek or maintain employment as caregivers to have access to victims. These individuals typically commit offenses with greater elements of planning and organization, although they may also commit impulsive offenses if their authority is threatened. Their offenses may include extreme physical or sexual violence or may be limited to simple harassment and degradation of the victim. The profile of many of these offenders is an individual with overwhelming feelings of inadequacy, lack of control over others, and an overwhelming need to assert control over others seen as vulnerable. For these offenders, control can take the form of bondage, torture, sexual assault, or a variety of other actions.

Corrupted caregivers typically do not plan to offend. Under some conditions, they may even be acceptable or exceptional caregivers. Lack of adequate training, supervision, or clear policy results in the development of abusive patterns of interaction by these individuals. At some point in their caregiving activities, most caregivers experience inappropriate feelings—anger or even sexual attraction toward a client. Most recognize that acting on those feelings is wrong, but some will cross the boundaries into offensive behavior. Often these offenders are corrupted gradually, in stages, but sometimes the deterioration is sudden—for instance, a resident with a disability slaps or spits at the caregiver and the caregiver explodes into a violent rage.

Of course, not all offenders are caregivers. Sometimes crimes against people with disabilities are committed by others with disabilities. Much of this can be explained by a lifestyles exposure model, that is, the clustering of people with disabilities into group living situations increases the exposure of potential victims with disabilities to potential offenders with disabilities. Two mechanisms may increase offensive behavior on the part of some people with disabilities. First, residents who have been abused by staff may go on to abuse other residents. Second, some disabilities result in damage to areas of the brain that control impulsive behavior, which can lead directly to lack of inhibition and a greater probability of offending.

### **Relationship Factors**

Many individuals with developmental disabilities must depend on caregivers to a greater extent than other individuals of a similar age.



This dependence on others may result in power inequities, and power inequities increase the possibility of abuse (Sobsey, 1994). In addition, people with disabilities may be exposed to a large number of caregivers because of the care requirements of the disability and the turnover in staff of service delivery systems. Exposure to large numbers of caregivers increases the risk that at least one will be abusive.

Healthy bonds with family members and other intimates provide a significant barrier to abuse and violence. Circumstances that commonly accompany disability can threaten or disrupt attachment and bonding. For instance, treatment of health problems may limit parent-child interactions. Moreover, parents are often implicitly and sometimes explicitly told that it is better not to get too attached to a child with a disability and that such a child will strain their marriage, career, happiness, and sanity. These negative expectations may interfere with parent-child bonding.

### **Environmental Factors**

Environmental factors can both lead to developmental disabilities and increase the risk of violence against those with disabilities. Sobsey and Calder (1999) noted the following examples of environmental factors:

1. Children born to mothers with severe substance abuse problems or who have endured spousal abuse during pregnancy are likely to be born with developmental disabilities. Children born into families in which violence was present before their birth are likely to be abused children.
2. Families of people with disabilities become isolated from their communities and extended families, which increases the risk of violence. Group homes and institutions can also be isolating.
3. Alternative living situations often cluster vulnerable individuals with those who are likely to abuse them without providing safeguards against victimization.
4. Foster care homes, group homes, and institutions have all been found to increase the risks of victimization compared with typical natural families.
5. Adults, adolescents, and even some children without disabilities have often been able to escape from abusive living alternatives by making other life choices. People with disabilities are often prevented from making such choices.

6. Disabilities affect routine activities and exposure to high-risk environments. Many people who have developmental disabilities do not drive and are therefore much more likely to rely on mass transportation, walking, or other ways to get where they need to go. A study analyzing patterns of the sexual abuse of children with disabilities and the sexual assault of adults with disabilities found that 5% of offenses were committed by specialized transportation providers and 10% of offenses took place in vehicles (Sobsey & Doe, 1991). In addition, people are often committed to institutional care because they are unable to look after themselves or they are dangerous to others. As a result, possible victims and prospective offenders are placed in close proximity with inadequate safeguards.

The Sobsey and Calder multifactorial model is the most sophisticated attempt to date to consider all of the factors thought to increase victimization risk of persons with disabilities. They conclude that more research is required to determine which of these—or other—mechanisms play a significant role in the victimization of people with disabilities.

