Sexual Abuse and Safety of Persons with Disabilities

This issue of The Voice® is written by SNA member Kristen Lewis and Emma Barry of Bowden Law Firm in Atlanta, GA. The firm specializes in special needs and disability estate planning, trust and wealth transfer planning and administration, guardianship and conservatorship planning, and charitable gift planning.

June 2023 - Vol. 17, Issue 6

The sexual abuse of persons with disabilities remains largely unrecognized, unprosecuted, and unpunished, and there is little awareness of this shocking crime. For many parents or guardians of individuals with disabilities, whether minors or adults, it is almost inconceivable that sexual abuse regularly occurs in places which are supposed to be safe environments, such as schools. Easier to comprehend is the idea that their loved one could wander outside of these "safe" venues and be victimized by a total stranger.

There is no absolutely safe environment for children or adults with disabilities; even family members, and others who are part of their support teams, perpetrate sexual abuse. Only 3% of the perpetrators of sexual abuse of persons with disabilities are ever prosecuted and convicted, leaving the other 97% to continue abusing. Criminal background checks reflect only convictions, simple arrests, or complaints.

The potential perpetrators of sexual abuse include family members, in-home direct care workers, day program staff, workplace staff, educators and other school staff, medical personnel, transportation providers, and *any other person* who has contact with people who have disabilities.

Perpetrators of sexual abuse can also include individuals who have disabilities ("peer-to-peer" abuse), many of whom have suffered sexual abuse themselves, often having concealed it, and who then inflict the same sexually abusive behavior on others and thus perpetuating it. Many do not believe their behavior is harmful to their victims.

What Should Guardians and Families Know About Abusers?

Sexual abusers may use one or more of the following tactics:

- Often intentionally avoid inflicting observable physical bodily injury, which delays the discovery of abusive behavior.

- Make victims feel complicit in the abusive behavior, leading to feelings of guilt and responsibility and fear of being punished by parents or guardians.
- Threaten violence against the victim's family members and pets if the abuse is reported.
- Try to convince the victim that no one will believe the victim if the abuse is reported.
- Try to convince the victim that sexually abusive behavior is normal and acceptable. The actions of perpetrators typically unfold on a continuum, starting with benign social touching and escalating to sexually abusive touching, and even rape, once the victim's trust has been cultivated. By then, the victim may not recognize the behavior as sexual or abusive.
- Prefer victims who are not "abuse aware" and who do not have a plan to identify, survive, and report the abuse.
- Commit sexual abuse in any of the following venues:
    - public and private schools and colleges,
    - day programs,
    - private single-family homes, group homes, and private high-end residential communities for persons with disabilities,
    - churches and other houses of worship,
    - day camps and overnight camps,
    - scouting facilities,
    - hospitals, nursing homes, mental health facilities, doctor's offices; and
    - vehicles used to transport victims to these venues.

Many young persons with disabilities receive minimal, if any, school-based instruction regarding sexual health and safety, including how to recognize sexual abuse, how to minimize the risk of sexual abuse, and how to respond if such abuse should occur. Moreover, even if there has been instruction on those topics, abstract sexual safety concepts, such as "good touch/bad touch" or "circles of intimacy," are often not sufficient to help someone with special needs know how to respond to the risk of sexual abuse in real life situations, or when the abuse unfolds in real time.

Experts in the fields of sexual health and safety urge the importance of teaching the proper names and functions of sexual body parts in order to increase a person's comfort level

when discussing the topic. If a sexual assault does occur, the person with a disability could then have the correct vocabulary to use if able to communicate about the assault. Ideally, those in the support network of a person with a disability should have appropriate, periodic discussions about sexual health and safety as an ongoing dialogue, rather than trying to tackle such sensitive issues in one or two conversations about "the birds and the bees."

Many persons with disabilities require direct care for activities such as dressing, bathing, and toileting, which increases their risk of someone taking advantage of this vulnerability and the increased access to sexual body parts. Ways to mitigate such abuse include:

- the use of a monitor in the person's room;
- teaching the person to use a medical alert button;
- use of hidden and unhidden cameras (the existence of which is discussed in advance with the direct care professionals);
- and a policy that a parent or other caregiver will randomly check on the care being provided without prior advance notice.

As parents and other caregivers assemble a team of direct care professionals to support the person with a disability, they must ensure that team members are individuals of integrity who will respect physical boundaries. Before employing any member of the support team, parents and other caregivers should discuss that any violation of such boundaries will result in the immediate termination of their employment and possible criminal prosecution.

What Are the Signs of Sexual Abuse?

The signs of sexual abuse are so subtle that the victim may be re-victimized many times before the abuse is suspected and discovered. Changes in a victim's behavior, habits, and demeanor are often wrongly attributed to benign causes. Cues as to the existence of sexual abuse include the following:

- Behavioral changes, such as becoming overly modest or suddenly promiscuous; being overly focused about one's body; and manifesting inappropriate new sexual behaviors.
- Selective mutism or other changes in prior communication abilities, changes in eating and sleeping habits, changes in dressing skills and preferences, and regression in other skills previously mastered.
- Asking questions about sex and pregnancy "out of the blue," commencing self-injurious behaviors (e.g., cutting), attempting suicide, acting abusively towards

others, destroying property, refusing to leave home, or insisting on sleeping with parents (or other "safe" family members) at night.

- Physical changes, such as genital pain and itching, unusual discharge or bleeding, stomach aches and headaches, changes in monthly menstruation, diarrhea or constipation, weight loss or gain, symptoms of sexually transmitted diseases, and burning or pain with urination or defecation.
- Psychological changes, such as sleep disturbances, bed-wetting, new fears or phobias, difficulties interacting with peers, excessive crying, depression, clinginess, aggression, running away, drug or alcohol use, isolation, moodiness, general social anxiety, irritability or anger, and a pronounced inability to concentrate or focus.

The absence of behavioral, physical, or psychological changes does not necessarily indicate the absence of sexual abuse, especially if the perpetrator has groomed the victim so successfully that the victim remains comfortable with the perpetrator's presence and actions. Importantly, if a sexual assault has occurred, traditional psychotherapy is often insufficient for victims with developmental disabilities, and more specialized therapy is often needed.

Parents and other caregivers are also advised to teach their loved ones about sexual health and safety in order to prevent their loved one from becoming a perpetrator of sexual abuse against others. If no one explains the "rules of sex," a person with a disability will not know what behavior is permissible. Such an untaught person may become aware of a legal or social rule only when he or she unknowingly breaks the rule and faces the consequences of violation.

Moreover, people with disabilities need a strong foundation in healthy sexuality and relationships so they can recognize and articulate their own sexual desires and preferences and determine which sexual expressions are not appropriate for them. Many persons with disabilities have consensual sexual relationships and raise children of their own, so maintaining sexual health is paramount in those relationships.

To maintain one's sexual health, it is vital that a person with a disability receive regular physical examinations of their sexual body parts and reproductive system. Such examinations are a cornerstone of maintaining overall health and often lead to the discovery of physical evidence of sexual abuse. However, it can be challenging to find a healthcare provider with appropriately modified examination equipment who is also sensitive to the person's cognitive special needs.

Although it is not possible to completely eradicate the risk of sexual abuse, if the person with a disability and their support team can formulate a plan to (i) minimize the risk of

abuse before it happens, (ii) help the victim report any abuse, and (iii) help the victim survive any abuse that does occur and secure appropriate follow-up psychological and physical healing and counseling, then the person with the disability can become better empowered and equipped to combat sexual predators.
