



Opinion

Volume 2 Issue 1 - July 2017

DOI: 10.19080/GJIDD.2017.02.555578

Glob J Intellect Dev Disabil

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# Violence against Women with Intellectual Disability: A Quest for Specific Sexual Violence Prevention Education in Tandem



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**Submission:** July 05, 2017; **Published:** August 25, 2017

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## Abstract

This paper examines the important issue of sexual violence against women with intellectual disability. It is well known that women with Intellectual Disability (ID) are disproportionately vulnerable to sexual exploitation and violence victimisation. What seems particularly concerning, is that despite some sexual violence programs already existing for women with ID, they do not seem to be broadly implemented and evaluated. We argue that sexual violence prevention programs should be offered in community settings, not only for women with ID but also healthcare workers. This, we expect, will result in further research and interagency collaboration, and eventually lead to reducing future sexual victimisation of women with ID.

**Keywords:** Disability; Exploitation; Prevention; Program evaluation; Sexual; Violence; Victimisation; Women

## Introduction

Violence against women, which includes harassment in the workplace [1], and intimate partner violence [2] is a pervasive problem and has been identified as an important public health and criminal justice issue [2]. Part of this violence is sexual victimisation, which disproportionately affects women in the general community. The incidence and prevalence of sexual assault on women is difficult to establish. However, it is widely acknowledged, that women with Intellectual Disability (ID) are disproportionately affected when compared to women with no ID [3,4]. The Diagnostic and Statistical Manual of Mental Disorders DSM-5 [5] defined intellectual disability as being on a continuum from 'mild' to 'profound' in severity level, having different features including impaired cognitive functioning (Criterion A), impaired daily functioning (Criterion B), and onset during development (Criterion C). This means, that a person with ID has lower (below 70) intellectual performance on an IQ test than someone with no ID. Often, interpersonal communication skills are impaired, which may create specific vulnerabilities in relation to sexual victimisation. This paper briefly discusses reasons for women with ID being disproportionately vulnerable for sexual victimisation. Then it examines the need for specific sexual

violence prevention programs. Following this, some existing programs are introduced. Finally, a discussion is provided on why health care workers require training themselves to assist and counter shortcomings of prevention programs for women with ID. The paper concludes with recommendations that community-based sexual violence prevention programs should be offered for women with ID as well as to health care workers in a 'tandem approach' to address shortcomings identified in the literature when programs are offered to women with ID alone.

## Specific vulnerability to sexual victimisation

A number of specific issues in relation to women with ID have been identified in the literature. They are even more vulnerable to sexual violence than women without ID [3]. This vulnerability is related to learned helplessness and dependence [7]. Being taught to be passive, cooperative and compliant due to the need of assistance may lead to a lack of assertiveness and a general inability to identify inappropriate behaviours. Women with ID are often dependent on those who abuse them not only emotionally, physically and sexually, but also economically. This may lead to feelings of helplessness.

Women with ID are easy targets, given that they are often financially and emotionally dependent on carers in a private space [8]. Therefore, it is unsurprising that women with ID are at a higher risk of sexual violence when compared to women with physical disabilities [3]. For example, lack of adaptive functioning skills such as adaptive reasoning, interpersonal competence and impaired understanding were issues identified as contributing to ongoing sexual victimisation by an intimate partner [9] which may exacerbate a sense of entrapment, particularly because women with ID have been found to lack sexual knowledge and understanding [9]. This is likely to prevent them from identifying abuse situations and having the assertiveness skills to reach out and seek help.

## Women with ID are sexual beings

Social myths seem to persist indicating a belief that women with ID are passive, child-like and non-sexual beings [3]. However, such misconceptions have severe negative impacts on women with ID. For example, Johnson et al. [11] reported that women with ID tend to lead secret sexual lives because of perceived social norms and a desire to comply with sexual expectations. This means that women with ID face the challenge of identifying inappropriate sexual encounters, and developing the courage to reach out. In this regard, it is fair to argue that intervention efforts should focus on providing women with ID with appropriate sexuality education and prevention training. Furthermore, healthcare workers require specific training themselves, which will likely challenge social misconceptions about women with ID and their sexuality. In the following, we discuss sexual violence prevention programs for women with ID and results of evaluation research. Then, we focus on the important role of healthcare workers to address identified limitations of sexual violence prevention programs for women with ID alone.