### CRIMINAL JUSTICE SYSTEM RESPONSE

In approximately the last 25 years, American society has made significant advances in providing support to people with developmental disabilities in the efforts of these individuals to achieve fair treatment. Major societal institutions, including education, business, and medicine, have responded to create fairer and less discriminatory treatment for all people with disabilities. However, not all societal institutions have responded with the same speed or thoughtfulness. We can quibble about whether education or medicine responded more quickly to the societal need to end discrimination, or whether either institution has fully succeeded. But I don't think there is much question that of all societal institutions, the criminal justice system is the last to adequately respond to the special circumstances of people with developmental disabilities. This remains true whether the individual with a disability has been accused of committing a crime or is the victim of crime. For people with developmental disabilities, the criminal justice system is the last frontier of integration. (Luckasson, 1999, p. 1)

Being a victim of crime and coping with the criminal justice system (police questioning, appearances in court, etc.) is stressful for anyone, but particularly for victims with a cognitive or developmental disability. If they report the crime to law enforcement authorities, there will be repeated questioning by multiple persons and several trips to the court to participate in the cases' investigation and adjudication. Depending on the level and type of cognitive disability, the victim may have trouble understanding the nature of the crime, may not understand the ensuing court process, and may not be able to recall sufficient detail about the offense for the police or by the time of the court hearing. Recalling information, particularly detailed information, can often be difficult for people with disabilities. However, some victims with disabilities have good memories of events (e.g., persons with autism often have very good memories), but they may have difficulty putting these memories into words (Sanders, Creaton, Bird, & Weber, 1997).

Repeated questioning, which is commonly used both in investigation and in court proceedings, often badly affects people with disabilities. For instance, people with Down's syndrome often perceive repeated questioning as threatening and try to appease the questioner, thus undermining their credibility (Sanders et al., 1997). Many people with disabilities have low self-esteem and confidence and repeated questioning sometimes emphasizes their relative powerlessness and unimportance compared with those around them. The criminal justice procedures will cause stress, as it does for all victims, but for victims with disabilities, that stress might be harder to cope with. Increased stress will, in turn, have a deleterious effect on memory and communication.

There has been virtually no serious study of how people with cognitive disabilities are processed by, and participate in, the criminal justice system. In 1989, the President's Committee on Mental Retardation sponsored a forum on the criminal justice system and persons with mental retardation. The papers presented at that conference were subsequently published in an excellent book, *The Criminal Justice System and Mental Retardation* (Conley, Luckasson, & Bouthilet,

1992). However, just 1 of the 13 chapters focused on victims—the other chapters all discussed defendants.

#### REPORTING THE CRIME OR ABUSE

In some victimization studies, the investigators asked the victims whether they reported the incident to authorities. A study conducted in Australia indicated that 40% of crimes against people with mild and moderate mental retardation went unreported to the police, and 71% of crimes against people with more severe mental retardation went unreported (Wilson & Brewer, 1992). A study in Canada found that almost 75% of sexual abuse cases were not reported (Sobsey & Varnhagen, 1989). Another study found that just 3% of cases of sexual abuse involving people with developmental disabilities were reported to authorities (Tharinger, 1990).

Investigators have noted that people with disabilities are reluctant to report abuse for many of the same reasons that nondisabled persons do not report, including fear of retaliation, dependency, and shame (Roeher Institute, 1994). But, for children and adults with disabilities, they have additional difficulties because they are disabled. The literature suggests that people with disabilities may

1. feel ashamed or feel that they are somehow to blame;
2. be afraid because they are unsure of the consequences of reporting (they fear losing privileges or removal to a more restrictive setting);
3. be dependent financially, physically, and emotionally on the person who abuses them;
4. feel isolated and unaware that many other people with disabilities have experienced violence;
5. lack the physical and communication skills to report;
6. have difficulty telling on or challenging the actions of an authority figure, given the compliance and obedience instilled in people with disabilities (for a review, see Roeher Institute, 1994).

Another obstacle to reporting is the victim's fear of not being believed or taken seriously. According to several reports (Roeher Institute, 1994; Sanders et al., 1997), women with disabilities often have negative experiences with police officers, which make it unlikely they will pursue future contact with them. The reports suggest that

many of the attitudes, stereotypes, and myths held by the public concerning women with disabilities are also prevalent among members of the police force. Police believe victims with disabilities lack credibility and, in addition, the police themselves lack standardized protocols for handling complaints by victims with disabilities, so responses are often individualized by the first responder (Roehner Institute, 1994; Sanders et al., 1997).

If the crime or abuse is reported, police and judicial authorities may not be able to—or choose not to—act on it. Sobsey and Doe (1991) found that although the offender was known in 95% of the cases, only 22% of the alleged offenders were charged with committing a crime. Of those charged, 38% were convicted.

Some states have attempted to improve the rate of reporting by enacting legislation. For example, Connecticut passed legislation making it mandatory to report suspected abuse of adults with mental retardation. Although such laws can help educate others about victimization among people with developmental disabilities, they hold little power if attitudinal barriers are not addressed by building significant, ongoing collaborations among the systems involved. Educating law enforcement is particularly critical.

In a study of police officers' training on disability issues, McAfee and Musso (1995) found that the only disability receiving notable attention in police literature is mental illness. Their state-by-state analysis revealed that only four states had training on mental retardation, two states had training on developmental disabilities, and one included learning disabilities (McAfee & Musso, 1995). It is not surprising, then, that officers believe stereotypes about people with developmental disabilities as fact. Sobsey (1994) describes five areas that should be incorporated into the ideal police training on people with disabilities: attitude training, awareness of medical and legal needs, multidisciplinary teamwork (learning how to coordinate with other agency staff who work with this population), court orientation (recognizing the complexity involved in bringing a victim to court), and specialist versus generalist training, in which some officers are given more detailed training to act as consultants in cases involving people with disabilities.

The ARC (Association of Retarded Citizens) of the United States has created a curriculum entitled "Understanding Mental Retardation:

Training for Law Enforcement.” Designed to take about 3 hours, it includes a video, worksheets, and handouts. The training covers such areas as understanding and identifying people with mental retardation; understanding different mental retardation syndromes, including fetal alcohol syndrome, Fragile X, and Down’s syndrome; and understanding other disabilities, such as cerebral palsy, epilepsy, deafness, Tourette’s syndrome, and mental illness. In addition, the training helps to create greater police awareness of the high incidence of victimization among people with developmental disabilities by including a section on why they are more likely to be victimized.

#### PROSECUTION OF THE OFFENDER

The available evidence suggests that cases are seldom pursued when the victim is cognitively impaired because such persons are assumed to have difficulty serving as credible witnesses in court. Of course, this in turn affects their vulnerability to abuse in that perpetrators perceive them to be less able to report the abuse and therefore have little fear of retribution. Sorensen (2000) writes that he was giving a talk about violence against people with disabilities when one prosecutor from a Southern California district attorney’s office casually announced in a meeting that “we never prosecute sexual assaults against victims with disabilities because you can’t win them” (p. 27). He goes on to report that, fortunately, an Alameda county prosecutor immediately responded by stating that “we routinely prosecute such cases and we win most of them” (p. 27). The literature seems to confirm that criminal convictions can be won in cases in which the victim is cognitively disabled, but it takes specialized training and may involve additional investigative and prosecutorial resources (Coles, 1990; Rogers, 1999).

Lack of follow-up from the criminal justice system appears to revolve around the question of competency (Dinerstein, Herr, & O’Sullivan, 1999). People with mental retardation are often classified as “people of unsound mind” (Rule 601 of the Federal Rules of Evidence) and therefore deemed incompetent to provide reliable evidence as a witness. These rules reflect societal myths about mental retardation rather than empirical evidence. Empirical evidence suggests that long-term memory capacity is not associated with intelli-

gence levels (McCartney, 1987). Several studies have found that people with mental retardation forget at a rate that is similar to persons without retardation (Kail, 1990), yet some other research reports that memory deficits are serious in children with mental retardation (Henry & Gudjonsson, 1999). In their review of the relevant literature, Henry and Gudjonsson (1999) conclude,

These studies imply that children with mental retardation can be as accurate and complete in their recall as are children without mental retardation in response to some types of questions. They also imply that children with mental retardation are more suggestible than are peers of the same chronological age. (p. 493)

In a recent experiment, Henry and Gudjonsson (1999) staged a live scene in a classroom for 11- to 12-year-old children with mental retardation and then asked them questions a day later about what they had seen. The responses of these children were compared to children of a comparable age without mental retardation. The results showed that the level of free recall was not significantly lower for children with retardation, and they produced no less additional information in response to general questions. However, children with mental retardation were significantly more suggestible. Factors such as a greater eagerness to please the interviewer, a reduced confidence in their own memory of the event, and a reluctance to disagree with an adult could all be potential explanations for this effect. The authors of this study cautioned about the use of closed misleading questions. Similar results were found in a controlled study by Perlman, Ericson, Esses, and Isaacs (1994).