## Sexual violence prevention programs for women with ID

Due to the severe impact of sexual violence, specific prevention programs have been developed. However, they seem to have limited positive impact, particularly in relation to women with ID [3]. As noted above, women with ID are at a higher risk of sexual victimisation than women with no ID. However, they tend to be less likely to receive specific education in sexual violence prevention including healthy relationships, appropriate touching and consent and sexual violence legislation [9].

Together with other scholars, we argue that women with ID are particularly in need to receive sexual education and assertiveness training to reduce their vulnerability to sexual violence [3,9]. This would counter socialisation of compliance and passiveness. If children as small as three years of age can benefit from sexual violence prevention programs see for example, Deblinger et al. [6] and Kenny et al. [10] training specifically for women (and girls) with ID should be provided with specific provisions to their needs.

There are already sexual violence prevention programs that were specifically developed for women with ID. For example, the 'Living Safe Lives' program [11] is an intervention that assists in decision-making competence in relation to intimate partner relationships with the aim to prevent sexual violence victimisation. The intervention is a 6-week program that was piloted with 38 women with ID and included general sexual education, assertiveness training and decision-making strategies.

Another program focused on young women with ID [12]. The Friendship and Dating Program (FDP) teaches healthy relationships and focuses on social skills development in participants. In addition, Hickson et al. [13] developed the ESCAPE-DD skills program for women with ID using an experimental research design, which built on previous programs Khemka et al. [14]. The program focuses on the development of appropriate decision-making skills using hypothetical vignettes and case scenarios of violence events.

Despite the innovative design of these programs and the rigour applied in their development, they have limitations. Effectiveness was found to be limited as it remains unknown whether or not the programs actually reduce sexual violence victimisation by trusted people such as carers and/or intimate partners. For example, participants seemed to struggle with concepts of sexual consent and appeared to be unable to accurately define sexual consent even after participation in the program Hickson et al. [13].

In this regard, healthcare workers play an important role in sexual violence prevention, particularly because women should be not left alone in the quest for sexual violence prevention [15]. Healthcare professionals, however, seem to lack appropriate knowledge and skills to discuss sexuality issues with their patients [16], which suggests that specific sexual violence prevention training should be offered to health care professionals in addition to women with ID.

## Sexual violence prevention training for health professionals

Lack of training in sexuality has been found to cause healthcare workers to feel uncomfortable in accepting the sexuality of women with ID, which leads to difficulty in discussing topics of a sexual nature [17,18]. Furthermore, given that sexual violence prevention is not only a women's issue [15], healthcare workers require specific knowledge of sexual violence to assist their clients [19,20] and understand their victim behaviour. If healthcare workers are denied specific training, this may result in them failing to detect signs of sexual violence, in particular when women are unwilling or unable to disclose their victimisation but there are clear indications [20].

Therefore, to aid women with ID in avoiding being sexually exploited and assaulted, it is important to include healthcare workers in the prevention efforts. Healthcare professionals should be offered specific sexuality training. This will likely allow them to feel more comfortable discussing issues of sexuality

with women with ID and increase awareness of signs of sexual violence along with appropriate responses.

## Conclusion

This paper examined the disturbing issue of sexual violence in the general community. It indicated that women with ID are disproportionately at risk of sexual victimisation given their unique vulnerability. Healthcare workers who work with women with ID need to have specific training on sexuality to feel comfortable discussing topics of a sexual nature as well as in detecting signs of sexual violence.

Given that specific sexual violence prevention programs for women with ID already exist, there is a need for rigorous longer-term evaluation to determine effectiveness. Such evaluative work would also allow identification of the mechanisms that best promote safe sexual relationships. The programs described in this paper seem promising and appear feasible to be used in community settings with attached evaluation designs. Clearly, focus of attention should be on prevention of sexual victimisation of those most at risk, namely, women with ID. We hope that knowledge about these programs will inspire implementation more broadly and generate research interest.

A distinct need for further implementation and evaluation of sexual violence prevention programs for women with ID should be complemented with training for healthcare workers. Consequently, we recommend that not only sexual violence prevention programs for women with ID be broadly implemented in community setting, but that this should be undertaken in tandem training for healthcare workers. We would like to encourage community organisations to implement sexual violence prevention programs with attached formative and outcome evaluation. This may be an important first step to achieve a systematic interagency collaboration for the benefit of some of the most vulnerable populations in contemporary society.

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DOI: [10.19080/GJIDD.2017.02.555578](https://doi.org/10.19080/GJIDD.2017.02.555578)

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