A person with mental retardation usually receives no special accommodations in court to assist with testimony. There are usually no advocates, no specially trained police, and no use of videotaped or closed-circuit television to substitute for live testimony. Special considerations are mandated in some countries, but they are not in the United States. England, for example, requires the presence of a legal advocate during police questioning of a person with an intellectual impairment. This person is usually someone close to the victim who will help the victim to understand what is being asked during the investigation. Scottish courts have the option to clear the court of spec-

tators when an adult gives evidence in rape cases, and they do so frequently when the victim is disabled. Procedures such as these are now commonplace in the United States with respect to the testimony of children, but they do not apply to adults with disabilities. Many argue that special procedures now in place for handling the reporting and prosecution of child abuse should apply to these cases as well. Rogers (1999) urges prosecutors to argue that "child friendly" statutes, normally triggered by chronological age, should also be triggered by mental age. "Child friendly" statutes include having a closed courtroom during victim testimony, using anatomical dolls, limiting the length of testimony and cross examination, allowing support persons to be present, and preventing undue harassment and accelerated court scheduling.

In 1998, the California legislature amended penal code sections 1346 and 1347.5 to provide alternative methods of presenting testimony of people with cognitive disabilities who are witnesses or victims of violent and/or sexual crimes. Alternative formats include the use of videotaped testimony as well as closed-circuit television. There are also provisions to

1. allow the witness reasonable periods of relief from examination/cross-examination, during which he or she may retire from the courtroom;
2. allow the presence of a support person or a regional center representative. The court may also allow the use of a person necessary to facilitate the communication or physical needs of individuals with developmental disabilities;
3. allow the judge to remove his or her robe if the judge believes that this formal attire prevents the full participation of the witness with a disability because it is intimidating;
4. allow the judges, witnesses, support persons, and court personnel to be relocated within the courtroom to facilitate a more comfortable and personal environment for the person with a disability, as well as accommodate any specific requirements for communication by that person.

When criminal convictions do occur, sentences for crimes committed against people with disabilities are often lighter, particularly for sexual assault (Laski, 1992). A number of possible explanations account for this: the difficulty of investigating these cases, the lack of



special training required for these cases among the police, and the negative stereotypes held toward this population. Some believe that because victims with disabilities may not fully understand what is happening to them, they suffer less. Offenders who have victimized people with disabilities rationalize their behavior by suggesting that the victims did not experience pain and suffering. Of course, this is absurd. Research shows that people with all kinds of disabilities suffer just as much emotional trauma and psychological injury as other victims, yet victim service programs are basically unavailable to them (Baladerian, 1991).

#### VICTIM RECOVERY AND ASSISTANCE

Victimization may affect people with developmental disabilities at least as powerfully as the rest of the population and perhaps more so. Because of a lack of preparation, information, education, and support, it is likely that assaults may be more terrifying and may cause them greater levels of distrust, depression, anxiety, and other well-recognized responses to trauma. According to Baladerian (1999), the personal impact of maltreatment for a child or adult crime victim may depend on any of several important factors: the role of the perpetrator vis-à-vis the victim, the number of attacks, the response of the family and others to warning of the attack, and the time and choice for future activities allowed the victim. Because the perpetrator is most likely to be someone in a position of trust, or perhaps of love, with the victim with a disability, the closer the relationship, the more devastating the impact of the abuse.

Both in child abuse and sexual assault, the response of others on learning of the assault has been identified as a critical factor in healing the victim. When the family and others close to the victim have a negative reaction, blame the victim, do not want to ever talk about what happened, do not believe that it happened, or protect the perpetrator, the results are psychologically devastating and set up a poor prognosis for the victim's ability to heal from the trauma. How the case is handled by the law enforcement agencies also has a powerful impact on the victim.

Psychological treatment and psychiatric treatment are important to the healing process for any victim, according to Baladerian (1999),

and thus for the crime victim with a disability. In many cases, no qualified practitioner is available for either individual or group treatment for victims with disabilities. Involvement of the family members in the treatment is a critical aspect to working with crime victims with developmental disabilities. Baladerian (1999) indicated that very few mental health practitioners demonstrate an interest in treating crime victims with a disability and that an exploration into motivating interest in such treatment is needed.

Why mental health providers do not acquire training in this specialty may be a function of the general societal lack of interest in people with disabilities, Baladerian noted. Most people agree that the majority of people involved with disability issues, regardless of the field of endeavor, have taken an interest because of a personal experience. Psychologists or other mental health practitioners who graduate from any college today are likely to have received 1 hour or less of training on treating people with disabilities.

Victims' assistance programs pay for psychological counseling for crime victims in every state. Approximately 10% of crime victims request psychological assistance through this program (Baladerian, 1999). It may be that potential mental health clients are never informed of this option by law enforcement officials, who are responsible for informing each crime victim of this program. Information on use by people with a developmental disability is unknown. Because few crime victims access the Victims of Crime Program, the pattern of underuse by people with developmental disabilities is likely to continue.

Specialized services for victims with disabilities, or generic services that include people with disabilities, are provided by a number of organizations, yet no data exist on either the presence of programs or use of rape treatment centers, national advocacy centers, or government-sponsored child abuse counseling programs. Vertical prosecution units—in which a single prosecutor handles the case from filing through sentencing hearing—would be enormously supportive to people with disabilities, noted Baladerian, but these are few and far between. Anecdotal evidence from such units suggest they result in an increase in convictions in crimes against people with disabilities.

There are thousands of rape crisis centers and domestic violence shelters across the country, yet very few can accommodate the needs

of women with developmental disabilities or mental retardation. This is definitely problematic because it can be more difficult for women with developmental disabilities to leave abusive relationships, then find and obtain services.

Project Action is a program of the Seattle Rape Relief, Advocacy, and Education that addresses sexual assault among people with disabilities. The mission of Project Action is to challenge the myth that people with disabilities are asexual, incompetent, and dependent. These myths are replaced with information and actions that support the empowerment and rights of people with disabilities. Project services include in-service professional training, case consultation, and resource referral, as well as access to direct services for people who have been victimized. The main focus is currently on providing community education to care providers because of the high demand for such programs. The training programs are presented in group homes and are tailored to the needs of each. Project Action services about 500 to 600 care providers a year across the state of Washington.

Many people have been doing what they can in their own communities with meager funding and community support. If this effort can grow into wide support and excellent funding, the experience of individuals with disabilities who become crime victims will change radically. Furthermore, if educational Risk Reduction Programs are instituted, it is possible that families and individuals can resist and report assaults better. Finally, with funding of programs, the interest of mental health practitioners may grow so that communities can serve all members of the public—not just those who do not have disabilities.

## CONCLUSION

As this review shows, very little research exists on victims with disabilities, so that the current state of knowledge is seriously inadequate. Simple changes to standard intake forms, police reports, and other data collection instruments would enable researchers and others to document the extent to which these problems occur. We need to better understand the various risk factors that are associated with victimization and criminal offending. We specifically want to understand more about the personal and developmental characteristics of victims and

perpetrators, the situational context and setting in which the crime took place, and the impact (e.g., physical, psychological) on both victims and perpetrators. We also need to know the extent to which crimes of different types get reported; who they get reported to; how the judicial system handles the report; what barriers exist to effective identification, prosecution, and sentencing of offenders; and how those barriers can be overcome. Finally, we need to develop and evaluate programs to prevent victimization and assist those who are victimized to cope with the effects of victimization.

Victims with cognitive disabilities are truly invisible, often being unable to advocate on their own behalf for services and equal justice. With better information, the issue should become more visible to the public, policy makers, and those who can fund training and education programs.

In many ways, the movement to address the justice system's treatment of people with developmental disabilities is very similar to that which has occurred over the past 20 years with other specialized populations, such as battered wives, elders, and people with AIDS. Those who work in these areas argue for greater awareness, victim advocacy and education, special accommodations in court, and data collection and research. In each of these areas, tremendous progress has been made, and similar progress will likely be made with respect to persons living with disabilities.

Yet, even more so than with these other victim groups, persons who have developmental disabilities have virtually no ability to organize and advocate on their own behalf without our help. They do not possess the financial, verbal, or organizational skills that would be necessary to launch such a campaign. Therefore, the onus of responsibility on those of us having these capabilities to work to "end the silence" of victims and defendants with developmental disabilities seems ever more pressing.

## NOTES

1. Descriptions of each of these projects are available at <http://www.acf.dhhs.gov/programs/add/pns02.htm> (accessed November 27, 2000).

2. The Bureau of Justice Statistics (BJS) is responsible for establishing this data collection program, and their activities are described in Chaiken (2000).

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